



THE EMPIRE OF TRAUMA

An Inquiry into the Condition of Victimhood

DIDIER
FASSIN
&
RICHARD
RECHTMAN

The Empire of Trauma

AN INQUIRY INTO THE
CONDITION OF VICTIMHOOD

*Didier Fassin and
Richard Rechtman*

Translated by Rachel Gomme

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For Anne-Claire and Vannina

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A New Language of the Event

IN THE DAYS FOLLOWING the attacks on the World Trade Center in New York on September 11, 2001, an estimated nine thousand mental health specialists, including seven hundred psychiatrists, intervened to offer psychological support to survivors, witnesses, and local residents.¹ One month later, a New York Academy of Medicine survey of one thousand people living in southern Manhattan revealed 7.5% of respondents suffering from post-traumatic stress and 9.7% from depression, an increase in the consumption of psychotropic drugs and alcohol, and an unusually high level of recourse to mental health services. But these phenomena were observed mainly in the white university-educated population.² Soon afterward another survey, of a larger sample representative of the US population as a whole, showed 4% of Americans suffering from post-traumatic stress—which, it emerged, was the same percentage as would be statistically predicted in the general US population, regardless of the events in New York. In other words, there appeared to be a sort of background level of trauma that was not greatly altered by the attacks. However, the proportion was higher among those who had had prolonged exposure to television coverage of the attacks on the Twin Towers.³ During this period a number of professional Web sites were set up or modified to respond to the demand for psychological support. Some three years after the attacks, an electronic search using the keywords “September 11” and “trauma” produced nearly 1.5 million results on the Web.⁴ The US

¹ See the article by Richard Gist and Grant Devilly in *The Lancet* (2002) and that by Matthew Dougherty on the Columbia University Health Sciences’ Web site (<http://www.cumc.columbia.edu/news/in-vivo>, accessed April 25, 2005).

² Sandro Galea et al. (2002) and Joseph Boscarino et al. (2004). In the *New England Journal of Medicine*, Galea et al. note, “Posttraumatic stress disorder and depression are the two most commonly studied mental health problems after trauma and disasters.” In *Psychiatric Services*, Boscarino et al. remark that “the racial and ethnic disparities in post-disaster mental health service use that we found were surprising, because free counselling services were available in New York City after the attack.” They note that African-American and Hispanic respondents to their survey had consulted mental health services only half as often as white respondents, even when they exhibited signs of post-traumatic stress.

³ W. E. Schlenger et al. (2002). While the figures for the population of New York were higher than the national average, paradoxically those for Washington DC were lower.

⁴ A Google search using keywords “trauma” and “September 11” made on April 25, 2005, yielded 1,470,000 results. The results included <http://www.traumaresponse.org> (with

Preface to the English Edition

TRAUMA HAS BECOME A MAJOR SIGNIFIER OF OUR AGE. It is our normal means of relating present suffering to past violence. It is the scar that a tragic event leaves on an individual victim or on a witness—sometimes even on the perpetrator. It is also the collective imprint on a group of a historical experience that may have occurred decades, generations, or even centuries ago. Today we talk of rape and genocide, of torture and slavery, of terrorist attacks and natural disasters in the same language, both clinical and metaphorical, of trauma: one signifier for a plurality of ills signified. However, when considering this semantic field, we tend often to minimize two important elements. First, we forget that the notion we take so much for granted—that a person exposed to violence may become traumatized and so be recognized as a victim—is in fact quite a recent idea. Second, the understandable pathos attached to the violent events that cause trauma leads us to ignore the fact that social agents are not passive recipients of the label “traumatized.” This is what this book is about: the historical construction and the political uses of trauma.

Our conversations with colleagues in the fields of social science and mental health, both in America and Europe, made us realize how deeply entrenched the concept of trauma is in our intellectual and emotional world. However, it is rarely called into question—either as a category of intelligibility or as an object of compassion. Questioning it in terms of its social construction and the uses to which it is put may even be seen as a form of post-modern relativism or misplaced cynicism. It is to challenge this taken-for-granted aspect of trauma that we committed ourselves to this inquiry into the contemporary condition of the victim. But we did it precisely because we profoundly believe in the historicity of common sense and in the political competence of individuals. It is not because we wished to discredit the well-founded work of psychiatrists and psychologists or to deny the reality of suffering that we undertook this long investigation into the archives of trauma and the scenes of victimhood. On the contrary, we take seriously all the actors who occupy society's stage. Hence, the reader will not find here either moral judgments on the trivialization of trauma or indignant denunciation of a society of victims, the kinds of criticisms that have become so common, especially in France. We are interested in the politics of reparation, of testimony, and of proof that trauma made possible and in their appropriation and diversion by the so-called victims. We are interested in the birth and deployment of psychiat-

ric victimology, humanitarian psychiatry, and the psychotraumatology of exile in Toulouse, in the Palestinian territories, and in the French organizations defending asylum seekers, respectively. In other words, it is the social history of trauma rather than the oft-told tale of its intellectual trajectory that we try to grasp—a social history that we will carry into the early twenty-first century.

This work of denaturalizing trauma and repoliticizing victims is based on fieldwork carried out in France and in the spheres of French organizations abroad. And certainly this specific French context is reflected in our discussion of a number of topics: traumatic neurosis after World War I, the reception of the DSM and the suspicion towards PTSD, the work of the French medical and psychological emergency units, the exportation of psychiatry by French doctors, and the resistance of NGOs to the exploitation of psychological certificates for refugees. In this sense, the book may be seen as a contribution to the historiography and ethnography of trauma in France. However, we are convinced that the phenomena we analyze are revealing of changes that extend beyond the French context, that belong to the wider, international world of concepts, affects, and values. The moral genealogy of trauma that we trace as a counterpoint to its more classical scientific genealogy, as well as the social problematizations of the condition of victim that we describe, have a global validity. From this perspective, we think of our inquiry as part of a political and moral anthropology of contemporary societies.

D.F. and R.R.

Paris, December 2008

political establishment was also quick to seize on the attacks—not only, as has been widely noted, to reinforce its international authority through a security structure set up by George W. Bush and Secretary of State Donald Rumsfeld, but also for the less widely remarked purpose of establishing its legitimacy within the United States, founded on its expression of empathy and reassurance. When, in December 2002, the Foundation for Psychocultural Research organized a major conference on post-traumatic stress disorder (PTSD) in Los Angeles, it naturally turned to Rudolph Giuliani, the former mayor of New York who was acclaimed for his management of the crisis, to give the opening address.⁵ Thus, psychologists treating victims of the tragedy and epidemiologists gathering statistics on its psychological consequences, Web designers and politicians were all coming to a similar conclusion: both survivors and witnesses, but also television viewers and residents of the United States in general were suffering from exposure to a traumatic event, the effects of which were to be dealt with mainly by psychiatric care.

Of all the possible consequences of the attacks on individuals—aside, of course, from the thousands who died—it is thus the psychological impact that emerges as the clearest, most lasting, and most incontrovertible: after the mourning, the trauma remains. The term “trauma” should, moreover, be understood here both in the restricted sense in which it is used in the mental health field (the traces left in the psyche) and in its more widespread, popular usage (an open wound in the collective memory), for the trauma affects both New Yorkers and the United States as a whole, both individuals and a nation. From the literal sense in which the term is used by psychiatrists (a psychological shock) to its metaphorical extension disseminated by the media (a tragic event)—and it is worth noting that discourse often shifts from one meaning to the other within the same passage, without particularly marking the distinction—the idea of trauma is thus becoming established as a commonplace of the contemporary world, a shared truth. No one thinks to question whether residents of Manhattan, or even a large proportion of US citizens, are psychologically affected and thus in need of specialist care. No one expresses surprise at the huge number of psychologists and psychiatrists present at the scene

“The 9/11 Trauma Response Database”) and <http://www.psychologistshelp.org> (which gave advice on its “Coping with 9/11” page).

⁵ The Post-Traumatic Stress Disorder Conference, UCLA, December 12–15, 2002. In the conference program the organizers write, “This conference addresses the profound effects of traumatic experiences, which persist long after the horrifying events themselves. The tragedy of September 11, 2001, testifies to this and underscores the importance of understanding the ways in which trauma shapes and is shaped by our culture and biology.” Justifying the presence of their guest of honor, they add, “On September 11, 2001, Mayor Giuliani brought strength and stability to the citizens of New York at a time of great trauma.”

of tragedy. This reading of the events is universally accepted. Faced with the violence of the facts, or even that of the television images of them, it seems so natural to invoke the notion of trauma that society's response of providing therapy appears to signal progress, both in our knowledge of the reality lived by those directly or indirectly exposed to the events and in the care offered by society and its representatives.

The reaction to the attacks on the World Trade Center was unique in its level of confidence in the reality of trauma, but it illustrates a generalized social phenomenon. In France, after the plane crash at Sharm el-Sheikh on December 3, 2004, during the hurried return of French citizens from the Ivory Coast on November 8, 2004, following the collapse of the Roissy air terminal on May 23, 2004, and upon the return of survivors of the South Asian tsunami on December 26, 2004,⁶ emergency aid and psychological support facilities were put in place. In specially installed cubicles, psychiatrists and psychologists offered "debriefing" or emergency preventive counseling to those directly affected and to their families waiting at the airport.⁷ Similarly, when the Somme River flooded in the spring of 2001 and in the Gard region in the fall of 2002, during hostage-takings in a shopping center in Cergy in 2001 and at a primary school in Clichy in 2005, following the suicide of a classmate or even the appearance of graffiti insulting teachers in Seine-Saint-Denis, medical and psychological emergency units responded, with experts in psychotraumatology working alongside their resuscitation-specialist and paramedic colleagues in the ambulance service. These are mental health professionals, trained in crisis management, who carry out on-the-spot "defusing" procedures for victims and witnesses, pupils and teachers.⁸ Similarly, in other countries, teams of psychiatrists and psychologists belonging to Médecins du monde (Doctors of the World, MDM) and Médecins sans frontières (Doctors without Borders, MSF) go to the aid of distant peoples ravaged by natural disasters, wars, or other calamities—survivors of earthquakes in Armenia and Iran, people who have lived through conflict in Bosnia and Chechnya, street children in China, and Romanian orphans.⁹ Psychological disturbance on the battlefield has become a serious

⁶ After a long delay, the French Department of Victims' Rights published a booklet for survivors of the tsunami, the introduction to which includes a note warning of the possible psychological effects of the event and gives a list of contacts for specialist services.

⁷ For an account of the "debriefing" technique, see the articles by François Lebigot (1998) and Lionel Bailly (2003).

⁸ For an account of the "defusing" procedure, see articles by Louis Crocq et al. (1998) and François Ducrocq et al. (1999).

⁹ The two organizations' humanitarian psychiatry programs are covered in their respective journals: *Médecins sans frontières. Medical News* (Psychiatry special) 7, no. 2 (1998), and *Médecins du monde. Journal destiné aux donateurs*, "The Wounds of the Soul," 56 (1999).

issue for military commands, initially as it affects the troops themselves (witness the “Gulf syndrome” affecting soldiers involved in the 1991 conflict in Iraq) and then also in relation to civilian populations (for example during the second conflict in 2003). Following the first Gulf War, US\$250 million was spent on hundreds of programs aimed at identifying the causes of mysterious symptoms presented by US veterans; however, in the absence of any satisfactory explanation of the origins of the condition, the treatment given consisted largely of behavioral psychotherapy. As the bombing of Baghdad began at the start of the second Gulf War, US authorities published estimates that 570,000 Iraqi children were at risk of post-traumatic stress and would need psychological care.¹⁰ In this wide range of situations, which looks more like “a certain Chinese encyclopedia” described by Borges than a systematic list drawn up by the American Psychiatric Association, the lowest common denominator is trauma—in other words, the tragic event and its psychological traces.

• • •

Contemporary society now accepts without question the notion that psychologists and psychiatrists intervene in situations of war and disaster, in cases of exceptional or even everyday violence. No one seems astonished when mental health professionals leave their care centers and consulting rooms to attend to the “psychically wounded” in debriefing spaces. The idea that tragic and painful events, whether individually or collectively experienced, leave marks in the mind which are then seen as “scars” by analogy to those left on the body, is just as easily accepted.¹¹ The idea that someone damaged by an accident or an attack can, under the victim compensation laws of his or her country, claim financial compensation for psychic trauma is judged entirely legitimate, even if, as is often the case, the person simply witnessed the event deemed traumatic. If a victim of torture or persecution provides a medical certificate testifying to post-traumatic distress in order to gain refugee status, this is generally accepted as relevant evidence, precisely because a line of imputability and inevitability has gradually been established between abuse and its consequences.

Twenty-five years ago the issues were not so clear-cut. Trauma was rarely evoked outside of the closed circles of psychiatry and psychology.

¹⁰ On the Gulf War syndrome, see the article by Enserink in *Science* (2003); the figures relating to the potential child victims of trauma during the second war in Iraq are cited in a *Newsweek* special report (April 7, 2003).

¹¹ In the dedication of his book, Claude Barrois (1998) states, “Almost all injuries leave scars. A person who has almost passed through the looking-glass never returns unscathed.

Psychiatrists and psychologists were unlikely to appear at the scene of individual or collective misfortune, except in the rare cases where courts sought their clinical expert opinion. And when they did become involved in situations of conflict or occupational injury, they questioned the reality of the symptoms presented by the wounded and survivors, always suspecting that the soldier's "neurosis" after a shock was simulated in order to avoid returning to the front,¹² and that the worker's "sinistrosis" after an accident concealed a more or less conscious desire for reparation.¹³ The victim—who in fact was rarely thought of as a "victim"—was tarred as illegitimate; trauma was a suspect condition. Thus, within a few years the course of history has changed: now the victim is recognized as such and trauma is a legitimate status. It is this new condition of victimhood, established through the concept of trauma, that we address in this book.

"My problem," Michel Foucault said toward the end of his life, "is to know how men govern (themselves and others) by means of the production of truth." He added: "By 'the production of truth,' I do not mean the production of true statements, but the arrangement of domains where the practices of the true and the false can be at once regulated and relevant."¹⁴ This is in effect our premise in this book. The question is not whether or not an individual who has experienced or been exposed to a dramatic event is suffering from post-traumatic stress, and hence whether he or she merits psychological care and financial compensation. Our goal is rather to understand how we have moved from a realm in which the symptoms of the wounded soldier or the injured worker were deemed of doubtful legitimacy to one in which their suffering, no longer contested, testifies to an experience that excites sympathy and merits compensation. The point is to grasp the shift that has resulted in what used to excite suspicion now having the value of proof—the shift whereby what was false has become what is true. We seek to grasp the historic moment when suspicion ended.

Even if his or her scar is well healed, it is indelible." Here we are in the realm of metonymy rather than metaphor.

¹² José Brunner's article (2000) on the First World War offers a glimpse into the intense discussion among neurologists and psychiatrists about this "neurosis," which effectively amounted to stigmatizing soldiers as calculating cowards, thus justifying particularly brutal treatment.

¹³ On this subject it is worth returning to Sayad's article (1999) on "sinistrosis." The author points out that by the 1960s and 1970s this label was used only to describe psychological distress observed in immigrant workers following accidents at work, which was explained purely in terms of their tendency to claim indemnities.

¹⁴ This extract, where Foucault (1994, pp. 20–34) also uses the expression "regimes of truth" (*régimes de vérité*, which means literally "regimes of truth-telling"), comes from a little-known text derived from a roundtable discussion with a group of historians on May 20, 1978.

This turnaround is played out simultaneously on two stages. On the one hand we have the professional circles of psychiatry and psychology, which as we shall see have been substantially influenced by social movements demanding rights, particularly for veterans and women who have suffered violence. It was the convergence of these disciplines and movements, as well as alliances between them, that gave rise to the diagnostic category of post-traumatic stress disorder, which was to become the keystone in the construction of the new truth. And it is in this context that further developments in psychiatric victimology and humanitarian psychiatry emerge. On the other hand, the more generalized and global idea of trauma, designating an irrefutable reality linked to a feeling of empathy, has spread throughout the moral space of contemporary societies. This trend is independent of opinions as to the validity of the diagnostic category as a way of accounting for the painful experience of tragic events in other cultural contexts. In fact, although there has been much criticism of what some see as a form of psychological ethnocentrism, the critics do not question the moral importance of trauma. Thus there are two orders of facts, one relating to the history of science and medicine, and one linked to an anthropology of sensibilities and values. Most of the writing on psychic trauma, particularly in the North American literature, looks at trauma from the first perspective, focusing on the research and debates that have resulted in the production of this new classification of mental illness.¹⁵ It seems to us essential, however, to consider these two orders of facts together, bearing in mind both the genealogy of the medical category and of the moral norms, both the invention of post-traumatic stress and the recognition of its victims, both what psychiatrists and psychologists say about trauma and how this issue is handled by journalists and support organizations. Trauma is not confined to the psychiatric vocabulary; it is embedded in everyday usage. It has, in fact, created a new language of the event.

The reading we propose in this book might be described as constructionist, in the sense that it explores the ways in which trauma is produced

¹⁵ The principal contribution in social science is Allan Young's book (1995), which traces the history of the category while analyzing the sociology of its use in a psychiatric treatment unit. In parallel, Ian Hacking's writings (1995) explore more broadly the reclassification of psychological disorders affecting memory, particularly around the emergence of multiple personalities. In the United States, literary studies have also played an important role in the investigation of the theoretical and practical issues raised around trauma, particularly in the field of psychoanalysis: Cathy Caruth (1996) and Ruth Leys (2000). All of these works effectively relate to an analysis internal to the field of psychiatry and psychology. This is even more true of mental health specialists themselves, whether they promote the concept of trauma, like Bessel van der Kolk et al. (1996), or challenge assumptions of its universality, as do Patrick Bracken et al. (1998).

through mobilizations of mental health professionals and defenders of victims' rights, and more broadly by a restructuring of the cognitive and moral foundations of our societies that define our relationship to misfortune, memory, and subjectivity. In this our approach differs from essentialist perspectives, which either (in the case of psychoanalysis) view trauma as a psychic given inscribed in the unconscious, or (as in the organicist paradigm) seek the material traces of trauma in the human brain.¹⁶ This is not to question the validity of psychoanalytic interpretations and neurophysiological observations; rather, our approach derives from a different epistemological choice. We are interested in the development of a category of thought and the emergence of a realm of truth. We do not dispute the universality of trauma or its variation in different cultures: we affirm that it is almost universally accepted and that the concept has been adopted in multiple cultural contexts. We are not asking whether, either in general or in specific cases, trauma is a relevant concept from the medical or social viewpoint: we are aware that it is considered as such in medical circles and in the social sphere. In other words, our viewpoint derives neither from a relativism that would implicitly or explicitly raise doubts about the concept of trauma by asking if it really exists, nor from a moral standpoint prompting us to contest the unrestrained use of the term, nor from a cynicism that might lead us to comment ironically on its tendency towards exaggeration.¹⁷ These viewpoints have their logic, but they are not ours. We are attempting instead to understand what we see as a major social shift in terms of its anthropological significance, to understand how a system of knowledge and values was shaken and how one truth was overturned and another produced. In short, we seek to understand how the contemporary moral economy has been reshaped.

If social sciences are of use to society—and we are convinced they are—it is by virtue of the critique they offer. This critique primarily addresses the concepts and tools with which the men and women of today think and transform the world—concepts and tools that are often invisible, and therefore unrecognized, by those who use them. Thus a critical reading of trauma rejects the naturalization of the concept.¹⁸ The simple fact that within the last two decades it has become standard practice to send psychiatrists and psychologists to places where people have been involved in

¹⁶ These two approaches can of course be reconciled, as van der Kolk and van der Hart (1995) show in bringing Freudian theories and neurophysiological observations together in a single analysis.

¹⁷ This perspective is what one of us has conceptualized as a "well-tempered constructionism" (Fassin 2004a) that involves a certain degree of "realism."

¹⁸ Notably by showing how the "trauma narrative" (Rechtman 2002) creates a resonance between the "human condition" of victim and the "clinical condition" of PTSD.

or have witnessed dramatic events should invite reflection. From our clinical experience and our ethnographic work with people who have been through terrible ordeals, we know that a painful past can resurface in veiled or violent form in the body or the mind.¹⁹ However, since this reality has only recently been recognized (that is to say, identified and legitimized), our question is: what does this social recognition change, for the men and women of today (whether victims or not), in their vision of the world and its history, and in their relationships with others and with themselves? When we consider the soldier suffering from nightmares and flashbacks as psychologically wounded rather than as a malingerer or a hero, what does this view of war and those who participate in it tell us? When the concept of trauma allows the survivors of an industrial accident to speak of their *a priori* right to compensation, regardless of any evaluation *a posteriori* of the facts in their individual cases, how are the management of damage and the administration of evidence altered? When witnesses testify publicly to the plight of the Palestinian people on the basis of cases reported by psychologists, how are the representation of their situation and the defense of their cause affected? When more credence is given to a medical certificate attesting to post-traumatic stress than to the word of an asylum seeker, what conception of the law and of the subject is operating? These are some of the questions we will be asking throughout this book. The answers we suggest sketch out what we will call a politics of trauma.

• • •

The history of the invention of post-traumatic stress in the late nineteenth century and of its rediscovery in the late twentieth century, thus allows us to trace a dual genealogy (part 1). The first strand, which belongs in the domain of psychiatry, psychology, and psychoanalysis, conceives trauma both at the level of theoretical debate (which has been analyzed many times) and in actual practice (particularly in the fields of forensic medical expert opinion and colonial medicine, which have not hitherto been the object of much attention). The second strand, which relates to social conceptions, traces changes in attitudes to misfortune and to those who suffer it, whether soldiers or workers, accident victims or survivors of the concentration camps. More specifically, it marks changes in attitudes towards the authenticity of such suffering. Although most research on trauma has focused on the first area, it seems to us that the second is an equally important factor in the emergence of the concept of trauma. What

¹⁹ For an account of our clinical work and ethnographic studies, see our work on disease patients in South Africa (Fassin 2007) and Cambodian refugees (Rechtman 2000).

is most revealing is the way in which these two histories have interacted. We can identify key moments in twentieth-century history at which trauma was able, with surprising ease, to lock into values and expectations embodied, in each case, in a very specific historical configuration. How did this acceptance of trauma come about? How did it travel from the First to the Second World War, from North American feminists to Vietnam veterans? How did clinical theory and everyday practice adapt to these changes in pathological categories and social norms? How and why has trauma been able to embody, equally powerfully, entirely opposing values? Examination of this dual—scientific and moral—genealogy of trauma gives us a key to understanding each of these turning points. We end this first phase of our study at the point where post-traumatic stress disorder has achieved universal acceptance, but our aim is not simply to emphasize the discontinuity marked by the end of the era of suspicion that hung over victims of violence. We also try to demonstrate a continuity, perhaps more fundamental, by means of which psychic trauma affirms the ultimate truth of humanity and negates other possible schemes of description and action.

From within the social context of constant change that has prevailed since the late 1980s, we have chosen three cases emblematic of the contemporary politics of trauma. Our first case study concerns the development of psychiatric victimology and intervention on the scene of assaults and accidents, hostage-taking incidents, and natural disasters; it focuses primarily on the so-called emergency medical and psychological units that have been established throughout France. We will examine an incident that had, and continues to have, major local and national resonance: the explosion at the AZF chemical factory in Toulouse on September 21, 2001 (part 2). Our second case study looks at the boom in humanitarian psychiatry and its work in the aftermath of earthquakes and war, in refugee camps and rehabilitation centers, through the missions of *Médecins sans frontières* and *Médecins du monde*. We will focus on one specific case where humanitarian psychiatry has been applied, probably the arena that has received the highest investment of both human resources and political stakes—the Israeli-Palestinian conflict, in the context of the second Intifada, which began in September of 2000 (part 3). Our third case study focuses on nongovernmental organizations operating in the field of the psychotraumatology of exile, particularly among asylum seekers and victims of torture. We focus on the activity of the main organization providing health care to immigrants in France, the *Comité médical pour les exilés* (Medical Committee for Exiles, *Comede*) (part 4).

So we have three scenes: the first is local, the second far distant, and the third lies between the two since it deals with foreigners hoping to gain official status. These three scenes delineate three spaces—national,

international, and transnational. Their diversity illustrates the ubiquity of the contemporary politics of trauma—from the local to the global, from the mental health system to the social management of major disasters—within which three new fields are opening up: psychiatric victimology, humanitarian psychiatry, and the psychotraumatology of exile. Together these three define the boundaries of a diffuse global concept of trauma which, we stress, has formed within less than a decade, and which bears witness to an important shift in mental health care. It is important both in terms of the growing number of actors involved (particularly psychologists, who have always been by far the most numerous in the field of social suffering and whose domain of intervention is much wider than trauma alone), and in terms of the implicit significance of their activity, which is directed at a radically new public (psychiatrists, for example, now deal with people who are not sick, but who are suddenly affected by the impact of abnormal events). Thus we wish to highlight a dual social innovation: the invention of new areas of knowledge and practices, and the discovery of new patients and subjects.

In each of these three arenas, offering care to people deemed to be victims of trauma demarcates a field of common problems (the relevance of diagnostic categories, the provision of appropriate psychological care), but the particular logic of each case raises specific political questions in the context of the social issues particular to disasters, war, and persecution. After the AZF accident the central concern of victimology was to repair the damage suffered, and the concept of trauma was important as a means of validating the status of accident victim. In humanitarian psychiatry, bearing witness to the suffering of the Palestinians and the Israelis during the second Intifada brought to light tensions within organizations, among their donors, and in the broader public. Trauma has created a new vocabulary for explaining causes and prejudices. In the psychotraumatology of exile, the growing suspicion weighing on asylum seekers means that demonstrating trauma becomes an additional way of testifying to the reality of persecution. Politics of reparation, politics of testimony, politics of proof—in all three cases, trauma is not simply the cause of the suffering that is being treated, it is also a resource that can be used to support a right. These different uses of trauma thus reveal a partly utilitarian dimension of the concept, which emerges when this notion is actively mobilized. In noting this our aim is not cynical (suggesting that the classification is being manipulated for aims stated or unstated), but is rather to avoid reifying the concept by suggesting that the social significance of trauma is the same everywhere and for everyone; we seek to show its relative autonomy in relation to psychology and psychiatry in general (those who adopt the term to some extent move beyond these

structures). Seeing trauma as a resource is, however, not simply a theoretical issue. It is also an ethical one: in asserting the tactical dimension of trauma we are recognizing the social intelligence of the actors involved.

• • •

This book is born of research that we began separately fifteen years ago, one of us around the politics of suffering, and the other around the invention of trauma,²⁰ and then developed together. Our encounter happened on this common subject, which we propose to call the politics of trauma, and which we want to test through an empirical investigation. This study was conducted between 2000 and 2005.²¹ It involved consulting a wide range of medical archives, reading hundreds of pages of paper and electronic documents produced by the institutions concerned, interviewing individuals we met in the three arenas mentioned above, and observant participation in the activity of the actors involved and in the life of these institutions.²² We are grateful to the PhD students who collaborated in this study: Estelle d'Halluin, who was studying sociology at the École des hautes études en sciences sociales, and Stéphane Latté, who was preparing his diploma in social sciences at the École normale supérieure.²³ We are

²⁰ Seminars by Didier Fassin ("The Politics of Suffering") and Richard Rechtman ("The Ethnization of Psychiatry"), at the École des hautes études en sciences sociales in the early 1990s.

²¹ Within the framework of two study programs launched firstly by MiRe (Mission de recherche expérimentation [Mission for Research Experimentation]) of the Ministry of Social Affairs, and subsequently jointly with the CNRS (Centre national de la recherche scientifique [National Center for Scientific Research]) and INSERM (Institut national de la santé et de la recherche médicale [National Institute for Health and Medical Research]).

²² In using the term "observant participation" our aim is to invert the canonical term "participant observer" by indicating that our primary role was as actors in the arenas in which we, in a secondary capacity, analyzed the issues. For one of us (Didier Fassin) this involved a position on the Board of Directors of two of the nongovernmental organizations studied (Médecins sans frontières, of which he became vice president, and the Comité médical pour les exilés, of which he later became president); and for the other (Richard Rechtman) membership in several official study groups in the Ministry of Social Affairs (on psychological emergency, on the treatment of victims of torture, on psychiatric expert reports, and on mental health and violence). This was admittedly a difficult position for both of us, but one in which the two dimensions (political and scientific) were clearly stated at the outset.

²³ Estelle d'Halluin conducted some of the interviews with humanitarian organizations and associations working with asylum seekers, and undertook one month's research in the Gaza Strip; her work was reported in a master report, *Guerre et Psychiatrie. L'intervention humanitaire en Palestine* [War and psychiatry: Humanitarian intervention in Palestine], EHESS, Paris, 2001. Stéphane Latté conducted some of the interviews at the Toulouse site; he had previously undertaken a study of victimology, which provided some of the material

also grateful to Sylvie Fenczak for her enthusiastic acceptance of the French version of the book, to Fred Appel for his unfailing support of its English publication, to Rachel Gomme for her remarkable work in translating our *L'Empire du traumatisme*, and to Eva Jaunzems for her subtle suggestions while turning it into *The Empire of Trauma*.

In the pages that follow we show how social agents—psychiatrists and psychologists, of course, but also accident victims, refugees, lawyers, and activists—make use of the category of trauma and the notion of post-traumatic stress disorder, appropriating, reformulating, or even twisting them. This is a testimony to how much we owe to all the actors who permitted our critical examination of their practice, and to our hope that this study will prove useful to those among whom they work. However, it goes without saying that the analyses we propose of these practices are entirely the responsibility of the authors.

for the master report *La naissance de la victimologie. Institutionnalisation d'une discipline et ébauche de construction d'un group improbable: les victimes* [The origins of victimology: The institutionalization of a discipline and outline of the construction of the unlikely category of victims], ENS-EHESS, Paris 2001. Both took part in the two studies we led.

PART ONE

The Reversing of the Truth

OVER THE LAST 25 YEARS, trauma has become established as a unique way of appropriating the traces of history and one of the dominant modes of representing our relationship with the past. It is a major social fact that has received much attention, most of it focused on the invention of post-traumatic stress disorder.¹ This social fact has a much broader significance, however, than its trajectory in the clinical realm. It concerns both individuals and communities, since the boundary between the two is not always clear, particularly when considering the experience of individuals subjected to collective violence. The discovery of the painful memory is a major anthropological phenomenon of contemporary societies.² It extends simultaneously to realities with a very wide range of historical reference: thus in the United States the concept of "cultural trauma" has been applied to slavery, the Holocaust, and 9/11, all of which are seen as wounds in the collective memory that contribute to the construction of identity in different social groups—African-Americans, Jews, and all Americans, respectively.³ While it is relatively circumscribed in time, this phenomenon of the reconstruction of the past is not limited in space: over the last century, the concept of "historical trauma" has been applied to the colonization of Latin America and Africa, the atomic bombs at Hiroshima and Nagasaki, apartheid in South Africa, the Palestinian Intifada, the Soviet regime in Lithuania, the Troubles in Northern Ireland, the civil war in Sri Lanka, and the industrial disasters at Bhopal in India and at Chernobyl in Ukraine.⁴ In each case, collective memory is articulated as

¹ The concept of post-traumatic stress disorder (generally known by the acronym PTSD), which we will examine in depth in the first part of this book, was introduced in 1980 in the third revision of the US *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III).

² The three volumes of the major international study conducted by Veena Das, Arthur Kleinman, Margaret Lock, Mamphela Ramphele, and Pamela Reynolds, *Social Suffering* (1997), *Violence and Subjectivity* (2000), and *Remaking a World* (2001), can be read as an ambitious fresco retracing the emergence of this painful memory into the public sphere in contemporary societies (Fassin 2004b).

³ See Alexander et al., eds (2001), where Neil Smelser offers this definition of cultural trauma: "a memory accepted and publicly given credence by a relevant membership group and evoking an event or situation which is a) laden with negative affect, b) represented as indelible, and c) regarded as threatening a society's existence or violating one or more of its fundamental cultural presuppositions." Arthur Neal's recent history of the United States, *National Trauma and Collective Memory*, is written exclusively from this trauma-based perspective.

⁴ Historical trauma is an expression coined by Dominick LaCapra (2001). The memory of the events cited here is studied respectively in the work of Michael Taussig (1987), Achille Mbembe (2000), Maya Todeschini (2001), Didier Fassin (2005), John Collins (2004), Vieda

a traumatic relationship with the past in which the group identifies itself as a victim through its recognition of a shared experience of violence. Notwithstanding the different contexts, the moral framework that emerges is the same: suffering establishes grounds for a cause; the event demands a reinterpretation of history.

"To articulate the past historically does not mean to recognize it 'the way it really was.' It means to seize hold of a memory as it flashes up at a moment of danger." This famous dictum of Walter Benjamin, who gives greater stock to the violent imprint left in the memory than to a patient reconstruction of the past, is somewhat premonitory with regards to contemporary issues.⁵ Following Benjamin's "illumination," we could define trauma as the sudden emergence of memory at the moment of danger. In effect, as we read his prophetic statement, it is easy to understand how wounded memory gives rise to a history of the vanquished which, as Reinhart Koselleck argues, inevitably imposes itself over the victors' version, simply because it offers a more truthful expression of the "experience of history."⁶ The slave, the colonized, the subjugated, the oppressed, the survivor, the accident victim, the refugee—these are concrete images of the vanquished whose history, far from disappearing along with their experience of defeat and misfortune, is reborn in the memory of subsequent generations. Thus, as Ron Eyerman remarks in reference to the formation of African-American identity in the United States, this identity is constituted not in those who were enslaved, but in their descendants, to whom the account of suffering and humiliation has been passed on.⁷ In other words, collective memory possesses a sort of latency. This view is modelled on the clinical latency of post-traumatic stress, which is characterized by the appearance of the first symptoms some time after a painful event. France has not escaped this pattern, with numerous signs in recent years pointing to the return to a buried, unspoken history—of the slave

Skultans (1998), Allen Feldman (1991), Veena Das (1995), and Adriana Petryna (2002), among others.

⁵ See the short article, "On the Concept of History" (1996), written in 1940, shortly before Walter Benjamin committed suicide, and published posthumously in 1942. Writing this text when he was fleeing the Nazi regime, he passionately contrasts the history of the victors with the tradition of the oppressed.

⁶ See Reinhart Koselleck (1997), who argues, "If history is made in the short run by the victors, historical gains in knowledge stem in the long run from the vanquished." This is primarily because, since events did not occur as they expected, the vanquished are forced "to search for middle- or long-range reasons . . . to frame and perhaps explain the chance event of the unique surprise."

⁷ Ron Eyerman (2001) explains, "As opposed to psychological or physical trauma, which involves a wound and the experience of great emotional anguish by an individual, cultural trauma refers to a dramatic loss of identity and meaning, a tear in the social fabric, affecting a group of people that has achieved some degree of cohesion."

trade and colonial violence, of sanctions against Haiti and torture in Algeria, of collaboration under the Vichy regime and defeat at Diên Biên Phu, of the brutal reprisals at Sétif in 1945 and the Paris massacre of Algerian demonstrators in 1961—a hidden and painful history whose victims are now demanding recognition and sometimes reparations.

This memory is one that French historians have failed to take on—at least until recently. What they seem to have retained of “the experience of history” are primarily Pierre Nora’s “sites of memory” (the description of which reinforces commemoration without casting light into the darker reaches of the past), and François Hartog’s “regimes of historicity” (the analysis of which demonstrates a tendency towards a focus on the present without grasping its tragic aspects). In short, they have barely heard the voices of the vanquished.⁸ There is a striking contrast here between North America and Europe. While some have complained of an excessive focus on trauma in US social sciences, its virtual absence in French historiography is no less remarkable. The call from some intellectuals for a right to amnesia thus appears premature, to say the least. Before condemning the “abuse of memory” with Tzvetan Todorov, or championing the “need to forget” as Marc Augé suggests, we ought to leave some space for the right to recount what happened.⁹ Anthropology, because it aims to understand the views of others, is perhaps particularly well placed to take on this challenge. In any case, the social context is pushing the discipline in that direction.

The memory of the Holocaust is clearly the starting point for the contemporary manifestation of collective trauma in the public arena. As we know, the emergence and unfurling of this memory did not follow immediately after World War II and the discovery of the extermination camps.¹⁰

⁸ In this regard the great undertaking of reconstituting “realms of memory” (*lieux de mémoire*) led by Pierre Nora (1997) is doubly revealing, giving no space either to the sites of the vanquished (in particular offering virtually nothing on colonial history), or to traumatic memory (systematically preferring the heroic version). While François Hartog (2003) pays more attention to the plurality of experiences of time, his analysis of “regimes of historicity” (*régimes d'historicité*) is restricted to memorials and heritage, failing to grasp the tragic aspect of the call for a different kind of remembering.

⁹ As Tzvetan Todorov (1995) sees it, inflated memory consecrates the exaggerated status of the victim: “Being a victim gives you the right to complain, to protest, to make demands.” Marc Augé (2001) argues that an excess of memory deprives the modern world of the ability to enjoy the moment, and even of the truth of memory: “Oblivion is a necessity both to society and to the individual. One must know how to forget in order to taste the full flavor of the present, the moment, and of expectation, but memory itself needs forgetfulness.”

¹⁰ Psychoanalyst Dori Laub (1995) suggests that “the silence about the Holocaust after the war might have been . . . a continuation of the power and the victory of the delusion” which, during the war, led people to deny the extermination of the Jews and to discredit those who spoke of it, even within the Jewish communities.

Collective remembering was a gradual process, coming through the first books by survivors (primarily those of Primo Levi) and collections of testimonies (some, such as the Fortunoff video archives at Yale, aimed at an academic audience, and others, like the work of Claude Lanzmann, made for a more general public), through historiographic studies, some of which were strongly contested (the work of Raul Hillberg and Daniel Goldhagen, for example) and occasionally through controversial screen works (such as the TV series *Holocaust* or the film *Schindler's List*), and finally through a belated commemoration procedure (concluded in 2005 by the celebration of the sixtieth anniversary of the liberation of Auschwitz and the completion of the memorial to the murdered European Jews in Berlin). Putting in place what Michael Pollak calls "the management of the unspeakable"¹¹ was a long and painful process.

The memory of the Holocaust is, then, a paradigm for trauma, and this in two ways. First, it represents the most extreme reach of violence, and as such has become an unavoidable reference point for any experience of pain, of suffering, and hence of trauma. Even Holocaust denial paradoxically reinforces this extreme aspect, by revealing the starkest form of the historical lie. Second, it developed after a period of silence, a fact that attests precisely to its traumatic nature. It is because of the delay between the event and its painful exposure to the public gaze that the process can be qualified as trauma. These two aspects establish the link between the collective and the individual, as Freud did in *Moses and Monotheism*: on the one hand, we have the foundational drama which is played out for the Jewish people and replayed for each individual within it, and on the other, the necessary delay before the appearance of the memory trace (in the group) and neurotic symptoms (in the individual). Thus in psychoanalysis the analogy between what is happening at the collective level and what is going on at the individual level establishes a connection between the culture and the psyche, a connection which today lies at the heart of the politics of trauma: the collective event supplies the substance of the trauma which will be articulated in individual experience; in return, individual suffering bears witness to the traumatic aspect of the collective drama.

It is on this basis that the matrix of the painful memory of the Holocaust can be universalized—independently of one's position on the question of whether it is exceptional or exemplary, unique or extreme. In contemporary thinking this universalization takes two distinct forms. The first, empathy, posits a sort of communion in trauma. This is the principle

¹¹ In the three accounts by female survivors of the camps which he presents, Michael Pollak (1990) notes that they "show to what point the silence of deportees can be easily, but falsely, likened to forgetting."

defended by Cathy Caruth,¹² who argues that the urgent need to bear witness, to produce "a speaking and a listening from the site of trauma" does not relate to "what we simply know of each other, but to what we do not yet know of our own traumatic pasts." She adds: "In a catastrophic age, trauma itself may provide the very link between cultures." Thus, she suggests, contemporary sensitivity to the misfortunes of the world derives from this hidden wound that allows us to understand others not on the basis of their experience, but through our own. The second—and critical—form of universalization suggests that trauma derives from a common font. This is the viewpoint offered by Slavoj Žižek,¹³ who suggests that the concentration camps and "all the different attempts to attach this phenomenon to a concrete image (the Holocaust, the Gulag)" only "elude the fact that we are dealing here with the 'real' in our civilization, which returns as the same traumatic kernel in all social systems." Extending Freud's thinking, he holds that, beneath varied appearances and in different forms, it is always the same ultimate gulf that is revealed.

If we adopt either of these points of view, the humanist or the radical, which are today the largely dominant viewpoints whether or not they are explicitly formulated, the universalization of trauma results in its trivialization. In these models, every society and every individual suffers the traumatic experience of their past. Not only do scales of violence disappear, but their history is erased. There is no difference between the survivor of genocide and the survivor of rape; this is in any case the clinical view. But can we be satisfied with this reading? On the boundary between historiography and psychoanalysis, Dominick LaCapra,¹⁴ whose work on the Holocaust centers on examining the links between past and memory, testimony and interpretation, suffering and reparation, has often expressed concern about this development, proposing instead an approach "historical, social, and political specificity" of traumatic experiences, in order to avoid "the self-deceptive confrontation with transhistorical, structural trauma." This tension between universalization and historicization shows us that the notion of "trauma" has become a general way of

¹² Cathy Caruth (1995), one of the principal analysts of trauma, argues that Freud's own last work bears witness to this tension: "*Moses and Monotheism* tells not only about the ancient trauma of the Jews but about Freud's own unsettling departure from Vienna in 1938."

¹³ Slavoj Žižek (1989) bases his theory on the work of Lacan: "The Lacanian thesis is . . . that there is always a hard kernel, a leftover which persists and cannot be reduced to a universal play of illusory mirroring . . . the only point at which we approach this hard kernel of the Real is indeed the dream." Giorgio Agamben (1997) arrives at the same radical generalization about the camps on the basis of very different theoretical premises.

¹⁴ In a densely argued piece, Dominick LaCapra (2001) strives to hold at a distance both historians and sociologists who reduce explanation to a single historical context, and philosophers and writers who offer a strictly structural reading.

expressing the suffering of contemporary society, whether the events it derives from are individual (rape, torture, illness) or collective (genocide, war, disaster).

The psychoanalytic understanding of trauma facilitates this return to the collective through the individual, from the intimate wound to the wounded memory, and perhaps even more from the human to the inhuman. Trauma in this reading is not simply the consequence of unbearable experiences, but also in itself a testimony—a testimony to what has happened to the human. But it is a testimony that also bears witness to the persistence of the human even in those extreme situations that threaten to dehumanize the victims. Even where inhumanity has reached its most tragic expression, as in the Nazi camps, this approach suggests that some element of humanity inexorably resists dehumanization—and it is this humanity that the trauma of the survivors manifests. Trauma is both the product of an experience of inhumanity and the proof of the humanity of those who have endured it. This dual role explains the contemporary use of the concept of trauma in situations where other moral vocabularies were formerly used. Thus, only a month after the French daily newspaper *Le Monde* published General Aussaresses’¹⁵ first confessions about torture in Algeria, it devoted a full page and its editorial to the memory of Algerian war veterans. Under the eloquent headline “350,000 Algerian Veterans Suffering from Psychological Distress Related to the War,” the paper’s correspondent recounted the torment of these men who, thirty years after the events, relived in nightmares and sometimes in hallucinations the horrific scenes they had witnessed, in which they had often been complicit and had sometimes participated. The editorial argued that, in order to heal these “psychically wounded” veterans, France should establish “a truthful relationship with its past” so that they could emerge from the “trauma of the Algerian war.” As with Vietnam veterans in the United States, trauma was not restricted to the victim; it also burdened those who had committed atrocities. Commenting on this belated discovery of persistent wounds from the conflict, psychoanalyst Alice Cherki—a for-

¹⁵ Interviewed by Florence Beaugé in *Le Monde*, November 23, 2000, General Paul Aussaresses admitted and justified the practice of torture by the French army during the Algerian war. This testimony subsequently became part of the polemic unleashed by *Le Monde*’s publication, on June 6, 2000, of the account of a young female FLN member, also interviewed by Beaugé, who was tortured for three months by the French army special services in Algeria. On June 22, General Marcel Bigeard first denied the facts, and then, on the same day, was obliged to retract his statement when General Jacques Massu confessed and expressed remorse. However, it was Aussaresses’ statements that reignited the debate, because unlike Bigeard he admitted the torture, but in contrast to Massu he showed no regret. Florence Beaugé’s investigation and the editorial on the subject appeared some months later, on December 28, 2000.

mer sympathizer of the Algerian National Liberation Front (FLN) and a close colleague of Frantz Fanon (she contributed a preface to his *The Wretched of the Earth*)—took up *Le Monde's* argument in almost identical language and conceded, albeit in more nuanced terms, that the torturers were themselves often traumatized.¹⁶ The spirit behind this sudden flurry of interest in the psychological condition of veterans of the Algerian war was not one of exculpating those responsible for the atrocities (as the court case mounted against General Aussaresses at the same time demonstrated), nor of justifying their actions (as some too quickly alleged); rather the aim was to affirm that, even in their acts of torture, these soldiers remained human beings. Here too lay a traumatic memory. The broad application of the concept of trauma makes it possible today to both recognize and go beyond the status of victim—something that was impossible within the Holocaust model. By applying the same psychological classification to the person who suffers violence, the person who commits it, and the person who witnesses it, the concept of trauma profoundly transforms the moral framework of what constitutes humanity.

However, the success of the diagnostic category, and its anthropological implications, can only be understood in the context of this historical movement through which trauma has become established as the most salient trace of the tragic event in human experience. This process is, moreover, interactive, creating what Ian Hacking calls a “looping effect.”¹⁷ A collective belief in the existence of wounds stemming from the history of peoples and individuals became a focus for psychiatrists and Vietnam veterans, psychologists and feminists, who found, in the accounts of survivors of the Holocaust or Hiroshima (and also in clinical writing related to them), the elements that they would later use to define and justify the entity of post-traumatic stress disorder. The new reality, thus designated and authenticated, in its turn fed the representations and demands of those with direct or indirect experience of these painful events, transforming and at the same time legitimizing suffering and complaints.

The huge difference in society's attitudes to “trauma neurosis” in the late nineteenth century and “post-traumatic stress disorder” in the late

¹⁶ Such as those who issued a manifesto in *Le Monde* testifying to their distress since their return from Algeria and to the painful silence they had maintained. See Philippe Bernard and Sylvia Zappi, “Les aveux du general Aussaresses réveillent les cauchemars des anciens d'Algérie” [“General Aussaresses' Admissions Revive the Nightmares of Algerian Veterans”], *Le Monde*, May 20, 2001, which appeared shortly after the publication of a book by the general.

¹⁷ The “looping effect,” as described by Hacking (1998), is the impact that an individual or group's designation or classification has on that individual or group: for example, the consequences for an adolescent of being labelled schizophrenic.

twentieth century is due not to more refined diagnostic tools, but rather to a narrowing of the gap between the climate of public opinion and the preoccupations of mental health professionals, between the moral economy and medical theory. Thus the idea of a psychologization of memory seems to us unsatisfactory, because it presupposes a unilateral and unambiguous process. It would be more correct to speak of the traumatization of experience, in other words the conceptualization of the past event as a painful scar, which is both perceptible to the general public and clinically identifiable. How does thinking about individual experience in terms of trauma, and collective memory in terms of wounds, transform our vision of humanity? How does representing social responses in terms of healing, whether in the literal terms of psychiatry or as political metaphor, alter our way of interacting with the world? These are the questions we want to explore.

But if trauma has today come to embody images of the most unacceptable suffering, if its psychological effects symbolize at best a radical fringe of what is human, while its traces must be preserved in the very body of its victims in order to ensure a highly hypothetical "never again," this is certainly not because a group of clinicians committed to the cause of victims wished it to be so. Their role in the contemporary historiography of post-traumatic stress disorder has probably been overestimated. At most they have functioned as catalysts within a process of profound social change that has recast the role of the trauma survivor who, once merely a victim, has become a witness to the horrors of our age.

Thus our aim here is not to question the clinical relevance of the concept of trauma. Still less do we wish to condemn psychiatric victimology, humanitarian psychiatry, or psychotraumatology which, notwithstanding their numerous detractors, often bring comfort and relief to suffering individuals who, without this intervention, would have been abandoned to their fate. Nor do we propose to denounce the psychiatrization of society, the current fear of which is just one more sign of the very social movement it purports to describe. Finally, we do not assert that contemporary human beings are comfortable in a passive attitude of suffering, commiseration, and repentance—yet another accusation that is prevalent today. Far from taking such a prescriptive and ultimately moralizing stance, our intent is merely to understand this phenomenon whereby, in less than twenty years, the notion of psychological trauma has imposed itself on society in such a way as to become the central reality of violence.

How was a notion inherited from clinical psychiatry, via psychoanalysis, able to infiltrate social discourse, articulating what clinicians had never before been able to say? This is what we seek to discover, because as we see it, the empire of trauma is the product not only of scientific developments, as is commonly suggested, but also of social history. In

other words, it may owe less to advances in knowledge than to changes in the moral climate. Crystallizing the ethical expectations of each era, it has, in different periods and sometimes at the same time, articulated diametrically opposed values: dishonor and honor, fraud and truth, cowardice and courage, shame and pride, pretence and suffering, guilt and innocence, inequity and justice, the meaninglessness and the fundamental significance of a collective memory. Each of these contrasted pairs represents a stage in our investigation, by which we aim to understand how the contemporary construction of a psychological truth arose in response to a question society was asking. This question, addressed to psychology and psychiatry, was not, what are the effects of trauma? or what psychological mechanism can help to explain it? Rather, since the notion of trauma first emerged, the question has been, who are these traumatized people? The issue was not primarily trauma, or even the events that cause it, but the human being in his or her singularity and his or her weakness. For a century this human being suffering from trauma was seen as different from others: weak, dishonest, perhaps a phoney or a profiteer. Then a few decades ago she or he became the very embodiment of our common humanity. It is this shift from one truth to another, from a realm in which trauma was regarded with suspicion to a realm in which it carries the stamp of authenticity, that we seek to analyze.

A Dual Genealogy

IN ITS ISSUE OF JANUARY 13, 2001, the *British Medical Journal* published an article by psychiatrist Derek Summerfield on "the invention of post-traumatic stress disorder,"¹ which was to unleash a storm of protest among specialists in this diagnostic category, and above all among those suffering from the syndrome. When the BBC News Web site reported Summerfield's critical position that day, it provided a large forum for the ensuing debate. No less than fifty-eight responses were published on the journal's Web site in the six months following the article's publication,² and the debate grew through electronic forums and message boards where trauma psychiatrists were invited to make statements on the psychiatrist's polemical assertions. This was not Summerfield's first venture into the fray, however.

A senior lecturer at the teaching hospital of St George's in London and a specialist in humanitarian psychiatry, Summerfield had already travelled the world for various NGOs and was recognized for his work as a clinician in most of the war zones and refugee camps of the planet. His clinical expertise also extended to the treatment of asylum seekers in Britain, notably through his work for the Medical Foundation for the Care of Victims of Torture in London. He first came to public notice in 1997 with a strongly worded article in *The Lancet*,³ which argued that post-traumatic stress disorder (PTSD) was essentially a Western construct that imposed a medical model on the suffering of people in war situations, thus encouraging the emergence of a trauma industry that could be exported to any culture. His criticism was expressed on three grounds. It was first historical, as he reminded readers that the invention of PTSD was closely linked to the North American context of the Vietnam War. Next he considered

¹ See Summerfield (2001) and the electronic edition at <http://news.bbc.co.uk/1/hi/health/114078.stm>.

² See <http://bmj.bmjjournals.com/cgi/eletters/322/7278/95#29143>. After a gap of two years the controversy was reignited in 2003 with the publication of a similar analysis which reiterated Summerfield's main criticisms but emphasized the part played by the American Psychiatric Association in the deliberate invention of a "false" notion (PTSD) for political purposes: Australian psychiatrist and medical anthropologist Yolande Lucire thus opened a new chapter in the conspiracy theory, which her detractors were quick to criticize.

³ Summerfield (1997). It was this article that provoked the first reactions (de Vries 1998), since it contained a direct attack on the interests vested in the spread of PTSD.

political implications, laying great emphasis on the major economic repercussions of the extraordinarily rapid development of PTSD, the only psychiatric category that conferred an immediate right to financial compensation and thereby justified the development and revival of psychiatric expert reports. He pointed out that the spread of PTSD had been accompanied by the growth of careers for lawyers, experts, clinicians, therapists, and psychotraumatology counsellors. Finally, on the ethical front, he condemned this psychiatric categorization of the experience of war and exile, which reduced both combatants and civilians to an all too easily assigned clinical category. However, none of the arguments he put forward was strictly speaking new.⁴ The following year a collection of essays on war trauma edited by Patrick Bracken and Celia Petty,⁵ in which Summerfield reiterated his views, marked the emergence of a whole current critical of PTSD and the use of the concept within international psychiatry.

The reason the short 2001 article, which contained little that was new, provoked public controversy was that on this occasion trauma survivors protested against what they saw as a personal attack. But while forceful, Summerfield's criticisms are not of the victims themselves—whether or not they express suffering following a traumatic event. He does not accuse them of simulating a pain they do not feel, nor does he suggest that those who suffer misfortune are guilty of wishing, consciously or unconsciously, to escape their fate by taking refuge in illness. On the contrary, being a man of his times, he resolutely stands up for victims and, championing their cause on the basis of the authority of his status as a humanitarian doctor, testifies on behalf of the most oppressed, condemning the many faces of the oppression that burdens them.⁶ What Summerfield does argue

⁴ The relativist critique had surfaced alongside the development of PTSD from the early 1980s. Even before the syndrome was officially recognized through its classification in DSM-III, this clinical concept had been the subject of several discussions within the psychiatric community on the subject of its relevance in other cultures. An editorial in the *British Journal of Psychiatry* asked whether the emergence of PTSD was due to an increase in the number of disasters, greater awareness of traumatic distress and traumatic situations, or a misuse of the category to describe less-specific situations or disorders (Jackson 1991). Similarly, the political use of the category had been analyzed and critiqued by sociologists (Scott 1993) and anthropologists (Young 1995). The ethical aspect of the debate appears somewhat surprising today since—as Nancy Andreasen, editor of the *American Journal of Psychiatry* (1995), judiciously noted—PTSD is probably the only psychiatric diagnosis that has such appeal for patients. Unlike other mental disorders, which carry a pejorative connotation, the PTSD label is sometimes, paradoxically, taken up by patients themselves as a badge of normalcy.

⁵ Bracken and Petty (1998). The contributors to this volume are psychiatrists, social scientists, and senior nongovernmental organization staff.

⁶ Particularly in Palestine. Derek Summerfield (2004) published an article in the *BMJ* on the state of health among the Palestinian population, testifying to the oppression they were suffering. The article was relayed on Web sites supportive of the Palestinian cause, and

is that under North American influence, trauma has become the most insidious form of Western domination. He asks whether the unprecedented spread of this clinical category, used and abused by modern psychiatry to designate, classify, and treat the consequences of trauma, might not serve interests other than those of the victims. Voicing concerns about the hidden intentions of Westerners who dominate war zones, he suggests examining who profits from the success of the psychotraumatology enterprise, in order to unmask those who are pulling strings behind the scenes.

THE SIGNIFICANCE OF A CONTROVERSY

Reactions to the article were heated. Attention was focused not on the offended response of a handful of trauma specialists,⁷ not on the declarations of faith from the few laypeople who had been involved in the groups that developed the new clinical category and who were angered by what they saw as denigration of the democratic process they had taken part in, nor even on the polite support of a number of specialists in the history of science who pointed out that these "revelations" were already widely known,⁸ but rather on the protests of the victims, those in whose name Summerfield was speaking. Feeling themselves cheated by his questioning of the psychiatric category which, in their view, had been created over the previous two decades precisely in order to defend their hard-won rights, they not only condemned his arguments but also challenged his right to speak in their name. "I did not ask to suffer from intrusive thoughts, flashbacks, nightmares, and all the other myriad of symptoms connected with PTSD . . . nor do I expect any victim of a violent crime or witness to a traumatic event wanted the aftereffects of being such a witness. . . . Who are you to assume that you can tell how another person may react to any news?" one of them protested, questioning the psychiatrist's authority on the basis of his own experience of suffering. And another, revealing his in-depth knowledge of debates among mental health specialists, argued:

Summerfield quotes with apparent approval a remark in the *American Journal of Psychiatry* to the effect that if anyone liked a psychiatric diagnosis they were

reproduced in several languages, provoking a fierce debate. See <http://www.france-palestine.org/article706.html> and http://www.palestinemonitor.org/new_web/support_derek_summerfield_british_medical_journal.htm.

⁷ Cf. Glenn Hakanson, "History Is Not Conspiracy Theory," at <http://www.bmj.bmjjournals.com/cgi/eletters/322/7278/95#12656>.

⁸ Cf. Andra Litva, "Thinking about the Social Usefulness of Any Diagnosis," January 15, 2001; Anthony Stadlen, "Déjà vu," February 20, 2001; Vanessa Pupavac, "Pathologising War-Affected Societies," April 25, 2001, at <http://www.bmj.bmjjournals.com/cgi/eletters/322/7278/95#11940>.

given it would be PTSD. Has he ever really listened to a patient describe the hell of their nightmares and flashbacks? Has he looked at their pallor, their red-rimmed eyes, their bitten fingernails and thought that this was merely a construct of media hype and compensation neurosis? Perhaps he has been lucky enough never to suffer an accident or witness any horror in his medical training that had the power to linger in the memory and reappear in dreams? It is hard otherwise to explain such an outlook.⁹

Clearly, Summerfield's position is not widely accepted today. One cannot simply assume one is free to speak for victims, even if one sees them every day in one's clinical practice. The British psychiatrist learned this to his cost, for in criticizing the trauma industry publicly he came across as one of the last representatives of a repressive moral order that preferred to blame victims rather than comforting them. His denials fell on deaf ears, because merely the act of questioning the use of psychological means to prevent, cure, and treat the consequences of psychic trauma, or simply to comfort bereaved families, was seen as an attack on the fundamental rights of victims.

Summerfield's story reveals a profound paradigm shift that has occurred over recent decades and which is characterized by two significant developments. The first is that authority to speak in the name of victims is now measured by the speaker's personal proximity to the traumatic event. This development, which can be securely dated to the 1980s, was to determine the nature and form of both scientific and lay discourse on trauma. Summerfield's arguments were unacceptable to the victims because he claimed to defend their cause while at the same time condemning the trauma model as inherently Western. In doing so, he unwittingly revived doubts as to the authenticity of their suffering, restoring a link to the attitude of skepticism toward victims that had prevailed for over a century. Moreover, he distanced himself from the activist testimony of humanitarian psychiatrists and psychologists by adopting a truth position based only on his clinical knowledge. The second development was even more unexpected, because it reconciled the aspirations of some victim support groups with the orientation of certain groups of psychiatrists. This hitherto unthinkable marriage of convenience between social movements and mental health professionals came about not through giving clinicians the task of speaking for the victims, but on the contrary by giving the words of the victims themselves a form of clinical authority based on moral premises.

The growing influence of victims' associations, the proliferation of professional medical and social support structures, media coverage of

⁹ See "Victims' Suffering Is Real," January 14, 2001, and January 19, 2001, at <http://bmj.bmjjournals.com/cgi/eletters/322/7278/95#11900>.

psychological care for survivors of all sorts of disasters, the establishment of medical and psychological emergency units in France, and even the creation of a Ministry for the Rights of Victims, are both symptoms and catalysts of these changes. The victim's word can no longer be doubted—to the extent that in 2004 the Minister (who did not remain long at her post) went so far as to suggest enshrining in law a “presumption of good faith” (on the model of the presumption of innocence), which would prohibit the expression of doubts as to the authenticity of a victim's testimony unless evidence to the contrary was provided.¹⁰ This reversal, which as we shall see dates back to the 1980s in the United States and the 1990s in France, was the result of an unprecedented meeting of the interests of victims with those of psychiatrists. It is all the more remarkable that psychic trauma should become the locus for this validation of victims' stories, because nothing in the development of psychopathological concepts would have predicted such an outcome. Indeed, it is not in advances in psychiatry and psychology that we should seek the reasons for this transformation. On the contrary, it was changes in the social order and social values that, if they did not actually produce the clinical innovations, at least made them possible.

We therefore argue that the reconfiguration of the relationship between trauma and victim, in which the victim gains legitimacy as trauma comes to attest to the truth of his or her version, has a dual genealogy—on the one hand scientific, based on the definition of trauma, and on the other moral, focused around the acknowledgment of the victim. Both have their roots in late nineteenth-century Europe. The scientific lineage passes through the great names of early twentieth-century psychiatry and psychology, notably Charcot, Freud, and Janet. Both in agreement and in contradiction of one another, they first established the reality of psychic trauma, which was to become a central pillar of their subsequent theories.¹¹ Moreover, it is in this intellectual tradition that the transformations of the concept, from neurosis to post-traumatic stress, from seduction theory to the fantasy hypothesis, are rooted. Thus a continuity emerges

¹⁰ Established amid a blaze of publicity by Jacques Chirac the day after his party was defeated in the 2004 regional elections, the Ministry for the Rights of Victims symbolized the government's new goal of responding to the concrete needs of the French people. While it was not strictly speaking new, since it took over from the Victims' Office, which already existed under the authority of the French Lord Chancellor, the appointment of Nicole Guedj to this post was clearly intended as a strong message to the victims' associations that the voice of victims would finally be heard (interview with the Minister on October 21, 2004).

¹¹ The most complete history of trauma neurosis is that by Allan Young (1995). A more succinct analysis can also be found in Hacking (1995), who takes a very anti-Freudian stance. By contrast, the genealogy traced by Ruth Leys (2000) includes an extensive account of Freud's contribution to the psychoanalysis and understanding, and even the problematization, of trauma.

that takes us from the first descriptions of survivors of train accidents and, later, war casualties in the late nineteenth century, to the broader vista of the late twentieth century that includes survivors of sexual abuse and torture. Most historians suggest that changes in collective sensibilities—i.e., in the way in which trauma and more particularly the victims of trauma are depicted—come about as a result of scientific developments.¹² But in fact the direction of this causal relationship is far from one way. There is a moral genealogy running parallel to the scientific development. It derives from the collective process by which a society defines its values and norms, and embodies them in individual subjects. That process functions by taking account of the ways in which trauma neurosis is understood and using them to legitimize or exclude, compensate or condemn those who, for a long time, were neither thought of nor named as victims. This history is also and above all a history of hierarchy and inequality which, more cruelly than many other aspects of human life, distinguish between individuals who have suffered painful events. The way in which one's suffering is viewed will depend on their status or their social usefulness. Thus, the history of trauma is one that expresses, in the most concrete terms (by awarding compensation for an accident at work or a war wound, or more recently by providing treatment to victims of a violent event), a particular idea of the human being, of her or his relationship to the nation, and of the solidarity a society should have with its maimed, whether they are in the open for all to see or hidden away. Therefore, alongside an intellectual history of trauma, we need to give consideration to its social history.

THE BIRTH OF TRAUMA

The path to trauma psychiatry was opened by Charcot, who took great interest in the earliest accounts by London doctors, between 1866 and 1870, of the effects on the nervous system of powerful disturbances following railroad accidents. The surgeon John Eric Erichsen was the first to describe the clinical symptoms manifested by some survivors of these accidents. At that time clinical accounts did not use the term "trauma neurosis," nor was there any suggestion of a psychological etiology. The cause was thought to be a nervous system attack that could not be detected by the methods of the time, but would be identified in the future through the development of more effective exploratory techniques. Initially the attacks were attributed to micro lesions of the spinal cord re-

¹² For example, Claude Barrois (1988) and Louis Crocq (1999) systematically make this type of inference in their articles, which are in fact histories of a diagnostic category.

sulting from the railroad accident. The condition was referred to as "railway spine," and later, when hypotheses regarding its etiology were refocused, as "railway brain." The syndrome was again studied by the German psychiatrist Oppenheim, who gave it the now well-known name "trauma neurosis."¹³ But when Charcot seized on this notion it was not with the aim of deepening knowledge of the consequences of railroad accidents, nor even of extending it into the psychological arena. In fact, from the outset he contested the specific nature of this disorder, proposing that it should be subsumed under the heading "hysteria." As Ian Hacking has rightly pointed out, the trauma model allowed Charcot to confirm his hypotheses on hysteria (particularly the form it took in male subjects) and thus to remove it from the sphere of gynecology and give it a neurological identity. Trauma neurosis was not the true object of Charcot's scientific interest; it was merely that he found the parallels with hysteria, indicated by certain symptoms, useful in demonstrating that hysteria affected both sexes, the strong as well as weak, both effeminate men and the most virile, indiscriminately.

It was Freud and Janet who introduced a psychic etiology into theories of trauma, but with marked differences in their analyses. For both, trauma neurosis offered an opportunity to affirm, in opposition to Charcot, the exclusively psychological origin of hysteria, but they had no interest in pursuing the fate of accident victims. For them, the critical issue lay elsewhere.

As early as his philosophy thesis on psychological automatism,¹⁴ Pierre Janet introduced the idea that hysteria originates from psychic trauma. Trauma neurosis represents an adult's response to an event in early childhood. Thus Janet moved a clear step beyond Charcot in connecting the etiology of hysteria with a psychological response to an external trauma. He did not see the anatomical link that Charcot postulated. But while he considered hysteria as a psychological illness, the nature of trauma remained problematic. His thesis was that it derived from a shock resulting in a purely mechanical psychological reaction (in contrast to a neurological, i.e. anatomical reaction) arising in a predisposed psychological terrain. It was thus the coming together of an external trauma with this psychological precondition that resulted in hysteria if the trauma occurred in childhood, or in trauma neurosis if it happened in adulthood.

Charcot's lessons enabled Freud to construct his own theory of hysteria while borrowing from trauma neurosis the idea that an external etiologi-

¹³ His book *Die traumatischen Neurosen* is cited in all bibliographies on psychic trauma and became the founding document of trauma neurosis, despite the fact that the notion existed before Oppenheim and that he himself remained an ardent defender of the neurological hypothesis.

¹⁴ Janet (1889).

cal agent was taken into the psyche and gave rise to the symptoms of hysteria, which by this time were well known. In this first paradigm, known as seduction theory, Freud linked hysteria to a sexual trauma in infancy.¹⁵ The parallel with trauma neurosis was essential to his demonstration: the fact that in adulthood certain events can provoke symptoms similar to those of hysteria was proof that common hysteria, though it could not be explained by any recent event, was also a trauma pathology, one that was caused by childhood events. "The closest analogies to these conditions of our neurotics are furnished by the types of sickness which the war has just now made so frequent—the so-called traumatic neuroses. . . . The traumatic neuroses are, fundamentally, not the same as the spontaneous neuroses which we have been analyzing and treating. . . . Yet on one point we may emphasize the existence of a complete agreement between the two forms. The traumatic neuroses show clear indications that they are grounded in a fixation upon the moment of the traumatic disaster. In their dreams these patients regularly live over the traumatic situation; where there are attacks of an hysterical type, which permit of an analysis, we learn that the attack approximates a complete transposition into this situation."¹⁶ In this way Freud worked trauma into his general theory of neuroses. Inverting traditional understanding, he used the symptoms as a basis for affirming the existence of a forgotten or repressed trauma. Nevertheless, even before he abandoned this first theory in 1897, Freud was already changing his attitude toward childhood trauma. In his new view, hysteria did not emerge as a result of sexual abuse in childhood. Rather it was because the sexual was already traumatic in the psyche that encountering abuse in childhood gave rise to hysteria. He believed that the hysteric was already sick from the sexual before encountering the abuse that would give rise to the symptoms of hysteria.

Thus two radically opposed conceptions of trauma coexisted in this theory of hysteria. The first, classic theory sees the source of trauma as an external event (sexual abuse during childhood). This theory was influenced by observations of trauma neurosis but also, and probably more significantly, by the ideas of Freud's great rival Janet, whose hypotheses were enjoying international success at this time. However, Freud restricted trauma to the sexual sphere, while Janet included all potentially traumatic events. The second conception of trauma, which surfaced even in Freud's first writings, is much bolder and more personal, since it presupposes that the sexual is already traumatic in the unconscious. The traumatic event is not the sole etiological agent. It is at most, as in Janet's view, the cause of the trauma's emergence. But Freud goes much further, attempting for the first time to assign psychological content to the notion

¹⁵ Freud and Breuer (1956).

¹⁶ Freud (1920 [1916]), p. 237.

of "trauma." Psychological trauma is not only the organism's reaction to an external event, it is integral to the way the psyche functions.¹⁷ Thus the traumatic, in the psychoanalytic sense of the term, is already present even before an event causes it to manifest itself. "For the expression 'traumatic' has no other than an economic meaning," he writes, "and the disturbance permanently attacks the management of available energy. The traumatic experience is one which, in a very short space of time, is able to increase the strength of a given stimulus so enormously that its assimilation, or rather its elaboration, can no longer be effected by normal means."¹⁸ This represents a fundamental shift in theory.

The abandonment of seduction theory, to be replaced by the fantasy hypothesis, thus appears as a direct consequence of this second conception, which was to supplant definitively the idea of an external causal agent.¹⁹ With the publication of *The Interpretation of Dreams* in 1900, Freud offered a brilliant demonstration of his first intuitions. Dreams in effect supplied him with material that was above suspicion, since the issue was no longer whether what patients were saying was true or not, dreams being by definition unverifiable, nor even whether or not their unconscious desires drove them to commit or submit to what they reproached themselves for, but rather to show that "unconscious thought" could on

¹⁷ In Freud's work the notion of "trauma" has to be linked to that of repression, which is a thread running through all of his work. In his early writing repression and the unconscious are virtually indistinguishable, insofar as the unconscious is seen as essentially constituted of repressed representations: see in particular the correspondence with Wilhelm Fliess (Freud 1979). In *The Interpretation of Dreams*, Freud modified this initial approach, emphasizing that the unconscious cannot be reduced simply to repressed memory, and introduced the idea of the return to repressed memory (Freud 1900 [1913]). Subsequently he refined the notion still further, while retaining the close link with the idea of trauma. For example, when the psyche is subjected to irreconcilable internal excitations (which it literally cannot tolerate), it immediately puts in place a mechanism that Freud terms repression to bar them from consciousness in order to protect psychic integrity. Thus repression ensures that intolerable excitations do not reach consciousness in the form of psychic representation, by detaching the intolerable affect from its original representation. Hence the work of repression distances the representation, but cannot remove the affect attached to it. In the Freudian view, it is the affect that is traumatic, because it causes a breach in the psychic economy. By detaching the affect from its original representation, the psyche eliminates the intolerable representation from consciousness, but allows the affect corresponding to it to become linked to another representation, usually harmless and acceptable to consciousness, which will however, become a source of psychic suffering (a symptom), less devastating, but whose origin the subject, by definition, fails to recognize.

¹⁸ Freud (1920, pp. 237–238). Modern psychoanalytical literature regularly makes reference to this central hypothesis.

¹⁹ Contrary to Masson (1984), who suggests that Freud would have had no theoretical reason for abandoning seduction theory in favour of fantasy theory had he not been subject to intense external pressure, it seems to us more correct to consider that the first theory of hysteria contains the seeds of elements of the second, positing trauma as one of the organizing principles of the organism.

its own be the source of or unleash the symptoms of which these patients complained. "Psychic reality," for which Freud strove to create a place in science, had at least as much power, if not more, over consciousness and the unconscious as the manifestly real. He took trauma definitively into the arena of the psyche, and in subsequent psychoanalytic writing the term "trauma" was used to show clearly that what was under discussion was not the external event but rather the internal force which, when it encountered certain events or fantasies, would produce the pathological manifestations described by psychiatric semiology. For Freud as for Janet, the event was not the key to trauma neurosis.²⁰ Both believed that the study of trauma neurosis formed the perfect basis for the development of more general concepts of psychopathology.

Paradoxically, however, while in the aftermath of World War I the dominance of trauma neurosis theory established Freud as the victor in this debate, the reversal of 1980 and the emergence of PTSD would, as we shall see, mark a return to Janet's way of thinking.²¹ The formula that gradually began to emerge from the 1960s onwards literally reversed Freud's hypotheses, shifting the blame for trauma neurosis from a traumatic sexuality from which everyone suffers to a traumatized sexuality, the cause of which lies squarely on the shoulders of an external abuser. But at the beginning of the twentieth century, clinical practice in the care of psychic trauma was guided not so much by scientific debate as by more trivial questions of compensation, especially in the context of employment.

LABOR LAWS

Far from the lofty academic circles where scientific theories were being debated, the notion of trauma neurosis emerged in another arena, where

²⁰ Both Young (1995) and Hacking (1995) argue that the opposition between Freud and Janet rests above all in their conceptions of memory. In the view of these authors, memory is the central factor in trauma neurosis. Without denying the importance of this factor, it seems to us nevertheless that it played a minor role in the social practices which were being established at the time. Conceptions of the time were far from considering trauma an illness of memory, further still from the notion that it involved collective memory. Moreover, we shall see later that the shift from individual memory to a collective memory of horror is much less assured than appears here.

²¹ This revival of Janet's theories in contemporary psychiatry is not limited to post-traumatic disorders. Multiple personality disorder, the epidemic of which has been studied by Ian Hacking (1998) and Sherill Mulhern (1991), would never have seen the light of day without the unwitting support of Janet's early ideas on the splitting of personality. Alain Ehrenberg (1998) even makes this return to Janet the center of his analysis of the current prevalence of depression as a diagnosis.

it would remain for over half a century. The premises were laid down from the first descriptions of the condition in 1866. Whether or not there was an invisible anatomical lesion, whether the disorder was a form of secondary hysteria or a distinct illness, whether the disturbance was neurological or psychological, one thing seemed certain from the outset: these disorders appeared after an event, and more specifically (a reflection of their frequency and novelty at the time), after a railroad accident. In the context of the emerging insurance industry, these disorders called for compensation, and it was on this premise that the first doctors to become interested in neuropsychological disorders subsequent to shock based their work. Erichsen himself battled with railroad companies to force them to compensate the injured, even when they presented no physical injuries.²² Thus, the primary context for trauma neurosis in the late nineteenth century was financial compensation. Unlike all other forms of mental illness—where the etiological agent, although it might vary over time and with different theories, is never an external party that can be prosecuted—trauma neurosis offered grounds for suggesting a right to compensation, given the nature (albeit undefined) of its causal agent.

However, the psychiatrists and psychologists who succeeded these pioneers specialized in providing expert opinion on the victims of psychic trauma, and they were much less conciliatory toward people complaining of the condition. A new discipline had been established to accompany the application of the 1898 law on accidents at work.²³ Forensic psychiatry, which until then had been confined to the evaluation of major criminals or “abnormal inmates” in prisons, found in trauma neurosis an opportunity to enlarge its domain of expertise.²⁴ This is a crucial point. Contrary to widespread belief in psychotraumatology circles, trauma neurosis was not restricted to military psychiatry until the recent emergence of victimology.²⁵ While general psychiatry textbooks said little about the disorder, the main texts in forensic psychiatry expounded on it at some length. It is there that we must seek the first attempts by society to actively engage trauma; there too we can measure the influence of social conceptions which establish the norm, the value of a subject, the price of a life. And

²² Hacking (1995).

²³ Thus, in his report on sufferers from trauma neurosis, given at the 19th Congress on Forensic Medicine in France, Costedoat (1935) stated that “trauma neuroses, born with the railroads, proliferated when the 1898 law on accidents at work came into force.”

²⁴ On the development of forensic psychiatry in the prison context, see Michel Foucault’s series of lectures (1999) and Marc Renneville’s book (2003).

²⁵ It is true that in France most modern writing on trauma neurosis is by military psychiatrists, who find it easy to claim that their discipline was the only one to concern itself with this disorder (Barrois 1988; Crocq 1999; Crocq, Sailhan, and Barrois 1983; Vaiva, Lebigot, Ducrocq, and Goudemand 2005).

it is there that we first encounter the psychiatric theory about the obscure reasons for workers “preferring” to be sick rather than to serve the nation through their labor, which anticipates the suspicion that would, a few years later, be turned on soldiers accused of not wanting to defend their country in a time of danger.

We are far here from the key clinical cases analyzed by Charcot, Freud, and Janet, where the detailed study of symptoms, personality traits, and behavioral characteristics of the patient constituted the basis for a process that genuinely aimed at advancing knowledge. Alongside the handful of cases that served to establish the pioneering conceptions and which have been widely revisited in the modern literature on trauma, a multitude of fragments of individual stories can be found in the chronicles of forensic medicine. Following an accident at work or on the railroad, a fire in a poorly maintained building, or an emotional shock in a factory, the workers of the early twentieth century found to their cost that the same law that protected them by granting them financial compensation also relegated them to the degrading new status of “hysterical trauma victim.” As the archetype of a clinical category, which, more than any other, focused the social prejudices of the time, inspiring scorn and drawing suspicion, trauma neurosis came into conflict with the moral values of the nation.

Railroad accidents remained center stage for some time, principally because they caused a major public stir. The novelty of the train as a means of transport, the anxiety of the first users, and a few spectacular accidents in the early days of the railways sufficed to make it one of the great dangers threatening the population as a result of advances in science and technology. Giving prominence to the mental consequences of accidents, even in those who suffered no physical injury, risked reviving popular fears and exciting a degree of compassion for the traumatized. However, survivors of railroad accidents were not the largest group of patients subject to a diagnosis of trauma neurosis. Against a background of rapid economic expansion, where working conditions remained harsh and often dangerous, and where labor rights were still in their infancy, the greatest number of trauma neurosis diagnoses were given to the victims of workplace accidents.²⁶ But at the dawn of the twentieth century society was much less benevolent towards workers than towards the victims of railroad accidents, and a new notion emerged to account for the psychological after-effects of accidents at work. Initially the aim was to find a specific disorder that could be distinguished from railroad trauma neurosis and would align, as narrowly as possible, with the provisions for compensation enshrined in the law of 1898.

²⁶ Georges Vigarello (2005).

In December 1907, giving evidence before the Fourth Chamber of the Civil Tribunal of the Seine, Edouard Brissaud introduced the term "sinistrosis." A former pupil of Charcot, Brissaud was a doctor at the Hôtel-Dieu hospital and a professor at the University of Paris school of medicine.²⁷ He returned to the idea again in a 1908 article in *Le Concours Médical*, and this publication established "sinistrosis" as a diagnosis that would retain its legitimacy until it was abandoned in the mid-1970s.²⁸ The first lines of this short monograph set the tone:

In all the countries which provide compensation for accidents at work, "insured" injuries take much longer to heal than "non-insured" injuries. The whole question of sinistrosis boils down to this hard, unarguable, and uncontested fact. What is the cause of this prolonged incapacity to work? It is a morbid state—sinistrosis—which consists in a very particular inhibition of the will, more precisely, of good will.

The psychiatrist was nevertheless conciliatory, refusing to consider sinistrosis as malingering or even as hysteria, and expressing regret that insurance company doctors systematically confused these conditions. A disease peculiar to workers in the industrial era, he argued, sinistrosis emerged after an accident at work, often minor, and was characterized by a categorical refusal to return to work, even when the injuries had healed, until financial compensation had been awarded. The clinical signs were similar to those of hysteria: fatigue, nightmares, pseudo-paralysis, and diffuse pain with no neurological basis. They were also similar to those of trauma neurosis. Brissaud asserted that it was because the 1898 law gave them the right to compensation that workers retreated into this "claimant's" disease. The symptoms did not respond to suggestion, stimulation, or even "strong" methods, and only disappeared when compensation had been awarded. A rapid ruling on compensation for the distress was therefore called for, without awaiting complete recovery (which would not occur in any case), in order to award a sum which should

²⁷ Cited by Costedoat (1935).

²⁸ Brissaud (1908). Until the end of World War II, sinistrosis and trauma neurosis were treated in the same way. However, trauma neurosis gradually gained much greater social recognition, while sinistrosis took the stigma of inhibition of goodwill to the level of caricature. Transferred from the world of workers to the great waves of migrants from North Africa in the 1950s and 1960s, sinistrosis became the preferred diagnosis to qualify the suffering of "immigrants seeking to take illegal advantage of the generosity of the French state." In the 1970s, with the emergence of a highly politicized psychiatry of migration (Berthelier 1994, de Almeida 1975), the concept was sharply attacked and condemned as a racist tool used to exploit immigrants.

nevertheless be modest.²⁹ In conclusion, Brissaud noted that although theoretically middle-class people were just as likely as manual laborers to develop *sinistrosis*, the working conditions of the laboring class unfortunately gave rise to more frequent accidents.

Many of the writers of the time shared neither Brissaud's diagnostic interpretation nor his relative concern for the workers making claims, and while they accepted his clinical description, they considered *sinistrosis* a simple variant of trauma neurosis, which itself was to be classed with hysteria.³⁰ Despite symptoms that sometimes differed, the two concepts rapidly became associated, precisely because a supposedly exaggerated demand for compensation formed the pathological core of both conditions. Indeed, according to specialists in forensic medicine, *sinistrosis* and trauma neurosis were both "claim neuroses." In their view, the bad faith of those suffering from *sinistrosis* was equivalent to that observed in trauma neurosis, and the persistence of sufferers' symptoms despite robust treatment was proof that they had little will to recover. The suspicion hanging over the cause of these two clinical conditions (malingering or prior weakness) was reinforced by the interest that patients (almost all of them manual laborers) showed not only in the expectation of compensation but also, and perhaps even more, in their alleged inability to return to work and thereby to serve their country. The solution proposed for these recalcitrant patients was a speedy but definitive offer of limited financial compensation, calculated to break the cycle of gains and get them back to work as quickly as possible. Thus the issue of compensation was crucial and put specialists in what they themselves found to be an ambiguous position. Ideally these patients, whether they presented with *sinistrosis* or trauma neurosis, should not receive financial compensation (because their deception was more or less conscious and they suffered from a prior psychological weakness), but the law of 1898 opened a clear avenue for them, and only financial reparation would put an end to their complaints. However, whether such patients were "genuinely" sick or "pretending," the conclusion was the same: these men had no regard for the values of the nation and deserved to be treated with the disdain they aroused. The neurologist Joseph Babinski was already saying that "a hysteric who will not be persuaded that he is cured must be suspected of bad faith."³¹ This implied judgment held equally for those suffering from *sinistrosis* and from trauma neurosis.

²⁹ Brissaud added this note some years later, much less generous than in his first article: "Permanent incapacity benefits should be awarded, but at a very low level, much lower than that appropriate for similar disorders which have an organic origin" (Costedoat 1935).

³⁰ See Héacan's historical reference (1954).

³¹ Cited by Costedoat (1935).

Thus, a few years before the outbreak of World War I, suspicion of malingering, bad faith, and financial motives had already spread through the field of trauma neurosis. Military psychiatry, borne along in the patriotic fervor, simply took up and radicalized diagnostic and therapeutic methods that had already been tested by putting workers suffering from claims neurosis back to work. Forensic psychiatry paved the way. Thus, contrary to the dominant historiography of trauma neurosis, which presents current conceptions as deriving from the first descriptions of the disorder in the late nineteenth century, the history of the evolution of clinical concepts and social usages of psychic trauma is far from being a story of a long and difficult struggle for recognition of the rights now accorded victims.³² While the clinical category has undergone no semiological modification since those first writings, thinking about the psychopathology of trauma has undergone radical changes, marked by ruptures, reversals, contradictions, and conflicts that owe more to the development of social sensibilities and to economic and political tensions than to movements within psychiatric or even psychoanalytic epistemology. The history of claim neurosis affects specific groups: first workers, later immigrants, and, of course, rank-and-file soldiers (rather than officers)—the workforce in a rapidly expanding industrial society and cannon fodder for its great international conflicts. It is the reluctance of these patients to accept their allotted role in society that renders their psychological illness suspect.

Today it is widely held that trauma enables people who are suffering to share the common lot of a suffering humanity, without distinguishing victims on the basis of social position or of the kind of painful event they have experienced. We will show, however, that hierarchies and inequalities are still firmly in place. In returning to this first moment when trauma was introduced into forensic psychiatry, we have in a way been uncovering its archaeology. Next we will broaden our perspective to look at the history of trauma in military psychiatry.

³² Rechtman (2002) puts into perspective the function of this rhetoric in the contemporary usages of trauma.

The Long Hunt

MOST HISTORIANS OF THE FIRST WORLD WAR recognize that extolling patriotism was the main tool used by the army to bolster its soldiers' fighting spirit.¹ However, while the ultimate sacrifice of "dying for one's country" (*pro patria mori*) was promoted as the highest ideal,² the day-to-day reality of the "carnage of 1914–1918" reveals a very different attitude toward death and the hell of battle. At the front, on both sides of the trenches, fear was far stronger than fighting spirit. It was fear that governed the troops' morale, despite the military authorities' intense propaganda efforts to glorify the heroic ideal. The companionship of a few comrades in misfortune huddled together, the group drinking sessions following an attack on the enemy, even the exhilaration of unleashing a "murderous madness" were but different facets of this same fear, individual or collective, which took the place of heroism.

In *La Guerre censurée* [The censored war], Frédéric Rousseau gives a vivid account of the daily life of soldiers confronted with the horrors of a conflict that was to transform the public image of war.

This war, more than any earlier conflict, called into question habitual ways of portraying death, including and most particularly death in combat. It tore the blindfolds from several million men; it ripped the veils which until that point had hidden behind-the-scenes events from the living. In the course of this long war, for tens of millions of men, death became visible (it was everywhere), they could smell it (it stank), they could hear it—and this was completely unexpected. Conventional notions disintegrated, the centuries-old code was blown apart. Part of the scandal of this war lay precisely in the unprecedented, unheard of spectacle that it presented. All modern defenses against the anguish of death dissolved. The soldier in the Great War was no more prepared than any other man of the early twentieth century to confront such horror. In the preceding century, Western man appeared to have broken definitively with the culture of torture and massacre. Never had repugnance towards bloodshed and sensitivity to horror and suffering reached such a level; never had intolerance for these ills been so great. And yet this was what the soldiers were going to have to face."³

¹ See, for example, Keegan (1998) and Wahnich (2002).

² Kantorowicz (2004).

³ Rousseau (1999, p. 203).

A plunge into the chaos that the world became for soldiers in World War I shows us a day-to-day life where fear is the foundation of all the combatants' reactions: fear of death, fear of being wounded, fear of day or of night, of attack or of waiting, of corpses and of the predators that hover around them, fear of one's own body. This is a restricted world where the isolation of the ranks is cannily maintained by their officers, who dole out scraps of information on the progress of battles and the scale of offensives. The men are cut off from the rest of the world, their only point of contact being an invisible enemy crouched a few dozen meters away and ready to kill at the slightest movement and, behind the lines, a fearsome military police, authorized to shoot any deserter on sight. In such conditions, self-sacrifice sometimes becomes the only way of escaping the unrelenting fear that paralyses muscles and releases sphincters, piling shame and humiliation on top of terror—the fear that freezes conscience at the same time as it opens a vision of hell in which bodies blown to pieces or horribly mutilated form the only horizon. Should you throw yourself forward to meet death in an apparent burst of heroism, or fall back like a coward to be mown down by your own side? Dying for one's country most often comes down to a simple choice of the source of the lethal bullet, death at the hand of foe or friend.

COWARDICE OR DEATH

In this impossible situation, where death either through bravery or through desertion seemed inevitable, evacuation on medical grounds was often the only way out. The role of military doctors here was crucial, and it was to see an unprecedented expansion over the course of this war.⁴ Surgery, medicine, and the prevention of infection were practiced as close as possible to the front, just behind the front lines, not only in order to administer first aid as quickly as possible, but also—and perhaps especially—to reduce the number of soldiers evacuated to the rear and enable the “lucky ones” (those with less serious injuries) to return to combat as quickly as possible. Although it was possible for men to be removed from the hell of the front on medical grounds, the decision on who would be evacuated and who was well enough to return to the fray was closely controlled by the military authorities. Doctors were given the heavy burden of deciding on the immediate fate of the wounded. They had to evaluate the extent of injuries rapidly and then make an even more decisive

⁴ Sophie Delaporte (2003) has analyzed the development of medical thinking over the course of the First World War, as well as emphasizing the ambiguities inherent in the close collaboration between physicians and military authorities.

assessment. Was this an authentic war wound or a self-inflicted mutilation that could be classed as an act of covert desertion? Seeking out malingerers became the central goal of medical screening.

However, while the heroism of those with physical wounds went unquestioned (provided that they were not suspected of self-mutilation), psychological damage was not looked upon nearly so favorably. The psychologically damaged were classed with soldiers who sought to escape combat by deliberately wounding themselves or who refused treatment in order to avoid returning to the front, and they were regarded with the same suspicion.⁵ Traumatic neurosis earned the contempt of the entire military establishment—rank-and-file troops, officers, even doctors. However, not all mental disorders were tarred with the same brush. “Combat madness,” a serious manifestation of anxiety, panic, and exhaustion, which was rife in the trenches, escaped condemnation. This murderous insanity could be seen as an act of bravery, albeit senseless bravery, driving men to the supreme sacrifice and sowing death and terror among the enemy ranks. Though tainted with insanity, such a sacrifice was seen as an exemplary death that could revive the zeal of the most despairing and encourage others, fired up with renewed combat fervor, to take advantage of the resulting enemy confusion by launching a surprise offensive. Suicidal behavior came to represent the essence of heroism, transforming an unreasonable act ultimately motivated by fear into a burst of courage. It excited admiration, renewed hope, and reignited ardor in the troops.

“Trauma insanity” was something else entirely. It isolated the soldier from his companions in arms. Unable to move beyond fear and anguish, he submitted pathetically to them. Instead of restoring the dignity of combatants, it disgraced them. Rather than galvanizing the troops, it weakened them by ruining their morale; rather than glamorizing patriotism, it rejected it simply to preserve the individual’s life. It appeared all the more illogical because by turning its back on death, on the essential sacrifice that, ideally, each man must be willing to make, it endangered the group and each of its members. It was therefore necessary to make an example of those suffering from the condition, in order to restore collective honor. By defining traumatic neurosis as the pitiful alternative to “dying for one’s country,” the armed forces essentially set a context for interpretation and treatment that would prevail throughout the years of the war, on both sides of the conflict. Traumatic neurosis, a combat

⁵ Nonetheless, Delaporte (2003) emphasizes that the attitude of doctors towards soldiers who deliberately injured themselves in order to escape combat softened increasingly over the course of the war. This development, which Delaporte sees as reflecting a greater sensitivity to the suffering of combatants, contrasts with the persistence of pejorative stigmatization of those suffering from psychic trauma (Brunner 2000).

illness recast as the selfish desire, whether conscious or unconscious, to escape enemy fire, came to occupy center stage in the theater of disgrace. A man's patriotic convictions, his sense of duty, and the jolts of his conscience and unconscious desires were subjected to meticulous analysis, judged, and often condemned. Suspicion set the tone for diagnostic and therapeutic practice.

However, this suspicion directed at war neurosis was, in a way, very similar to that which had contaminated physiopathological and etiological conceptions of *sinistrosis* from the time that condition was first identified. Claims for financial reparation were automatically questioned. World War I temporarily mitigated the fear of fraudulent compensation claims,⁶ but this gave way to a more damaging charge: cowardice. In the early years of the century, there was already a tendency to associate the malingering of *sinistrosis* and traumatic neurosis sufferers with cowardice. The malingerer was at worst a fraud or conniver, at best a vulnerable patient who passively allowed himself to be misled by his own weakness and indulged an imaginary suffering. But the context of the war reinforced this tendency. Malingering was classed as a sort of "psychic desertion," doubly to be condemned because it both failed to conform to the patriotic ideal and could undermine morale in the ranks. Thus war neurosis reveals what is seen as a conflict of interest between the soldier suffering from it, who tries through his illness to escape the carnage of the trenches, and the interests of the military, which asserts that morale depends on the patriotic consent of all—and therefore of each individual—to the sacrifice of their lives. There is no place here for bearing witness to horror, even if it is carved into the psyche.

THE BRUTALIZATION OF THERAPY

All the historians who have examined the role of doctors, and particularly of psychiatrists, during World War I make the same observation.⁷ In none of the countries involved were the army medical services in any way

⁶ Even during the war the question of reparation for combat shock remained current and often reinforced suspicion of those suffering from trauma—as witness the categorical verdict of Dr. Clovis Vincent, an ardent supporter of the most brutal therapeutic methods, as we shall see: "This is a highly moral issue: we are asking the men at the front to give all they can, to give more than they can on a physiological level. It is also an issue of justice. The amount that France can give to those of her subjects wounded in her service is finite, that is, this amount is represented by a number. So I ask, is it not just to make the whole of this amount available to those who are genuinely no longer able [to fight]? Is it just to share it with men who could still fight if they wanted to?" Cf. Vincent's 1916 article in the *Revue Neurologique*, cited by Rousseau (1997, p. 15).

⁷ See in particular Brunner (2000), Delaporte (2003), and Rousseau (1997, 1999).

prepared to receive the flood of psychologically damaged patients that began in the very first months of the war. They add that this is all the more surprising given that they had access to scientific data that should have alerted them to the psychological risks of modern warfare. Russian reports on the psychiatric consequences of the Russo-Japanese War of 1904–1905 had been widely disseminated. Referred to and commented on in several different languages—including, in 1912, in the main French psychiatry journal of the time⁸—these reports documented the fact that losses due to psychological conditions had been sufficiently extensive to justify the establishment of “special sections for the treatment of insane soldiers.”⁹ According to the historians, the lack of preparation explains both the chaos in the medical services generated by the psychologically wounded and, particularly, the approach taken by psychiatric practice towards these “patients,” which was decidedly more inquisitorial than compassionate.

However, these historians suggest a more qualitative explanation for the psychiatric violence. As José Brunner points out in the case of Austria-Hungary, and Sophie Delaporte and Frédéric Rousseau show for France, the theoretical lineage of war neurosis—which passed through the great work of Oppenheim, Charcot, Freud, and Janet—in no way accounts for the therapeutic methods established from the very beginning of the war to treat traumatized soldiers. These authors, like those who hold to a chronological historiography of traumatic neurosis, take the view that war psychiatry, because it adopted the patriotic ideal, was forced to modify early theories on trauma in order to make them compatible with the expectations of the military authorities.¹⁰ Thus, according to this interpretation, the war resulted in a detour in the history of traumatic neurosis, marked by extreme diagnostic and therapeutic techniques which sometimes went as far as brutality.¹¹ Placed under the supervision of the military authorities, war psychiatrists had little choice but to conform to their

⁸ The *Annales medico-psychologiques* [Annals of medical psychology], which still bore the subtitle *Journal de l'aliénation mentale et la médecine légale des aliénés* [Journal of mental insanity and forensic medicine for the insane], was probably the French psychiatry journal most widely read by French psychiatrists, both civilian and military, at that time.

⁹ Cygielstreich (1912a and b).

¹⁰ In order to exonerate psychiatry in general from responsibility for the implementation of therapeutic methods that sometimes amounted to little less than torture, the classic historical account of war neurosis usually attributes the most problematic aspects of this period to a handful of individual psychiatrists—notably Professor Wagner von Jauregg, whose widely publicized trial in Vienna at the end of the war offered the undeniable advantage of a scapegoat (see Brunner 2000, Barrois 1988, Crocq 1999).

¹¹ Brutalization is a concept that was developed by the German historian George Mosse (1999) to explain the violence meted out to soldiers during the 1914–1918 war. Sophie Delaporte (2003) takes up this concept and also applies it to military medicine, at least in France.

expectations. According to this view, Clovis Vincent's famous "torpille,"¹² electrotherapy, psychological coercion, and persuasion were simply consequences of this passive acceptance of military pressure. Moreover, it is suggested, the failure to anticipate the extent of psychiatric damage reinforced the need to hunt out malingerers.

In fact the case is far from proven. In contrast to this theory that the brutality of some war psychiatry was an accident of the history of traumatic neurosis caused by the unexpected extent of the tragedy and powerful pressure from the military, we want to advance a different reading, in which World War I, rather than marking a temporary hiatus in the clinical treatment of traumatic neurosis, actually leads to a convergence between scientific conceptions of war neurosis and the ethical ideas that were to remain associated with it until the late 1920s. This convergence occurred during World War I, when the image of the soldier traumatized by combat revealed the limitations of patriotic rhetoric. For it was above all the moral qualities ascribed to trauma patients, their lack of national or patriotic pride, their weakness of personality, and the suspicion in which their medical condition was held, that determined the social and medical responses to trauma that were established during the war years. The event itself, psychiatrists thought, the horror of combat, was simply the window that revealed the weakness of these men who were ultimately more unworthy than ill. In this sense, war psychiatry does not derive from the theoretical genealogy of the early twentieth century. Freud's early work had no influence in France and very little in Austria, at least at the beginning of the war. In Britain the first psychoanalysts did not begin practising until about 1917, and the content of their writings shows how little they were heeded. Janet's model had no more authority; as we have seen, it remained limited to a particular experimental psychology of hysteria, which was only much later associated with traumatic neurosis.

In 1914 the dominant paradigm in the psychiatry of war neurosis was still that of forensic medicine, with its suspicion that trauma, hysteria, sinistrosis, and malingering were all motivated by personal advantage. Thus, if we restore war psychiatry to its proper place in this genealogy—that of the forensic medical treatment of traumatic neurosis—the hypothesis of a major change in thinking does not hold. On the contrary, the model implemented by the various military health services is on a continuum with experts' reports on traumatic neurosis relating to workplace accidents. From this point of view, instead of seeing in their response a lack of preparation, we could say rather that the European armies' health services were fully prepared, but prepared to receive "psychic deserters" and not the psychically wounded. The medical strategies that were very

¹² Electrical "torpedo." —Trans.

quickly established testify to precisely this expectation. Moreover, the data from the medical literature on the Russo-Japanese War already tended in this direction.

In two articles published in 1912, Adam Cygielstreich articulated the basic principles which, combined with experience of civilian expertise in traumatic neurosis, were to form the ground for an overarching medical strategy within which suspicion of rank-and-file soldiers was the dominant force. Analyzing the material gathered by the Russians, Cygielstreich compared reactions following unexpected accidents, such as natural disasters, with those that resulted from more long-term conflicts, such as the Russo-Japanese War or the Russian Revolution of 1905, which he termed "social upheavals." The key point in trauma, as we know, is generally to evaluate the role of the event in the emergence of a reactive mental disturbance. According to Cygielstreich, there could be no doubt that it was not the event itself that was traumatic, but the surprise which it engendered. This explained why natural disasters could incite disorders in any subject, regardless of predisposing factors, while social upheavals only gave rise to disorders in people who, even without this particular upset, would have presented with mental problems: "The only victims of the revolution in Moscow were those who, by virtue of their psychopathological constitution, were predestined to this fate. Any other physical or moral agent might have produced the same effect. Political trauma should be considered a trigger rather than a determining cause of mental illness."¹³ In Cygielstreich's view, surprise could not account for battlefield trauma. Soldiers expected extreme experiences and prepared for them; some were even impatient for battle because they wished to be released from their anxiety. Thus, neither the event itself nor the element of surprise could be held responsible, since surprise was after all relative. A soldier knows that even the most alarming event—the explosion of a shell during a period of calm, for example—could occur at any moment. The data from the 1905 Russian Revolution showed that the more committed combatants were to the revolutionary ideal, the less susceptible they were to pathological reactions. Here we recognize the thinking that was to become so firmly entrenched. High morale among the ranks, patriotism, and the commitment of each individual to the just cause of the war were not only indispensable to the ultimate victory, but also factors that reduced the number of psychiatric casualties. The key element of this theory appears in Cygielstreich's final remark: "It is generally thought that those who suffer nervous illness are almost exclusively officers, educated and refined people. It has always been assumed that the rank-and-file soldiers, recruited from among peasants and farmers, are resistant to disturbances

¹³ Cygielstreich (1912a, p. 144).

of this order and thus not subject to nervous illness. This data appears to confirm long-established thinking that neurosis is extremely rare among rank-and-file soldiers and should not detain the attention of doctors."¹⁴ This comment makes explicit a notion that was widespread in psychiatry in the early twentieth century, namely that purely reactive neurotic conditions were to be found only in more educated subjects capable of analyzing the totality of a situation, perceiving its dangers, assessing its risks, and thus of feeling its consequences, first intellectually and then emotionally, to the extent of becoming frozen with fear. According to this theory, the ranks, less cultivated than the officers, lacked precisely these faculties of analysis. Since they were incapable of comprehending the totality of the issues facing them, any fear they showed was explicable only as the product of their own constitution, their condemnable selfishness, or their lack of fighting spirit. Thus, traumatic neurosis was not a typical mental illness in rank-and-file soldiers. Yet it presented in numbers that surpassed all expectations.

The question occupying the health services throughout the war was, therefore, not what events are liable to produce long-term pathological effects, but which soldiers are likely to develop a condition inappropriate to their social standing. Who were the men who were not protected by patriotism? What was the reason for their weakness, given that the event, the war, could not be the sole cause? Why did some yield to fear or anxiety to the extent of developing a mental disorder, while others subject to the same ordeals not only resisted but found resources within themselves to galvanize their comrades? Who are these soldiers who refuse the supreme sacrifice of their lives, preferring to take refuge in illness rather than to fight alongside their brothers in arms? These questions, put to war psychiatry by the military authorities, were accompanied by another, perhaps even more crucial question: Were these men not liable to undermine the morale of the ranks? Could they communicate their fear to others and cause epidemics? Should they be removed from the group in order to avoid contagion, or should they be forced to return to the front and take up arms again as soon as possible? The mental health procedures established by all the armies reveal how these questions were settled. The procedures adopted focused on the traumatized individual rather than on the situation, still less on the events that caused the trauma. Doubts regarding patriotism were resolved by presenting these men as malingerers and cow-

¹⁴ Cygielstreich is contrasting nervous illness (in this case combat shock) with psychosis (Cygielstreich 1912b, p. 260). Some Russian doctors asserted, on the contrary, that with better conditions for the examination of patients, and the abandonment of preconceived ideas about the rank-and-file, the proportion of those suffering neurosis would be the same as that among the officers. But the statistics showed 8.1% of officers suffering from neurosis, compared to only 1.3% in the ranks.

ards. The arguments put forward by medical experts, who even before the war had been suspicious of traumatic neurosis and of its oft-cited similarities with hysteria, provided further weapons in a medical arsenal designed to expose malingerers, unmask cowards, frighten the fearful, discredit the sick, and above all discourage other men of the ranks from adopting the same tactics to escape combat. The procedure most widely used by all military medical services was “faradism,” the application of electrical current to the skin.¹⁵ Initially developed to treat muscular paralysis, electrotherapy found a secondary use as a diagnostic and therapeutic method in the treatment of “hysterical pseudo-paralysis,” where the electrical current was believed to thwart malingering and to relieve functional hysterical paralysis. The same principle was applied to war neurosis: psychic immobility was likened to a hysterical paralysis that could be relieved by the application of an often painful electrical current that would force malingerers to admit their deception.

In France, Clovis Vincent quickly became known for his “persuasive” methods. He was doctor-in-chief for a local garrison in Tours, but he accepted patients from any of the fronts who had proved resistant to the usual therapies. Vincent was a devotee of the use of high-strength galvanic current, which he combined with injunctions to get well, or even with threats when the patient refused to recover. He boasted of regularly obtaining rapid results after what he termed a “merciless struggle” between patient and doctor. This struggle should be primarily psychological, he asserted, with the electric current serving simply as an illustration of the doctor’s determination. The patient who “refused” to get better had to be persuaded that he had no choice until he finally admitted his weakness and expressed pleasure and gratitude at his recovery. In a 1916 lecture to the French Neurological Society, Vincent described his methods: “Many inveterate hysterics whom we treated and cured immediately showed great joy at their recovery. Only a moment before, they were fighting us and seemed to be doing everything they could to avoid getting better. To ‘get them,’ we had to engage in a real battle. For an hour or sometimes two hours we hounded them (with exhortations repeated a thousand times in different ways, insults very often unjust, oaths, anger manifested in various ways, all supported by strong galvanic excitation), and through all this we had the impression that they were resisting recovery, that they wished at any price not to get well. Inevitably, the exhausted doctor, whose efforts seemed all in vain, would begin to suspect that they were malingering. But a moment later they became and remained happy.”¹⁶

¹⁵ See Eissler (1986) and Brunner (2000) on the use of this method in Austria-Hungary, Porot and Hesnard (1919) and Rousseau (1997) on France, and Rivers (1918) on Britain.

¹⁶ See Société de neurologie, session of June 29, 1916, “Au sujet de l’hystérie et de la simulation, par le docteur Clovis Vincent” [“On the subject of hysteria and simulation, by Dr Clovis Vincent”], pp. 104–7.

Recovery, he continued, could only be medically confirmed if the patient himself admitted, after the treatment, that he was better and wanted to return to the front.

For the most severe cases, Clovis Vincent had invented an electrical machine that delivered currents much stronger than those used by other medical services. Known as the "torpille" ("torpedo"), this machine sowed terror among rank-and-file to the extent that some would stop speaking of their suffering and their symptoms at the very mention of this shock treatment. Its reputation, however, remained unsullied in medical circles even after a long trial in which its use was challenged by a soldier with severe *camptocormia*.¹⁷ In one "torpille" session, this man had resisted the doctor violently, punching him in order to escape the electric current. At no point in the trial was Vincent's reputation called into question. Some experts expressed reservations about the use of strong galvanic currents, but none dared challenge this prestigious colleague who had published extensively and, moreover, enjoyed broad popular support.¹⁸ The affair made headlines in the newspapers, and it seemed that the whole of France supported the brave doctor, champion of the patriotic ideal.

Not all doctors resorted to such methods. As a rule, low-intensity currents were used, and the aim was not necessarily to cause pain. However, in all cases the primary intention was to expose malingerers, and then, through repeated sessions and the use of authoritarian arguments, to stimulate a decisive rejection of everything that these "weak" men were alleged to prefer to their patriotic duty. Neither faradism nor the efforts at persuasion aimed to treat the soldier's symptoms, which might include nightmares, anxiety, or pseudoparalysis. The treatment focused instead on his personality, his faults, what caused his weakness, all the factors that made him different from his comrades in arms.

¹⁷ *Camptocormia*, or progressive lumbar kyphosis, is a postural anomaly marked by abnormal flexion of the trunk. It appears in standing and is exacerbated by fatigue. It is due to weakness of the lumbar paravertebral muscles caused by fatty involution of the paravertebral muscles and most often affects patients over the age of sixty, especially women. During the First World War the muscular origin of this condition was not yet recognized, and it was classed as hysteria or even malingering.

¹⁸ In her book on World War I doctors, Sophie Delaporte (2003) recounts the Deschamp affair, which made headlines between June 1916 and August 1917. Deschamp, a Zouave, was prosecuted for refusing treatment (subject to the same punishment as desertion, i.e., the death penalty) and assaulting an officer. In the end the prosecution went forward only on the charge of assaulting a superior, removing the threat of the death penalty. Medical opinion was divided over this affair: some more sympathetic specialists attempted to show that Deschamp was not directly responsible for his violence, this being due rather to the "torpille" treatment which prompted the assault—thus tarnishing Vincent's image somewhat. Popular opinion was equally impassioned: the public supported Vincent and expected the malingering Deschamp to be convicted. But the verdict was in Deschamp's favor, and he was awarded an exemption from service with pension, although he was to remain under strict medical supervision.

Thus war psychiatry, with or without electrotherapy, offered both an answer and a solution to the questions posed by the military authorities: Who are these men? And how is it possible to bring them back into combat? They were the “weaker” soldiers, and authoritarian methods of persuasion, combined with electrotherapy, would transform weaklings into true fighters with a hunger for victory. By imposing a violent discipline on bodies and minds, war psychiatry was thus able to pride itself on transforming a hysterical trauma victim into a healthy soldier—in other words, on making a man who was different into a man who was normal (shell shock being by definition an illness that did not affect the normal man). All accounts of the cures of traumatized soldiers culminate in this victory of moral values. No mention is made of the disappearance of the symptoms, still less of any permanent side effects. Semiology, so prevalent in the diagnostic stage, is completely absent from the evaluation of the results. Only the newly acquired values of the recovered soldiers are exhibited, like trophies attesting to the victory of these disciplines of body and mind in the service of patriotism.¹⁹ In other words, pain was not the object of these treatments that so dominated the field of military psychiatry. With the exception of Clovis Vincent and a few others, who maintained that the essence of the treatment lay in pain and fear, most clinicians drawn into the practice of war psychiatry deplored what we would today call the side effects of the technique.²⁰ What was crucial in these treatments was not pain, which was of no use or interest; but rather the ability to extract a confession, and then to convince the patient to give up his trivial, individualist motives that were incompatible with the moral values underpinning patriotism.

AFTER THE WAR

The medical service of the Austrian army was deeply involved in the use of electrotherapy, with strengths of current that varied widely depending on the clinician.²¹ But it was also in Austria that this therapeutic method was challenged, in a well-publicized court case brought against Professor Julius Wagner von Jauregg in 1920, for the use of inhumane techniques.

¹⁹ In their responses to Clovis Vincent’s famous lecture, Babinski and Meige supported his assertions. Babinski sees them as confirmation of his own ideas about “surprise treatment.” In Meige’s view, “when the patient admits defeat—recognizes that he is better—his burst of gratitude is yet another sign confirming the nature of his illness” (*Société de Neurologie*, session of June 29, 1916, p. 105).

²⁰ Eissler (1986).

²¹ Brunner (2000) for an overview of military psychiatry in the armies of the Austro-Hungarian Empire.

This was the most radical challenge to the method in the history of war neurosis. The record of the trial, which has been faithfully retranscribed by Kurt Eissler,²² gives the measure of the issues surrounding traumatic neurosis during the great war. But the very fact that such a trial took place, challenging one of the most respected figures in Austrian psychiatry, also reflects specific historical conditions in Austria that help us to understand why the trial had such importance in the historiography of trauma.

A number of elements played a decisive role in the conduct and outcome of Wagner von Jauregg's trial. First, the defeat of 1918 marked the collapse of the Austro-Hungarian Empire and the failure of the national ideal that underpinned it. In this context, it was much easier to envisage and to mount a challenge to patriotism, which had been the justification for using brutal therapeutic methods to treat neurosis patients and malingerers, particularly because there was at the same time an urgent need to provide financial compensation to soldiers humiliated by their defeat. Second, while electrotherapy found its most widespread application in the Austrian and German armies, it was also in these countries that the first war psychiatrists challenged these brutal methods, proposing that they be replaced with a psychoanalytic approach. Thus, already having suffered attack from within its ranks during the war, Austrian psychiatry was vulnerable to infiltration from the outside by psychoanalysis. There was no danger that the charges against Wagner von Jauregg, and through him against classic Austrian psychiatry as a whole, would devastate mental health care in Austria, since Freud and his disciples were in position to step into the breach. There was thus a homegrown alternative, which meant that this trial could not result in the "suicide" of the profession.

Wagner von Jauregg, director of the prestigious Vienna Neuropsychiatric Clinic, was already well known for his work on the treatment of dementia praecox using a range of inoculations, work that earned him the Nobel Prize for Medicine and Physiology in 1927. Freud was called as a witness in his trial and, while he stated his opposition to electrical methods, which he saw as useless and unethical, he defended the honor of his colleague and friend. It was clear, he said, that Wagner von Jauregg did not set out to cause pain; it was essentially because he was mistaken about the etiology of shell shock that he was able to believe honestly in the efficacy of electrical methods. The cause of war neurosis was not located

²² Eissler created the Freud archives in New York in 1950, and continued as director until 1980. It was in this role that he unearthed the archives of Wagner von Jauregg's trial, in which Freud appeared as a material witness. But it was also because Eissler himself had been fascinated by combat shock during the Second World War, when he served as a psychiatrist with the American army (Eissler 1992).

in the consciousness of soldiers, still less in a reprehensible desire to avoid combat, but in their unconscious, something to which they had no access and which nevertheless over-determined the meaning and function of their symptoms. Wagner von Jauregg was unaware of these principles, he concluded, because of his vigorous opposition to psychoanalysis.

In this famous statement Freud proved himself extremely inventive as he managed in one stroke to protect the honor of his colleague, condemn electrotherapy, destroy the etiological hypotheses of his opponents, and ridicule their naïve conceptions of neurotic psychology, while at the same time preserving the link between hysteria and traumatic neurosis that was absolutely central to his general theory of neuroses.²³ Recent historiographers of post-traumatic stress attach a great deal of importance to this trial, probably exaggerating its consequences²⁴ in their desire to see the breakthrough of psychoanalysis in the years 1916–1920 as a definitive rupture with the anomalous period of medical brutalization during the war. This version ignores two key points, however. First, there were no other trials like Wagner von Jauregg's anywhere in Europe, and no contemporary source indicates that this trial had any influence in other countries. Second, suspicion continued to hang over the social manifestations of traumatic neurosis for many years to come. In 1920 the breakthrough introduced by psychoanalysis in this domain was still far from solidly established.

In a parallel development, psychiatrists in Britain had begun protesting against the stigmatization of psychically wounded soldiers as early as 1917, but it was only after the war that their view became more widely accepted, particularly in the United States. The greatest advocate for this view was probably William Halse Rivers, a psychologist and anthropologist already well known for his ethnographic work in Southern India and Melanesia. He had studied the psychoanalytic technique and approved its theoretical approach, despite some differences with Freud.²⁵ From 1914 to the end of 1917, Rivers practiced at the Craiglockhart military hospital, where he had the opportunity to treat British soldiers whose courage in battle could not be doubted. The case of Siegfried Sassoon,²⁶

²³ Questioned by the presiding judge, who was irritated because he was unable to distinguish neurosis clearly from malingering in the various experts' reports, Freud answered: "All neurotics are malingerers: they simulate their illness unwittingly, and that is their illness." Cited by Eissler (1992).

²⁴ Wagner von Jauregg was acquitted by the Austrian court and continued his already brilliant career without difficulty until his Nobel Prize in 1927. Austrian psychiatry did not collapse after this trial, and in fact was late to take on the Freudian legacy in its entirety.

²⁵ Pulman (1986).

²⁶ Siegfried Sassoon (1886–1967) became well known as a poet after the war. Extracts from his work, particularly from his collection *The Huntsman*, can be found at <http://www.geocities.com/CapitolHill/8103/Sassoon1.html>.

officer and war poet, soon became famous because, according to Rivers, it showed that shell shock could occur in the bravest of men and that pacifism was not necessarily a characteristic of cowards. In his lecture to the Psychiatry Division of the Royal Academy of Medicine on December 4, 1917, which was reprinted in its entirety in *The Lancet* of February 1918,²⁷ Rivers took the opposite view to the theories then current and attempted to reveal, behind the horror of combat, the humanity, solidarity, and courage of the ranks and of their superiors. It was not patriotism, he said, nor fighting spirit, nor even hatred of the enemy that best characterized these men's bravery, but rather the sense of fraternity that linked them one to another. And it was perhaps also this powerful feeling that made them vulnerable when the atrocity of war caused them to lose their closest comrades. But this humanist theory, with its sympathetic understanding of the soldiers, was not popular with the British medical services. Trauma patients continued to be compared to deserters for a long time to come, and sometimes they shared the deserters' tragic fate: i.e., the death penalty.

In France, in contrast to Austria, there was never any official condemnation of these psychiatric practices, and unlike their British colleagues, French psychiatrists never questioned the brutality of their supposed treatments. This failure to criticize war psychiatry—or at least some of its compromises with conscience²⁸—was due in part to a unique convergence in France of military psychiatry, forensic psychiatry, and what was to become colonial psychiatry. This little-known aspect of the history of war neurosis is crucial to understanding the suspicion that continued to hang over hysteria and trauma until the 1970s, despite new theoretical perspectives which appeared to have moved beyond stigmatization. From the late 1920s onwards, hysteria and shell shock were indeed no longer dishonorable conditions that brought shame on anyone suffering from them. The stigma was not, however, removed from sufferers in all social categories. Two groups remained unaffected by the reevaluation, and they inherited all the earlier stereotypes: these were workers who had suffered occupational accidents, whether they were labelled with trauma neurosis or *sinistrosis*, and natives of the French colonies, particularly the “Muslims” of North Africa and the “Blacks” of sub-Saharan Africa. Let us see how this came about.

²⁷ Rivers (1918).

²⁸ With the notable exception of Frédéric Rousseau, there has been not the slightest condemnation of the practices of French military psychiatry. On the contrary, the lack of a trial equivalent to that of Wagner von Jauregg in France seems to have been interpreted by today's commentators as proof that therapeutic brutality was only imposed on Austro-Hungarian troops. This observation is all the more surprising given that those writing at the time explained their ideas and their practices in detail. If any proof is needed, rereading Vincent, Babinski, Régis, Porot, and Dumas, to cite only the most famous, will provide it.

A FRENCH HISTORY

After the war, the patriotic ideal remained common currency in France. Military doctors who had won fame for their treatment of shell shock enjoyed much higher prestige than did their colleagues in the defeated armies, as well as moral and scientific authority derived from the dreadful years they had dedicated to treating the wounded. It was these same doctors who, a few years later, were to take over the field of war-injury compensation, and once again they were particularly harsh toward those suffering from psychic trauma. Some of these demobilized military doctors also contributed to the rapidly developing discipline of colonial psychiatry. In 1919, in their treatise on war medicine, Antoine Porot and Angelo Hesnard were still justifying the use of electrotherapy both for exposing malingerers and for treating hysteria-trauma patients, but the question of what caused these disorders had become critical. In their view, only acute psychotic reactions directly imputable to a specific event conferred the right to a war pension. Otherwise things had not changed since the war. The same accusations were levelled at trauma sufferers: weakness of character, selfishness, "debilitating flaws," and, of course, a lack of community spirit, which took the place of a lack of patriotism, since the goal was no longer to send men back to the front, but to reduce the number of those with a right to a war pension.²⁹ Georges Dumas's summary of military medicine, also published in 1919,³⁰ repeats this same list of character traits, and it was to remain the standard text on traumatic neurosis until the 1950s.

However, from 1925 onwards the gradually increasing influence of psychoanalysis on French psychiatry did much to reduce the stigma attached to hysteria and to neurosis in general.³¹ The concept of traumatic neurosis was no longer in favor with official psychiatry which, under the influence

²⁹ Porot and Hesnard (1919).

³⁰ Dumas (1919). This professor of experimental psychology at the Sorbonne was a pupil of Janet. His virulently anti-psychoanalytic views dominated the French scene for several years. Like his academic colleagues, who were also close to the neurologists, he had a decisive influence on forensic psychiatry.

³¹ Roudinesco (1986). With the launch of the journal *L'Évolution psychiatrique* [Development of psychiatry] and the formation of the association of the same name in 1925, psychoanalysis entered the French medical world. The association and the journal were set up following a split with the Société Médico-psychologique [Society of Medical Psychology], which remained dedicated to psychiatry and forensic medicine. For the first time in France, psychiatrists like Eugène Minkowski (or later Henri Ey), and psychoanalysts, including René Laforgue, Sophie Morgenstern, and Rudolph Loewenstein, collaborated in founding an organization. It was not until the early 1930s, however, that it came to exert any influence.

of Freud, gave it a very marginal place, somewhere between a vestige of military psychiatry and an almost experimental model of hysteria. Theories of psychic trauma were enriched by contributions from psychoanalysis and particularly by the introduction, in 1920, of the death drive, a concept that could help to explain the recurring nightmares characteristic of traumatic neurosis without departing from the general principles of dream interpretation.³² From the 1930s onwards Freud's writings were principal references for official psychiatry on the question of trauma. The dominant psychiatric paradigm had moved far from the idea of the traumatic neurosis caused by a violent event. Trauma had become a concept free from the event in the generic sense of that term. It now inhabited the greater world of general psychopathology. In this view, inherited as we have seen from Freud's second theory of hysteria, trauma is neither the event itself nor the psychic consequences of the event. It is primarily the economic process that overwhelms the psyche's capacity to adapt. It is in a way the source of neurotic symptoms, whatever they may be. The tragic event represents only one source of trauma, among many others, with shell shock being only a particular case. But discussions in the academic arena were far removed from the everyday uses of the concept of trauma as it was applied in forensic psychiatry and, increasingly, in colonial psychiatry.

On the one hand, medical specialization in traumatic neurosis expanded markedly, to the extent that a number of forensic medicine conferences were devoted to it. Impenetrable to the new developments in psychoanalysis, forensic medicine remained the main arena where experts still discredited those suffering from trauma, condemned their quest for compensation, and cast doubts on their moral character and community spirit. Successive conferences on forensic psychiatry followed the same pattern. The identification of traumatic neurosis with *sinistrosis* and hysteria remained the dominant model, at least until the 1954 report in which civil procedure was still driven by suspicion of the two conditions.³³ This suspicion mostly fell on the character of accident victims, whose usually modest social origins allegedly prompted them to seek either exemption from work on the grounds of disability or financial compensation, if not both.

On the other hand, the emerging discipline of colonial psychiatry took what it had learned from its military heritage and applied it in a new sphere, adding to it the culturalism and racism then prevalent among med-

³² It is in *Beyond the Pleasure Principle* (1920) that Freud introduces the concept of the death drive. For the first time some dreams can be interpreted as relating not to the essential principle of dream interpretation (the realization of a desire in a dream), but as the converse, the mark of a repetition compulsion directly related to the trauma.

³³ Evrard (1954), Héacan and Ajuriaguerra (1954).

ical doctors in the tropics. Public health was beginning to develop in all the colonies, and with it colonial psychiatry, which made its first appearance in Africa.³⁴ Antoine Porot, the founder of the Algiers School, was one of the central figures. War had given him the opportunity to examine a large number of soldiers belonging to “colored” regiments who served under the French flag in North Africa. In 1918 he published “Notes on Muslim Psychiatry,” which was to remain an authoritative text until decolonization. In this essay the so-called Muslim mentality is described as particularly conducive to hysteria, the tendency to claim benefits, deceit, and malingering in order to escape the responsibilities of more civilized men. In his 1919 treatise on war psychiatry, Porot returned to this theory to explain the etiology of the mental disorders of war and asserted that “Muslims’ affective life is reduced to the minimum and plays out within the limited circle of basic instincts.” This, he explained, accounted for their low level of fighting spirit and their tendency to prefer flight to combat. However, when they could not escape combat they showed little anxiety and tended to be indifferent “towards the emotions of war.”³⁵ Natives, it seems, were different from other men on the battlefield.

Thus, alongside the intellectual history of trauma, with its brilliant debates between internationally renowned psychiatrists, psychologists, and psychoanalysts, great figures like Freud and Janet, there was everyday mental health practice, forensic and colonial, that confronted trauma with a mix of scientific vulgate and prejudice (in the former case of class, in the latter of race). It is remarkable, and generally little known, that these partially autonomous fields in French psychiatry communicated not only synchronously (through exchanges of ideas) but also diachronously (through the transmission of ideas). On the one hand, forensic psychiatry and military psychiatry shared moral values and social judgments, resulting in the same disparagement of those suspected of failing to meet the expectations of the nation. On the other hand, there is a shift in space and time from military to colonial psychiatry, but native soldiers were merely an exotic clinical curiosity which bolstered the suspicion of malingering on the part of trauma patients and reinforced the well-established contempt for the colonized. In a final twist, colonial psychiatry, returning to France after independence, reencountered forensic psychiatry; the issue

³⁴ See René Collignon (2002) and Richard Keller (2001) on French colonial psychiatry.

³⁵ Porot (1918), Porot and Hesnard (1919). According to the latter, “The heavy military contribution required of North Africa, which necessitated the calling up of entire classes, gave us a great mass of natives, a formless block of primitive men, deeply ignorant and credulous for the most part, very far removed from our mentality and our reactions, and with no experience of any of our moral concerns or of the most basic of our social, economic, and political concerns.”

was still trauma, or rather *sinistrosis*, and the patients were still workers, but this time former colonial subjects who had become immigrants. We will explore later this ultimate irony of the history of trauma in France. But first we must return to the period after World War I, in order to understand the role played by psychoanalysis in changing the way in which trauma was viewed by both scientists and the general public.

The Intimate Confession

IN ORDER TO UNDERSTAND the major shift in attitudes that occurred in the mid-1960s, we need to look back at the growing influence of the psychoanalytic understanding of trauma during the first half of the twentieth century. Right from the outbreak of the First World War, Freud was convinced that everyone should participate in the war effort. In particular, he was resistant to issuing exemption certificates to neurosis patients who consulted him, taking the view that these patients should serve their country like everyone else, since their symptoms were not incapacitating enough to justify releasing them from their duties. His theory of secondary gains tends in the same direction, since it suggests that if the subconscious benefits of illness are greater than the discomfort of the symptoms, the illness is likely to continue indefinitely. The concept of secondary gain is essential, but radically different from the idea of a conscious—for example, financial—motive. The patient is clearly unaware of the benefit conferred by the illness and may even complain of the problems it causes him. In no case does secondary gain equate to a deliberate exaggeration of symptoms. But the doctor is aware of the function of the symptoms and in treatment must thwart this regrettable tendency to maintain a pathological, and, moreover, pathogenic equilibrium. In this light, refusing exemption and urging neurosis patients to respond to the call of their country could be seen as therapeutic methods.

Nevertheless, before Freud testified in Wagner von Jauregg's trial in 1920, he had played only a minor role in the controversy. It was his disciples who had the greatest influence, notably Karl Abraham, Sándor Ferenczi, Ernst Simmel, and Victor Tausk. Today these four psychoanalysts are generally considered the true originators of the modern theory of psychic trauma, even though each in his own way drew heavily on Freud's work.¹ Their contribution, however, was not limited to theory. History also records that they were among the first to oppose the therapeutic brutality imposed on those suffering from war neurosis. Adherents of authoritarian psychotherapeutic methods based on suggestion and threat did believe that, ultimately, the contribution of electric current was

¹ In the chapter on traumatic neurosis in his general theory of neurosis, psychoanalyst Otto Fenichel (1953) describes the four as a decisive influence, though he believes that it was Ferenczi's contributions that had the most lasting influence.

small compared to the results that could be obtained by psychotherapy alone. The goal of therapy was for the patient to recognize that he was ill and that his motives were selfish, and then to renounce his symptoms and accept the values of the group. But it was these four psychoanalysts serving in the Austro-Hungarian armies who actually worked to end the use of repressive therapeutic methods, proposing that the psychoanalytic method be adopted in their stead. Their contribution was essential, though its significance only became apparent after the war. So we must now return to this history and its repercussions (which continued even beyond World War II), in order to grasp how, under the influence of psychoanalysis, suspicion of trauma victims changed course but did not disappear.

WAR PSYCHOANALYSIS

In Austria, psychoanalysts emerged strengthened from the debate on the use of brutal and inhuman techniques in the treatment of war neuroses. They proposed an approach based exclusively on the words of the patient. They also denounced the use of persuasion or intimidation, preferring to devote themselves to listening to the psychically wounded. Contemporary historians are divided as to whether this represented a genuine break with accepted practice or should simply be classed with the other therapeutic methods of the time, with some preferring to pay tribute to the few psychoanalysts who were bold enough to oppose medical brutalization.² Abraham and Tausk stood up on several occasions in defense of soldiers prosecuted for desertion, arguing that their attitude, while it was reprehensible from the military point of view, was the result of a reactive disorder.³ The important thing, in their view, was to expose the irresponsibility of soldiers charged with actual desertion or with faking a nervous illness.

At the Ninth Belgrade Evenings of Medicine, in March of 1916, Tausk delivered a lecture on an unusual and highly polemical subject, the psychology of the deserter.⁴ While summary execution of men who abandoned the battlefield was the norm, and the verdict of military courts on any who were tried tended to be extremely harsh, Tausk sought to

² Emphasizing the advances advocated by war psychoanalysis, Rousseau (1997, p. 27), adds: "The followers of psychoanalysis, still few in number and with little influence, were unable to impose either their ideas or their methods." Brunner (2000) is more critical, drawing a distinction between war psychoanalysis and post-war psychoanalytic theories that abandoned the patriotic model. However, he does not address the question of the persistence of the suspicion paradigm, which was to be the dominant model in theory and practice over the succeeding decades.

³ Trehel (2006).

⁴ Tausk (1916).

understand the deserters' motivations and to classify them in relation to context and personality structure, in order to plead for greater clemency. His position did not endear him either to the military hierarchy or to other army doctors. However, his training in law, which he had studied before psychiatry, gave him the authority to question the values of patriotism where they served not to defend the homeland, but to accuse and condemn compatriots. He drew a parallel between deserters and sufferers from shell shock, of which he gave a subtle and detailed account, and in conclusion asserted that like some deserters, those suffering from shell shock were not cowards. The source of their illness was to be found neither in their conscious motivation nor in the event itself, but rather in their unconscious—in other words, in something that was out of their control and more powerful than their will. Putting these men on trial was therefore unjust, because they were not responsible for what was happening to them. Authoritarian or even brutal therapeutic methods would never be effective, because they targeted only the will, which was not the source of the disorder. Tausk's essential argument thus rested on uncovering unconscious motives in order to assert the innocence, under the law, of those suffering from neurosis. In this sense, there is a significant reorientation here: the aim is to denounce the repressive practices of military psychiatry and to penetrate deeper into the psyche to unveil motives which, being unconscious, cannot be evidence of guilt.

Yet this is where the ambiguity of the psychoanalytic approach emerges. Bringing the unconscious into the question undoubtedly offers a much more honorable way out for neurosis patients, and also, incidentally, for psychiatrists. But it simply shifts suspicion to the unconscious, ascribing to the symptoms the same function as in the classic psychiatric approach. Those suffering from shell shock are no longer classed as malingerers or cowards, but the question still remains: Why does their illness lead them to avoid combat? Moreover, even in the psychoanalytic view, the unconscious motive is not far removed from the conscious motive, since psychoanalysts, like their more repressive colleagues, do not see the event itself as sufficient to explain the onset of war neurosis, given that most of the soldiers exposed to the same conditions emerge psychologically unscathed. The norm is for soldiers always to endure war conditions. Even the most progressive, audacious, and ardent defenders of neurotic patients, like Victor Tausk, made the same observation: these men were motivated by an unconscious desire to avoid combat. Some German psychoanalysts⁵ even took the view that these patients were traumatized not by what they had experienced, but rather by what they had not wanted to face.

⁵ Brunner (2000).

What made them able to take refuge, unwittingly, in their illness? The investigation into the depths of the unconscious made possible by psychoanalysis proved far superior to all other techniques in explaining the nature of the unconscious desires and conflicts involved in trauma, but there was still no questioning the moral prejudices, which psychoanalysts shared with their psychiatrist colleagues. Karl Abraham took the view that it was the power of intrapsychic conflicts in shell shock sufferers that prevented them from adhering to the just principles of warfare. As reluctant to die for their country as to kill, these weak men were governed primarily by an overdeveloped narcissism. Abraham began his keynote lecture on the psychoanalysis of shell shock as follows:

A soldier, called up at the outbreak of war, was wounded on the 12th of August, 1914. Before he was completely cured, he secretly left the military hospital, returned to the front, and soon afterwards received a second, and some months later, a third wound. When he returned once more to the front, he was buried by an exploding shell and was unconscious for two days. After this fourth trauma he showed emotional but no neurotic disturbance and certainly no signs of anxiety, depression or agitation. Another man went to the front, fell into a pot-hole during night fighting, was unhurt, but immediately afterwards developed the most severe type of neurotic tremors and presented the picture of a nervous breakdown. How are such differences to be explained?⁶

The answer to this question lay in the unconscious:

The histories of such people, and even more a deeper analysis, reveal to us why one man remains essentially well all through the most severe physical and mental trials of the war, whilst another reacts to a relatively small incident with a severe neurosis. It is found with great regularity that war neurotics were even before the trauma—to call it for the time being by the common name—emotionally unstable, especially with regard to their sexuality. Some of them were unable to fulfil their duties in everyday life; others were able to do so, although they showed little initiative or a weakened drive. In all cases sexual activity was restricted, and libido inhibited by fixations. Many war neurotics had, already before the war, shown poor or limited potency. Their relationship to the female sex was disturbed, by partial fixation of the libido in the developmental phase of narcissism to a greater or lesser extent. Their social and sexual functioning was dependent on certain concessions to their narcissism.

In wartime these men are placed under entirely different conditions and are faced with extraordinary demands. They must at all times be prepared to sacrifice themselves unconditionally for the general good. This involves the renunciation of all narcissistic privileges. Healthy individuals are able to suppress their

⁶ Abraham (1923, pp. 60–61).

narcissism entirely. Just as they are able to transfer their love, so they are able to sacrifice their ego for the community. In this respect those predisposed to neurosis fall behind those who are healthy.

Their passivity is apparent not only in the sphere of the ego drives, but equally in the sphere of the sexual drives. Narcissism breaks through. The capacity for transferring the libido is lost, like the capacity for making sacrifices for the community.⁷

Thus, shell shock had its roots in the subject's early life. The violent event made neurosis manifest, but it did not cause neurosis. The problem was with the patient, not with the war. The similarity between this discourse and the suspicious, accusatory attitude that most of society then held towards the psychically wounded testifies to the powerful influence of social convention on the theoretical positions taken by these war psychoanalysts.

Not all were so clear-cut in their judgments. Sándor Ferenczi, for example, was less accusatory. He accepted the idea that neurotic symptoms following combat could persist in order to prevent a return to the front, the illness offering secondary gains which might range from exemption from service to obtaining a pension. But he did not believe that war neurosis necessarily derived from this. Unlike Abraham, he held that overdeveloped narcissism—which he also detected in most of those suffering from trauma—could inspire fighting spirit in some subjects, or in others might result in a desire for recognition and military prestige. When confronted by a traumatic event, these subjects, who were in the habit of overestimating their capabilities, would experience a sudden collapse in their feeling of omnipotence, which would produce a deep narcissistic wound that would in turn give rise to the symptoms of trauma.⁸ Thus, the same ingredients functioned very differently in Abraham's and Ferenczi's models—etiologically for the former, reactively for the latter. Nevertheless, they both rejected the idea that the event was the determining factor. Both maintained that traumatic neurosis was not suffered by all World War I soldiers; the personality of the victim played a major role, as did personal history, sexual activity, internal conflicts, patriotic aspirations, relationship to the group and to the notion of the "good," and a sense of duty or sacrifice. Trauma was always the individual response of non ordinary men confronted with basic ethical choices which they were unable to take on. Unlike other psychiatrists, whose moral evaluation they nevertheless shared, the psychoanalysts refused to blame these men.

However, our point here is not to condemn what could be seen as a compromise that the war psychoanalysts made with the patriotic ideal.

⁷ Abraham (1923, pp. 61–62).

⁸ Ferenczi (1918, 1978).

The First World War was probably the historical event of the twentieth century in which the patriotic ideal was most fully shared by all European peoples. It would be naïve and anachronistic to imagine that psychoanalysts alone could have been spared this sentiment, which did not, in any case, preclude condemning the horrors of the war. What is much more striking is the basic presumption behind the positions taken by the war psychoanalysts. Whatever their attitude towards shell shock patients—sympathetic on the part of Ferenczi and Tausk, more accusatory in Abraham's case—they did not view these patients as respected witnesses of the horrors of the conflict. Their illness was not the product of historical circumstance but of their own tendencies. These were not ordinary men placed in extraordinary situations, as they would come to be seen in the second half of the twentieth century. To treat them, psychoanalysis had to help them finally to understand what distinguished them from their comrades in arms. To reach this self-knowledge they would have to unearth their flaws, delve into their unconscious desires, search in their life history for early harbingers of their current weakness, and explore their fears and their cowardice. They must be enabled to admit, without threat or violence, why they had been traumatized, why they were so different from the others. And then they must be able to change so as to resemble the others, to accept common values, appreciate them, and submit to them. In order to be freed from suspicion, victims of shell shock had to take the long and tortuous path of intimate confession through psychoanalysis. This was the price for having their trauma recognized as an accident of their personal, individual history.

And this trajectory of confession fitted almost perfectly into the mechanisms of suspicion that the Austro-Hungarian medical services had put in place. It did of course create much more humane conditions for the victims of trauma, but it did not radically depart from the requirement for avowal imposed by the military authorities. In fact, the effect of the structures of suspicion was not only to pave the way for the therapeutic brutality unleashed during the war years; they also helped to develop another, much more lasting therapeutic tool, which was already emerging in the practice of civilian trauma neurosis specialists. Therapy would now require the acknowledgment of intimate weaknesses, whether great or small, the revelation of selfish tendencies, the admission of guilt to the extent of revealing unconscious desires, and it would entail a process of subjectification by which the individual motive, personal history, and ultimately the self-confession were systematically seen as more important than the event deemed traumatic. Inaugurated by electrical methods and therapeutic brutality, once the war psychoanalysts had humanized it and removed its cruelty, this discipline of avowal was subsequently able to extend to the treatment of all forms of trauma. Self-confession came to

represent the central motif of the trauma narrative. The event features in this narrative only as the pretext for intimate revelation, for the trauma is already present, within the individual history of each patient, and it is this preexisting—structural—trauma that will ultimately explain the impact of the event.

A PROFITABLE SICKNESS

"It is time for us to revise our ideas about traumatic neurosis and shell shock. The end of the war will probably leave us in deep economic disarray. It is essential that at this time the state's fragile budget is not endangered by thousands of parasites leeching money from it: If we are not careful, if we do not plan correctly, we will see a legion of false war invalids. Our duty as doctors is to defend the community against such abuses." This patriotic exhortation opposing war pensions for those claiming psychic wounds was issued early in the war, in 1916, and it was followed by a meticulous denunciation of the social factors favorable to the production of traumatic neurosis. The rhetoric is worthy of Clovis Vincent in full oratorical flight. The author, however, was not a military psychiatrist: Marcel Moreau was a well-respected Belgian specialist who had gained solid experience in the courts defending the state and private insurers against financial claims from accident victims, particularly in cases of workplace accidents. It was for this reason that he emphasized the resentment felt by workers towards society, arguing that they used traumatic neurosis as a way of "receiving money without providing their labor in exchange." His knowledge of the drain on resources caused by compensating accident victims prompted him to alert Belgian specialists, judges, and health authorities to the risk of an epidemic of "lucrative neuroses" in wartime. However, unlike his French colleagues, Moreau did not reject the concept of traumatic neurosis, nor did he class those suffering from it as malingerers. He did not even accuse them of a conscious desire to escape their military duties or deny their suffering. Like all sick people, they had a right to the attention of doctors and society. But that right did not imply a right to financial compensation.

This was the nub of the issue. Traumatic neurosis was seen as a genuine mental illness, sometimes leading to incapacity. It always caused suffering to the patient and often to those close to him who had to bear with his complaints. It could result in the loss of employment and financial resources, to the point where the sufferer became completely idle. But it was not the accident that caused the traumatic neurosis. Rather, the fact that it might lead to monetary compensation directly engendered the symptoms—hence Moreau's preference for the term "lucrative neurosis."

Why should society pay these patients, who were no different from other mental illness sufferers who received no financial compensation? The deceptive etiology of traumatic neurosis, mistakenly sought in the event, which was at best the trigger, did not justify making it the responsibility of the nation, or even of insurance companies. These patients were not responsible for what was happening to them, but neither was the state, unless it passed laws awarding compensation for accidents at work. As proof of his argument, Moreau asserted, on the basis of the German medical literature, that traumatic neurosis did not occur unless accident victims were potentially eligible for compensation, nor in cases where the victims belonged to social or professional classes with little interest in financial reparations. This was the case, he noted, with skilled workers, company directors, and senior civil servants, who always preferred to continue exercising the profession they enjoyed rather than receiving an income paid out of state funds. Traumatic neurosis did not occur in these classes simply because, in the absence of any anticipated gain, there was no motive for the neurosis.

Quoting liberally from Emil Kraepelin,⁹ Moreau asserted that in every country where a large number of sufferers from traumatic neurosis were found, these disorders had appeared only after the introduction of occupational compensation laws. In Germany, for example, when Oppenheim coined the term "traumatic neurosis" in 1889, the law on accidents at work had been in force for four years. In Japan the epidemic came later, starting in 1911—exactly one year after the implementation of a similar law. In the last years of the nineteenth and the early years of the twentieth century, the same coincidence occurred in all the countries that passed laws supporting workers' rights—in France, Switzerland, Sweden, Denmark, Italy, and even Australia. According to Moreau, the patients themselves were not solely responsible for this exponential growth in traumatic neurosis. They shared responsibility with sympathetic doctors, families intent on insuring their incomes, and in fact with the entire nation, which was over-benevolent toward what amounted to a disguised workers' protest. Moreau held that curing traumatic neurosis should be entirely a medical matter and should not involve financial compensation. Commenting ironically on the waiting game played by other specialists, particularly psychoanalysts who sought some reordering of psychic mechanisms as a sign of complete recovery, he argued that there was "another, rapid and radical, way of curing neurosis: refusing any compensation to the patient."

⁹ German psychiatrist Emil Kraepelin took as his life's work the development and refining of a classification of mental illnesses: the eight edition of his handbook *Clinical Psychiatry*, which appeared between 1883 and 1909, charts the development of his theories.

These words could have been written during the First World War, so characteristic are they of the climate of suspicion that reigned in psychiatry at that time. But they appeared in the *Journal belge de neurologie et de psychiatrie* [Belgian journal of neurology and psychiatry]¹⁰ in 1942, when Europe was once again devastated by an almost equally bloody war. There were, however, two major differences between the new ideas and earlier concepts, both in forensic medicine and military psychiatry. First, traumatic neurosis was now accepted as an authentic illness. After more than twenty years experience dealing with victims of workplace accidents, forensic psychiatry had at last secured a solid understanding of this pathology. Traumatic neurosis was now recognized as a separate clinical category, distinct from malingering. It was a genuine illness that followed, but was not caused by, an accident. The more radical, like Moreau, took the view that the etiology lay in compensation; while more moderate specialists saw traumatic neurosis as similar to Brissaud's *sinistrosis*, and thus as a virtually hallucinatory conviction constructed around the damage caused by an accident but without the altered consciousness characteristic of psychosis. The second difference affected the status of victims. Like the first it derived from the experience of mental health specialists dealing with civilian cases. They had come to recognize that trauma was characteristic of the psychological condition of some accident victims. The source of the disorder was still not deemed to be the event itself, but rather the benefits expected from it. Nevertheless, victims had a right to seek compensation, and it was this idea that Moreau challenged in his article. Previously, factors existing before the event—the sufferer's personality or his original, underlying trauma—had undermined the victim's legitimacy by dissociating his pathology from the accident or event he had experienced. Now it was circumstances after the event—the benefits that the victim, consciously or unconsciously, hoped for—that sustained the illness. Paradoxically, this idea created a real link, albeit indirect, between the accident and the disorder.

VICTIMS OF THE SELF

These conceptions—that traumatic neurosis was a consequence of the search for compensation—also became established in World War II military psychiatry. However, the influence of psychoanalytic concepts on trauma in this arena was much less central than the traditional historiography of psychoanalysis and post-traumatic stress suggests. Most French writers—whether military doctors like Claude Barrois and Louis Crocq,

¹⁰ Moreau (1942).

or historians of psychoanalysis such as Élisabeth Roudinesco—see World War II as marking a radical shift in thinking about trauma, a shift that had already begun after the Great War under the influence of psychoanalysis. We have already seen that this reading of World War I is inaccurate. It is even more deceptive in relation to World War II, because it confuses two radically different developmental paths and ascribes to war psychiatry concepts that were unknown to it until much later, several years after the liberation of the concentration camps.¹¹ In fact the etio-pathogeny of trauma—as psychoanalysis conceptualized it following Freud's introduction of the death drive in 1920—was not a major issue in efforts to diagnose and prevent war trauma. Psychotherapeutic models based on early abreaction of trauma (the reduction of the emotional stress that results from the simultaneous release of affect and verbalization during the course of psychoanalytic treatment) did, however, become widely established in the treatment of trauma victims, wherever the influence of psychoanalysis was beginning to be felt, alongside the techniques of hypnosis and readaptation which still prevailed.

The situation in Britain offers an example of this gap between theory and practice. From the moment Britain entered the war, the military authorities expanded the range of psychiatric involvement by inviting some psychoanalysts to participate in the recruitment and selection of members of the armed forces. Experts in psychological functioning were asked to identify candidates suitable for officer training. Whereas it normally took several months to identify and then train officers, personality tests and group role plays observed by psychoanalysts made it possible to form a relatively accurate assessment of the personal qualities, sense of responsibility, and leadership potential of candidates within a few hours.¹² At the same time, the therapeutic approach to war neurosis was being reinvigorated by the group methods inspired by North American psychoanalysis. But in this case too, the experiments were of limited influence and short-lived. In general, the dominant practice remained detection of malingering, and those suffering from shell shock were treated so that they could be sent back to the front. Still suspected of wanting to evade combat, they

¹¹ See Barrois (1998), Crocq (1999) and Roudinesco (1986). In fact this desire to impose a putative conceptual continuity is part of the rhetoric of psychiatric victimology, which seeks to validate itself through a continuous history in which the discipline becomes recognized in the mental health field at the same time as, or even before, the recognition of victims' rights. But as we shall see, matters were much more complex than a simple translation of science into policy, and the forces involved much more powerful than those ascribed to a handful of trauma specialists.

¹² As Major Turquet acknowledged when he was invited to the one-day conference on British psychiatry organized by *L'Évolution psychiatrique* in 1947: even after it had been accepted, this innovation came to an abrupt end around the middle of the war.

were far from enjoying the status of war casualties. The reality of their trauma was still being measured in terms of their personal fragility.

Nevertheless, in September 1945, after a three-month stay in London, Jacques Lacan expressed enthusiastic approval of these practices, which he saw as deriving their efficacy from Freudian psychoanalysis, and which he pronounced revolutionary. In his impassioned text he lauded the two great pioneers, John Rickman and Wilfred Bion, the psychological methods used to select future officers, and the innovative group psychotherapy treatment practiced at Northfield Hospital. Enthusiastically classing the group practices based on reinforcement of the ego (which he later opposed adamantly in his teaching) with the changes in British psychiatric theory wrought by the influence of psychoanalysis, Lacan omitted to mention that the military authorities had quickly terminated the experiments.¹³ Wilfred Bion, as his biographer confirms, was regularly sidelined within military psychiatry. He was never given positions of responsibility despite his illustrious history as a veteran of World War I; in fact, he was probably the only psychiatrist who was not promoted during World War II. Even the experiment at Northfield ended in failure for him, when he was transferred for no apparent reason after only six weeks. It was only much later, after the idea of therapeutic community had become commonplace, that the experiment became a classic and was taken up by others, including in the United States.¹⁴ During the war British psychiatry was largely closed to such innovations.

In the US armed forces the situation was just the same. Abram Kardiner's writings,¹⁵ which urged early detection of traumatic reactions to war and the use of methods inspired by psychoanalysis, had some influence on theory. The dominant model in the military medicine, however, remained that of challenging trauma victims, and the central concern of

¹³ Lacan's enthusiasm in this lecture (1947) testifies both to a lack of knowledge of the generality of psychiatric practice during the war in Britain, and a desire to defend the place of psychoanalysis in French psychiatry. It is worth noting, too, that in this text, which runs to more than twenty pages, Lacan says virtually nothing about shell shock, and when he does he uses the denigrating and suspicion-laden vocabulary of the time.

¹⁴ Bléandonu (1990).

¹⁵ After undergoing psychoanalysis with Freud in Vienna in 1923, Abram Kardiner returned to the United States and attempted to apply psychoanalytic principles to the treatment of trauma victims he was seeing at a veterans' hospital in New York. Faithful to Freud's teachings, his writing on shell shock retained the stamp of psychoanalysis, though he was keen to emphasize the autonomy of the condition relative to transference neurosis (Kardiner 1941). He was also close to Rivers and categorically opposed to questioning the fighting spirit of those suffering from trauma. His ideas were recognized in American psychiatry during World War II, though the principle that the previous personality of the patient was a determining factor was retained.

clinicians was rooting out malingerers.¹⁶ The image presented by psychologically destroyed men was intolerable in American eyes. The heroic ideal of the freedom fighter setting out to save old Europe and returning victorious, crowned with glory, did not match up with the haggard faces, the accounts of nightmares, of waking drenched in sweat, and of paralyzing fear, even far from the front.

The military authorities were clearly aware of this. After commissioning the director John Huston to make a propaganda documentary on the treatment of soldiers traumatized during combat, they refused permission for it to be distributed, let alone broadcast. *Let There Be Light*, made in 1946, was to be the last part of a trilogy directed by Huston celebrating US combatants in the Second World War. With no political agenda, and anxious to keep scrupulously to the task he had been given, Huston applied to the letter the principle of objectivity he had followed in the two previous documentaries. For more than three months, he filmed the daily life of former combatants hospitalized at Mason General, a military hospital on Long Island. The courage and sense of sacrifice of these men was clearly portrayed, as the Pentagon had requested. But equally apparent was the fact that some of them were utterly destroyed: their fear, their shame, and their tears showed clearly, as did their contempt for military authorities. The film also documented the arrogance and harshness of the psychiatrists and the brutality of some of their therapeutic methods. Remarkably, when the film received its world premiere at the Cannes Film Festival in 1981, the emotional response of the viewers and the critics was muted, for the film did not meet the expectations of an audience seeking revelations about the military and medical practices of the time.¹⁷ Essentially, the documentary showed what everyone by then knew: war not only kills soldiers, it also destroys the lives of survivors, who carry forever the psychological scars left by their horrific experiences.

The difference between the interpretation of earlier periods and the reading of today demonstrates how views on war and its victims have changed. In 1946 the horrors of war could not be expressed by showing the psychic suffering of those who had fought for freedom. These unfortu-

¹⁶ Kurt Eissler (1986) explicitly confirms this in his book on the trial of Wagner von Jauregg. In an appendix, he takes a detour in which he tries to show that malingering, in fact much rarer than was believed by military psychiatrists during World War II, should be considered a form of traumatic neurosis. But the purpose of this digression is to emphasize more clearly the climate of suspicion that prevailed in the ranks of the US army.

¹⁷ It took an intense campaign by John Huston and the American Association of Directors to persuade US Vice President Walter Mondale to order the public release of the film. But after the first showing, the well-known critic Andrew Sarris, reviewing the film in the *Village Voice*, judged it conventional and unoriginal, a simple propaganda film glorifying psychoanalysis.

nate casualties were far from courageous witnesses to the events of their time. Their suffering did not suggest heroism; nor did it indicate a threshold beyond which whatever humanity remained would be lost in a sort of painful insanity. Their nightmares had not yet come to represent traces of a collective memory that would persuade those with power in the world that such things must never again be allowed to happen. In 1946, the suffering of these soldiers who had been psychologically destroyed by the war was considered only a pale reflection of the reality of war, which must be hidden from view—not in order to conceal the horrors of war (they were well known and widely condemned), but because the suffering of a group of men who were more vulnerable than others said nothing about the war itself. It simply exposed the intimate inner life of a few who could not or did not know how to stand up to war. These ravaged combatants were not victims whom it was possible to honor for their courage or their sacrifice. Legal or governmental recognition of the position of these men was also problematic, particularly because of its implications for financial compensation. Kardiner's position on this question is very revealing. While he makes a point of defending the semiological unity of traumatic neurosis and rejects the idea that compensation produces it, while he takes up the cudgels in defense of trauma victims and pleads for not only humane, but also comforting methods of treatment (going so far as to suggest that nurses offer affectionate mothering), he is nonetheless categorically opposed to compensation. "On the basis of what we know . . . about the traumatic neuroses, we can pose the question of whether this neurosis should be compensated. The answer is decidedly that it should not. What then should be done with these cases? They should be cured."¹⁸ In Kardiner's view, combat shock should not confer the right to compensation; rather it should be treated as early as possible. Only rare cases resistant to all kinds of therapy merited an invalid's pension. Kardiner added that awarding compensation as a war casualty too early would prevent any clinical improvement, as the patient would take refuge in secondary gains. In the eyes of the psychoanalysts, as of American society in general, those suffering from war trauma had not yet gained victim status.

THE ISSUE OF SURVIVAL

It was a different historic encounter that was to revolutionize social sensitivities, culminating in a complete reconfiguration of the notion of trauma. And in this case psychoanalysis immediately provided a key that the concept of traumatic neurosis, whether civilian or military, was

¹⁸ Kardiner (1941, p. 237).

completely unable to offer. In the course of its brief and unfruitful partnership with military psychiatry, psychoanalysis, which had since the 1920s been developing theories of trauma independently of civilian work in traumatic neurosis, was to have its seminal encounter with the experience of the survivors of the Nazi concentration camps.¹⁹ The psychoanalytic advances, which had hitherto made little headway in the public arena, suddenly found a very broad audience. For the first time, it was possible to put words, concepts, and images to the unspeakable, an experience humanity could not imagine: the planned, industrial-scale extermination of millions of individuals, with the aim of destroying what was human in mankind.

What did remain of the human after such an experience? The concept of traumatic neurosis was clearly incapable of answering this question. None of the etiological factors hitherto adopted to explain the development of traumatic neurosis as a chronic condition (whether pre-morbid personality traits or external circumstances favorable to the persistence of symptoms) bore any relation to the experience of the survivors. The notions of malingering, cowardice, selfishness, overdeveloped narcissism, secondary gains, class interest—all the stigmas attached to traumatic neurosis, could not be applied to these people in striped pyjamas who were emerging directly from hell. An entirely different paradigm was called for.

Bruno Bettelheim sketched the first outline of a new approach as early as 1943.²⁰ A psychologist of Austrian origin, he had been interned in the concentration camps at Dachau and Buchenwald from 1938 to 1939. Released just before the beginning of the war, he was able to emigrate to the United States where he would become director of the Orthogenic School in Chicago, which specialized in the treatment of autism. He based a number of articles on his experience in the camps, which were published together in 1952, in the tellingly titled collection *Surviving*, and developed a model of autism based on imprisonment in the concentration camps. In his early writing he sought to explain the psychological consequences of incarceration and the psychic adjustments it demands of the would-be survivor. Inspired by the work of the British psychoanalyst Melanie Klein, he proposed a reading based on what was known of child development, emphasizing the psychic qualities existing prior to incarceration. Since Bettelheim had no experience of the extermination camps, the world of the concentration camps that he described, while terrifying, is not commensurate with the horrors Primo Levi and Robert Antelme later revealed

¹⁹ Marcus and Wineman (1985).

²⁰ See the article "Individual and Mass Behavior in Extreme Situations," *Journal of Abnormal and Social Psychology* 1943, 38, pp. 417–452, reprinted in Bettelheim 1979.

in their writings,²¹ which later were the subject of studies by other psychoanalysts. Nevertheless, his ideas remained a key influence in clinical practice until the late 1960s, particularly thanks to the support of two important psychiatrists, Robert Lifton and Mardi Horowitz, and the creation of a new clinical entity, “survivor syndrome,” which replaced traumatic neurosis as a description of the symptomatology of civilian victims.²² Two aspects of this new clinical presentation have generally been ignored in the work of historians, although they are significant in the history of the rediscovery of post-traumatic disorders. They relate to the two distinct paths—initially social, then clinical—taken by the notion of trauma, and they prefigure the uses of this notion that would become widespread throughout the Western world thirty years later.

The first aspect is the way the traumatic experience was repositioned to become a testament to the unspeakable.²³ Whereas previously trauma related to an individual and subjective experience, the concept was now enlarged to represent universal human experience. It became the locus of a particular kind of knowledge that eminently suited, it would seem, the psychoanalytic paradigm: the subject’s own knowledge of himself and his limits, knowledge of others who did not survive the ordeal, and knowledge of man in general. This gave rise to an abundant literature—psychoanalytic of course, but also philosophical, sociological, psychosociological, and even literary—on trauma and memory.²⁴ With this shift, the experience of the concentration camps became the favored model for explaining what can happen to human beings in extreme conditions. Giving form to the memory would, it was suggested, leave a kind of moral trace in the collective consciousness that should prevent humanity from repeating its horrific mistake. On this level, survival depends in a sense on

²¹ Bettelheim recognized this himself in a later text, “The Holocaust One Generation On” (1979). See also Levi (1959) and Antelme (1992).

²² Robert Lifton joined the US Army as a psychiatrist after the war, and served in Japan, working with survivors of Hiroshima. He was influenced by Bettelheim’s concepts, and was particularly interested in the influence of the context in triggering pathological emotional reactions (Lifton 1968). It is worth noting at this point that Robert Lifton and Mardi Horowitz were to play a key role in the transformation of traumatic neurosis into PTSD on the basis of the experience of Vietnam veterans. Lifton’s book *Home from the War* (1973) became recognized as the great classic of psychological literature on the Vietnam War. See also Horowitz (1974).

²³ For a critique of the notion of bearing witness to the unspeakable, see Benslama (2001) and Rechtman (2005).

²⁴ The list of texts ranges from accounts of experience of the camps to critical analyses of theories of trauma. Writers of the latter favor the psychoanalytic reading as a tool for deciphering reality: see, for example, Cathy Caruth (1996), Ruth Leys (2000), Paul Ricoeur (2000), and Régine Robin (2003). However, with the notable exceptions of Allan Young (1995) and Ian Hacking (1995), these works fail to grasp the actual contribution of psychoanalysis to the creation of this paradigm.

the scar left by what happened to those who are no longer present. In contrast to the image offered by the combat shock patient of soldiers psychologically damaged by battle, the trauma of the survivors testified to the transgression of a fundamental boundary, beyond which social life was destroyed. Thus, the psychic destruction of the survivors became the corollary of the physical disappearance of all those who did not return. If the survival of some testified to the elimination of others, it was also because psychic trauma had become the essential constituting factor in this memory of the unacceptable, a memory of which the survivors became the guardians.

The second aspect that has been ignored in the historiography relates to psychiatry. The reconfiguration of traumatic experience as collective social memory did not have the impact that might have been expected on clinical and therapeutic practices established to treat Holocaust survivors. At the end of the war psychiatric thinking was already oscillating between a tendency to deny the existence of psychological problems among the survivors (they had survived because they were the strongest)²⁵ and an opposite tendency to believe that the absence of feelings of persecution, nightmares, anxiety, and depression in a survivor was a sign of mental illness (a normal person should experience these symptoms).²⁶ Bettelheim's understanding of the suffering of survivors offered a more nuanced approach to this dichotomy between those who survived and those who died, and inverted the question that had haunted the earlier concept of traumatic neurosis. The question was no longer, who were these men who presented with psychological disorders, but rather, how had they managed to survive the impossible? In his attempt to understand the phenomenon of survival, Bettelheim explored the whole range of psychological factors that might have been involved in the process of extermination, studying how some psychic processes were able to resist destruction while others, no doubt more essential to the psychic economy, broke down, drawing the subject on to certain death. Thus Bettelheim did not deny the decisive influence of the context of the events, but he put it in a perspective with the intrapsychic shifts caused by such an experience. It was in the combination of the two that the prisoner's fate was decided. Therefore, contrary to the reproaches that have often been levelled at him, Bettelheim did not argue that the weakest had died. He tried to understand how, in such extreme situations, some could survive, and asked what psychic and

²⁵ In one of the very first reports on Holocaust survivors, presented in Washington at the 1948 conference of the American Psychiatric Association, Friedman argued against the idea that the survivors possessed psychological and physical qualities superior to others, on the grounds that the "implication of this statement . . . dishonored millions of martyred dead" (Krell 1984).

²⁶ As Krell puts it (1984): "To be sane after the camps is not sane."

moral qualities were needed in order to escape death.²⁷ In doing so he shifted the focus of the psychoanalytic theory of trauma by suggesting that the trauma-generating situation carried at least as much influence as individual psychological factors. In this sense he departed radically from the exclusively psychogenic approach and was the first to incorporate the nature of the event into the unfolding of the process of trauma, and by extension, of survival. Paradoxically, this break with tradition prefigured future developments along both paths, which eventually would run counter to one another. On the one hand, psychoanalytic reformulations focused precisely on determining the nature of trauma-generating situations in order to identify the intrapsychic and situational processes that combined to engender the disorder.²⁸ But on the other hand, the theories that were later developed in North American psychiatry, and emerged in DSM-III, used Bettelheim's break with traditional thinking as a basis for rejecting the psychogenic view, for criticizing the focus on the personality of the trauma sufferer, and for treating the situation purely as an event "outside the range of usual human experience." The image of the survivor, though altered from that of the sufferer from traumatic neurosis, nevertheless remained imprisoned in ambiguity. In its emphasis on what distinguishes the survivor from a hypothetical fellow prisoner who did not survive, Bettelheim's clinical approach fails to separate the two images and postulates a priori that the fate of the former is closely linked to that of the latter.²⁹ Even in therapy, survivors would give accounts of the deaths of the others.

The notion of survivor guilt appears for the first time in Bettelheim's early writings. It derives directly from his conception that survival is determined above all by the prisoner's will to survive, sometimes at the cost of neglecting others. Robert Lifton and later Mardi Horowitz took up this idea and gave it a theoretical foundation, making this symptom the main element in survivor syndrome. However, in the view both of these authors and of Bettelheim, survivor guilt is not justified by the actions, behavior, or even the ideas the survivors might have had about their comrades in misfortune during their detention. The survivor's self-blame is ungrounded, but it remains present, obsessive, destructive, and it reveals an insistent unease about the reasons for his survival. It is not the therapist

²⁷ This theoretical position is based in a moral view of survival for which Bettelheim has been justifiably condemned, notably by Michael Pollak (1990).

²⁸ See the pioneering work by Dutch psychiatrist Hans Keilson (1980, 1992) on orphan child survivors of the Holocaust. Rather than identifying a single traumatic event or trauma-generating context, Keilson argues for a series of traumatic situations, each presenting its own lines of tension and leading to multiple dissimilar trauma processes.

²⁹ For a critical reading of this comparison of the dead and the survivors in therapeutic practice, see Rechtman (2006).

who suspects the survivor of bearing any responsibility, it is the victim who suspects that she owes her survival to something shameful or even underhanded, since so many others in identical circumstances died. For the clinicians who brought it to the fore, survivor guilt was not evidence of legitimate remorse, but a clinical sign of pathology. It amounted to an almost hallucinatory idea that would never find any genuine confirmation but that, by virtue of this very fact, could never be allayed. Thus survivors remain hostages to guilt, to the point that they constantly seek in their memory, in the inmost depths of their intimate thoughts, even their most fleeting and wildest thoughts, the true source of this guilt in order to at last break the vicious cycle of doubt and suspicion that overwhelms them. As long as they do not know why they are still alive, they are uneasy, because there was no justice in the death camps. Their very lives accuse them; the very fact that they had the good fortune to survive is reason for remorse. Survivor guilt became the defining symptom of this traumatic suffering. It was both the focus of psychotherapeutic treatment and the diagnostic marker actively sought by clinicians, sometimes to the point of suggesting it or of doubting the legitimacy of the trauma in cases where it was not present.

In this emerging relationship between trauma and the moral qualities of victims, the attention focused on this symptom seems like a relic of the suspicion of the previous era. It was now the victims who directed suspicion at themselves and gave expression to it in their accounts of their experience. But it was also in the confession, promoted in therapeutic practice, that this suspicion could be resolved (as previously in patients with combat shock), by reconciling the intimate experience of the victims with moral inquiries into the enigma of extermination. With this last avatar of suspicion, the treatment of survivors also crosses paths with the social trajectory of traumatic memory. The hypothesis of survivor guilt offered practical confirmation of the recast image of victims as witnesses.³⁰ By virtue of their presence alone, survivors were the only eyewitnesses to the destruction of those who were now absent. Through their guilt they inscribed within their suffering the memory of those who could no longer bear witness.

Thus it was in this dual role, of survivor and trauma victim, that Holocaust survivors were called on to testify to what happened to human beings in the death camps. Even though, as Agamben suggests³¹ (and Primo Levi before him), the only true witnesses were those who were no longer there to testify, those for whom the process of the destruction of humanity

³⁰ For a discussion on the aporia of the witness in the camps, see Fassin (2008).

³¹ On the basis of the testimonies of the survivors, in particular Primo Levi. See Agamben (2000).

was completed, survivors remained under the obligation of testifying in their place—often in their name, but always in their memory. There is nothing here that compares to the experience of the traumatized soldier, whose testimony to shell shock was as unwelcome as his illness was suspect. With the survivors of the camps, testimony to trauma—more even than the testimony of the trauma victim—was gradually recognized as offering ultimate truth about the human condition. It is in relation to this unprecedented perspective that we can now consider the universalization of victim status in the last three decades.

An End to Suspicion

THE YEAR 1980 SAW THE PUBLICATION OF DSM-III, the third edition of the American Psychiatric Association's classification of mental disorders.¹ It included a new clinical entity, *post-traumatic stress disorder*, or PTSD. The result of years of debate within the organization, the disorder was the outcome of negotiation and compromise around its definition and its interpretation. Even the name "post-traumatic stress disorder" was a subject of controversy. The identifying criteria were precise. The patient needed to have experienced a stressful event such as would lead to clear symptoms of distress in most people. The symptoms, which might occur in any combination, were of three types: recurrent, intrusive recollections, such as waking dreams, frequent nightmares, or painful flashbacks; avoidance of situations that aroused recollections of the event, accompanied by a numbing of general responsiveness to the external world which might seriously affect social interaction; hyper-alertness and exaggerated startle response. In order to be classified as PTSD, these symptoms should persist for at least six months. The semiological outlines of PTSD were virtually identical to classic descriptions of traumatic neurosis, merely refining and stabilizing the criteria for the diagnosis. The first criterion, however, was a major departure. It effectively affirmed that any normal individual might suffer from such distress if he or she were exposed to an event deemed traumatic. This marked a complete reversal in attitude. There was no longer any need to posit a weak personality, since the symptoms represented a statistically normal reaction to the event. There was no need to seek out any original trauma, since the event alone was sufficient to produce the distress. The sincerity of the victim of trauma was no longer in doubt: he or she was a priori credible. The question of secondary gains was no longer raised: the diagnosis conferred the right to appropriate reparation. A new era in thinking about trauma had begun.

At least, this is the generally accepted version of the history of PTSD. According to this version, the formulation of the new diagnostic category ushered in the second—modern—era of trauma. However, while we do not wish to downplay the major role played by US psychiatrists, the APA,

¹ See the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)*, 3rd edition (1980).

and the new DSM classification, we believe that the importance of the medical history of trauma is to a certain extent outstripped by the role that social history played, both prior to DSM-III (because the inclusion of the new classification resulted from the actions of players with no connection to the mental health field), and afterwards (given the widespread adoption of this classification over the last twenty years, in contexts far removed from the psychiatric arena). In this chapter, therefore, we explore the interactions of these two historical trajectories. Two contexts—sexual politics, on the one hand, and military claims, on the other—were key in the development of PTSD. The protagonists were, respectively, US feminists and Vietnam veterans. Both were campaigning to assert rights on the basis of a recognition of trauma. But the focus of their struggles and the alliances they formed with mental health professionals were very different.

WOMEN AND CHILDREN FIRST

In the early 1960s US society was basking in euphoria and prosperity, as the middle classes gradually discovered the benefits of economic expansion. The model US family became the supreme icon of this new utopia, in which the role of women was central. The private house, the family car, domestic appliances, shopping malls, and, of course, television emerged not only as the instruments of this economic miracle but also, and perhaps even more, as the actual indicators of social success. Women had won a new place in this society, a place that was enthusiastically promoted in advertising aimed specifically at them. No more tiresome domestic chores! Electrical appliances, made possible by advances in technology, would from now on do the housework, more or less automatically. Women would finally be free to devote themselves entirely to the mission conferred on them by a triumphant nation: ensuring the welfare of future generations as “loving wives and dedicated mothers.” But far from celebrating the great advances wrought by the technological revolution, in 1963 Betty Friedan offered a radical deconstruction of it, which was to become the manifesto of the emerging women’s movement.² The “happy housewife heroine” was the target of all the movement’s attacks: her much-vaunted well-being was condemned as a fabrication designed purely to reinforce the alienation of women. The economic miracle was of no benefit to women; on the contrary, it imprisoned them in a role for which there was no justification.

² In her famous book *The Feminine Mystique*, Friedan offered a detailed critique of the condition of modern women.

From the outset, the attitude to Freud in these feminist texts was one of ambivalence, a combination of respect and condemnation. He was respected because the feminists located themselves within the disalienation movement initiated by psychoanalysis. Psychoanalytic theory grounded their aspiration to fulfil themselves as individuals. They also observed in psychoanalysis an attempt to liberate individuals from the moral prejudices that condemned them to conform to social expectations. But as activists concerned with the lot of women in society, their view of psychoanalysis was much harsher: first, the Freudian theory of femininity based on penis envy cast woman as an incomplete man and introduced a hierarchy between the two; and second, the place given to sexuality in psychoanalytic thinking restricted the role of the woman, who had gained far less from the much-trumpeted sexual liberation movement than had men. Thus it was a question of gender politics as much as of sex. The place of the mother in Freudian theory added a third polemical dimension, because it amounted effectively to reconciling the mother to her assigned role, a role that society used to marginalize her, and it anticipated that she would feel guilt if she moved away from this role. But the most decisive attack on Freudian theory came not from feminists but from the defenders of childhood, with whom the feminists made common cause. The issue of trauma was at the heart of the debate.

While violence against children has always existed, the issue of what we now call "child abuse" only became a political priority in the United States in the early 1960s.³ It was in the context of the "War on Poverty" that charitable associations campaigning against "cruelty to children," which had begun to form in the Victorian era but had not been particularly active since that time, expanded their activities. With wide public support and enjoying broad political consensus, they targeted the social, economic, and even psychological factors that formed the context in which violence against children occurred. They did not, however, address sexual abuse within the family. As in all industrialized countries, campaigns against child abuse helped to establish new public policies enshrining the state's right to scrutinize the intimate environment of the family, and recognizing the child as a person with rights. Combining social and moral concerns, the movement aimed to support economic development of the poorest families, but also to help mothers by reasserting the value of their role. In Parents Anonymous groups, modeled on Alcoholics Anonymous, "abusive parents" relearned family values, maternal sacrifice, and wifely devotion. The defense of these values was articulated within a naturalist vision where abuse was interpreted as a "biological" aberration in

³ The history of this recognition has been traced by Barbara Nelson (1984). See also Ian Hacking (1995, 1998) and, for developments in France, Georges Vigarello (2005).

human behavior. In 1977, in the inaugural issue of *Child Abuse and Neglect*, the first scientific journal devoted exclusively to child abuse, the editor-in-chief began his declaration of intent as follows: "Next to making sure of its own survival, the prime task of any organism is to reproduce and provide offspring to ensure the survival of its species. In child abuse we see a seriously distorted form of this basic biological process."⁴ This was far from the feminist arguments against motherhood as the natural role of women. Nevertheless, although everything seemed to set them against one another—the family ideal, religious values, male domination, the privileging of motherhood as women's key role, respect for traditional US values, silence on sexual abuse—progressive feminists unexpectedly found themselves aligned with the campaign to protect abused children, and thus were able to win a new audience, one legitimized by trauma.

Florence Rush, a social worker already active in the women's movement, was the first to recognize this convergence of interests. In a paper she gave in New York on April 17, 1971, to hundreds of women who had come together for the Radical Feminist Rape Conference, Rush lifted the veil on sexual abuse of children. She showed vividly, on the basis of her professional experience with sexually abused girls, that child abuse was very often sexual, that it prefigured the lot of women in society, and that the fight against this deliberately ignored phenomenon was also, if not first and foremost, a women's struggle. Denouncing the silence of public authorities, and even more that of psychiatrists, she was the first to counter the psychoanalytic orthodoxy: women who, twenty or thirty years after the events, revealed a history of sexual abuse perpetrated by relatives—apparently benevolent fathers or uncles—were not expressing vague Oedipal fantasies, confusing what they had not experienced with what they desired. The psychological effects observed in sexually abused girls—their nightmares, their anxiety, their panic in the presence of men—were symptoms attesting to the reality of their experience. And if the distress of some children was now seen as incontestable proof of the violence they had suffered, why should similar traces not be found in the psyche of women and accepted as evidence that they had really undergone what was so often denied?⁵ Rush's paper thus opened a new arena in the women's struggle: while denouncing sexual violence against girls, she proposed that similar abuse suffered by women should also be exposed. Expanding the assault on "the American way" that had been so successful for Friedan, sexual abuse of children became the mark of male domination, the

⁴ Steele (1977).

⁵ Florence Rush, "The Sexual Abuse of Children: A Feminist Point of View." Paper presented at the New York Radical Feminist Rape Conference, New York, April 1971; reprinted in Rush (1980).

unacceptable privilege of the patriarchy, and the very symbol of traumatized sexuality. At this time sexuality did not yet represent, as it would for the second generation of feminists, a legitimate playing field.⁶ At best it was simply a distraction that diverted women from true fulfilment, particularly professional fulfilment. At worst sexuality degraded, abused, raped—in a word, traumatized—within a vast conspiracy of silence maintained by men (through their institutional structures in media and politics), and ultimately by psychoanalysts.

Thus it was in the name of their past traumas, of all the abuses they had suffered in childhood, but also in the name of the silence imposed on them and the unacceptable indulgence shown to their oppressors that feminists were demanding a right to reparation. "Incest survivors," as they began to call themselves following Rush's speech, having learned the lessons of the psychiatric and psychoanalytic notions of trauma that were developing at the time, began to compare their experience of traumatic memory to that of Holocaust survivors. The shift from traumatic experience to bearing witness to the unspeakable, introduced a few years earlier in psychoanalytic discourse, gave them a new perspective from which to assert that the suffering of women who had been subjected to sexual violence was comparable, at least in certain respects, to that of the survivors of the Nazi concentration camps. Like the latter, they faced massive denial—the denial of the abusers, of course, and that of any witnesses, but also that of the victims themselves, who were often unable to talk about the horrors that had so damaged them. According to psychoanalytic thinking on traumatic memory, the silence of victims can be interpreted as additional proof that an event of violence, so far beyond the pale that it cannot be expressed, has taken place. The victim's denial thus emerges as the last defense of a traumatized psyche, powerless in the face of an event that cannot be humanly tolerated. Once the psychological effects of sexual violence had been revealed, the very silence of the victims became evidence against abusers who believed themselves protected by that silence.

Here the attack was on Freudian theory itself. At the time clinical practice was heavily dominated by psychoanalysis and, being based on Freudian theory and not receptive to new ideas on trauma and memory, did not allow for this recognition of sexual trauma in childhood. Feminists condemned Freud's fantasy hypothesis, maintaining that he knew the range and extent of the abuse his female patients had suffered. He had explicitly stated as much in his first theory of hysteria, when he said that

⁶ At this point the debate is far from the militant feminism where sexuality became "both the engine of liberation and the instrument of domination" of women, as Eric Fassin puts it (2005).

the suffering of these adult women was the direct consequence of incest. Why had he changed his mind at the turn of the century? Why had he retracted and invented the fantasy hypothesis? Why had he opposed his most faithful disciple and friend, Sándor Ferenczi, who still believed in seduction theory? The answer seemed clear: He did not want to face reality. Fantasy theory, Rush argued, was simply an invention that formed part of the great conspiracy of silence around incest and sexual abuse, into which Freud had allowed himself to be drawn despite being the first to realize the truth. A few years later this theory found unexpected support in Jeffrey Masson's highly controversial book, *The Assault on Truth*.⁷ According to Masson, although he had irrefutable proof of the traumatic etiology of hysteria, Freud committed the sacrilege of hiding the truth in an effort at accommodation with the society of his time.⁸ This book was the first in a great wave of attacks on Freud and psychoanalysis, which now stood accused of every possible crime. Psychiatrists' and psychoanalysts' concealing of the truth of sexual abuse became the central tenet of campaigners for abused children, and a lineage was established for the conspiracy of silence that led from the first psychiatrists to the present generation, from Esquirol to Freud.⁹ But this controversy also points to another aspect of the rediscovery of post-traumatic disorders, which has been insufficiently recognized by historiography, even though it foreshadowed major changes taking place in US psychiatry at the time.

For despite their attacks on Freud, it was in psychoanalysis that feminists sought the support they needed to establish the truth of sexual abuse. In this they followed the path taken by advocates for victims of child abuse, who based their arguments on the work of clinicians. Radiologists were the first to suspect physical abuse of young children, when X-rays revealed multiple fractures for which there was no medical explanation;¹⁰

⁷ Trained as a psychoanalyst, a friend and pupil of Kurt Eissler, and the director of the Freud archives in New York, Jeffrey Masson became interested early on in Freud's correspondence. With Eissler's support he was able to consult the unpublished archives freely, notably the letters to Fleiss that Anna Freud had not included in the selected correspondence in *The Origins of Psychoanalysis* (1954). Convinced that there was a link between all the unpublished letters, Masson took a stand against all psychoanalytic institutions, arguing that Freud had deliberately abandoned seduction theory under pressure from the Viennese middle classes; this is the central theory of Masson's *The Assault on Truth* (1984).

⁸ In fact Masson produced virtually no evidence to support his argument. While doubts can be detected in Freud's letters, what emerges is the theoretical interest he found in fantasy theory, rather than an acquiescence in denial. See, for example, the review of Masson's book by Charles Rycroft in the *New York Review of Books* (April 12, 1984), which highlights its inconsistencies. See also Masson's defense in the same magazine, in the issue of August 16, 1984.

⁹ Olafson, Corwin, and Summit (1993).

¹⁰ The key text (Kempe et al. 1962) was systematically reprinted throughout the literature on child abuse.

pediatricians then began to alert the authorities and helped to bring suspects to justice by producing irrefutable clinical evidence.¹¹ American feminists therefore felt that proof of sexual abuse in childhood should also be provided by medicine. They expected doctors to testify in the name of all abused women, to speak for women who remained imprisoned in the silence of trauma, and to emulate their pediatrician colleagues by taking a public stand to expose the indelible traces of sexual abuse. But how were these traces to be found, so long after the actual violence? This was where the expectations placed on psychoanalysis were greatest.

For psychoanalysis, even if the fantasy hypothesis was discarded, the discovery of trauma symptoms in a woman who recounted experiences of cruelty in childhood did not automatically imply a link between this abuse and her suffering, and hence did not constitute legally admissible proof. In order to give expression to their past and present sufferings, women still had to undergo the ordeals of the trauma narrative and the revelation of intimate fantasies, and they had to confront the hypothesis of underlying incestuous desire, as well as suggestions of complicity on the part of the victim. Working within these therapeutic structures, which were still based on the model of intimate confession inherited from the war psychoanalysis of 1914–1918, eliminating suspicion was still a lengthy process. There was no guarantee that the external cause of the suffering would finally be acknowledged, and it was this acknowledgment that the feminists most needed. The issue was not finding sympathetic therapists—there were already many who were addressing the distress of these women—nor denouncing the institution of psychiatry, as did the anti-psychiatry movement of that time.¹² The feminists needed legitimate clinicians whose word would not be questioned. In order for women to be at last heard, psychiatrists had to step beyond the individual dialogue and testify publicly, not only to the authenticity of the suffering, but above all to the reality of the abuse.

Clinicians were indeed able to testify to the suffering of these women, and they did so, but their tools, unlike those of the pediatricians championing abused children, were such that they were unable to expose the perpetrators, much less to bring them to justice on the basis of irrefutable proof. In these circumstances, the gap between the women's movement and the response of psychoanalysts could only deepen. Although psychoanalysis had encouraged the recognition of long-term trauma and enabled US feminists to recognize their own experience via the notion of the survivor's traumatic memory, the feminists eventually turned on psychoanaly-

¹¹ These doctors created the International Society for the Prevention and Treatment of Child Abuse and Neglect, and founded the journal *Child Abuse and Neglect* in 1977.

¹² See in particular Castel (1980).

sis, criticizing its powerlessness to demonstrate publicly the reality of traumatic events affecting individuals. Thus, the attacks made by the women's movement on Freudian fantasy theory are part of the disconnect that we have demonstrated between the language of collective trauma and individual clinical practice with trauma sufferers as it was introduced by psychoanalysis after World War II. On the one hand, psychoanalysts put forward a conception of collective trauma which establishes a moral link between the collective memory of trauma and the traumatic event. On the other hand, individual clinical practice sought to relocate this event in the history of each subject, which amounts to questioning its significance. The increasing gap between these two social trajectories of trauma testifies to the rise of a shared aspiration to transform clinical practice with trauma victims into a politics of trauma.

THE CONSECRATION OF THE EVENT

The proof that the feminists so urgently needed was to come from a very different strand of psychiatry. It was a minor strand at the time, but was destined to grow and to spread its influence well beyond the United States. Robert Spitzer, a New York psychiatrist initially trained in Reichian psychoanalysis, proposed to give psychiatry a more scientific basis and to align it with the new aspirations of US society. This unexpected convergence, between a clinical movement seeking scientific legitimacy and a social movement looking for political legitimization, sealed the fate of the traumatic event. From now on the event would be recognized as the exclusive etiological agent of post-traumatic disorders.

Since the early 1970s a huge internal reorganization, both theoretical and institutional, had been under way in US psychiatry. Reeling from its clash with the anti-psychiatry movement, the discipline's image was doubly tarnished.¹³ In the medical world psychiatry was regularly accused of lacking a scientific basis. Both its diagnoses and its theories were routinely contested. Seen as unreliable, because they had a low level of reproducibility from one clinician to another, and of little validity, because clinicians were relatively unsure of the pathological reality of what they claimed to describe, psychiatric diagnoses were viewed by many doctors as a hazy amalgamation of moral judgments, received ideas, and outmoded theories. Public opinion saw psychiatry as an instrument of social control, which wrongly classed all of the undesirables that US society did not

¹³ Kirk and Kutchins (1998).

know how to deal with as insane.¹⁴ It was in order to combat this image that the American Psychiatric Association (APA) undertook to revise its classification of mental disorders,¹⁵ modifying not only the title and etiological hypothesis for the majority of diagnostic categories, but more fundamentally, quite literally revolutionizing the social uses of psychiatry.

Under the direction of Robert Spitzer, work began on the new official classification in 1974. Each diagnostic category was reworked by a group of clinicians comprising the senior specialists in that field. In addition to increasing the reliability and validity of diagnoses, the goal was to rid psychiatry of traditional hypotheses that had not been scientifically proven.¹⁶ This provision, which aimed to put psychiatry on an atheoretical basis, necessitated a purely descriptive approach to the categorization of mental disorders. Published amid a blaze of publicity in 1980, DSM-III had within ten years become the standard reference for modern psychiatry. For the first time in the history of the discipline, new hypotheses and the new ideology they supported were resonating with the needs and expectations of users. Twenty-five years and three revisions later,¹⁷ there is less enthusiasm. Having conquered the world in the name of a radical scientific revolution, the different versions of the DSM have reverted to being no more than a classification system, and they no longer carry the promise of a radical new vision. Even the great advances in diagnostics are now being reevaluated. Allen Frances, the director of DSM-IV, recently acknowledged that little had changed in the everyday practice of clinicians. Robert Spitzer himself no longer hides his disappointment, admitting that many problems remain to be resolved if psychiatry is to be rendered truly scientific.¹⁸ However, although DSM-III has not produced the promised scientific revolution, social reform in psychiatry since the 1980s

¹⁴ See the controversy unleashed by psychosociologist David Rosenhan's famous experiment (1973), in which mental health professionals presented themselves at psychiatric institutions claiming to hear voices, and were admitted without therapists questioning their condition. For a critical reading of the influence of this controversy on the development of US psychiatry, see Rechtman (2000).

¹⁵ The APA had already produced two classifications of mental illness, the *Diagnostic and Statistical Manual for Mental Disorders*, DSM-I in 1952, and DSM-II in 1968. Heavily influenced by psychoanalytic theory, these two manuals no more met the needs of mental health professionals than they did those of insurance companies, which sought more reliable psychiatric diagnoses that could be included in the policies they offered. This point is essential if we are to understand the success of DSM-III.

¹⁶ On this point, see Balat (2000). Despite the many criticisms of the classification since it was issued, both of its categories and of its hegemony, it has to be recognized that these have been restricted to mental health professionals, while the influence of the new psychiatry was growing in American public opinion during this time (Rechtman 2002, 2003).

¹⁷ DSM-III-R (1987), DSM-IV (1994) and DSM-IV-TR (2004).

¹⁸ See the January 2005 interview with Spitzer and Frances in *The New Yorker* (Spiegel 2005).

remains a significant consequence of this movement, which began in the United States. The place given to psychic trauma and the recognition of the status of victim are probably the most striking illustrations of this.

The encounter with the aspirations of the women's movement offered an opportunity to demonstrate psychiatry's new capacity to meet popular expectations, particularly those of groups oppressed by the social order, which psychiatry had always been reproached for serving. Robert Spitzer had already garnered a major victory in 1973, when the APA's Assembly voted to strike out the diagnosis of homosexuality. After several years of debate, internal struggle, threats of splits, and external pressure, the United States thus became the first nation to "de-pathologize" homosexuality.¹⁹ After this victory over the conservative elements within psychoanalysis,²⁰ Spitzer was appointed director of the DSM-III task force, a post that was little sought after at the time. The aim of the task force was clearly stated from the outset: to bring scientific criteria to both the classifications and the practice of psychiatry, but more importantly, to redefine mental illness independently of any moral judgments.

Redefining the condition formerly known as traumatic neurosis meant that the concept would be recast free the stigma of suspicion, in the hope of winning over feminists in the same way as gay rights activists. Adopting the new name of post-traumatic stress disorder (PTSD), the task force quickly agreed to abandon the term "neurosis." While the movement to eliminate this term in other categories (particularly depression and the anxiety disorders) met with remarkable hostility, to the extent that the whole process of revising the DSM was called into question,²¹ there was broad consensus on the abandonment of "neurosis" in the definition of trauma reactions. Nevertheless this marked a sea change with profound political implications. By jettisoning "neurosis," the architects of the new DSM were rejecting a century-old legacy of suspicion. The clinical signs of PTSD remained those of classic traumatic neurosis, but the status of the traumatic event had fundamentally altered, becoming the necessary and sufficient etiological agent. The withdrawal of the neurotic paradigm

¹⁹ In 2002 the World Psychiatric Association launched a new campaign to raise awareness among scientific psychiatric associations in all member countries, inviting them to withdraw the diagnosis of homosexuality from their classifications, where it is still included in many cases.

²⁰ Portrayed as a victory of progressives over psychoanalytic conservatism, for the promoters of DSM-III the withdrawal of the diagnosis of homosexuality marked their break with traditional psychiatry (Bayer and Spitzer 1982, Bayer 1987). For a discussion of the influence of minority groups on contemporary psychiatry, see Rechtman (1999).

²¹ For an overview of this debate, see the article by Ronald Bayer and Robert Spitzer (1985).

marked the end of searching for the causes in the unconscious of the victim and of the crusade to discover fraud or malingering. The task force on post-traumatic disorders came to a consensus: the event was the sole etiological factor. This conclusion neatly fit the agenda of supporters of victims' rights.²² No longer was it thought that intrapsychic activity and the combination of a fragile personality with an event that that personality was unable to assimilate, were the key to trauma; now it was an event "outside the range of usual human experience" that disturbed the psyche's normal capacity for resistance. There was no longer any need to delve into the depths of the soul or to seek out predisposing factors in the subject's personality or history. The event had become the sole cause of the pathology. Suspicion had definitively disappeared. This about-turn from previous theories was remarkable: for the first time, under the definition proposed in 1980, the formerly pathological response had become a normal response to an abnormal situation.²³ Bearing no relation to the trauma narrative, removed from an individual's history, without reference to previous personality structures, trauma thus appears as solely attributable to an unfortunate encounter between an ordinary person and an extraordinary event.

This definition, which was immediately hailed as a great leap forward, suited all those campaigning on behalf of victims, since all that was now required was to diagnose characteristic symptoms and to locate an antecedent uncommon event as the cause. A century of clinical suspicion directed against traumatic neurosis patients by both civilian and military practitioners collapsed under the effect of this new definition—even though it had yet to receive any empirical validation.²⁴ Vietnam veterans drew lessons from this radical shift that they would put to good use in their campaign to obtain financial reparation and bring about the end of the war.

²² In relation to the expectations of the women's movement, what made it possible to win public recognition for traumas resulting from the sexual abuse suffered by women was of course the invention, at the same time, of "multiple personality disorder" (Hacking 1995, Mulhern 1991, 1998). But this diagnosis would not have been possible without the prior recasting of traumatic neurosis, and above all without the opening statement that the event was exclusively responsible for PTSD.

²³ In the definitive version published in 1980, DSM-III gave the following definition of PTSD: "The development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience. These symptoms include: recurrent recollections of the traumatic event, numbness or diminished responsiveness to the outside world, and various neuro-vegetative, dysphoric or cognitive symptoms" (APA 1983, p. 256).

²⁴ No empirical epidemiological data were available at the time when the PTSD task force decided to define the traumatic event as the sole etiological agent.

THE LAST WITNESSES

The task force that designed the new diagnostic category in DSM-III was comprised of psychiatrists who were particularly sensitive to the problems affecting Vietnam veterans. The theme was of course of particular interest to them, since the best specialists in post-traumatic disorders were to be found among the ranks of military psychiatrists. Some had already become known for their support of veteran rehabilitation programs, and for the stand they took against the war.²⁵ All were keen to widen the boundaries of PTSD to include a number of clinical symptoms that had been gathered together in the condition popularly known as “post-Vietnam syndrome,” an unofficial diagnostic category that did not confer the right to compensation. A great deal was at stake. The Veterans’ Administration, on the one hand, was not in favor of this broadening of criteria. If all veterans who had experienced “uncommon events” were to be compensated, this would enormously increase their administration’s burden. Activists, on the other hand, hoped for a double gain from this merging of categories, since it would confer not only the right to financial compensation but also the social status of “war victim,” which was more attractive than that of defeated soldier.

The long-drawn-out, thorny debate contributed to delays in the definitive incorporation of PTSD into the official classification system.²⁶ From the outside it must have seemed that the new theoretical framework would be very open to the immediate inclusion of psychological disorders related to the Vietnam War. In fact the semiology of PTSD was virtually identical to that of the condition formerly known as shell shock, which developed, as we may recall, on the model of traumatic neurosis to describe pathological reactions to combat in World War I. Moreover, the new definition of the traumatic event meant that soldiers suffering from the condition would no longer be challenged, and allowed this mental disorder to be considered a normal response to an abnormal situation.

²⁵ The task force included Robert Lifton and Mardi Horowitz, who had both contributed to the definition of survivor syndrome, as well as Chaim Shatan, a colleague of Lifton’s, and Jack Smith, a former marine who had been active since his return from the war in the organization Vietnam Veterans Against the War. For more details on the composition of the task force, see Young (2002).

²⁶ To mark the appearance of DSM-III in 1980, Robert Spitzer gave an interview to one of the APA’s official journals, *Hospital and Community Psychiatry*, in which he stressed the transformation ushered in by PTSD (Spitzer 1980). Expressing his delight at having contributed to creating a new theoretical framework for this complex concept, he nevertheless admitted that the inclusion of Vietnam veterans was one of the most difficult points in the drafting of DSM-III, and probably the most contentious.

Things had changed so much since World War II that the average person could readily empathize with the confusion, fear, anxiety, and trauma of the young conscripts, with no discredit to them. Since the horrific discovery of the genocide of the Jews, the role of trauma in the moral economy of US society had legitimized compassion for such formerly silent sufferings. Combat shock sufferers were no longer to be hidden away, the better to glorify the qualities of their braver comrades in arms; moreover, the increasing unpopularity of the war meant that the latter were no longer seen as heroes. The brutality of the battles, the mounting casualty numbers, the anxiety of soldiers' families—all these factors, highlighted by intense media coverage, made this war more and more a presence in the everyday life of the United States. It seemed to be happening under the very eyes of the people, on their doorstep, within their own being. Trauma—which everyone understood and, at least to some extent, shared—was no longer a mark of cowardice or malingering. Suspicion no longer had any place in this conflict that sent young men into hell.

However, the inclusion of the symptoms presented by Vietnam veterans in the PTSD rubric still posed a crucial problem, both to the editors of the new classification and to US society in general. What should be done about the suffering of soldiers who were guilty of war crimes? A few years earlier, in November 1969, the US people were stunned to discover that their GIs were implicated in wide-scale carnage. Revelations about a massacre in My Lai, a Vietnamese hamlet where more than four hundred people (women, children, and the elderly) were killed by a US company on the morning of March 16, 1968, stunned a public convinced that this was a "just war."²⁷ No US soldiers died in the incident. The villagers had been executed with inexplicable savagery. The massacre caused a scandal and prompted a major investigation focused on identifying responsibility in the chain of command, but more particularly on the personality of the soldiers involved. Were these bloodthirsty monsters or ordinary men who, when placed in an exceptional situation, became capable of horrific crimes? Even if the war was to blame for the atrocities, court-martialling the individuals involved and their officers could not answer the question.²⁸

²⁷ Hushed up for over a year by the military authorities, who were nonetheless well aware of the carnage, the affair was revealed by an independent journalist, Seymour Hersh, in the November 20, 1969 issue of *Life* magazine. It was taken up the same week in *Time* magazine, then in *Newsweek*, and finally on CBS television.

²⁸ Lieutenant Calley, who led operations at My Lai, was found guilty and sentenced to life imprisonment, but was pardoned a few years later by President Nixon. Most of the depositions made at the court-martial are still available on the Internet. A surprising poll conducted at the time, which showed widespread public sympathy for Calley and disagreement with the sentence, can also be found at <http://www.law.umkc.edu/faculty/projects/trials/mylai/mylai.html>.

Who were these men who were capable of committing the worst possible crimes, in cold blood?

After eliminating the hypothesis of prior mental illness or even of pathological symptoms that emerged at the moment of the events, psychiatrists and psychologists were astounded at the extent of the impact of the war on combatants. It became clear that in extreme conditions where violence had become an everyday phenomenon, where the fear of death drove men to anticipate an attack at every rustle of sound, where the discovery of the bodies of their comrades, sometimes savagely mutilated, aroused murderous impulses, and where isolation from the rest of the world meant that they ended up relying only on themselves and a handful of comrades for their survival, the limits of good and evil could be pushed beyond the imaginable. These men were not completely responsible for what happened to them, Robert Lifton claimed. More precisely, it was the war, and particularly the nature of combat in the hostile Vietnamese jungle, where invisible enemies were an ever-present danger, that had led these men to become what they were never meant to be.²⁹ According to Lifton, normal behavior derives from the subject's capacity to adapt to his environment. In the very specific context of Vietnam, adapting to the extraordinarily difficult conditions of life sometimes required such extreme psychic reorganization that civilian moral values could not stand. Among themselves these soldiers were inseparable comrades, bound by powerful values, to the extent of sacrificing themselves without hesitation to save one of their own, but these same men were capable of the worst brutality towards their enemies (or those they perceived as enemies), to the point where they forgot that these enemies were human beings.³⁰ In support of his argument, Lifton focused on the case of the only soldier who had refused to participate in the massacre. He had not managed to integrate with his company and showed signs of psychological unease that marked him as an outsider even before the massacre. Lifton argued that on the day of the massacre his reaction was not "normal," even though today it seems to us the more "right." In any case, we cannot know the exact reasons for his refusal. Was it clear-sighted ethics or pathology that prevented him from merging with the collective formed by his group? Whatever the case, the experts came to a unanimous conclusion in relation to the other soldiers: these were ordinary men placed in an extraordinary situation.

²⁹ Lifton (1973) used the term "atrocious-producing situation" to describe the context in which these soldiers became capable of committing incomprehensible crimes.

³⁰ In his deposition Calley built his defense on the notion that he had never had the sense that he was killing human beings; he was simply "doing his job that day," applying to the letter the orders he had been given "to destroy anyone supporting the Vietcong ideology."

So should they be condemned? Of course, said the psychiatrists: even if they had been motivated by powerful internal forces that merited medical attention, they were still aware of what they were doing. However, they were also victims of the Vietnam War, who held the details of the atrocities in their tormented memory, reliving them in nightmares. Sometimes even when awake they could smell the stench of death, hear the footsteps of their enemies, taste blood and gunpowder; they experienced the full range of their fears over and over, as if they were still in the war zone. These men should therefore be considered war victims, broken by what they had witnessed and by what they themselves had done—men traumatized by what the war had made of them. But they were also men who, it was claimed, had acted under the influence of survivor guilt. Putting a radical twist on a concept he himself had put forward a few years earlier to describe the psychological symptoms of survivors of the Holocaust and Hiroshima, Lifton suggested that these soldiers, who had seen so many of their comrades die, had been consumed by the same survivor guilt as the Jewish and Japanese survivors. By destroying the illusion of their group's invulnerability, the death of one of their number raised an inevitable question for the survivors: "Why him and not me?" At My Lai, this outlook unleashed brutal violence that gave meaning to the sudden senselessness of survival, making it possible both to restore the group's cohesion and to recover a sense of self that could discharge survivor guilt.³¹ Both victims and survivors, these men were also witnesses to the most horrific scenes that war could produce.

The members of the PTSD task force, who were heavily involved in defending the interests of veterans and particularly in the campaign against the Vietnam War, wanted to include the traumatic symptoms of those who had committed atrocities in their new category. The signs presented by these damaged soldiers were identical to those of PTSD: the event they had encountered was clearly outside the range of usual human experience, even if they had been the perpetrators of it rather than the victims. Survivor guilt, although it was far from extending to the memory of their victims, also bore witness to the trauma they had undergone. On the strictly psychiatric level, there was therefore nothing to distinguish these trauma victims from others who would be diagnosed as having PTSD.³² The issue in the decision of whether or not the psychological sequelae of Vietnam veterans belonged in the category of PTSD, was to

³¹ Lifton (1973, p. 46).

³² As a New York specialist in PTSD pointed out to us at a conference in Paris in 2000, "For a doctor, when someone breaks their leg the diagnosis doesn't depend on the context (whether he broke his leg kicking someone or being kicked). A broken leg is still a broken leg, regardless of the reason, good or bad, just or unjust, for the fracture."

decide also whether the perpetrators and the victims of atrocities could be combined in a single category. Should psychiatric investigation be limited to identifying the characteristic clinical symptoms of PTSD? Should those who had committed such atrocities be considered, from the strictly medical point of view, ordinary trauma victims and be subject to the same diagnosis of PTSD, independently of any moral condemnation of their actions? Or should a moral dimension be introduced into the medical practice, preventing the victims and the perpetrators from being included in the same diagnostic category despite the similarity of their symptoms?

The solution was ultimately simpler than it appeared, since classing the perpetrators of atrocities with the victims offered significant political advantages for both pacifists and supporters of the war. For Vietnam Veterans Against the War, it was essential to reveal the full horror of the war's atrocities, particularly those committed by US troops, but it was equally important not to place the responsibility on the soldiers themselves. The image of the soldier traumatized by his own actions, an outgrowth of Lifton's concept of the "atrocious-producing situation," allowed them to denounce the war without directly condemning those fighting it. On the other side, for the military authorities who, after My Lai, could no longer cover up the extent of the crimes committed, the soldiers' trauma offered the undeniable advantage of mitigating some of the horror by showing men now destroyed by what they had done. For both sides, the "self-traumatized perpetrator," to use Allan Young's terms,³³ became an essential image that supported their position, however much they diverged politically in their account of the American defeat. For My Lai was not an isolated case. As clinicians gathered the testimony of traumatized veterans, the scope of the abuses committed by US troops against civilian populations grew, and horrifying details came to light. Some veterans had been directly or indirectly involved in acts of torture or summary executions; others admitted that they had taken some pleasure in raping and mutilating. It was these veterans, returning from the war with hitherto unknown psychiatric symptoms, who would benefit from PTSD, since they were directly traumatized by the actions they had committed during their service.³⁴ The members of the DSM-III steering committee therefore accepted the task force's recommendations and included in PTSD the conditions presented by all military personnel affected by the war, regardless of whether they had suffered or caused the traumatic

³³ Young (2002). As Allan Young notes elsewhere (1995, p. 125), of the seven classes of events liable to provoke PTSD, only one related to violence suffered; the other six comprised situations (distinguished from one another by the degree of awareness of the horror, and the degree of pleasure) where the trauma victim was the perpetrator of the atrocity.

³⁴ Levenberg (1983).

event. The definition of the disorder did not call for any analysis of the moral circumstances. Acts committed with full awareness and even with enjoyment could give rise to PTSD. Continuing the move away from a psychology that delved into the depths of the unconscious, the new concept of psychic trauma thus also abandoned investigation of the twists and turns of consciousness.

THE HUMANITY OF CRIMINALS

The inclusion of perpetrators of atrocities was, however, not merely an accident of contemporary US history. We agree with Allan Young that classing perpetrators together with victims in this way was the perfect way to manage Vietnam veterans, both politically and financially, but we do not concur with his suggestion that this makes the reclassification a purely circumstantial phenomenon that would disappear once the conditions favoring its broad acceptance by society had faded away. In our view, the gesture has a broader and more lasting significance. The recognition of the self-traumatized perpetrator is not simply the product of the sudden emergence of this "ecological niche"³⁵ created by the return of Vietnam veterans: it derives more fundamentally from the encounter between traumatic social memory and individual testimony to horror, which now became merged in the image of the victim. Indeed, if we consider the dual lineage of theoretical models and social usages of trauma that we have documented, we see that the cooperation between victims and perpetrators, introduced in response to a temporary situation in the United States, marks a break that we can describe as anthropological. For the first time since World War I—but on diametrically opposed grounds—the clinical paradigm and the social norm come together and mutually reinforce one another, making trauma the universal language of a new politics of the intolerable.

As far as the clinical paradigm was concerned, abandoning suspicion meant that the uncommon nature of the event itself had to be brought to the fore, in order to highlight the very ordinariness of the victim. In terms of social norms, classing perpetrators of atrocities with victims of violence offered a new insight, reinforcing the notion that trauma was indeed the locus of incontrovertible fact. In this version, testimony to trauma—independently of any individual narrative, but also of any moral evaluation—holds ethical truth that clinical practice can finally confirm: trauma is itself the proof of an unbearable experience. We should be clear here that

³⁵ To quote Ian Hacking (1998), who proposes this concept to explain the birth—and death—of short-lived categories of mental illness or transient mental illness.

psychiatry did not exonerate these soldiers; it simply attributed to the perpetrators of atrocities a vestige of humanity that was manifested through their trauma. Their suffering—even if they expressed no remorse—showed they still shared in the humanity that their cruelty would seem to have destroyed. Clearly, the image of the atrocities committed by the US forces could not simply be erased because a few psychiatrists declared that the men responsible for these acts were victims of the war. The media, in any case, was not deceived, for these men continued to be caricatured as “baby killers,” a term of contempt that still today³⁶ revives the antagonism between supporters and opponents of the Vietnam War.

Films and novels make no concessions in their depictions of these men capable of the worst. From Michael Cimino’s *The Deer Hunter* (1978) to Barry Levinson’s *Good Morning, Vietnam* (1978), through Francis Ford Coppola’s *Apocalypse Now* (1979) and Ted Kotcheff’s *Rambo* (1982), to Oliver Stone’s *Born on the Fourth of July* (1989), portrayals of these soldiers’ suffering do not exonerate them.³⁷ In his novel *The Human Stain*, Philip Roth sketches, over a few pages, a hyper-realist portrait of a Vietnam veteran suffering from typical PTSD, who cannot rid himself of the ghosts that haunt his nightmares. Transformed into a killer in civilian life, he feels murderous rage at the mere sight of the slant-eyed waiter in a small Chinese restaurant. But there should be no mistake: although the courts were lenient with veterans who had committed war crimes, the new classification of mental illnesses did not exonerate them, for it no more explained than it excused the acts they had committed. In fact it said nothing about them.

North American psychiatry offered two levels of response to the question of who were these men who were capable of committing the most odious crimes. On the one hand, it allowed the nation to confront its defeat in Vietnam. Instead of facing up to the impossible choice of either condemning some of its soldiers for their actions or itself assuming responsibility for their crimes, the nation could rest easy in the psychiatrists’ comforting conclusion: these were ordinary men placed in extraordinary

³⁶ At the beginning of the second Gulf War, those opposed to the US intervention revived this term. During the 2004 presidential campaign, John Kerry, himself a Vietnam veteran and subsequently active in Vietnam Veterans Against the War, was attacked by Vietnam veterans who formed an association, Vietnam Veterans Against John Kerry, for this purpose, and accused him of having used the term “baby killers” against US soldiers. See <http://www.vietnamveteransagainstjohnkerry.com>.

³⁷ However, this tendency of US cinema to reveal the atrocities of the Vietnam War shifted after 9/11. The release of Randall Wallace’s film *We Were Soldiers* (2002), which celebrates Vietnam veterans and coincided with the beginning of the campaign in Afghanistan, marked a turning point that was immediately recognized by the media. One *Wall Street Journal* columnist expressed his approval in an article titled “We Were Soldiers, Not Baby Killers”: <http://www.opinionjournal.com/columnists/bminiter/?id=105001721>.

conditions who needed to be cared for rather than judged and perhaps condemned. Trauma, and particularly PTSD, which included them in the same diagnostic category as victims, provided a compromise solution. It gave all veterans, including the perpetrators of atrocities, a status that conferred the right to compensation. Moreover, it allowed the latter the benefit of the doubt with the aim of rehabilitating them, crediting them with a residue of humanity evidenced by the traumatic memory they retained of their actions. But most of all, it introduced a radical shift in the social significance of violence. While the new concept of trauma eschewed any valuation of the individual act, it revealed the unbearable character of the event in general. In the eyes of clinicians the perpetration and the suffering of crime were rendered equal under an identical diagnosis of PTSD, but the trauma revealed that something had happened that was sufficiently terrible to leave a trace in the psyche of apparently healthy individuals. Thus it demarcated a new normative field, separating the normal from the abnormal, the ordinary from the extraordinary, the acceptable from the unacceptable. In other words, trauma as reinvented by US psychiatry in the 1980s removed the moral dimension from clinical practice (since it refused to draw any distinction between the criminal and his victim) and articulated an ethical truth that lay beyond individual judgment (since it claimed to recognize the locus of the intolerable). From the moral to the ethical: this was clearly a profound change in the outlook on violence. However, as we shall see, in the practical activities of psychiatrists and psychologists, as well as in the lay application of their categories, moral evaluation continues to be reintroduced, even when the intangibility of the ethical is acknowledged.

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Beginning with the attempts to formulate a psychoanalytic and historical analysis of the genocide of the Jews in Europe, the notion of trauma had acquired a social usefulness without equivalent in human psychology. It was the mark of trauma that revealed the extraordinary persistence of humanity among the survivors of the Holocaust; and it was the pain of trauma, inscribed in the collective memory, that would prevent a repetition of the horrors. The persistence of the psychic scar guaranteed that the memory of the intolerable would never be erased. But the meaning of that trace was still inextricably linked to the moral qualities ascribed to survivors—their innocence and their weakness in the face of the brutal forces that overwhelmed them—and to the empathy they inspired. Now, through this encounter between conceptions of memory and clinical practice, trauma was seen as the locus of an essential truth about humanity that stood apart from the moral qualities of the victim. This thinking is

far removed from the dominant ideas about the damaged soldiers of World War I, whose symptoms were seen as evidence of cowardice or duplicity. It is also a long way from the theories that tried to explain the suffering of soldiers in World War II, whose weakness, while it was more acceptable, nonetheless still had to be concealed.

Now perceived as a normal response to an abnormal situation, the concept of psychic trauma entered the public arena and trauma became a common word. With or without PTSD, with or without DSM-III, the spread of this new language of trauma encouraged victims who had not yet seen themselves as such to recognize their victimhood. Specialized journals were launched,³⁸ societies were set up, and popularized versions of the latest scientific thinking about trauma became widely available on the Internet. Victims of all forms of violence (domestic, political, or other) awoke to the realization that, through the medium of PTSD, psychiatry now recognized their psychological pain.³⁹ From the mid-1980s on, more and more books on trauma, aimed at a general audience, were published. Clinicians, therapists, and former victims gave accounts of their experiences, but especially of the traumatic suffering and the enforced silence that the category of PTSD now enabled them to break. A call to experience the liberation of speaking out was the basic element uniting all these initiatives. The pathological response to trauma was a normal one, so there was no reason why victims should hesitate to come forward.

It was now in fact possible to be traumatized without knowing it. This marked a significant qualitative leap from the traditional concept of psychic trauma. Not only did victims no longer have to prove the reality of their trauma, but those who did not recognize themselves as victims were being sought out, offered help, and enabled to obtain the compensation

³⁸ The Veterans' Administration naturally published its own bulletin, *PTSD Research Quarterly*, which became the official journal reviewing US research on post-traumatic disorders. But it was the creation of the Society for Traumatic Stress Studies in 1983, and then of the International Society for Traumatic Stress Studies and its *Journal of Traumatic Stress*, that contributed most to the development, the international spread, and the high level of visibility of PTSD on the world stage.

³⁹ Thus the home page of the site devoted to British veterans reads as follows: "How do I know if I am suffering from PTSD? [A list of simple questions follows:] Do you feel any of these apply to you: I was on active service during my career; I was victimised during my service, etc. Are you suffering any of the following which might be related to the above: I suffer flashbacks and nightmares; Since my service I now have a serious drink or drugs problem; I feel depressed, isolated, lonely and confused; I have tried to commit suicide because I just cannot cope with my feelings; I am irritable, hyper-alert and have sleep problems; I am angry with life; I feel I am the only one suffering like this and think I am going mad, etc. Remember . . . Post-Traumatic Stress Disorder is a natural emotional reaction to a deeply shocking and disturbing experience. It is a *normal* reaction to an *abnormal* situation." (<http://www.ptsd.org.uk>)

to which they were now entitled. This progression paved the way for the development of a vast system for identifying sufferers, increasing public awareness, and guiding patients to reputable specialists. This system was at once a reflection, a product, and the instrument of the new social visibility of post-traumatic stress. The proliferation of Web sites, dedicated journals, and specialized support centers, and the emergence of new disciplines (psychiatric victimology, humanitarian psychiatry, the psychotraumatology of exile) testify to the vigor of trauma psychiatry. But it was above all the acceptance, by society, of the idea that trauma was a variant of normality, that enabled the rapid spread of the concept into new arenas. Long rejected or hidden, trauma became a genuine public health concern—and this worldwide, since, contrary to sociological predictions about civilization and prophetic announcements of the end of history, violence of all kinds was clearly all too evident in many parts of the world.

Thus the expansion of the concept of trauma seems to indicate a general approval of the attractive idea that something of the human resists all forms of moral destruction. It is in the name of this vestige of humanity that compensation is demanded for damage suffered, that witnesses testify against all forms of oppression, and that proofs of cruelty endured are brought forward. However, behind this consensual rhetoric of trauma, which has produced its own grammar of analysis and its own vocabulary for action, differences and disagreements are emerging. Trauma is asserted as a principle in whose name indignation is expressed and legitimized, but at the same time it annuls other moral or political positions. On the one hand, we note that not all accept the status of victim conferred on them through the medium of trauma in the same spirit. And on the other, it becomes clear that individuals themselves are not content to behave as passive victims of the labelling process, but are redefining trauma, or even denying it. This is what our studies on the explosion in Toulouse, the war in Palestine, and asylum seekers in France definitively demonstrate.

PART TWO

The Politics of Reparation

THE RESEARCH, WHICH WE HAD BEGUN A FEW MONTHS EARLIER, had led us that day to the French Ministry of Health, to the office of the Haut Fonctionnaire de Défense¹ (HFD) who headed the National Committee for Medical and Psychological Emergencies (CNUMP). Set up by a decree of May 29, 1997,² and launched with great ceremony by then Health Secretary Bernard Kouchner at its inaugural session in January 1998, this committee had been slow to establish itself. As soon as Kouchner had taken up his post, the HFD had decided to reactivate its National Network for Psychological Emergencies, by organizing task forces to prepare recommendations which the National Committee was to present the following September. At this time the three most recent major events in which local Medical and Psychological Emergency Units (CUMP) had been heavily involved were the Mont Blanc Tunnel fire (March 1999), the Air France Concorde crash (July 2000), and the hostage-taking at Fresnes high-security prison (May 2001). But it had proved difficult for the Ministry of Health's HFD teams to involve themselves in the organization, regulation, and national co-ordination of psychological emergency services, because the state authorities remained doubtful, even suspicious, about the clinical reality of post-traumatic stress disorders. The lack of epidemiological data and of prevalence studies that could demonstrate the nature of the population's psychological needs in disaster situations, the lack of consensus within the profession on the benefits of early debriefing, the problem of training psychological emergency workers, and of course the financial implications were still troubling those in charge of the state's centralized services. Not entirely convinced of the existence of a health threat from a disorder that was still somewhat hypothetical, but fearing that they risked neglecting a future health problem with unpredictable consequences, the health authorities were seeking the assurance of a regu-

¹ Created under a 1959 edict, the corps of Hauts Fonctionnaires de Défense (High Civil Servants for Defense, HFD) is directly attached to the Prime Minister's office via the relevant minister for each department. Within each major ministry department, except for the Department of Defense, there is an HFD responsible for co-ordinating the logistical and operational infrastructure of protection of the population within the field covered by the ministry.

² The decree of May 29, 1997, provides for the creation of a hierarchical national network for medical and psychological emergencies, subdivided into seven super-regions coordinated by a National Committee (CNUMP). In each region a permanent unit (CUMP) comprising a psychiatrist, a psychologist, and an administrative team monitors, regulates, and coordinates structures within the region. The regional authorities are restricted to appointing (from among local practitioners) a referring psychiatrist responsible for drawing up a list of volunteers who can be mobilized in case of need.

latory framework comparable to that of the Mobile Medical Emergency Service (SAMU).³ The “contaminated blood” scandal of a few years earlier, when for lack of preventive measures thousands of persons had received HIV-infected blood, was still fresh in everyone’s memory. That affair had unleashed a crisis within the Ministry of Health and led to the HFD’s services being placed at the center of an extensive regulatory system created to oversee “the field of protection of the population’s health in exceptional situations arising without warning,” in the words of one official. Our meeting with the HFD, which had been postponed several times, was for 3:00 PM on September 11, 2001.

The interview was supposed to last only an hour. However, by the time we emerged, still in a state of shock at what we had just witnessed on the second floor of the main Department of Health building, it was 7:00 PM. The foyer was strikingly deserted, and drawn-looking security guards were bustling around the few visitors. Outside, the lively activity of the last few days of summer had suddenly been replaced by collective stunned inactivity. Opposite the building a group of passers-by were crowded around a car stopped at a red light, its radio turned up to full volume, broadcasting a newflash. Further down the street, the same announcement was heard from dozens of motionless cars, whose drivers had forgotten to continue driving. All the radio stations had interrupted their usual programs to relay and comment on the news. In the space of a few hours, the hitherto hypothetical threat of collective trauma, which had haunted the state services, seemed to have been dramatically realized on a global level. The experience of the attacks in New York was immediately translated into the new language of trauma, in France just as elsewhere.

For us everything began at 3:50 PM in the Department of Health’s center of operations, two doors down from the HFD’s office where our interview was taking place, when the HFD’s deputy burst into his office to inform him of the disaster. Despite the tension and the lack of precise information—it was still thought that other planes were flying towards European capitals, including Paris and London—crisis organization immediately got under way. The first meeting was of all staff, in the deputy’s office, but there was still no detailed information.⁴ The Vigipirate plan⁵

³ In France, general hospitals have their own emergency ambulance services, called either SMUR [Service Mobile d’Urgence et de Reanimation] or SAMU [Service d’Assistance Médicale d’Urgence], which are directly connected to the resuscitation ward. More than an ambulance, the SMUR or SAMU is an authentic outdoor medical team with physicians and nurses specially trained in emergency medicine and resuscitation.

⁴ The secure communications network was soon swamped by the flood of contradictory information and, astonishingly, it was the American cable channel CNN that provided the news in the HFD’s office.

⁵ The Vigipirate plan is a national security system with several levels of alert.

was immediately put into effect, together with a plan of action co-ordinated by the HFD. There were fears of an attack from the air, with the threat of huge numbers of injured swamping hospital services; and collective panic was anticipated. Within an hour the entire civil defense system was activated. At this stage the emergency was clearly not of a psychiatric nature. However, the HFD's administration was bombarded with calls from medical and psychological emergency units in the provinces. While awaiting instructions, most of them had already mobilized their teams and were ready to travel to Paris to deal with the psychological consequences of an attack, or to leave for New York to provide international aid. It was only towards 7:00 PM that the first request for psychological assistance was recorded. It came from the offices of Air France, which was calling the emergency services to Roissy-Charles de Gaulle Airport to meet passengers coming off a Paris-New York flight that had been forced to turn back. The captain had taken the precaution of telling his passengers that crowded airspace and bad weather conditions had prevented him landing at JFK. The passengers only learned the real reasons for the change in plans when they arrived back in Paris. A total of ten minor anxiety episodes were noted and easily cared for by the main airlines' ground staffs. The psychological emergency services were ready for action within an hour after the official announcement of the attacks in New York and Washington, and they remained on alert throughout the week.

However, the new emergency psychiatrists did not restrict themselves to waiting in the shadows for a government decree authorizing deployment of a humanitarian mission to the United States. Unable to be active in the field, a parade of specialists came forward to contribute their analyses of the event and its psychological consequences on television, radio, and in the daily press.⁶ With a legitimacy now equivalent to that of retired army officers or government officials—the usual commentators on this kind of event—psychiatrists and psychologists explained to the population shocked by images of the collapse of the Twin Towers that this visual sharing of the event could result in psychic trauma almost as serious as that affecting the direct witnesses of the attacks. It was later claimed that the continual replaying of the images from 9/11 had produced, in both children and adults, recognizable psychic trauma in the form of recurrent nightmares, startle reactions, and a painful feeling of powerlessness, which required rapid treatment.⁷ Thus, although the attacks took place on the other side of the planet, the potential for trauma in the public

⁶ Under the alarmist headline "Major Risks of Psychological Aftereffects," the September 14 edition of the French daily *Le Monde* carried articles by the main representatives of medical and psychological emergency services in France.

⁷ See the study by Courbet and Fourquet-Courbet (2003).

arena—even once the fear of similar attacks in France had passed—was established. But the French could rest easy, it was asserted: Medical and psychological emergency units were on standby throughout the country, and experts in psychiatric victimology were ready to step in.

In the United States during this period, huge numbers of health professionals were mobilized. Scores of clinicians, both psychiatrists and psychologists, spontaneously rushed to offer their services to the people of New York, paying little attention to the open letter to the American Psychological Association from nineteen eminent specialists in trauma, who warned of the iatrogenic risks of “wild debriefing.”⁸ Calls for people to speak out proliferated in the media and on huge billboards, inviting survivors, rescuers, witnesses, or even those who had merely viewed the events on TV to contact a telephone help center.⁹ Richard Mollica, an internationally recognized psychiatrist and the founder of the first center for the identification and treatment of PTSD in Southeast Asian refugees in Boston in the 1980s, alerted the world to the risk of exponential growth in post-traumatic disorders, not only among New Yorkers, but throughout the whole of the US population exposed to the TV images of 9/11. The restraint shown by the media, which refused to broadcast images of dead or dismembered bodies, altered nothing: the impact of the first pictures was enough to produce an emotional shock on a level equivalent to what the viewer saw. The first epidemiological studies focused on this issue and sought traumatic aftereffects well beyond the area directly affected by the attacks. The main study, conducted on a broad sample of the population in the five days following the attacks, established that more than 45% of US residents were showing significant symptoms of stress, and 90% exhibited at least one clinical sign.¹⁰ While it was subsequently widely cited, this study nevertheless said nothing about the nature of the trauma. Was it patriotic emotion or identification with the victims, the loss of the feeling of US omnipotence or an empathetic reaction that caused citizens to suffer like (and for) those who had lost loved ones? Of course, neither

⁸ Republished on the official APA Web site, together with the response of the Association's governing body and various comments: <http://www.apa.org/monitor/nov01/letters.html>.

⁹ Advertisements posted by the New York Public Health Department in the subway and most public places read, “Even heroes need to talk. New York needs us strong. Call 1-800-Lifenet,” or “Feel free to feel better.” The ads were intended to encourage the people of New York to seek help.

¹⁰ Schuster et al. (2001). In their conclusion the authors drew the attention of US clinicians to the health risk represented by this problem, suggesting that they should be ready to treat traumatized patients even thousands of miles from the site of the terrorist attack. This study was cited in 272 international publications over less than four years (according to the Scopus citation index), and extended by huge longitudinal studies analyzing the ongoing progress of these initial traumas.

of these hypotheses conformed with the new definition of post-traumatic disorders, for while the notion of trauma can readily be broadened to the collective on a metaphorical level, extending it to the clinical assessment of individual experience is much more controversial.

There is indeed no doubt that the US population was shocked, distressed, stunned, saddened, angered, and that many may have felt deep pain, sincere compassion, and a sense of injustice. But that is quite different from asserting that all or a large proportion of Americans were traumatized as contemporary US psychiatry understands the term. In order to meet the current criteria, these persons would have had to experience the event, to have felt intense distress approaching a feeling of imminent death, and amid this overwhelming emotion, their psychic defenses would have had to have been overcome by stress. Was this clinical reality present? This was what the later studies, extending the first survey, attempted to establish, emphasizing the correlation between the images on television and the development of post-traumatic pathology. The argument was that TV viewers, more than those on the spot who were generally unaware of the full extent of what was happening, saw simultaneously the planes flying into the towers, the fires and the collapse of the towers, the bodies falling from the buildings, the panicked crowds in the streets, the wounded, and the smoke and dust. No immediate eyewitness would have experienced this level of "reality." The etiological hypothesis therefore conformed to the requirements for a PTSD diagnosis,¹¹ and "remote trauma" was established as the new name for this variant, effectively identical to the classic form because there was indeed a real and affective experience of the event—in this case through the images on television.

Thus, both in Paris and in New York, both among the specialists on the French National Committee for Medical and Psychological Emergencies and among US psychiatrists conducting major epidemiological studies, trauma as collective ordeal and trauma as clinical entity were tending to merge. The evidence furnished by the 9/11 tragedy reinforced the abandonment of suspicion: the event was traumatic for everyone on both the metaphorical and the medical levels. Not only did 9/11 extend this convergence, or even confusion, far beyond national borders (and even beyond the Western world), it also widened the population of victims beyond those directly exposed (by including remote viewers). What was new here was that in order to have experienced trauma as the result of an event, it was no longer necessary to have been directly affected by the event. Even though one had not lived through the war, endured the perse-

¹¹ However, later studies reduced the emphasis on the media as an etiological agent, classifying it instead as one of the contributory factors. See in particular Ahern, Galea, Vlahov, and Resnick (2004) and Manos (2003).

cution, or experienced the sexual violence, it was now possible to be traumatized by virtue of the fact that one identified oneself as part of the same human community, the community affected by the event.¹² The contribution of psychiatry here was at once crucial and marginal. It was crucial because it confirmed the reality of individual trauma far from the site of impact, and thus demonstrated that the metaphorical level of collective trauma is not simply rhetoric or an illusion: individuals indirectly exposed to the event can suffer from post-traumatic distress. It was marginal because this clinical proof of the reality of trauma did not need to be reproduced in each individual: in fact, the statistics did not confirm the hypothesis of a health crisis, since later epidemiological studies showed levels of trauma symptoms which, while they were higher than those commonly observed in a reference population, were well below the normal threshold of PTSD in a population subjected to one or more uncommon events.¹³ Despite the active participation of mental health specialists and the repeated use of the metaphor of collective trauma, 9/11 did not become an objective psychiatric event, but remained a subjective social experience.

In this the attacks in New York both crystallize and illustrate the tension between the clinical approach to post-traumatic stress and the social uses of trauma, as demonstrated by the parallel rise in psychiatric victimology and medical and psychological emergency units in France during the 1990s. This tension was revealed with special intensity by the explosion at the AZF factory in Toulouse on September 21, 2001. In this case the concept of trauma was called into play in order fully to recognize the suffering of victims, and especially for the purposes of offering them compensation for the consequences, both psychic and social, of the event they had experienced.

¹² This is what gave George W. Bush legitimacy when he embarked on his crusade against terrorism the day after the 9/11 attacks, and conversely what made him unpopular after Hurricane Katrina, when everyone observed that he did not feel himself to be part of the community of victims, who were mainly African-American and poor.

¹³ International studies suggest that the threshold for PTSD is one-third of people presenting the complete syndrome, one-third showing non-specific signs of psychological suffering, and a further third remaining free of any pathology (Breslau and Davis 1992). In the period following 9/11, the figures never reached these levels (Schuster et al. 2001; Schlenger 2004).

Psychiatric Victimology

THE WAVE OF TERRORIST ATTACKS that took place in Paris in the summer of 1995 pushed the issue of psychological emergency to the forefront of public policy concerns. The first incident, the July 25 bomb explosion at the St-Michel RER station, plunged France into the horror and anguish of terrorism: the emergency workers who went to the aid of the injured, the ambulances racing to the scene with sirens screaming, and the grim toll of the dead drew the media spotlight.¹ Less than three weeks later, on August 17, a second bomb in the Place de l'Etoile once again called emergency workers into action. But this time a psychological emergency assistance team was on hand to treat those who were emotionally affected, and the press, in what was to be the start of a long period of cooperation between media and emergency services, made much of this innovation in care for the victims of terrorist attacks. It was generally agreed that this new development in crisis response was due directly to the intervention of the French President. On July 28 Jacques Chirac had visited the injured in the company of his Secretary of State for Humanitarian Action, Xavier Emmanuelli, and a group of psychiatrists. Chirac praised the courage of the emergency workers but, noting the bombing victims' "intense state of shock," expressed surprise that no psychological support was available. He is therefore credited with initiating the introduction of psychological treatment into the range of first aid offered by French emergency services at the scene of collective disasters.

Over the next few days Xavier Emmanuelli was asked to set up a team of experts to study ways of responding to this newly identified need. He was well suited to the task, having close links with the very few specialists in what was still an embryonic discipline, psychiatric victimology. He himself had taught the only university-level victimology course in France. Emmanuelli's team included Louis Crocq, a former military psychiatrist well known for his work on psychic trauma and for setting up the first treatment center specializing in this field; François Lebigot, also a military doctor; and Patrice Louville, a psychiatrist who already worked with the SAMU of Paris. The group had met only once when the second bomb

¹ Eight persons were killed and 117 injured at the Saint Michel station attack claimed by the Armed Islamic Group. In the attacks at the Place de l'Etoile and Musée d'Orsay, 17 and 29 persons were injured, respectively.

exploded at the Arc de Triomphe. Although they had had no time to develop a strategy, some of them accompanied the emergency services to the scene. On October 17, 1995, there was a third attack at the Musée d'Orsay metro station, and the medical and psychological emergency assistance team, which was now up and running, became more extensively involved. The team's nurse described for us the extremely difficult working conditions at the scene. Her testimony clearly expresses the distress of the first psychological emergency workers:

What I remember is the disorganization, there were lots of emergency workers, but we didn't really know where to go in, we ended up standing around looking at each other. At first there was a big feeling of . . . I was going to say, wanting to give up. It was really difficult, and then very quickly we got our feet on the ground because there were victims in distress. My first memories are of people crying, shouting, reaching out to us—and paramedics who said they didn't know what to do because there was nothing practical that could be done for them, they weren't injured, but they were holding up the flow of medical treatment. At the same time they couldn't be ignored; they had been part of the event. Before they would have been put in a bus and taken to the emergency wards. But now these were the people we would be caring for at the scene.

Medical and psychological emergency units (CUMP) were set up over the following months with remarkable speed. The development of this institutional structure is often linked to the emergence of the new discipline of psychiatric victimology, and to the existence of a network of trauma specialists, particularly among military psychiatrists. These two facts are undeniable, but what underlies them is the increasing power of a new player: the victims' movement, which had come into being a dozen years before.

VICTIMS' RIGHTS

The attack at a Paris restaurant on December 23, 1983, marked a turning point in the history of the victims' rights movement in France. That evening a large bomb exploded in front of an upmarket restaurant, Le Grand Véfour, where many customers were still dining. The blast devastated the restaurant and injured a number of people who were quickly taken to the nearest hospitals. No one has ever claimed responsibility for this act. The armed group Action Directe, which had carried out several attacks during this period, denied any involvement, adding that the target would have had no political significance for their campaign. A mafia racket or an insurance swindle were suggested, but there was no evidence to support these theories. The case file was closed.

A few months later, when the restaurant reopened, the event was almost forgotten, and the media celebrated the rebirth of this prestigious Paris establishment. A reporter from the *Figaro* newspaper went so far as to claim that the attack had ultimately generated "more fear than harm." But the twelve people injured in the blast included a woman who remained in critical condition for several weeks. Françoise Rudetzki fought fiercely for her life and to maintain her bodily integrity (rejecting the doctors' recommendation that one of her legs be amputated). Her steely determination inspired others with new fighting spirit and led to a victims' campaign against silence. In January 1986, Rudetzki set up the organization SOS Attentats [SOS Attacks], and she went on to become famous on all fronts of the struggle for state and government recognition of victims' rights.

The Grand Véfour attack offers a perfect example of the way victims were treated up to that point. The physically injured were adequately cared for by the health services, but they were immediately forgotten by the authorities. As for the psychological consequences, a link could have been made to the notion of trauma already current in the United States, but there was as yet no collective awareness of such aftereffects in France. No reference was made to the traces that might be left by the event in the psyche of people affected. No special measures were put in place to help these women and men who had suddenly found themselves defenseless in the face of violence and who, in some cases, were left with serious psychic scars, irrevocably changed by their experience. Obtaining financial compensation was akin to negotiating an obstacle course. Not only did victims have to instigate court proceedings in their own names, they also had to locate a guilty or responsible party with sufficient funds to pay reparations and, obviously, they had to win the court case. When psychological damage was claimed, each individual victim had to prove the validity of her or his claim throughout the entire course of a process in which suspicion outweighed compassion, and lawyers and judges constantly called into question the claimant's good faith. For at this time victims were still subject to suspicion—not (as in the era of traumatic neurosis) suspicion that they might be responsible for their suffering or that they harbored a personal weakness that was fertile ground for their disorder, but rather suspicion of their honesty, or more precisely, of the truthfulness of what they were saying and of their motivations. They were suspected of seeking financial gain. To express one's suffering was not yet viewed as a public testimony to human tragedy, but merely as a personal affair. It was trapped within the confines of the individual. Victims were no longer blamed, but they were not listened to either, much less heard.

In her autobiography, written and published nearly twenty years after the attack, Françoise Rudetzki writes in great detail about the agony of

her long months in the hospital and the many obstacles she faced in ensuring that the damage she had suffered was recognized and addressed by the authorities.² Courageously she disclosed the depths of her pain and described the ways in which her body had been maimed. She was candid about medical procedures that violated her intimate, personal space, about the recurrent psychic suffering, and about her distress at the withdrawal of loved ones, and she provided meticulous descriptions of dozens of surgical operations. Each line seems imprinted with a sense of veracity. And this is crucial—for the detailed narration of her experience is above all the basis for an account that went beyond the individual story, an account of a truth common to all victims. This generalization of her experience is based on two major changes in the tone of the victim's account: she replaces compassion with condemnation, and she calls for collective compensation rather than individual reparation.

On the one hand, Françoise Rudetzki's testimony definitively rejected the language of pity, replacing it with an assertive appeal for social justice. The people affected by terrorist attacks were doubly victims: first of the violence of the act itself and its physical and psychological consequences, and secondly of the conspiracy of silence that surrounded them, plunging them into oblivion and denial. Thus the victim's personal story was transformed into a political cause. The language was that of social struggle, except that what was denounced was not oppression but the indifference, denial, and even contempt that was the victim's lot. Paradoxically, it was by pushing the intimate revelation of her suffering to the limit that Françoise Rudetzki was able to make of her story so much more than a plea for compassion. For the issue was no longer to appeal to readers to understand her unhappiness and to pity her for what she had endured. Her goal instead was to show, through her suffering, that the struggle for "survival" waged by every victim was an unjustly solitary one, ignored by the public and receiving no social or political support. The thoroughness of her account exposed the negligence of others, of those who refused to acknowledge the harm suffered by victims and ignored their political testimony. The scandal was precisely this collective indifference, which condemned victims to facing alone the painful consequences of the events that had damaged them. By denouncing this indifference Françoise Rudetzki was accusing the legal system of unfairness in which the government was complicit. Her accusations raised the issue of national solidarity.

² Rudetzki (2004). While her personal tragedy and her courage in exposing it to public view in order to establish a collective cause were clearly crucial to the recognition of victims of terrorist attacks, the success of this campaign can only be understood in the light of sociological developments that transformed the public's perception of disasters and of the political legitimacy of the victims. (Vilain and Lemieux 1998).

On the other hand, the aim of this plea was to reintroduce the thorny problem of reparation in a new way: by publicly claiming collective compensation rather than waiting patiently for individual charity. Right from the start, SOS Attentats' fight to persuade the government to set up a fund to cover compensation for victims of attacks was both a central issue and the source of the association's appeal. Quite apart from the financial aspect, setting up a fund would represent public recognition of a fundamental right granted no longer to isolated individuals, but to a legitimately constituted group within society. The establishment, in 1986, of the Guarantee Fund for the Victims of Acts of Terrorism and Other Crimes, at the same time as the National Institute for Support of Victims and Mediation (Inavem) was established, assured the place of a new category in the social arena, that of victims, and enabled this group to win legitimacy through activism, through the work of its organizations, by political lobbying, by a media presence, and by its newly recognized rights.

Although the part played by Françoise Rudetzki and SOS Attentats was key to this public recognition of victims' rights, social mobilization had begun several years earlier with the efforts of victims' rights associations to support litigation brought by crime victims. In February 1982, Robert Badinter, the then Garde des Sceaux [Minister of Justice], had initiated a study of the assistance available to crime victims to counterbalance his department's efforts at better safeguarding the rights of those charged with crimes. The committee set up for this purpose was asked to come up with proposals to ensure that assistance was "open to any victim, without discrimination, available and easily accessible, neither inquisitorial nor restrictive." The proposed measures were to be "focused on the victims' future, so that they are able, after the interruption caused by the attack, to return to normal life." In September 1982, the Department of Justice set up a Victims' Office within its Directorate of Criminal Affairs and Pardons, to coordinate and develop, in collaboration with the courts and all departments concerned, the reforms and actions required in the arena of victim protection. Thus the Victims' Office had a dual mission: to improve compensation claimants' experiences in the legal system, and to support the establishment of associations that could offer victims information, advice, and a listening ear.

Inavem was to become the umbrella organization for these associations. It brought together their aspirations, defined their areas of activity, coordinated their missions, managed their relations with public authorities, and acted as intermediary in the authorization of state subsidies. It had representatives in all the main governmental bodies that offered support to victims—the Guarantee Fund for Victims of Acts of Terrorism and Other Crimes, the National Parole Authority, and the National Council for Victim Support—and quickly became the keystone for the imple-

mentation of victims' rights. For the first time victims had a structure dedicated to advancing their cause publicly and collectively, and one to which all victims' groups could relate, regardless of any differences between them. Until that point, the movement had been suffering the consequences of its rapid and uncoordinated development. Victims' groups would form spontaneously after particular incidents, but the very nature of these mobilizations around a given event necessarily meant that they were ad hoc, ephemeral, and prone to fall apart in the face of lengthy and costly legal proceedings.³ The establishment of the Guarantee Fund and the creation of Inavem marked the emergence of a united movement that could now bring together different interests under a single banner, and that was likely to grow, given the regularity with which new issues related to victims emerged.

In the space of less than ten years, between the end of the 1980s and the beginning of the new century, victims' activism succeeded in moving them from the back burner to the forefront of media attention. And this success, which was of course due to the efforts of the victim-activists themselves, who were now ready to mobilize on any front where injustice still reigned, was largely demonstrated in the unlikely arena of psychic trauma. Even before the French version of DSM-III—and with it, the concept of PTSD—appeared in 1983, revised ideas of psychic trauma were beginning to find public acceptance. But lay understanding of trauma was still based on World War II notions about traumatic memory, and the term “trauma,” only vaguely understood, was more often used to designate symptoms of suffering than the core nature of the damage. Moreover, the clinical practices used by psychiatrists and psychoanalysts with patients suffering from psychic trauma were seriously out-of-date, still stemming in a direct line from the suspicion-laden notions about traumatic neurosis that prevailed during World War I.

In June 1986, when the French parliament was preparing to vote on a law on individual compensation for victims, SOS Attentats commissioned the National Institute for Health and Medical Research (Inserm) to carry out the first epidemiological study of the psychological consequences of the terrorist attacks. Its “clearly defined focus was to determine whether there was such a thing as collective experience that should be taken into account in determining compensation.”⁴ The results exceeded expecta-

³ The Committee for Compensation of Crime Victims (CIVI), set up in 1977, provided individual compensation for victims in cases where the perpetrator did not have funds to pay it. Given the slow case-by-case nature of the process, and the three years before compensation could be awarded, this response was unsatisfactory, particularly after the wave of terrorist attacks in the 1980s.

⁴ Dab, Abenhaim, and Salmi (1991). The person leading this study was the brother of Françoise Rudetzki, Dr. William Dab, himself personally involved in the campaign for

tions and showed significant correlation between the seriousness of physical injuries and the associated psychotraumatic symptoms; they also revealed that a significant proportion of those who had witnessed the attacks but had suffered no physical injury also presented symptoms of psychic trauma.

This first study provided the victims' rights movement with a weighty argument for the recognition of the legal status of all victims of terrorist attacks, as well as data on the kind of the damage they had incurred, even when there was no physical injury. Victims' associations had found themselves confronted with the problem of people who had been present at the scene of an attack but had suffered neither physical injury nor damage to their property. Despite recent advances, the legal definition of the victim was still narrow and excluded so-called involved individuals.⁵ This limitation was doubly important to the victims' movement. First, in the movement's view those involved were survivors, in other words people who had experienced the same event as the injured and had an acute awareness of what they had escaped, which brought them close to the physical victims. By virtue of their identification with the victims, they represented a potentially large group highly sensitive to the issues confronting the victims and likely to reinforce the ranks of the activists. Second, in supporting their demand for recognition, the victims' rights associations demonstrated a capacity to take on new causes and to expand their range of activity beyond the existing rigid categories of victims. For the victims' rights movement, the "involved" were unquestionably as much victims as those who had recently been granted rights.

The central argument regarded the issue of psychic trauma. Activists insisted that the victims recognized as such by the law and persons involved by virtue merely of their presence shared, beyond any differences between them, an identical invisible injury, often neglected and rarely compensated. Public recognition came later, during the spate of attacks in Paris in the summer of 1995. But with the results of Inserm's study on the epidemiological consequences of terrorism, the movement already had gained a powerful tool that could unite all victims under a common umbrella, even those who did not yet recognize themselves as such. By blurring the boundary between visible and invisible injuries, trauma became the mark of all victims: the injured, the survivors, and the "involved," a

recognition of victims' rights. His contribution was to offer scientific proof of the consequences, particularly the psychological effects, of the attacks. But as Stéphane Latté (2001) notes, it was only after completing the study that, through meeting Louis Crocq, he discovered the existence of PTSD and was thus able to put a name to the psychological symptoms he had observed.

⁵ For a detailed analysis of the development of victims' rights, see Cario (2006). For an overview of the issue in relation to the question of trauma, see Cesoni and Rechtman (2005).

group that would include rescue workers and therapists, and soon even television viewers. Thus psychic trauma completed the process of victim legitimization by providing the unifying element it had lacked: a common hub joining the destinies of all the affected.

However, clinical proof remained to be provided. In France, it was a long time before the victims' associations' appeal to psychiatrists was heard. Whereas in the United States feminists had found powerful allies among the reformers of psychiatry in their campaign to establish the authenticity of traumatic memory, in France the representatives of victims' associations had to rely only on their own energies and on a handful of clinicians who were marginal to the psychiatric establishment. Collaboration between the broad spectrum of victims' rights campaigns and psychiatry was limited to drawing up lists of practitioners, psychiatrists, and psychologists who were potentially sympathetic to their cause. Generally disseminated by the victims' associations, these lists helped victims find a therapist who would listen to their complaints. This was a far cry from mobilizing the support of the psychiatric community as a whole.

What was true for the victims of terrorist attacks was even more true for victims of sexual violence.⁶ The fields of psychiatry and psychoanalysis were accused of fostering a reactionary, stereotypical image of women and of blocking the path to their liberation. They were also suspected of lending support to the idea that male sexual violence was a response to female masochism. These prejudices remained in play even though women's testimony to support organizations regularly emphasized the failure of their previous attempts at psychotherapy. Taken as a decisive argument against the entire institution of psychiatry, these failures, in the support organizations' view, revealed the indifference or even hostility of psychiatrists and psychoanalysts to the harrowing problem of sexual abuse. Nevertheless, the movement quickly accepted the concept of trauma, seeing it as a way to win recognition of the social scourge of sexual abuse and to come together with other victims' support organizations, while remaining at arm's length from the professionals involved. Despite being "de-psychiatrized," the language of trauma thus remained a powerful factor in drawing victims together. It enabled potential members of the movement to recognize their common injury and established bonds between them through the offer of therapeutic alternatives drawn from their own resources, such as help centers and support groups, usually led by former victims of sexual violence who had already emerged from what they termed their "passage" through trauma.

⁶ As Marie-Anne Bach and Sylvia Klingberg show in their study of organizations supporting victims of sexual violence. See their contribution in Fassin and Rechtman (2005a).

Thus, at the beginning of the 1990s, the victims' organizations' intensive campaign to use the notion of psychic trauma in calling for the rights of victims to be recognized, stalled at the door of official psychiatry, which showed little inclination to subscribe to the cause. Not finding the kind of support in the psychiatric establishment that they were winning from the legal system, activists turned to the few specialists who were championing a new approach to psychic trauma within the as yet unestablished discipline of psychiatric victimology. As we have seen, the category of PTSD eliminated all suspicion of victims. When this classification reached France, through the publication of DSM-III in 1983, it might have enabled the aspirations of the victims' movement to come together with psychiatry. But on the contrary, the context in which the new manual appeared only exacerbated tensions between the parties, leaving victimology to develop on the margins of official psychiatry.

THE RESISTANCE OF PSYCHIATRY

Amidst the turmoil of a discipline seeking renewed legitimacy within the medical establishment, two radically different events converged to redraw the map of French psychiatry. The first was the publication of the French version of DSM-III in 1983. The second was the institutional acceptance, in 1982, of psychiatry as a medical discipline on an equal footing with fields such as cardiology or hematology.

Coordinated by Pierre Pichot, who at the time was professor at the neuropsychiatric clinic [Clinique des maladies mentales et de l'encéphale] of Sainte-Anne's Hospital in Paris, the publication of the French translation of DSM-III was greeted with relative indifference in psychiatric circles. Even the 1984 conference organized to promote the manual⁷ was an almost private affair, attended by only a handful of psychiatrists in addition to the team of translators. The reviews in scientific journals were equally lukewarm, barely mentioning the debates and controversies that the new diagnostic system had already generated in the United States.⁸

⁷ Proceedings published the same year (Pichot 1984).

⁸ Articles relating to the French translation of DSM-III in the main psychiatric journals numbered only six, most of them short. They included a twenty-line review in the 1984 edition of *L'Évolution psychiatrique*, a mildly humorous editorial in *Synapse* on the low impact of this manual on French thinking (Olivier-Martin 1984), and an article in *L'Information psychiatrique* summarizing the changes introduced by DSM-III (Bourgeois 1984). Only the private-sector psychiatrists' journal devoted a sharply critical article to it, condemning the abandonment of the Freudian viewpoint and particularly the removal of hysteria as a diagnosis (Leclerc 1984). It was only later in the 1980s that the first comparative analyses exploring potential convergence and/or divergence between French and American ideas appeared (Ohayon and Fondarai 1986; Rager, Bénézech and Bourgeois 1986; Garrabé

The social advances furthered by DSM-III, such as the abandonment of the diagnosis of homosexuality and the support it provided to the women's movement, were either ignored or derided. Reviews simply noted this as the latest in a long line of attempts to group mental illnesses according to a simple, essentially symptomatic principle inherited from the nosology of the early twentieth century (particularly that of Kraepelin). In a psychiatric culture where references to psychopathology prevailed—whether psychoanalytical, phenomenological, or inherited from Henri Ey's organodynamism—the tendency was rather to scoff at the atheoretical nature of the manual than to entertain the improbable idea that it might influence French thinking. In the main, DSM-III was seen as an exotic curiosity that provided amusement in official circles, where casual readers occasionally cast a glance at the non-psychoanalytic publications of US psychiatry. Thus, when it appeared on the shelves of specialist libraries, no one imagined that this 500-page volume (more than a third of which consisted of appendices) would be capable of usurping the throne of French psychiatry, let alone of eroding the supremacy of psychoanalysis.

The reasons for this reaction to DSM-III are to be sought in the particular circumstances that prevailed in French psychiatry at the time. In 1968 the disciplines of psychiatry and neurology had gone their separate ways, and psychiatry became a specialization with its own course of clinical training. Non-academic psychiatrists practising in specialist hospitals (what were previously known as "asylums") achieved a level of intellectual and clinical authority generally reserved for academic staff at teaching hospitals. As pioneers of the sector, that is to say of the French psychiatric care establishment, these hospital psychiatrists⁹—clinicians such as Lucien Bonnafé, Georges Daumézon, Henri Ey, Philippe Paumelle, Georges Lantéri-Laura, Gérard Oury, and Paul Sivadon—continued the lineage of the great French specialists in mental illness. They trained a generation of younger clinicians, edited the main scientific journals, organized the professional associations, and wrote most of the theoretical texts that made up the corpus of French psychiatry. In the early 1980s France was clearly not the United States! Psychiatry was still drawing in new generations of clinicians, attracted by the dynamism of its institutional perspective and its close links with psychoanalysis. The death of Jacques Lacan in 1981 in no way lessened the intellectual and social influence of psychoanalysis. Despite the schisms between different psychoanalytical schools, Lacanian psychoanalysis was as popular with future

1989). But even in these texts the tone was not polemical. The institutional and political debates that would fan criticism of DSM-III were still to come.

⁹ Usually referred to as "hospital-based" or "sector-based" psychiatrists to distinguish them from those working in teaching hospitals.

clinicians, psychiatrists, and clinical psychologists as in intellectual circles, where it influenced the analysis, commentary and interpretation of film, literature, politics, the social sciences and, of course, the misfortunes of contemporary humanity, and was seen as an essential key to understanding the world. Less prominent in the public arena, but still dominant on the clinical scene, the psychoanalytic associations, which were members of the International Psychoanalytic Association, maintained their hegemony in the teaching and practice of psychiatry, to the extent that the various branches of the Freudian tradition competed with one another for the training and recognition of new generations of clinicians. And they did so without paying the slightest attention to developments on the other side of the Atlantic, the first wave of which had just quietly arrived on French shores.

At the same time, in 1982, legislation brought psychiatry into the fold of medical specialties.¹⁰ A reform of medical training abolished the channels that had previously allowed doctors who had not passed their resident examination to choose a medical specialty. Among other effects, this measure replaced the possibility of exclusive training in psychiatry with a common course of training for resident specialists in general academic hospitals, in which psychiatry, now only one discipline among the others, had a much smaller number of posts than the previous structures had offered. Despite student campaigns, the law came into force the following year and laid down a regulatory framework in which the newest residents trained in academic teaching hospitals would for a number of years work alongside the last generation of residents formed in psychiatric hospitals.¹¹ The conflict between hospital psychiatrists and their university colleagues intensified in the late 1980s. While still in the minority, the academic psychiatrists held the keys to the future of the profession, and they jealously guarded the privilege of recruiting and training most of the new professionals. With the legislation favoring the teaching hospital specialists, hospital-based psychiatrists shifted the terms of the argument and disparaged the kind of teaching given to budding psychiatrists, and more particularly the place of psychoanalysis in their training. Criticizing the psychopharmacological and biological orientation of university psychiatry (despite the fact that many chairs were still occupied by psychoanalysts), the hospital-based psychiatrists mounted a major campaign to challenge what they saw as the damaging effects of the recently imported American paradigm.

¹⁰ Law no. 82-1098 of December 23, 1982, on medical and pharmaceutical studies.

¹¹ Decree no. 83-785 of September 2, 1983, establishing the status of interns in medicine and pharmacology.

Although it aroused no controversy when it was published, and few of the teaching hospital services tried it out at the time,¹² DSM-III gradually became a central point of contention. For some it represented the culmination of the academic anti-psychoanalysis movement and a sign of the decline of psychiatry. Others saw it as a vehicle for the modern principles of a psychiatry that had at last become scientific. From the 1990s onwards, there were countless publications in which the mere term “DSM-III”—sometimes shortened to DSM, although the two previous versions, particularly DSM-II, had been strongly influenced by psychoanalytic thinking—was used to criticize the positivist drift of psychiatry internationally and the risks to the discipline in France, or conversely to assert the emergence of a psychiatry freed from the stranglehold of Freudian theories.¹³ However, rather than sparking productive debate about the new nosology, which was as yet little used (even by those who championed it), DSM-III was used as a weapon in a polemic focused on other issues.

We should note, moreover, that the dividing line between the psychoanalysts and anti-psychoanalysts did not by any means coincide with that between the teaching hospital specialists and the hospital-based psychiatrists. A number of chairs in psychiatry were still held by influential psychoanalysts, like Daniel Widlöcher and Serge Lebovici in Paris. In Strasbourg Lucien Israël taught psychoanalysis in his capacity as professor of psychiatry, and many of today’s Lacanian psychoanalysts are still influenced by him. Antoine Porot’s students, who obtained a number of professorial positions on their return from Algeria, combined psychoanalysis with a social psychiatry tinged with culturalism and philosophically inspired phenomenology. With the exception of a handful of units that were conspicuously oriented towards psychopharmacology, academic psychia-

¹² DSM-III and its later versions were not recognized in day-to-day practice, except in a few teaching hospital services that used them in their psychopharmacological research, and by some practitioners of cognitive behavioral therapies (CBT). The World Health Organization’s International Classification of Diseases, ICD-10, remained the only official reference for psychiatric data collection in France, whether in relation to epidemiological studies or health administration.

¹³ The term “DSM” once again came to be used pejoratively in the early years of this century, with the rise of cognitive behavioral therapy (CBT). For opponents of these techniques, DSM-III and its revisions (DSM-III-R, DSM-IV, and DSM-IV-TR) abruptly became the symbolic targets for attacks aimed at the new paradigm of CBT—all the more so as supporters of CBT were quick to proclaim its scientific legitimacy on the basis of DSM. See the debates arising from the amendment to the French Public Health Code, presented to parliament by deputy Acoyer in October 2003, which proposed regulating the practice of psychotherapists, the controversy aroused by Inserm’s study evaluating the efficacy of psychotherapies in February 2004, and the polemic following the publication of the *Livre noir de la psychanalyse* [Black Book of Psychoanalysis], which criticized Freud and his followers, in the fall of 2005. This opposition to the Freudian legacy is analyzed by Vannina Micheli-Rechtman (2007).

try was no more anti-psychoanalysis than some of the hospital-based psychiatrists, whose numbers included ardent opponents of the Freudian heritage. Thus the belated rallying of the teaching hospital psychiatrists, whatever their ideological and theoretical orientations, to DSM-III, owed more to what they clearly recognized as their interest than to shared conviction. Now that "evidence-based medicine"¹⁴ had replaced the epistemology of the individual case, clinicians had to show their good will by submitting to internationally recognized methods of evaluation. The new nosology offered an opportunity to regain some credibility within the medical establishment.

In this context, the appeals of the victims' associations were unlikely to be heard by official psychiatry. Preoccupied with its internal disputes and its short-term future, the psychiatric establishment, whether inside or outside academe, was little inclined to explore the nuances of PTSD. Support was therefore to come from an emerging discipline—one that was still struggling to define itself.

AN AMBIGUOUS ORIGIN

Victimology in France was born out of a double ambiguity. On the one hand, as the new discipline emerged in the mental health field it called itself by a name created in the field of criminology in North America. In the late 1950s a specialty had developed that focused on the "victims" of violence and was based on studies published a decade earlier.¹⁵ Noting that psychology's contribution to understanding crime had thus far been limited to analysis of the perpetrator, the founders of victimology held that it was equally important to understand what was happening to the person subjected to the criminal act. Paradoxically (in the light of the subsequent social use of the term) but logically (given the inherent suspicion of the victim at the time), the new discipline aimed to unearth "victimogenic predispositions" that made the person who suffered the violence a "latent victim." In *The Criminal and His Victim*, Hans von Hentig even wrote that "in a considerable number of cases, we meet a victim who consents tacitly, cooperates, conspires, or provokes," making her/him "a causative element" of the crime.¹⁶ During the 1970s and 1980s, the devel-

¹⁴ This term, used in the United States and Britain (Marks 1999), implies strict rules for measuring the efficacy of medical intervention, often on the basis of controlled therapeutic trials, and hence making use of statistics.

¹⁵ See Mendelsohn (1956) and von Hentig (1948), generally considered the inventors of the term "victimology." For a recent reevaluation of this field, see Fattah (1992).

¹⁶ See von Hentig (1948). This kind of categorization and analysis later led some people to accuse victimology of sharing the logic of "blaming the victim."

opment of criminal victimology followed a similar path to that of psychiatry and society at large, towards rehabilitation of the victim who was gradually freed from suspicion of complicity with the criminal and began to have her or his rights recognized. But although victimology in France was constructed around a notion of trauma that had been entirely recast by American psychiatry, French victimologists hesitated to adopt the new reading suggested by PTSD. They preferred to dust off the old concept of traumatic neurosis, and claimed that they were returning to the Freudian purity of the concept, particularly following the line of Sándor Ferenczi, who had shown concern early on for the fate of victims.¹⁷ The terminology varied significantly, the only common denominator being the refusal to make use of the term “PTSD.” Some used the classic term “traumatic neurosis,” others coined the term “psychic trauma,” and some simply discarded the prefix “post” and talked about “traumatic stress.”¹⁸ For these French pioneers anything was preferable to adopting the US nosology, despite the fact that it had been the vehicle for the full recognition of victims.

The designation of this branch of psychiatry is still subject to debate. As Stéphane Latté notes, “victimology is one of those things that everybody talks about, but nobody does.”¹⁹ With the exception of Gérard Lopez, who was one of the small group that founded the French Institute of Victimology, the university degree in victimology, and the Victimo network, most of the pioneers in this field hesitated to lay claim to the term. The risk for military psychiatrists, who played an essential role in establishing the discipline within the health service administration, particularly through the medical and psychological emergency units, was that they would become even more marginalized in relation to civilian psychiatry—academic or otherwise—since as we have seen civilian psychiatry, for various reasons, was not inclined to accommodate DSM-III, still less PTSD.

¹⁷ The breach between Freud and Ferenczi took place in 1932, at a lecture Ferenczi gave entitled “The Passions of Adults and Their Influence on the Sexual and Character Development of Children,” at the conference organized to celebrate Freud’s seventy-fifth birthday. To some extent Ferenczi was rehabilitating seduction theory, and this won him criticism and hostility from his audience. This text was one of the key elements in the debate on the return to seduction theory among North American feminists, and later in France when it was reprinted there (Ferenczi 2004).

¹⁸ See Barrois (1988), Briole (1993), and Crocq (1999). Significantly, these three pioneers of psychiatric victimology—or at least, the men responsible for introducing the issue of trauma into contemporary psychiatry—were all military doctors.

¹⁹ See Latté (2001, p. 18). The author even jokes about the “parti des sans-logie” (-logy-less party), playing with the reference to the “sans-logis” (homeless) and quoting the president of the Victimology Association who told him, “The word came later. I’ve never liked using it—I thought it was a meaningless term. All these ‘ologists’ and ‘ologies’ springing up everywhere. I don’t like this talk about victims; I prefer to speak *with* victims or to speak of the suffering of victims.”

Speaking out alongside victims' associations to champion a field with dubious scientific foundations and an unofficial institutional framework was problematic for them. Only a few took the plunge: they included Louis Crocq, the founder of the French Association for the Study of Stress and Trauma. Others, like Guy Briole, director of the Val-de-Grâce School (the military hospital of Paris), preferred to keep their distance. The issues were different for private psychiatrists, who also entered the fray. For them access to the media (through the victims), to publication (via their writing), and to the university (through their teaching) represented a clear added value in terms of social recognition. Potential confusion with the criminological branch of victimology was not an issue, since some of the criminological specialists were collaborating with them in their writing and teaching on the subject.

These ambiguities in psychiatric victimology (including even the name of the discipline) persisted until the late 1990s and contributed to the instability of the nascent field. Its few supporters, whether civilian or military, largely worked in close partnership with the victims' rights movement, at the risk of becoming identified with the movement and thus reinforcing the reservations of their colleagues. They were also criticized for these "dangerous liaisons" by the health authorities, particularly the mental health office of the Directorate-General of Health, whose officials frequently questioned the need for the care facilities dedicated exclusively to victims of psychic trauma that they were asked to subsidize. The issue for the authorities was not whether they should be treating victims' psychic trauma: all the international literature as well as the recent Inserm study demonstrated the high incidence of traumatic disorders among victims of attacks and accidents, as well as the need for early and appropriate care. Their problem, as the director of the Office of Mental Health told us some years later, was rather to decide if it was necessary to set up treatment structures outside of the existing treatment system: "Why was the existing network of psychiatry in the outpatient sector, which was supposed to ensure almost complete coverage of mental health needs throughout France, not deemed capable of taking on this new mental health need? Why should these associations' services be supported, thereby legitimizing a new specialization within psychiatry without first seeking the approval, or at least the opinion, of medical authorities in the discipline?" he asked.

The public health authorities received no opinion other than that of the victimologists themselves and the representatives of the victims' associations, and this, to quote people we interviewed, gave "the strange impression of a conflict of interests between the two sides." There was no input from general psychiatry, either from the university or hospital practitioners.

The very choice of the term “victimology,” with or without the adjective “psychiatric” (or sometimes “clinical”) to distinguish it from criminological victimology, reflects the ambivalence of the field’s founders about what it actually was. On the one hand, the term clearly articulated a desire to locate this clinical practice on the side of the victims, in close partnership with others who supported victims, such as the magistrates who had been won over to the cause and themselves claimed their own field of judicial victimology. On the other hand, the choice also reveals a decision to define this new field not by its clinical object, psychic trauma, but by the subjects it aims to support, the victims—and this is unique in the history of psychiatry.

Rather than seeing this term, adopted with so much ambivalence, as a simple circumstantial effect of the increasing recognition of victims (as those involved themselves maintain), it seems to us important to situate the new field within a longer genealogy, that of forensic medical expert opinion. Once again, as during the great era of traumatic neurosis, it is in the judicial archives, the summaries of civil law and the reasons given for judgments in compensation cases, that we find the earliest traces of a movement towards victimology. As we have seen, the first form of victimology was a branch of criminology that emerged during World War II, in the context of extending understanding of the motives and character of criminals to understanding their victims with equal clarity. In the view of criminologists, the encounter between the criminal and the victim was not due to mere chance. While the criminal had an “innate” propensity to commit crimes, it was nevertheless believed that he had to come into contact with a victim sufficiently “docile” to allow him to exercise his “predator’s talent.” The psychological victimology of the 1950s and 1960s put forward an analytical model based on the psychological characteristics of victims themselves; we find a remnant of this today in studies that seek to determine whether the perpetrators of sexual crimes were themselves abused in childhood. However the issue was not, as today, to understand the effects of violence on the victim, but rather to show that the victim already presented specific psychological characteristics that inevitably led him/her into an encounter with the aggressor.²⁰ And here we gain a sense of the journey made by this discipline as it moved from evaluation of circumstances prior to the crime (the terrain of the victim) to analysis of

²⁰ One adherent of this viewpoint, Henri Ellenberger, who was professor of criminology at the University of Montreal, put forward one of the first typologies focused on the masochism of some victims. Alongside the “criminal-victim,” who would shift from one role to the other over the course of his life and depending on circumstances, Ellenberger identified a group of “latent” or “potential” victims who presented “general, permanent, and unconscious dispositions leading them to play the role of victim, through masochism, lack of interest in life, or fatalism, or through a feeling of guilt associated with poorly integrated success.” (Ellenberger 1954).

the aftermath (the effects of trauma). This change in perspective enabled the second version of victimology to abandon once and for all the difficult issue of "favorable terrain"—for the crime, in one case, or for the neurosis, in the other—to focus exclusively on the traces left by the violence.

Although the psychiatric victimology of the 1980s and 1990s definitively broke with its criminological past (when the reasons for the victim's misfortune were sought in his or her character), it nevertheless retained one fundamental element of that heritage, namely the role its practitioners played as experts in legal proceedings. In the recent expansion of psychiatric victimology, expert reports prepared for legal proceedings have played an even more decisive role. Remarkably, most of the pioneers of the discipline, as well as its later proponents, were either trained in or joined the ranks of civilian psychiatrists working as expert witnesses, like former military psychiatrist Louis Crocq, or like civilian psychiatrists Gérard Lopez and Pierre Sabourin, who made major contributions to the institutional development of psychiatric victimology and to the care of victims of sexual violence within the family, respectively. And it was because of their position as experts that the victims' rights movements called on them for help. In fact, when victims began speaking out through their representatives, a major shift occurred in the focus of medical expertise. Until that point victimological expertise had been considered a judicial tool little concerned with the fate of victims, but it now became an additional weapon in the victims' arsenal or, more precisely, in the compensation process. In the United States in the 1970s, this weapon was primarily aimed at making public the evidence of the reality of trauma for the purpose of justifying compensation, but paradoxically this was not the case in France, since the language of trauma had already been widely adopted. Here it was used principally to demonstrate that compensation was also a therapeutic act that could speed the healing process.²¹ In other words, at the same time as confirming the social legitimacy of compensation, victimological expert opinion also suggested a possible way out of trauma.

It had never before been claimed that expert opinion could produce a therapeutic effect, even though this might occur if the expert's skill was combined with an equal desire to encourage the subject to seek therapy. During the era of traumatic neurosis, experts had indeed conceded that granting compensation might improve the psychological condition of

²¹ This theme of the therapeutic or pre-therapeutic effects of psychiatric expert opinion was widely exploited by some specialists in preparing expert reports on perpetrators of sex crimes. Roland Coutanceau, for example, argued for a criminological psychology devoted to the perpetrators of sex crimes, suggesting that a period of expert examination allowed the criminal to face his actions, his motives, and his unconscious associations, and could lead him to accept the principle of therapeutic treatment. (Paper presented at the conference of the Société française de médecine légale [French Forensic Medicine Association], November 17, 2003, in Paris).

claimants, but the process depended not on the effect of the expert examination nor on the financial compensation, but simply on the disappearance of the reason for the persistent complaint. Victimology now went further, suggesting that compensation in itself had genuine therapeutic value. This argument established a new relationship between society and its victims, anticipating the subsequent shift of the language of trauma towards a politics of reparation. The argument had already been made by the early campaigners for victims' rights, such as Françoise Rudetzki: in order to establish the legitimacy of reparation, they suggested that financial compensation represented above all a public recognition of victims' status. Without it, victims were doubly dispossessed of their personal history—first by the event, which had changed the normal path of their life, and then by the legal decision that they had no case, which literally suggested that what they had experienced had no reality.

However, evoking the therapeutic value of compensation, which was widely proclaimed by victims, their representatives, some magistrates, and the media had remained a purely rhetorical device which in the courts could at best soften the hearts of those present, at worst leave them indifferent. Now, however, the testimony of an expert victimologist could validate what had been no more than a metaphor of psychological rehabilitation. Like an invisible wound awaiting the application of salve to begin healing, trauma, now seen as common to all victims, whether injured or witnesses, called for radical therapeutic measures such as might interrupt the progress of disease, even if they could not restore the subject to his or her previous condition. The new alliance between victimology experts and victims' support organizations made much use of this validation process, highlighting the expectation that compensation would in itself have a healing effect on a still-gaping psychological wound. Therapy was thus a direct product of the expert's report, since the issue now was not simply to compensate for a past injury but to prevent progression of the condition, in the medical sense of the term. Thanks to this reversal of the traditional model of expert opinion, psychic trauma soon found a place in official psychiatry.

A RELATIVE AUTONOMY

Beginning in the early 1990s²² there were many new initiatives in victimology. Louis Crocq set up of a Psychotraumatology Clinic at the Saint-Antoine Hospital, and Gérard Lopez subsequently established the Insti-

²² For an analysis of the institutional development of psychiatric victimology in France, see the study by Stéphane Latté (2001).

tute for Victimology. Crocq and Lopez were also involved in developing the first university degree program in victimology, which today is offered by the medical faculty at Necker University Hospital in Paris. A number of books were also published, all by authors from within the restricted circle of the civilian and military founders of the discipline, headed by the prolific Crocq and Lopez. A little later the first issue of the *International Journal of Victimology* appeared; this was an electronic journal published by Christophe Herbert, who defined himself as a "clinical victimological psychologist." At the same time help centers, help lines, support groups, specialist clinics, and professional training courses and monitoring structures were developing rapidly throughout France, as the map drawn up by Action Research for Exchange between Victims of Incest (Arevi) showed.²³ These led to the emergence of new specialists to populate this rapidly expanding field: social workers, educators, and of course psychologists. The latter, taking over from the psychiatrists, made major contributions to the development of the day-to-day practice of victimology, while the psychiatrists retained the privilege of producing the scientific literature.

Thus the beginning of the twenty-first century presents a stark contrast to the previous climate of the ostracism of people suffering from the consequences of violent events within the mental health field.²⁴ French psychiatric journals regularly referred to trauma in their pages, and even devoted one or several special issues to the subject. Even among psychoanalysts, of all persuasions, the theme was popular and became the subject of numerous conferences, scientific meetings, workshops, seminars etc., where the exogenous nature of some traumas could be openly debated, without rejecting psychoanalytic theories but while recognizing the ills of the earlier clinical climate of suspicion. Even PTSD was no longer a contentious issue that divided practitioners, insofar as each agreed to recognize that this US entity was simply a variant of the much more fundamental rediscovery (which French psychiatry and psychoanalysis had already brought to the fore) of the reality of trauma. However, the new legitimacy of victimology and the calm acceptance of post-traumatic stress resulted less from a revision of psychiatric and psychoanalytic theories than from the universalization of the issue of victims and the dissemination of the concept of trauma in society at large. In France even more than in the United States, the dynamic in operation derived much more from the social

²³ For the map, see <http://inceste.arevi.org/page/ressourcesguidesaidesb.htm>.

²⁴ On April 29, 1997, French daily *Le Monde* hailed the birth of victimology in an article titled "A New Branch of Criminology," a title that shows that the discipline's criminological heritage had not been forgotten by everyone, and that victimology was still most often to be encountered in the legal arena. The article highlighted "serious gaps in psychological support for victims."

sphere than from the professional field. It was victims who justified victimology, not the reverse.

For that very reason victimology enjoyed only limited autonomy. Its undeniable success remained closely dependent on progress in the recognition of victims' rights, a process initiated by the victims' associations. Both the public authorities and official psychiatry saw victimologists as serving the interests of the pressure group. The founders of the discipline were aware of this weakness, asserting that "victimology is, as everyone knows, a separate discipline," and that "the French Victimology Society situates itself in an academic and scientific context rather than an ideological and polemical one, in order to facilitate genuine dialogue that will further the development of knowledge."²⁵ But victimologists had difficulty in escaping institutional marginalization, which was evident even in the physical spaces they occupied. Either relegated to modest outbuildings on a hospital's premises (like the psychiatric department in the Saint-Antoine Hospital where Louis Crocq set up his clinic) or entirely separate from public health care structures (like Gérard Lopez's Institute of Victimology, which operated from private premises), victimology or psychic trauma clinics were still supported mainly by the networks of associations. The dominance of the latter was also revealed in their contribution to the training of future victimologists. Not only were victims' organizations associated with university training programs, on which some of their members taught, they also supplied victims with lists of "trusted practitioners," a practice that rendered the new university degrees somewhat suspect.

Thus, despite the sudden visibility of their field, victimologists remained bound by the circumstances in which their discipline had been born. The tenuous links they had skillfully woven with the domains of expert opinion and therapeutics—the very links that had enabled them to win a decisive hearing alongside other parties involved in victim support—led them to limit their field of operation to self-declared victims or to those directed to them by the victims' associations. In this way, psychiatric victimology remained a specialist practice that intervened at a secondary, and generally subsidiary, level in the overall process of the recognition of victims.

As we saw in the aftermath of 9/11, the encounter between new concepts of psychic trauma and the administration of emergency psychological care was to transform this power relationship by lifting the boundaries that had previously defined the population potentially affected by trauma. This development is often ascribed to the activism of victims and victimologists. While this activism, to which we have devoted a lengthy analysis, is important, it seems to us that the way in which the concept of trauma

²⁵ Lopez (1996).

became shared knowledge forms part of deeper—what we might call anthropological—transformations that made this activism effective and even possible. More still than the “risk society” that Ulrich Beck identified and analyzed, what the terrorist attacks, accidents, and disasters have produced is a “danger society.” The issue is not so much the statistically measurable and more or less predictable possibility of a real event. Rather, trauma has become common property, part of everyone’s life, its reach extending far beyond the scope of psychiatric expert opinion. This was what French society was to discover on September 21, 2001

Toulouse

TEN DAYS AFTER THE COLLAPSE of the World Trade Center towers, France was rocked in its turn by an event that sent a shock wave through the country, arousing fears of a repeat of the attacks in New York and Washington. At 10:17 AM, a violent explosion shook the city of Toulouse. Its force was such that it was felt thirty km away, and initially it was impossible to tell anything about either the location or the nature of the explosion. Within minutes the city was virtually paralyzed: telephone lines were cut, public transportation was suspended and the main roads blocked. In the districts closest to the site of the explosion, houses were gutted, and a thick layer of dust and white particles lay over a scene of devastation. Local radio stations began to broadcast alarming and contradictory reports, calling on the people of Toulouse first to leave the city, and then to hunker down at home. At first it was thought that a series of explosions had simultaneously detonated at several of the city's nerve centers—the Town Hall, the aerospace manufacturing plant, the gunpowder and explosives factory, or the chemical industrial zone—and there were fears of a major terrorist attack. Around 11:45 it emerged that the explosion had in fact destroyed the AZF chemical factory in the south of the city. Tensions rose still higher at this point. An opaque cloud had spread over the city, giving rise to rumors of chemical contamination. However, by mid-afternoon the city authorities were able to announce that there was no threat of toxicity.

Despite the initial confusion, emergency teams were quickly in place. A first aid post was set up at the edge of the factory zone. The dance of the ambulances then began, their progress slowed by traffic jams that worsened by the hour. The entire city was in a state of shock, everyone rushing to aid those worst affected, or to the explosion site in search of news of a loved one. By the end of the afternoon, the initial toll was about twenty dead at the factory site, and several thousand casualties in the immediate area and further away within the city. There was huge damage to property, affecting the whole of the district around the factory—houses, schools, businesses, public buildings, and even roads. Of the twenty-seven thousand dwellings hit by the blast, ten thousand were virtually destroyed. Outside of Toulouse, the entire nation watched in disbelief as a scene reminiscent of the attacks in the United States was played out,

to the point where the press began to speak of "Manhattan Syndrome."¹ The same group of commentators appeared on TV screens and radio broadcasts, putting forward their hypotheses on the cause of the tragedy and also on its consequences. From the outset, the theory of a chemical accident was combined with the hypothesis of a terrorist attack. Among the people of Toulouse the terrorist theory dominated, despite initial denials that pointed to an industrial accident. Some believed that the truth was being covered up for political reasons; others refused to credit the idea of human error, which would point the finger at workers in the factory who were already devastated by the death of thirty of their fellow employees. Those with hindsight observed sardonically that the city had been living on a powder keg for twenty-four years, and that it had been feared it would explode at some point. But the inquiry was just beginning.

In a succession of reports that essentially rehashed the commentary and analysis on 9/11 heard throughout the previous week, everyone used the same language to describe their shock. As after 9/11, the term that recurred the most frequently in the expression of collective emotion was trauma: the trauma of the injured and of those who had lost loved ones, the trauma of the city of Toulouse, the trauma of the entire nation as, through this generalization, the French people as a whole had the feeling that they shared in the ordeal. The tone was set within hours of the accident. That afternoon Philippe Douste-Blazy, the mayor of Toulouse, issued a solemn appeal to all the city's psychiatrists and psychologists to come to the aid of the traumatized population. Inspired by a simultaneous burst of compassion and solidarity, many mental health professionals made their way to the Town Hall to await instructions, while others rushed to the accident site itself. Within a few hours 226 doctors, 45 psychiatrists, 486 psychologists, and 200 nurses had responded to the mayor's appeal.² In offices and factories, in schools and high schools, those in charge adopted appropriate measures to ensure security, reassure those present, enable a flow of information and thus contribute to the collective effort, and all either demanded a psychological support unit to care for people affected by the disaster or set up one of their own.

While the mayor's appeal was certainly a catalyst for this mobilization of mental health professionals, who are rarely to be found at such scenes

¹ See the article in *Le Monde* on September 23, 2001, the day after the tragedy: "From Manhattan Syndrome to the Fear of a Toxic Cloud." The reporter commented, "Toulouse is gripped by Manhattan Syndrome. Some swear that a plane crashed into the factory."

² Figures supplied by the report of statements from Toulouse Town Hall officials, published in the report of the Committee on the Explosion at the AZF Factory in Toulouse, commissioned by the French Department of Health. Available at the Web site of the National Institute of Health Monitoring (InVS): <http://www.invs.sante.fr/recherche/index2.asp?txtQuery=azf>.

of public drama, it does not entirely explain the extent of this collective phenomenon. The reason that most of the people we met in Toulouse immediately identified with the qualification of trauma, whatever their degree of involvement in the actual event, and that five years later, when the compensation procedure was finally reaching its conclusion, they were still using this language, was no doubt because recognition and reparation were now independent of clinical verification. Before the Toulouse disaster, trauma was still a clinical concept that the general public was beginning to appropriate, with the support of a number of specialists. After this event, trauma was freed from its medical roots and became a concept central to a new ordering of reality, of which everyone, or virtually everyone, could appropriate a part and use of it in relation to his or her own way of thinking. The universe of meaning in which the trope of trauma was being used no longer questioned the authenticity of the psychic wound: it took it as a given and went on to gauge, oppose, or even condemn the way in which trauma was recognized and treated. For the first time, clinicians had to reap the consequences of the success of the concept they invented. They met increasing competition for the right to manage the treatment of trauma, as public initiatives and self-help groups mushroomed. Just at the point when psychiatrists had made it possible to establish the clinical reality of post-traumatic disorders, victims and their supporters were beginning to seek freedom from this expert authority, which they saw as a hindrance to their own efforts.

Thus we need to analyze the conditions in which psychiatrists and psychologists were summoned to the scene of the disaster, the medical and psychological emergency assistance structures that formed the context for their work, the appropriation of the new language of the event by local participants, and finally the place of trauma in the debates and conflicts that arose around the issue of victims' compensation.

THE SUMMONS TO TRAUMA

Located in a working-class district in the south of the city, the AZF factory adjoined a psychiatric hospital with 370 beds (the Marchand Hospital) and a large housing project (the Mirail) built to house working-class families, and where unemployment rates were much higher than the average for the city. The explosion devastated the hospital: its entire infrastructure was destroyed, and its operations, including its mobile units, were thrown into disarray. This included the Toulouse Medical and Psychological Emergency Unit (CUMP), which was based at this hospital and which, rendered inactive for several hours, was paradoxically unable to contribute to the initial provision of psychiatric assistance. Cut off from the rest

of the world, hospital staff had to deal with the panic of mentally ill patients at the same time as treating the injured, despite the fact that their working facilities had been destroyed. But by early afternoon, patients were being transferred from the Marchand to other hospitals up to two hundred km away, and by evening the hospital had been fully evacuated with the help of emergency services from adjacent regions that had come to reinforce the Toulouse teams. At the same time, the injured were assembled near the hospital entrance where an emergency aid post was set up, close to the emergency ward and the pharmacy, and first aid was administered by the hospital's care staff to victims from within the AZF factory. However, no attempt was made to locate potential victims from inside the hospital itself. The scene in the Mirail district was one of similar devastation. The streets were full of debris, cars were destroyed, houses gutted, many injured people wandered the streets. While waiting for assistance, local people organized themselves and dealt with the most pressing issues. Class differences were erased; the wealthiest offered shelter to those who had lost everything.

The city authorities' first action, before any assessment of need had been made, was to set up a psychological help center at the Town Hall. So many people turned up that those staffing the center took the initiative to expand its operations and, following the model of response to a medical emergency, improvised a "control center" that dispatched mental health professionals throughout the city, sending some to officially organized units, and others out into the streets to offer debriefing to people there. Because of the urgency of the situation, instructions were issued in haste and the mobilization of resources was hurried. At no point were the qualifications and skills of volunteers checked, and they were given no specific tasks, simply asked to put their name on a list. Once they had dispersed, lack of coordination made it impossible to gather information on the number of people attended to, the nature and gravity of the distress observed, or the help offered. Many of the volunteers were practicing in an emergency situation for the first time, and they did not have the professional experience or the institutional contacts to refer the most serious cases of shock to specialists. The following day, when the official Medical and Psychological Emergency Unit (CUMP) started work again, it was already too late to set up the standard framework for controlling a disaster situation, which normally is the exclusive responsibility of this unit. Marginalized by the mayor's mobilization of his own medical networks (he is a former cardiologist), the CUMP was forced to restrict its operation to setting up a first aid post close to the factory. Eventually, most of the psychiatric resources were concentrated at the university hospital. Thus the structure set up in the hours following the explosion continued to operate for two weeks. Many independent psychiatrists re-

turned to their former public clinics and volunteered to meet with the traumatized people who continued to arrive. The university hospital responded to the demands of a crisis situation, extra shifts were organized, and more than four hundred diagnostic charts drawn up, but there was no coordination with the CUMP.

At the same time, initiatives were springing up throughout the city. In the districts most directly affected some residents coordinated individual efforts by creating victims' groups, and these soon became more formal associations. They were joined by lawyers, social workers, and even insurance agents, who volunteered to provide information, advice, and assistance to the already socially disadvantaged people of these districts. Volunteer psychologists offered support consultations on the same premises. While some residents were surprised at this sudden concern for their psychological welfare, others welcomed the opportunity to share their emotions and talk about their problems (sometimes unrelated to the event) with someone specialized in listening, while waiting their turn to meet with a lawyer or social worker. Across the board, in primary schools, high schools, businesses, and public facilities, there was the same concern to listen to the victims and to do whatever was possible to prevent trauma and its future consequences. This broadening of the psychological response to the disaster suffered by the people of Toulouse went beyond the intervention of specialists. For example, a glazier, describing his role among the "windowless" (as one group called themselves), showed no hesitation in saying, "You know, by listening to people at the same time as repairing their houses, I was also giving them psychological support." Even offering urgently needed items (blankets, food) was recast in terms of psychological support, as one coordinator of logistical aid emphasized:

What I can say is that our teams who were with the victims have done really good work; I think they've really done a lot of listening, although they're not psychologists. In the end I think everyone's been giving psychological support.

The same tendency was evident among the victims' associations, as this activist makes clear:

Psychological support means being available even on a Saturday. This guy turned up, his wife was in a real state. I was supposed to be somewhere else, but I couldn't leave them. And when they left they said, "Can I give you a hug?" So I think we're really giving them psychological support . . . I really think so, I really think the work we're doing is psychological support, and it gets results.

The victims did not concern themselves about whether they had been fortunate enough to be seen by a trained psychiatrist or psychologist; they were simply glad to have found a listening ear. Most of them, in any case, did not know whether those they talked to were psychiatrists, psycholo-

gists, nurses, or simply laypeople. But all of them were disappointed when they found that they could not come back and talk to the same person, as the volunteers went to different posts each day.

The volunteers found the situation no easier. Without a firm structure for their intervention, they found it difficult to assess their contribution. At some sites the number of psychologists available was greater than the number of people seeking support, so some volunteers held back from offering their services and waited patiently to be called on. Others were thrown by the nature of people's needs, which took them far from what they encountered in their usual practice. One of them recalled:

We were dealing with everything, not just psychological issues, far from it: there were the issues of property damage and legal questions. Sometimes they weren't seeing us as psychologists at all. In those cases it was hard because we had to explain that we couldn't do anything about this or that particular issue. They hoped we would help them get practical assistance, so we had to explain straightaway that no certificate we signed could support a request for rehousing or compensation, that we could do nothing. People were disappointed. Sometimes also it was difficult to distinguish between their distress and the practical issues of compensation.³

As the crisis progressed many came to question the usefulness of this work. The apparent importance placed on the treatment of trauma in the aftermath of the disaster contrasted sharply with the confusion of support methods and the disorganized delivery of psychological assistance: the proliferation of volunteers, the undifferentiated nature of the listening offered, and in some cases even competition between different participants.

These problems were interpreted in varying ways by the different parties involved. Some maintained that they were due to the huge scale of the accident, described by one specialist as a "resource-exceeding disaster."⁴ According to this point of view, the lack of coordination, the failure to verify the skills offered and to gather information on volunteers' activity, and the concentration on relatively less damaged areas (like the Town Hall district) to the detriment of the districts most affected (like the Mirail) were results of the nature of the crisis. Others felt that the immediate management of the disaster revealed more serious problems. The authors of the Department of Health team report, for example, criticized the city and national authorities' overall lack of preparation, given the location within the city limits of an industrial zone where some of the

³ The interviews with volunteer psychologists were carried out by Stéphane Latté.

⁴ See the report of the Institutional Committee for Epidemiological Follow-Up of the Victims of the AZF Accident, inaugural session, October 30, 2001. Unpublished, available from Inavem.

plants were classified as “Seveso-level” (i.e. high-risk). Rivalry between the national and local administrations was also demonstrated by their different understandings of their responsibilities in these difficult circumstances. According to official emergency psychology specialists, both in Toulouse and in Paris, the problems were due to the sidelining of the Toulouse CUMP and the city government’s willingness to short-cut the regulatory structure. One psychologist from the Toulouse CUMP remarked:

There was no question of getting involved in this huge mess, mixing up everything and anything. You have to understand that it just wasn’t possible, you have to imagine a list of five hundred psychologists and psychiatrists signed up at the Town Hall, who were deployed through the city. And then add to those the ones who didn’t register and all the psychs who sprouted up under the arm of the Red Cross and Catholic Aid. It was incredible.

As the spontaneous volunteers at the ad hoc units set up at the Town Hall and at the teaching hospital saw it, however, these problems reflected the shortcomings of the CUMP teams and their inability to cover the whole of the area in this major disaster. In a university city like Toulouse it seemed to them unthinkable that an emergency unit should not be closely linked to teaching hospital structures, and the disaster only strengthened that conviction. The accident in fact revived antagonism that had surfaced some years earlier, when the Marchand psychiatric hospital and the Purpan university hospital had been in competition to house the CUMP.

Some took their criticism still further, attacking victimology as a whole. They believed that the problems stemmed from the very concept of a psychological emergency, and even of treatment for psychic trauma. Denouncing psychiatry’s growing monopoly over human suffering, these critics found in the failures in Toulouse the evidence they needed for their condemnation of the “psychiatrization of the social,” as they phrased it. According to them, the idea of emergency care for psychic trauma was so diluted in the common understanding that it had lost all real meaning. The lack of discrimination among the categories of those who acted to support the shaken population, and the unease of the volunteers during and especially after the event, reflected the vagueness of the field of victimology, which was largely media-led. Other professionals would have been able to understand and to treat the people’s trauma. All the criticisms, even this radical view, had one thing in common: they condemned the failures of care and the limitations of the structures, but they never questioned the value assigned to trauma. In other words, far from declaring the end of the trauma paradigm, they reinforced it.

In this sense Toulouse marked a turning point in the history of trauma in France. For the first time, the primacy of scientific discourse and clinical

psychological practice was challenged by a political vision of trauma. The issue was no longer, as during previous campaigns, to advance the cause of victims by using the evidence of clinical trauma, but rather to appropriate the mobilizing power of trauma as a social fact. Victimologists thus lost a major plank of their credibility and legitimacy. Previously their knowledge had been sought out in order to establish the legitimacy of victims' rights campaigns; now it represented an obstacle to the expansion of trauma politics. Already of secondary status in the past, victimology now became insignificant, even suspect, at the very moment when care for the victims of trauma had gained the greatest social visibility and was recognized as a political imperative in the face of collective suffering.

This reversal must of course be seen in the context of psychic trauma's dual lineage—scientific and social. This is a genealogy that we have traced through many twentieth-century twists and turns, but it emerged even more clearly in the mid-1990s, at least in France, when the state made the decision to become directly involved in managing the psychological consequences of the wave of terrorist attacks in Paris in the summer of 1995. Trauma, it seems, has become "too serious" to be left in the hands of specialists.

EMERGENCY CARE IN QUESTION

In the early 1990s the idea of early mental health intervention for people exposed to events carrying a high risk of trauma (such as accidents, terrorist attacks, or natural disasters) was beginning to become established in the scientific literature, on the basis of the reported benefits of the "debriefing process." This process, also described as "de-shocking," involved producing a release of emotion immediately after the event in order to prevent post-traumatic disorders. But although it was widely used by the military health services, it was some time before early debriefing found equivalent applications in civilian medicine. Rescue workers were the first to dare to articulate a parallel between the problems inherent in their work and in military medicine, though they were more concerned with the trauma of the professionals than the victims. And indeed, like frontline troops, rescue workers underwent powerful experiences, the psychological consequences of which could include psychic exhaustion or even collapse. Military experience therefore appeared to offer fertile ground for studying the phenomenon, provided it was accepted that "collateral damage" (to the rescue workers) in emergency operations was comparable to the "psychiatric casualties" of armies in war. Initially considered the equivalent of "burn-out" (reactive professional exhaustion, usually af-

fecting overworked senior managers or company directors⁵), the emergency workers' fatigue was subsequently renamed "post-traumatic stress" and this at the very moment when the military debriefing technique offered hope of better therapeutic results than those obtained from more traditional therapies. Thus, in the early years, emergency psychiatrists worked at the emergency teams' bases, treating staff affected by psychologically distressing operations; they did not yet accompany mobile teams to the actual scene of the incident.

There were a few isolated attempts to include psychiatrists in emergency teams attending the scene of an accident or caring for the families of victims, but they remained the exception. For instance, when the Furiani football stadium, on the outskirts of Bastia, collapsed on May 5, 1992, the military doctor Louis Crocq was sent to the scene to make an initial assessment of psychiatric casualties. Similarly, when the passengers on an Air France plane were taken hostage in December 1994, the families were met by a psychiatric team in a room set aside at Orly airport. But at the same time, the Paris fire department asked one of their chiefs, a departmental doctor trained as a psychiatrist, to introduce psychological care into their emergency operations, and the doctor found that "the intervention context was much too complex, and the role of psychiatrists in it needed to be rethought." Moreover, "the practice of debriefing couldn't be applied with a broad brush. What was needed was not just particular skills, but above all years of experience of medical intervention in emergency situations where the victims are by definition unaware of what they have escaped." He believed that survivors should not be inundated with information on the nature of the incident. In fact, forcing on them the full facts about what had happened could generate a secondary, possibly traumatizing fear. The art of debriefing was not without iatrogenic risks. In his view, this aspect of the work was so delicate that he rejected any assistance from volunteers rushing to the aid of potential victims. His prudence meant that a few years later, when the medical and psychological emergency units were set up, he was relegated to the margins.

Dismissing such doubts, specialists in victimology had proposed creating a network of permanent units through France, which would be administratively attached to regional emergency services and able to mobilize a vast network of volunteer practitioners. Psychological emergency care was thus given equal weight with medical emergency care, and the two were to follow the same organizational structure. Based on civil defense models, the units were to respond only under clearly defined circumstances and to follow rigorous guidelines. Only the regional prefect (the state representative) had the right to call out an emergency unit, and in

⁵ Lorient (2000).

its turn the unit would mobilize its network of volunteers. When the decree for the creation of a national network for psychological emergencies was issued on May 29, 1997, several regions already had a unit. Despite a shortage of resources and organizational problems, the network received unprecedented media coverage. Every time a team was called out to deal with an incident that caught public attention, comments appeared in the press. Each time, the presence of psychologists was highlighted: they were interviewed and filmed.⁶ The media now focused more attention on the "emergency psychs" than on the other rescue workers.

Training programs proliferated, offering a huge range of the skills required to deal with all kinds of trauma, and they were open to new categories of practitioners. Specialist journals in emergency care, which formerly had given little space to psychological treatments, began to devote whole issues to them.⁷ Traditional psychiatric journals followed suit, one publishing a series of articles focusing on psychological emergency care under the title "Current Practice in Psychic Trauma."⁸ Emergency care came to preoccupy the practice of victimology to such an extent that it virtually effaced previous concerns. Even the debates on expert opinion and its links to care for victims were seen as a secondary issue. Just when victimologists were finding difficulty in freeing themselves from the shackles imposed by the victims' associations, psychological emergency care pushed them into the limelight, placing them ahead of the associations at the very forefront of events. Since the concern was no longer the treatment of symptoms developed some time after the event, but intervention at the scene itself in order to prevent those same symptoms, it became impossible to put limits to the range of those at risk: people who were directly or indirectly affected, rescue and support workers, and witnesses (even those who witnessed at a distance) all became potential victims. It was through this shift—from diagnosing trauma to simply declaring it, from treating it to preventing it—that trauma specialists were finally able to detach themselves from the world of the victims.

But with this unarguable success came growing unease within the profession, which gradually extended to all those who supported it. The extension of the domain of CUMP intervention effectively marked a new relationship between society, its victims, and those who cared for them.

⁶ For example, on October 1, 2002, the lead item on the 8:00 PM news bulletin on the France 2 channel was the opening of the trial of the perpetrators of the 1995 terrorist attacks. Right at the start of the report, the anchorman announced that "special arrangements are in place, with an emergency psychological unit set up next to the courtroom." <http://www.ina.fr/archivespourtout/index.php>.

⁷ See the December 1996 issue of the *Journal européen des urgences* [European Emergency Journal] 9, no. 4.

⁸ See the 2005 issue of *Synapse*.

And the heavy media coverage of “emergency psychs” made the field of psychic trauma intervention once again problematic. Blame was no longer leveled at victims; instead professionals were put on the rack. Units could be called out to floods or fires, a suicide or threatening graffiti in a high school—in fact the range of their activities became so broad that victimology was in danger of losing its focus. Practitioners began to accuse one another of straying from the core principles of the discipline. The criteria for intervention, call-out procedures, and treatment techniques were regularly questioned, as this specialist in psychological emergency, responsible for one of the largest services, ironically remarked:

One of my colleagues is a high-level professional in terms of skill and knowledge, but last year he struck out on his own forty-seven times because he keeps his radio tuned to the news all day, and every time some disaster happens he goes down there and says, “Hello, I’m a psychiatrist, how can I help you?”

The professionals were not the only ones to be challenged. The authorities were widely accused of calling out teams just to cover themselves, or even to palliate social ills they could no longer manage. The same psychologist added, “I see psychiatrists and nurses called out by the prefect to look after a farmer because he has to slaughter his herd. It makes no sense.” For local and national governments, which already had misgivings about the creation of the emergency units, the overuse of emergency psychological intervention and the lack of consensus among professionals (on the criteria for calling out mobile teams) provided further grounds for freezing financial support while awaiting clarification. In 2001 the National Committee on Medical and Psychological Emergencies was therefore mandated to draw up guidelines for CUMP intervention. Under the leadership of the HFD for the Department of Health, a number of working groups were set up and coordinated by a project leader who was an emergency care specialist. But in the fall of 2002 the National Committee, having failed to reach a consensus, was dissolved.

The press, initially full of praise for emergency psychiatrists, now scoffed at the “shrinks” who rushed to the scene as soon as a “trauma alert” was sounded. The press was, however, equally damning if they were absent or late to intervene in caring for people “in shock”—who were now generally assumed to be already victims of trauma. Forums and debate were everywhere in the national daily press, with each writer striving in his or her own way to shed scientific light on a hitherto marginal phenomenon that had suddenly become a reflection of the *Zeitgeist*. The issue was not trauma *per se*, nor distinguishing between true and false victims, but rather the management of trauma. It was no longer the newly conferred rights of victims that were questioned, nor the campaigns of the associations; it was the “psychiatrization” of individual or collective emotion that was the issue. Thus it was the professionals who found them-

selves in the dock. When they refused to “debrief” every individual present at the scene of an incident and judged it more appropriate to offer the less shocked a list of specialist practitioners, as they were entitled to do, they were mocked as “buck-passers.” But in November 2004, when they set up their mobile unit in the midst of stalls providing hot drinks and blankets in the arrivals hall at Roissy-Charles de Gaulle Airport, ready to meet the haggard passengers coming off the plane that had brought them back hurriedly from the Ivory Coast, the other support workers expressed surprise at their methods. In this context where there was no life-threatening emergency, they were not high on the priority list, as this response from a Red Cross volunteer who was manning a support unit set up for children waiting for their parents to complete administrative formalities testifies: “I’m sure it’s useful, but it’s more like something from a vacation center for children than professional deshocking treatment.” It seemed that psychological emergency workers were always doing either too much or too little—and since they were present at every incident covered by the media, they were exposed to criticism from all sides.

In 2002 the debate took a scientific turn when *The Lancet* published a meta-analysis of all the studies then available on the effects of early, single-session debriefing and concluded that the method posed some risks.⁹ Reactions were quick to follow. Some immediately challenged the authors’ method and conclusions, arguing that their bias led them to ignore the conditions under which emergency care was practiced and the criteria for the use of early debriefing.¹⁰ Others pointed out that the care offered by the units was by no means limited to US-type debriefing, which was very different from French practice.¹¹ However, the consensus as to the essential legitimacy of immediate treatment by victimologists had been lost. This series of challenges had a powerful effect on those involved. Now themselves experiencing the suspicion that had formerly hung over victims, specialists in emergency clinical psychology swung between collective defense of their working methods and criticism of colleagues alleged to have strayed from the principles of the discipline.

How are we to explain the shift in the perception of psychological emergency, within the space of a few years, from innovation to illusion? To understand this, we need to return for a moment to the founding act attributed to Jacques Chirac in 1995, which the accounts of all participants and commentators take as their reference point.¹² This moment serves, in fact, as a kind of origin myth, imposing a retrospective interpre-

⁹ De Soir (2004).

¹⁰ De Soir (2004).

¹¹ Crémniter (2002).

¹² In her interview with us in 2004, Nicole Guedj, Secretary of State for Victims’ Rights, herself naturally cited this prestigious origin to emphasize “the clear-sightedness of the President, who had already anticipated victims’ needs.”

tation on an event that brought immediate visibility to the cause Chirac was promoting, and thus blurred the contradictions it also raised. Without underestimating the contextual, even opportunist dimension of the French President's gesture, we also need to understand its strictly political significance. In effect, by attributing the origin of the medical and psychological emergency units to the state's highest authority, the myth promulgated a basic misunderstanding of the central issue in his speech. For the import of Chirac's remarks was not so much an invitation to set up specialist-led units, but rather to underscore the correctness of the general public's assessment: concern for victims is not the province of professionals, even if professionals must be the first responders. He was evoking collective responsibility, a responsibility that was universally acknowledged. Both President Chirac at Saint-Michel in 1995 and Mayor Douste-Blazy in Toulouse in 2001 expressed the sentiment that the misfortune of one group becomes a pain to be shared by all: "We are all victims of the attack or the accident," they might say. What the cameras focused on and the media attempted to reveal through their comments on "shrinks" was not a few psychiatrists and psychologists finding renewed credibility, but trauma itself, or rather the reflection of it that could be grasped through legitimate discourse by politicians as well as professionals.

It was precisely on this issue that victimologists and other emergency trauma specialists were challenged, being told, effectively, that they were not the only ones who could understand the reality of trauma. Other approaches, other viewpoints, could comprehend and analyze it. Trauma had become an essential human value, a mark of the humanity of those who suffered it and of those who cared for them. As the officer responsible for logistical support in Toulouse pointed out in an interview, "You don't need to be a psychologist to listen to, calm, and comfort fellow-citizens in pain or distress." But everyone already knew that. What one did not know, however, was that the work of lay activists would evolve into treatment for trauma that was administered not by professionals but by society at large.

INEQUALITIES AND EXCLUSIONS

Thus the recent history of trauma is marked by a series of appropriations and dispossessions. In the United States in the 1970s, the trauma victims' movement brought renewed legitimacy to the psychiatric profession. In France, however, the victims' campaigns of the 1980s gradually freed trauma from the conceptual framework forged by psychiatrists and made of it a platform for demanding rights. During this period mental health professionals, such as the new victimologists, continued to be called to

the scene of trauma events, but more in the role of secondary experts; these events, unlike individual acts of violence such as sexual abuse, were now viewed as collective dramas with a meaning that was patently obvious to everyone. With the institutionalization of emergency psychological assistance in the 1990s, the protection of victims was added to the responsibilities of public authorities. This transfer of responsibilities took the field of trauma management out of the hands of specialists, whose role was now beginning to be challenged. The AZF accident in 2001 underlined still further this dispossession of the professionals, consolidating the general public's appropriation of trauma, but it also marked out new inequalities and distinctions between groups of victims.

One thing was clear from the start. The deployment of psychiatric and psychological resources on a wide scale showed that trauma was no longer the business of a handful of victimologists attached to emergency units. As the activities of victims' associations and neighborhood groups took over from official structures, it became clear that it was in fact no longer the sole prerogative of mental health professionals of any stripe. Trauma had slipped out of the grasp of the experts. The many statements we gathered show that the entire population of Toulouse identified both with the image of the victim and that of the therapist. Both evoked feelings of compassion and solidarity. Everyone was both a victim, if only by proxy, and a kind of volunteer therapist serving others. We cannot, of course, ignore the performative effect of such statements which bring into being what they express, starting with the affliction itself. By calling oneself a victim one takes on victimhood; by calling oneself a therapist one assumes therapeutic powers. Nor can we forget that this kind of language comes most easily at times of wide-scale disaster, when there can be no doubt that trauma, by now a familiar word in the lexicon of suffering, is what we are seeing. Who could doubt it? But beyond this dual rhetorical dimension, we argue that two profoundly contradictory forces came into play in the AZF accident—forces that can be found at all scenes of trauma. The first asserts the universality of the victims, while the second institutes inequalities among them. We shall elaborate on these points.

At least in the first analysis, the AZF accident seemed to have affected everybody. While the districts adjacent to the factory were of course the most seriously hit, the explosion was so powerful that damage to property occurred as far away as the city center. The emotional shock associated with the violence of the blaze, the spectacle of devastation, the uncertainty as to the cause and consequent fears of terrorism, the fear that the entire city might be chemically contaminated, and—less concrete, but certainly decisive—the feeling of sharing a highly dramatic experience, all these factors worked together to produce a sort of communion of suffering. The metaphor of trauma brought people together, giving everyone the

impression of being as much involved, as much a victim, as anyone else. In all our interviews, the subjects related detailed personal accounts of their own trauma, a testimony to the widespread impact of the explosion. And without being prompted, every interviewee related his or her own experience as a part of the collective experience. No one was spared the emotional contagion, not even the “eight-year-old child traumatized just by his teacher’s tears.” Politicians, first the city’s mayor and then the President and Prime Minister, reinforced this sense of unity by talking about how the people of Toulouse, and then the entire nation, were brought together in a community of tragedy. It is clear that the ordeal of the AZF accident created a lasting form of collective identity in affliction—within Toulouse, if not the whole of France. By presenting the entire population of the city as victims and asking each individual to tend to the psychological wounds suffered by their fellow-citizens, Mayor Douste-Blazy himself embodied the new double-identity of the citizen of Toulouse—both universal victim and universal therapist. Uniting the entire population behind him, at least for the moment, in the same dynamic of compassion and solidarity that did not regard social status or political allegiance, he established a virtual community of victims while at the same time conveniently forgetting that the map of the zones worst hit by the explosion was almost identical to that of the city’s economically and socially disadvantaged areas.

And indeed, the “sacred bond” soon came unstuck. Following the initial rush of spontaneous solidarity, which in the immediate aftermath saw all citizens united as equals with all the old divisions forgotten, boundaries slowly began to reassert themselves. On the one hand were the direct victims of the accident (in the districts close to the factory), on the other the indirect victims (more distant from the epicenter of the explosion).¹³ In the areas with the greatest material damage, a hierarchy of trauma was established, as if to underline that the different degrees of exposure of the population reproduced preexisting social disparities. But among the political elite of Toulouse this hierarchy was ignored in favor of the notion of a collective trauma that took no account of the individual’s place in society. This discrepancy of viewpoints is reflected in the results of an epidemiological study undertaken by the National Institute for Health Monitoring (InVS).¹⁴ This study, as the authors point out in their final report, marked the first time in France that “a comprehensive structure

¹³ It is a regular phenomenon in disasters that inequalities are exposed after the sacred order of solidarity is invoked. See Fassin and Vasquez (2005) on the 1999 “Tragedia” in Venezuela.

¹⁴ On September 22, the authorities decided to arrange for epidemiological monitoring of the consequences of the accident, coordinated by the InVS. After the emergency response, the monitoring was the responsibility of two bodies: a scientific committee led by Professor

for epidemiological assessment of the health consequences of a disaster was set up as early as the day after the accident." The fact is remarkable, and rightly emphasized, in a country where the health information monitoring system is regularly criticized for its failure to react quickly (in the contaminated blood scandal of the 1980s, for example, or in the heatwave crisis in the summer of 2004). Still more remarkably, the study incorporated social analysis from the start. Social variables were taken into account in the design of the study—and not only in identifying differences in exposure to risk, but also in recognizing differences in the consequences of the accident.¹⁵ Thus, professional status, place of birth, and of course district of residence were among the factors taken into account. At the same time, the effects monitored were not restricted to health in the medical sense, but extended to property damage, living conditions, and the effects on everyday life.

Using the methods of social epidemiology, the study highlighted the unequal distribution of distress and symptoms among different populations. For while acute stress affected the entire city in the early stages of the crisis, longer-term consequences were closely linked to social inequalities.¹⁶ What the report's authors described as "post-traumatic stress" occurred much more frequently among "the most exposed," that is, those with "greater intensity of exposure to the explosion, whether personal (proximity, injuries) or indirect (a loved one affected)" and "more difficult circumstances as a result of the explosion in the medium term, in particular if their house was uninhabitable, they had financial difficulties or, for those with jobs, a negative impact on their employment (for example, a temporary lay-off)." All of these factors defining "most exposed" (spatial, social, material, somatic, affective) describe the same population: those who lived in the districts close to the factory, who already before the accident were living in precarious economic circumstances. These were the victims who now would suffer the most serious and most lasting effects of the explosion. To round off this first series of observations, the authors also noted that post-traumatic disorders were most often found in "the most vulnerable," whether their "vulnerability" was individual (for example, "prior experience of trauma" or "prior treatment for psychological problems") or collective (membership in "the most disadvantaged social groups," which included the residents of the zone close to

Thierry Lang, commissioned to undertake in-depth studies, and an operational committee that would evaluate and disseminate the results.

¹⁵ Unaware of this sociological approach to the effects of the trauma on the population of Toulouse, some authors nevertheless continued to evoke the collective and generalized character of the Toulouse trauma. See Pechikoff, Doray, Douville, and Gutton (2004).

¹⁶ The chair of the scientific committee had just co-edited the first French book on social inequality in health. See Leclerc, Fassin, Grandjean, Kaminski, and Lang (2000).

the explosion, people born outside of France, people with a low level of education, and also, among those employed, manual workers, tradesmen, craftsmen, and low-level white-collar workers). Thus a social map of trauma was drawn, in which economic background, professional status, and immigrant origin intensified the impact of geographical proximity, which as we have seen was itself socially determined because the poorest neighborhoods had been relegated to the same outlying district of the city as the dangerous chemical plants. Thus the consequences of the disaster could no longer be separated from the social realities against which they were set. This pointed to a “collective responsibility,” as the chair of the scientific committee put it¹⁷—which later provided a basis for assigning financial compensation independent of the assessment of individual cases.

These issues were at the heart of the social activism that followed the accident. Over a dozen victims’ associations (Association des sinistrés du 21 septembre [Association of September 21 Victims]), organizations supporting the injured (Vivre après AZF [Living after AZF]), bereaved families’ groups, and residents’ committees were set up to represent the people of Toulouse. Although an initial compensation payment was made, the community of the “windowless” struggled to win provision for the restoration of all housing. There was uncertainty about the reconstruction of the district, which reactivated the residents’ anxieties. In response, the victims’ associations came together in the collective Plus-Jamais-Ça-Ni-Ici-Ni-Ailleurs [Never-Again-Here-Or-Anywhere-Else], and demanded guarantees from the city authorities. But their energies were focused especially on the painstaking work of rebuilding the social fabric ripped apart by the disaster. Before the explosion, life had not been easy in these districts—unemployment, petty crime, and stories of abuse and violence featured regularly in the local press—but for all that there was a sense of community and solidarity among residents. The explosion of the factory and the destruction it caused, the departure of residents, the uncertain future of the chemical industry zone (with the jobs and businesses it supported), all these factors created further strain on the prospects of the district. To fight for future survival, campaigning groups seized all the tools available to them, and trauma was to prove the most effective.

In the Mirail, said one representative of a victims’ association, “people were experiencing internal explosions again and again, even worse than the property damage. What I mean is that underneath the damage to property, there are all these inner wounds that spring up suddenly and are so difficult to cope with.” The explosion not only reawakened old humiliations and inequities, but made them even more unbearable, giving rise to a sullen anger that carried risks of its own kind of explosion:

¹⁷ Minutes of the Committee for Epidemiological Follow-up, March 30, 2004.

The city authorities love us, but especially when we keep quiet . . . most of all when we keep quiet. . . . Well we don't want to keep quiet, we don't want to because it's . . . I think they don't realise that the social explosion could be huge . . . huge and uncontrolled, uncontrollable. . .

Aware of this danger, which risked destroying the district for good, the organizers of the associations worked day and night to restore a sense of democracy to their neighborhood. Trauma offered them a shared experience with which everyone could identify without a specialist's help. The same organizer added, "People don't go off to shrink on their own steam, they know them all too well"; they have all had prior dealings with psychiatry, and that too "is a traumatic element of the past." Indeed, she continues:

We're asking for compensation in money, something concrete. For people who can't even put words to what's intangible, I think it's important to give them an identity and recognize them as victims, in whatever way. I mean, the word victim has meaning for them. And once you're recognized as a victim, you can grieve for certain things. I'm realizing that the explosion is a way of remedying other things apart from the explosion.

Her words testify to hopes for building a kind of social and political citizenship that would produce results beyond compensation for the accident, giving its victims hopes for a future free of the despair and isolation of the past.

Whereas previously the campaigns of victims' rights associations had always made a point of restricting their action to the specific condition of victim, the survivors' associations worked in the opposite way. They appropriated the motif of the victim and the language of trauma in order to give voice to much older grievances that remained unsettled. The Mirail was the scene of this new collective awakening. The monopoly of the powerful over the management of the consequences of the explosion was countered by the insistence of the poorest on telling their own story, a story that began long before the destruction of the AZF factory. They responded to each mention of a generalized collective trauma by evoking specific aspects of their former circumstances. The language of trauma enabled them to voice inequality.

But beyond the widespread social disparities that were exposed and accentuated by the disaster, two categories of people were affected in a very specific way. These were the in-patients of the mental hospital and the employees of the chemical factory. The former remained invisible, despite the fact that they were, by virtue of their location, among the most affected. The latter were trapped in their dual position as both victims and suspects. Both categories were thus deprived of the social status of

trauma victims or, to put it another way, were excluded from the moral community of victims. They thus demonstrate one of the essential truths of trauma.

The destruction of the Marchand Hospital, which lay close to the site of the explosion, and the hurried redistribution of patients to various neighboring hospitals, in some cases more than two hundred km from their homes, did not generate any particular concern among the people of Toulouse. Immediately after the explosion, large numbers of politicians visited the site of the factory, but none crossed the street to offer support to the patients and staff of the psychiatric hospital, who were nevertheless seriously affected. It was several days before public health minister Bernard Kouchner remedied this injustice and visited the hospital site, but even then his statement was addressed exclusively to the staff. During the meetings of the follow-up committee, the fate of the mental hospital's patients was mentioned only once, during the introductory session, but it was then immediately linked to the fate of the hospital's staff. The epidemiological study did not extend to them either, admittedly to the great regret of the study's scientific director. This exclusion clearly indicates that the mental hospital patients were not considered victims of the disaster: they remained above all mentally ill patients to be catered to by the psychiatric care provisions already in place for them, rather than by the structures set up to care specifically for trauma. In the light of international scientific literature, the logic behind this is somewhat baffling, since the mentally ill are generally recognized as one of the groups most vulnerable to post-traumatic stress.¹⁸ In fact this exclusion does not simply reflect society's traditional tendency to push its "mad" people ever further away, an impulse that is now somewhat outmoded. Nor is it explained by the fact that, since they already had access to specialist care, these patients did not merit exceptional measures and would receive the necessary treatment in the hospitals to which they were transferred, since even in this case they would have had to be recategorized, at least partially, as "trauma victims." The truth of their suffering, which has never been contested, was not recognized because of their double status as patient and victim.

Why were these people categorized solely in relation to their preexisting pathology? As we have shown, the efficacy of the trope of trauma presupposed both the existence of a specific regime of truth and the recognition of trauma as distinct from previous pathology. No longer was the person testifying to trauma regarded with suspicion, but he or she still needed to be rooted in the collective reality of a tragic event in order for their testimony to be credited. This was not the case for mental patients. Not only

¹⁸ Frame and Morrison (2001), Mueser et al. (1998).

did they lack the ability to make use of trauma on their own behalf, but no one considered it necessary to do so in their stead. As the psychiatrists most devoted to their patients' cause admitted afterwards when we interviewed them, the mentally ill truly became an invisible category.

A different scenario was being played out in the devastated factory. From the start AZF employees had the sense of being subject to suspicion, and they feared a general hostility that might lead to the closure of the chemical industry zone and the loss of their jobs.¹⁹ Although they were at the forefront of the event, they did not share, or feared they did not share, the feelings of their immediate neighbors. The creation of the organization Plus-Jamais-Ça-Ni-Ici-Ni-Ailleurs, which directly challenged the future of the industrial zone, redoubled their fears, distancing them still further from the support structures established outside the factory. In any case, in the eyes of the local population, the AZF workers were not victims in the same way as others: they bore some responsibility, and this distanced them from those to whom they were socially closest before the disaster. This first breach in the general unity surrounding the trauma came almost immediately. The fate of the workers was addressed by a number of participants in discussions of the Committee for Epidemiological Follow-Up: the unions argued that it was important to recognize the position of the workers within the collective drama, so that long-term health consequences could be recognized. But while the studies had been able to establish a link between social conditions and health issues, this was, as we have seen, not possible in the case of the AZF workers. Within the factory the same tension was manifested: two inherently contradictory processes operated side by side. On the one hand, psychological support was offered to workers traumatized by the accident, but on the other, the issue of responsibility for the accident within the factory, either of workers or of the management, was never raised. The campaigns which were forming outside of the factory, denouncing the Total group, the world's fourth-largest gas and oil company, and the whole of the industrial zone, offered reason enough to be wary of such questions. For the unions a critical issue was at stake: cohesion within the company must be maintained at all costs in order to preserve jobs. This precluded taking a position that cast the workers as victims of the company.

The factory management therefore engaged a team of psychologists. The unions welcomed this, abandoning their traditional reluctance to engage with psychological support structures—which they generally accused of concealing the social causes of workers' suffering by individualizing their problems. But the union's decision to acknowledge trauma and

¹⁹ The interviews with AZF employees were conducted by Stéphane Latté and reported in detail in our collective research report (Fassin and Rechtman, 2002).

to accept the consequent psychological treatment was radically different from what was happening in the rest of the city. Here, the issue was primarily to ensure that what the workers confided to the psychologists did not come out in public. Recognizing trauma made it possible to recast the workers as victims of the accident, at the same time as excluding them from the general movement for recognition of trauma. During this process the factory presented a united front, despite the tensions and conflicts arising in the new alliance between unions and management; but nothing of these discussions, except the fact that, like the rest of the people of Toulouse, factory employees would be offered psychological care—in-house—filtered through into the public.

Thus, apart from the special cases of the patients at the Marchand mental hospital and the AZF employees, and despite the disparities we have noted, trauma became a commonplace in the social landscape of the city. Although psychologists and psychiatrists were involved from the start, and sometimes contributed to preventing or treating post-traumatic disorders, they were no longer the experts who testified to the reality of trauma. This reality had become a fact that went without saying, but also a shared resource in the quest for reparations.

CONSOLATION AND COMPENSATION

Since the earliest days of traumatic neurosis, compensation had been at the heart of the debate. The early specialists, who were asked to determine the correct amounts, saw compensation as the cause of the illness, and throughout the twentieth century, at least until the 1980s, it was the focus of the suspicion that hung over the victims of trauma. In France during the 1990s, victims' rights campaigns took up the theme of compensation, insisting on it as the legitimate follow-up to injury. Instead of seeing it as the cause of the illness (the quest for secondary gain producing symptoms and preventing recovery), they made it into a cause for the sick (compensation becoming a legitimate demand paving the way for the recognition, and psychic recovery, of victims). Thus, victims were no longer expected to wait for consolatory charity, but rather to demand just compensation. Consolation did not disappear, but it became somewhat secondary to financial reparation, in the sense that compensation brought consolation with it.

But although the right to reparation was now recognized in the collective consciousness and in law, the path towards it remained complex, painful, and strewn with obstacles. The first, and by no means least of these, expert scrutiny, involved the delicate question of imputability. This question was particularly tricky in the assessment of traumatic psycholog-

ical sequelae. If the victim had previously presented psychic disorders or had received prior psychiatric treatment, was it reasonable to impute responsibility for their present disability to the traumatizing event, thus conferring a right to full compensation? Or should the traumatizing event be considered merely to have aggravated preexisting symptoms, thus deserving a lower level of compensation? In the United States the category of PTSD had been forged precisely in order to get around this problem, since it presupposed that the symptoms could be directly imputed to the event. In France, where PTSD was not widely accepted in civilian expert witness circles, the debate over imputability remained heated. Victims' associations were prepared to offer support to all victims on the grounds that the difficulties they would encounter in their quest for compensation were such that an individual, without legal resources and often suffering from inner wounds, could not cope with them alone. Thus expert scrutiny remained a key point, on which all the rest of the process depended. The Guarantee Fund, set up in 1986 following the campaign by SOS Attentats, did provide compensation for all physical and psychological injuries resulting from acts of terrorism. But an accident in which the responsibility of a third party was at issue was a matter for civil law, reactivating the thorny question of imputability.

Thus, after the AZF accident the normal procedure would have been to obtain a court ruling, because the case involved a third party, the Total group, and the plaintiffs were, potentially, the entire population of Toulouse. Such a procedure would involve, in addition to civil litigation, a preliminary battle of expert opinions between insurance companies, in order to determine the responsibility of the Total group. On the initiative of the Department of Justice, a protocol for compensation was agreed between Total, the insurance companies, and the victims, so that the normal procedure could be bypassed. Without such an agreement there was a danger that the city's courts would be completely taken up with this case for years to come, since Total admitted civil responsibility but denied any criminal responsibility. The factory management feared, in effect, that civil court proceedings would imply a symbolic presumption of criminal culpability on the part of Total. The protocol of agreement provided for expert scrutiny of every individual applying for compensation, without the requirement that they first present a medical certificate attesting to genuine injury. In case of disagreement, there was provision for a private second opinion to be obtained, with a new expert examination, again so as to prevent the conflict becoming the subject of litigation. Finally, in order to avoid conflicts of interest, the appointed expert witnesses had to be included in a list of expert witnesses registered with the courts of appeal, thus eliminating those who had connections with insurance companies. Under these arrangements, much more flexible than the usual proce-

cedure for civil expert scrutiny, more than twelve thousand requests were registered, of which only thirty-five hundred were for physical injury. Fewer than three hundred were brought before the courts, where cases were systematically settled by negotiation rather than by a legal decision.

Despite this simplified procedure, the first expert reports were unfavorable to the claimants, as they rarely displayed the classic symptoms of trauma.²⁰ After some discussion, the chief experts agreed to add a category, officially dubbed “specific damage,” that would include in its criteria a variety of psychological signs and take into account as well more general social and economic considerations, such as the life difficulties faced by the claimant since the disaster. The amount to be awarded depended not on the clinical condition of the claimant, but on the cumulative weight of his or her problems. One of the main experts interviewed justified the procedure as follows:

Specific damage could be seen as bodily injury in a way, but it's injury that results in problems with everyday living, and these may be socio-economic in nature. For example, say someone has lost their job, or seen their home destroyed, or their relatives injured because of AZF—the impact of all these events is more or less indirect, outside the range of bodily injury. They may have a socio-economic component, but in all cases they also have psychological effects, which have to be included in the assessment of suffering. So it's a psychological experience and moral suffering related to the socio-economic consequences of the accident. That's why specific damage has a societal aspect, because these people may not have suffered direct physical injury, but they suffered because people they were close to suffered, because their flat was damaged, or because their work situation completely changed. So in this case it's not a question of bodily injury in the narrow sense. It's the devastation of their life. It's bodily injury in a broad sense, if you take the bodily to include changes in the conditions of life.

This extension of the definition made it possible for a large proportion of the population of Toulouse to receive compensation, at least those who agreed to sign the protocol. According to the experts, virtually nobody was ineligible for compensation. Even those who had not been in the city on the day of the explosion could benefit from the principle of specific damage, on grounds of their emotional experience of the accident and its consequences for their everyday life.

²⁰ In the epidemiological study, the occurrence of post-traumatic stress in the zone adjacent to the factory was 9.1% among men and 19.1% among women; in the zone classed as “further away,” the levels were 2.4% among men and 8.1% among women. See Lapierre-Duval et al. (2004).

Virtually everyone benefited under the specific damage provision. The exceptions were the "invisible." The mentally ill were implicitly excluded from the agreement. "It's a huge problem for the mentally ill," one of the experts told us, raising his hands to heaven in a gesture of powerlessness. His feeling was shared by psychiatrists, the most sympathetic of whom even admitted that there was as yet no plan in the works to provide compensation for the mental hospital patients—despite the fact that they had been severely affected by the disaster—although of course the matter would have to be attended to at some point. The employees of the factory fared little better. Trapped by the same contradictions as those which had shut them up in their factory in the first weeks after the accident, they were implicitly excluded from the compensation agreement. Although they could have benefited from it without prejudicing their rights under workers' rights legislation, regulations governing workplace accidents made it nearly impossible for them to sign on to the agreement. As employees, they were covered by the law on workplace accidents and had the right to Social Security benefits. But in order to receive additional compensation equivalent to that awarded to other residents of Toulouse, they had either to sign on to the agreement and claim "specific damage" or make a claim against the factory for criminal negligence. Those who were tempted to take this course found themselves in a difficult position in the company. Accused of putting their personal needs before the collective cause, they were criticized by both management and the unions (united once again in defense of the workplace). In the end only fifty-five employees made a claim against Total at the Social Security tribunal on the grounds of criminal negligence. The legal proceedings were not completed, and eventually the two sides agreed to sign a compromise granting the employees an additional allowance. Ultimately, the factory workers had no more need for individual psychiatric expert reports than did the rest of the population of Toulouse.

. . .

Before beginning our study we had formed the hypothesis that the unanimity with which the idea of a collective trauma had been accepted in almost all social milieux in the city would not withstand the test of compensation. But we have to recognize that, for all the structural and economic reasons we have described, a spirit of consensus overcame resistance to the notion. The only ones excluded from the consensus were the invisible—the mental hospital patients whose trauma went unrecognized—and the unwanted—the factory employees relegated to the domain of non-specific benefits. The reason for this consensus, and consequently for the awarding of compensation to all those who identified

themselves as trauma victims (with no expert verification required) was that the accident had taken on a political and moral dimension based on the collective identity of the victims. The compensation awarded did not by any means silence all the complaints or meet all of the demands of the population, but it helped to ensure that these complaints and demands were heard, including those relating to social inequality. The campaigns inspired by the lay appropriation of trauma also had their influence on the compensation procedure proposed, and particularly on the fine-tuning of it. The concept of specific damage was close to the idea of collective imputability highlighted and actively promoted by the Institute for Health Monitoring. The emotional charge aroused by the metaphor of collective trauma also played a role in the willingness of expert witnesses to award generous compensation for what they themselves called a terrible injustice. Seeing themselves as victims like everyone else, they told us that they considered it their duty to contribute to the collective reconstruction effort after the disaster. Financial compensation did not relieve all the tensions: campaigns continued and matters still remain to be settled with Total, but the social fabric of the poor districts, ripped apart by the explosion, was mended by a successful appeal for city-wide solidarity. By establishing a link between compassion and solidarity, and by allowing suffering to be transformed into action, the language of trauma and reparation played an essential role in building the moral community of victims, with its attendant political implications.

From victimology expertise in the courts to medical and psychological emergency assistance at the scene of disasters, from the attacks in New York to the accident in Toulouse, the history of trauma appears as a series of appropriations and dispossessions, with some people being included, on an unequal basis, and others being excluded. Those who upheld the cause of trauma on behalf of people who suffered without being able to express their suffering publicly were gradually dispossessed of their burden; the more their arguments swayed new audiences, the less need there was for their own efforts. In France, very few psychiatrists joined forces with the victims' movement campaigns for compensation. This is in marked contrast to the situation in the United States, where a powerful psychiatric establishment affirmed the reality of trauma and made common cause with the struggle for civil rights conducted by minority groups and forgotten veterans. However, in both cases trauma came to express an intolerable aspect of human destiny, the significance of which was recognized by the public authorities and formed the basis for actions they took. While the trauma of Vietnam veterans lifted the veil on the war's atrocities, the trauma of civilians today testifies to the horror of terrorism, the unbearable consequences of an accident, the unacceptable aspects of an event. It is not that our contemporaries are no longer able to bear

life's random violence and suffering, but that they have adopted a new vocabulary for describing and understanding it. Thus concern for victims is not simply a "fashion," pejoratively described as "victimization" in the French context. It is rather the sign of a human society that places the issue of suffering at the heart of its common concerns. Trauma has far exceeded the grasp of psychiatrists and their debates about how to define it. It is now a part of everyday language. It has descriptive value, but more importantly prescriptive value, calling for action (clinical, economic and symbolic) and reparation.

PART THREE

The Politics of Testimony

ON MARCH 8, 2002, several hundred psychiatrists and psychologists, mostly French, met at the Maison de la Mutualité in Paris, for the international conference "Trauma: Care and Culture," organized by Médecins sans frontières (Doctors without Borders, MSF). The large auditorium was full, as were the workshops afterwards on topics ranging from "Acute Emergency Care," "Post-emergency Care," and "Chronic Violence" to "Babies, Children, and Adolescents." In addition to the presentations, there were discussions and debates on the "field" experiences of those who worked—in conflict zones or refugee camps, among asylum seekers or rape survivors, in the South but also in the North—to relieve the suffering of women and men affected by the violence of the world. There were accounts from Armenia and Chechnya, from Kosovo and Bosnia, from Sierra Leone and Congo, from Guatemala and El Salvador, even from France. But the major focus was on Palestine, the emblematic test case in the provision of psychological assistance to populations in war situations. The conference of course served to showcase the activities of Médecins sans frontières and its pioneering role in the field of mental health. But beyond this promotional aspect—immediately apparent from the banners announcing the conference and from notes in the conference programs—was a performative gesture that, in retrospect, gave the event its significance.¹ The conference proclaimed itself the baptism of humanitarian psychiatry, and by so doing it brought humanitarian psychiatry into being.

Admittedly, ten years earlier Médecins du monde (Doctors of the World, MDM)² had organized an important conference in Bucharest, entitled "Mental Health, Societies, and Cultures: Towards a Humanitarian

¹ In his famous series of lectures at Harvard in 1955, later published under the title *How to Do Things with Words*, J. L. Austin (1970) uses the term "performative phrase," or simply "performative," to designate utterances that bring into being what they express. One of the examples he gives is that of naming, as applied to ships. "To name the ship is to say (in the appropriate circumstances) the words 'I name, etc.' " In the case of humanitarian psychiatry, it was the conference in its entirety that brought the discipline into being; that is, a meeting of psychiatrists who, within the framework of a humanitarian organization, were talking about what it means practice "humanitarian psychiatry," though they barely used the term. It is worth noting that while there were psychologists present, the speakers at this founding event included only the (medically qualified) psychiatrists, accentuating still further its performative character as the baptismal place of "psychiatric humanitarianism."

² Médecins sans frontières was created in 1971, partially in response to the silence of the Red Cross during the Biafra war two years earlier. Médecins du monde was founded in 1980 by a group of dissidents from Médecins sans frontières at the moment of the crisis of the Vietnamese "boat people." Bernard Kouchner was present at the founding of both organizations. Their budgets are 458 million euros (MSF) and 67 million euros (MDM).

Psychiatry.” For three days, in the international conference center opened by President Ceausescu a few years earlier, eight hundred psychiatrists and psychologists had discussed the psychological effects of the Romanian dictatorship and had highlighted the need to recast concepts of mental health. The conference was initially organized following the discovery of the terrible conditions in care institutions in the country, particularly orphanages, but in response to the large number of international specialists present, particularly from Latin America, had broadened in scope to encompass all expressions of political violence. However, while this was the first time that the words “psychiatry” and “humanitarian” had been linked in this way, the term did not really become established. There was more reference to “social linkage” and “extreme situations” than to “trauma.” This meeting of the two worlds of psychiatry and humanitarianism was not the product of a strategy: it resulted from circumstances and affinities. As a political project it had not yet matured.

It should be pointed out that the phrase “humanitarian psychiatry” was used by hardly any of those involved in the MSF conference at the Maison de la Mutualité. It did not appear anywhere in the text setting out the agenda for the day and presenting the association’s activities in this field; nor was it found in the title of any of the papers given that day. The talk was rather of “mental health,” “psychiatric missions,” and “psychological care programs.” Phrases such as “psychosocial approach,” “psychotherapeutic intervention,” and “assistance to people suffering from trauma” were more common than mentions of “humanitarian psychiatry.” But it was nonetheless in this historic conference hall, where so many political debates had taken place in the last sixty years, that humanitarian psychiatry was effectively named, and in the weeks that followed, the new terminology became established and widely used. The discipline quickly became an academic field, given legitimacy by manuals and teaching. While still unfamiliar at the time of the conference, the term now designated an arena that practitioners were keen to be involved in, a meeting point for newcomers to the humanitarian adventure.

In his presentation at the plenary session, Christian Lachal, the psychiatrist and psychoanalyst who initiated the MSF mission to Palestine at the time of the second Intifada, described humanitarian interventions in mental health and offered a full-blown defense of the practice.³ As he saw it, the aim of such humanitarian interventions was to construct a

³ The text of this paper was published, in modified form, as an article entitled “Setting up a Psychological Care Mission. Why? When? How?” available at <http://www.clinique-transculturelle.org/pdf/textelachal.pdf>. The extracts cited here are taken from that version, except for the reference to *Mother Courage*, which comes from the notes we took at the conference.

“pocket of humanity” in conflict zones, making it possible to “add a psychological and cultural dimension to the moral and political representation of the facts.” This would require a significant shift from the affective to the cognitive:

This means moving from empathy to trauma. Aid workers feel empathy for the people in distress they go to work with. They may say: psychologists are needed to help these people. But we must go beyond this first reaction, which is emotional and will therefore be short-lived. We need to move to a clinical approach, which may or may not be centered on notions of trauma and post-traumatic stress.

In other words, humanitarian psychiatry—and Lachal was the only person to use the term—consists in a process of rationalizing feeling, translating compassion into action, into acts of diagnosis and treatment. The boundary between the emotional and the clinical nevertheless remains porous, as his list of the five aims of these mental health programs suggests:

Comfort, through work with the group or in the community, involving presence, talking, empathy, sometimes prevention; treatment, using methods adapted to the context; training, by shadowing or other, more academic, methods; bearing witness, although the role of psychologists and psychiatrists in testimony is quite limited; and finally, evaluation.

With the exception of evaluation, which as we shall see is the weak point of humanitarian psychiatry (as MSF members themselves recognize), this is a remarkably clear summary of the substance of this discipline, which straddles two domains—that of psychiatry (comfort and treatment, in the tradition of modern psychiatry since the eighteenth century), and that of humanitarianism (training and bearing witness, in a dialectical practice that consists in dispensing knowledge to others while simultaneously making oneself their spokesperson). Lachal’s paper closed with a curious reference to Bertolt Brecht’s *Mother Courage*, in which he saw an unexpected parallel with humanitarian workers: “She lives through war, as we do. And like us, she takes care of her children.” This comparison was tinged with irony, as Lachal surely was not entirely aware. For while deploring the suffering of her children, *Mother Courage* still fears peace, since she knows that her business needs war and its privations in order to prosper.

But let us return to the conference itself. The fact that it was held in a building so charged with history, in a hall where so many debates had taken place, so many causes been championed, surely calls for some reflection. For those aware of what this center for political activism represented, deliberately anachronous juxtapositions come to mind. How

did people talk about the world's conflicts and injustices twenty years ago, when there was as yet no reference to trauma, and psychologists and psychiatrists were not being sent to help people facing crisis situations? What terminology was used for such situations? What interpretations and what solutions were put forward? If we think of Palestine, the period of dictatorships in Latin America, or, longer ago, the period of decolonization in Africa, there were other words, other readings, other methods of resolution that were used. The focus was not so much on trauma as on violence. The talk was of the resistance of fighters rather than the resilience of patients. Those who were being defended were always oppressed, often heroes, never victims. The focus was on understanding not the experience of people suffering, but the nature of social movements. No one thought in terms of psychological care; they campaigned for national liberation movements.

A different politics of testimony has emerged—although even today, the new language has not completely displaced the old. What we are seeing, in effect, is a phenomenon of ideological sedimentation, where one layer is deposited on top of the preceding one, without completely obliterating it. The old language may reemerge, or fusions may occur. This is particularly the case given that many of those involved, particularly the veterans of the humanitarian movement, were left-wing militants in the 1960s and 1970s. They are now using different words, different concepts, different arguments to speak of realities which, if not identical, are at least comparable to those they spoke of then. In this sense, the present-day causes and commitments to the disinherited of the world are set in a different political and moral landscape.⁴ It is this discovery of the previously unacknowledged psychic content of misfortune that we seek to explain.

How are the consequences of the horror of war to be treated when those subjected to it suffer less from visible wounds than from the “wounds of the soul”⁵ left by the experience and spectacle of violence? How can the “silent pain”⁶ of the protagonists of contemporary conflict be brought into the public arena? These are the questions that now face humanitarian workers in the field, as soon as urgent physical needs have been attended to by doctors, surgeons, and anesthetists. The reality of this suffering is of course not new, but the recognition of it certainly is.

⁴ As demonstrated by two political science analyses of new humanitarian activism: Dauvin and Siméant (2002) and Collovald (2003).

⁵ “The Wounds of the Soul” was the title given to a special issue of *Médecins du monde. Le journal destiné aux donateurs* [*Médecins du monde. Donors' Journal*] 56 (1999), devoted to “mental health.” The report focused mainly on Kosovo.

⁶ “Silent Pain Also Needs Care” was the heading of the editorial in *Médecins sans frontières. Medical News* 7, no. 2 (1998), a special issue on psychological care. This journal is aimed at “volunteers in the field.”

And does recognition not make it a little more real? In a report on Kosovo following the NATO air strikes and the return of Albanian refugees to their homes, the situation was described as a "mental health emergency" by humanitarian workers. "Post-traumatic stress is now the major health problem in Kosovo," the director of the Médecins du monde mental health program asserted at this time. Words, images, and testimony support such assertions, bearing witness to the universal nature and the seriousness of psychological distress, which often goes unseen. "You can't go by their smiles," says the nurse, looking at children and adults waving at the MDM organization's car. "They hide unimaginable tragedies." Three photos show a series of images in which a young woman suddenly brings her hand to her mouth in a gesture of distress. The caption reads, "She has just recognized her brother's clothes. He was killed. Doctors are close by to give her psychological support, helping her to put words to her suffering." The violence of the images and their captions cannot fail to strike the reader. A little further on, an extract from an interview with a village woman articulates another tragedy of war and its psychosomatic effects: "I don't have a home any more, and I don't know what has happened to my husband," the woman says quietly. "His body has never been found. Since then, I've had nightmares. I don't eat much. And when I do, I vomit afterwards." We are also told that in this Médecins du monde mission, each patient seen by the organization was asked a series of questions, so that "all those caring for them, even those who are unfamiliar with psychic trauma, are able to identify the symptoms during a physical examination." Suffering can thus be quantified.

These words, images, and studies, then, constitute the mechanisms for identifying, thinking about, and making public the effects of violence within the framework of what is known as humanitarian psychiatry. In order to begin our examination we need to distance ourselves from two habitual assumptions. The first is that this reality may be taken for granted, that it goes without saying that acknowledging trauma and responding to it with psychological measures are the only possible ways of dealing with violence and its effects. On the contrary, we need to show, through a reconstruction of the process, how this viewpoint came to be established over and above other possible perspectives. The second assumption involves a positive evaluation of the action taken by mental health professionals, which leads to their new forms of intervention being seen as progress in treatment methods. We will need to reject this normative view of a question that is still the subject of debate among specialists. In other words, in contrast to what humanitarians do (quite logically) in the pages of donors' journals, we are not asking if what is being said about the psychological impact of events is true or if what is being done about them is beneficial. We are asking a different question: Why are the

effects of disaster and conflict articulated in terms of trauma, and what effect does this new language have on the way in which the experiences and needs of victims of disasters and conflicts are viewed? We are attempting to grasp what it is that has changed with the introduction of psychiatry into the humanitarian arena.

If journalists and volunteers are to be believed, humanitarian intervention carries the dual aim of providing assistance and bearing witness. But whereas assistance to victims is consubstantial with the humanitarian movement (it was the founding principle of the Red Cross), bearing witness is a more recent feature. It was in fact the perceived need to bear witness that brought Médecins sans frontières into existence following the war in Biafra. In the case of humanitarian psychiatry, we shall see that while, like other forms of aid intervention, it is justified on the basis of this dual imperative, actual conditions in the field often limit the possibility of giving material assistance and thus shift the center of gravity towards bearing witness, an activity that adds new dimensions to aid. Our aim here is to show to what extent psychiatry is redefining the politics of testimony in humanitarianism. First we will trace the history of humanitarian psychiatry, examining the conditions and reasons for its emergence after the 1988 Armenian earthquake: Why there, and why at that time? We will next look at the case of Palestine during the second Intifada, the most politically sensitive of situations, and the one where the greatest proportion of resources is concentrated. How is the condition of those for whom humanitarians work represented in the language of psychology? We will need to reconstruct a success story, and we will need to decipher a language.

Humanitarian Psychiatry

ON DECEMBER 7, 1988, northern Armenia was hit by an earthquake, measuring 6.9 on the Richter scale, which virtually destroyed several cities, including Leninakan (now Gumri), the country's second largest city, leaving thirty thousand dead and one hundred and thirty thousand injured. Médecins sans frontières and Médecins du monde were among the international organizations that sent aid to the devastated population, in the form of equipment and personnel—doctors, surgeons, resuscitation specialists, and logistics experts. Dialysis units were set up to deal with acute kidney failure in patients crushed under the rubble. Clinics were opened and mobile teams organized to care for the injured and the sick. Blankets were distributed and shelters built to combat the harsh winter cold. Food was handed out. Returning from a trip to the scene, Xavier Emmanuelli wrote:

All along the darkened streets, in the cold, we passed silhouetted figures walking aimlessly, stunned. The city was enveloped in a freezing, grey mud. And the braziers glowing in the night without hope, the thousands of coffins spread through the streets brought to mind certain medieval engravings. It was like the end of the world.¹

But at the time this picture did not prompt those witnessing it to speak of collective trauma or to try to prevent psychological consequences; nor did it result in the dispatch of mental health specialists to the scene. The scale of the event was enormous, the tragedy all-encompassing, but what was seen were the bodily injuries, not the “wounds of the soul,” as they would be described in later years.

On December 26, 2003, an earthquake measuring 6.3 on the Richter scale hit southern Iran, destroying a large part of the town of Bam and killing more than thirty-five thousand people. Once again, MSF and MDM were quickly on the scene with equipment and teams. But while the mission provided nephrology services, tented clinics, and mobile medical units, and planes were chartered to bring in food and blankets, showers and latrines, drugs and dressings, the main focus of the mission was quite different. As the director of international missions for MDM explained,

¹ “Arménie. Quand tout s’effondre” [Armenia: When everything collapses], online article (October 18, 2004) under “Découvrir MSF—Histoire,” <http://www.msf.fr>.

"In terms of technical operations, we knew that by the time we arrived, forty-eight hours after the quake, there was no hope of rescuing any more survivors. So we focused our work on primary health care and set up a clinical psychological support service for survivors." The field coordinator of the mission gave details:

The unique aspect of our intervention is our empathetic support for the people. The Red Crescent has put in place a very pragmatic quantitative operation, distributing water and bread, for example. We focused on the human approach, with mobile teams of psychologists and psychiatrists ready to listen to the survivors speak of their trauma. It's really good to see people being cared for in both body and soul.

A doctor at the scene added, "A French-Iranian team of psychiatrists and psychologists is helping the children and adults who are most distressed by the tragedy. The first drawings pinned up in the children's tent are of hearts, beautiful houses, and flowers."² Aid workers were now practicing empathy and listening. In their tents, they were not just giving injections, but also opening play spaces supervised by psychologists; they treated infections and injuries, but also diagnosed trauma; mobile clinics held not just emergency kits, but also children's drawings. At a public meeting on the subject of changes in humanitarian activity, held a few months later at the Sorbonne, the director of missions shared his uneasiness with us: his association was now sending psychologists, not doctors, to disaster areas.

Thus, two similar events, separated by fifteen years, gave rise to completely different analyses and responses. Between Leninakan in 1988 and Bam in 2003, humanitarian psychiatry had entered the arena of international aid to disaster-hit populations, and psychological care had become an integral part of intervention. Neither had been present in Armenia. Or rather, it was in the aftermath of that earthquake that mental health care began to appear among the activities of aid organizations, particularly MSF and MDM. We therefore need to return to this seminal event, in order to understand the origins and trace the development of the discipline.

ONE ORIGIN, TWO ACCOUNTS

In the medical literature emergency specialists so frequently refer to the Armenian earthquake of 1988 that it has become a code word for disaster

² "Bam, une ville meurtrie" [Bam, a wounded city] and "Comprendre. L'ouverture d'un dispositif de soutien psychologique" [Understanding: Setting up a psychological support service], *Médecins du Monde. Le journal destiné aux donateurs* 74 (March 2004) pp. 2–7.

second only to the attack on the World Trade Center. There are several reasons for the prominence of this event in the history of trauma.³ Besides its brutal impact and the huge scale of the devastation, two additional elements played decisive roles. The first was political. Coming immediately before the collapse of communism in Eastern Europe, the earthquake was much more than a metaphor for the approaching break-up of the Soviet Union. In practical terms, it gave the West its first opportunity to enter this region, which had hitherto been firmly closed to all outside interference. The humanitarian organizations that had attempted to penetrate the Soviet world to condemn breaches of human rights and the use of psychiatry for repressive purposes now saw an opening through which they could become involved. "It was an earthquake within the earthquake—not just a natural disaster, but also a political upheaval," explained one member of MSF who took part in the mission. The second key element in the high profile of the Armenian earthquake was historical. For the Armenian diaspora throughout the world, the tragedy had a personal aspect. By making their way to the scene, they could show solidarity with the earthquake survivors in a country that was close to their hearts; more, it was a duty owed to a tragic past, the memory of which had been reawakened by the earthquake. "I went because it made me think of the losses the Armenian people suffered in the genocide. As if that wasn't enough, nature was adding her bit," said an Armenian psychiatrist working with MSF. This account suggests a current trauma reactivating an old one. But trauma was not the term used at the time: the talk was of mourning, not trauma. People were thinking not in the psychological language of treatment, but in the anthropological language of recognizing a debt. These two aspects of the event—the political and the historical—account for the massive mobilization of aid from around the world to help Armenia. But they do not explain why, or even how, psychiatry came to take on such a prominent role some months after the earthquake. To understand this, we must turn to those involved and explore the explanations they gave for their actions and the interpretations they put forward.

Let us look at the case of Médecins sans frontières. Marie-Rose Moro, the organizations's director of mental health programs, who only visited the scene some months later, gave her account in an interview:

I remember clearly how the decision was taken. There was the earthquake. The resuscitation specialists, surgeons, and doctors went out to take on the

³ In an article published in *Critical Care*, the major emergency medicine journal, David Crippen (2001), Associate Director of Emergency and Critical Care Medicine at the Pittsburgh University Hospital, stated the parallel explicitly: "Comparing the 1988 earthquake in Armenia . . . with the attack in New York on 11 September 2001 reveals similarities," he wrote, observing these in both the circumstances and the effects of the two events.

emergency work. Quite soon, there was nothing more for the emergency specialists to do, but the tents that were put up to house the injured were still full. People were anxious, bereaved, shattered by the violence of the event, and many of them returned with symptoms. We told them the program was coming to an end, but more and more people were coming for treatment. When they analyzed the demand in more detail, the teams realized that what people really needed was to talk; they were coming back in order to be listened to, comforted, reassured. So there was this sense of giving an account, of voicing, speaking, establishing a link through words. At that point some of the teams said, maybe they should send psychiatrists! The first to go were Armenians, because they obviously felt closest to the event, and it's worth remembering that they offered their help spontaneously, more as Armenians than as psychiatrists. There was a series of missions. At that time it was considered something external to the program: psychiatrists went out, did their work, came back, and others went over.⁴

Thus at this stage psychiatry was secondary, a complement to traditional humanitarian activity, and non-specific, simply offering psychological support. Its role was not defined until some months later: "One day," Moro continues, "the director of operations said, 'Maybe we need to put something more structured in place.' And then they came to me and said, 'You're into psychiatry and anthropology, you should be able to do psychiatry in other places.' And I went without really thinking about it, I saw the proposition as a great opportunity and an honour."

In her written version of this story, Moro recalled the conditions in which psychological symptoms were identified by the MSF mission in more detail:

From the start of the aid missions, doctors' reports remarked on the high level of psychological distress among the survivors. A study by Médecins du monde noted that 70% of children in the disaster zone presented with serious signs of trauma, but the report did not give a detailed description of their symptoms. The psychologists and psychiatrists who were then sent to the area by Médecins sans frontières confirmed these observations. But it quickly became apparent that the treatment they were able to offer on the spot was not adequate. The Armenians called on us to help devise care structures that could offer longer-term treatment to children and their families affected by the earthquake.⁵

⁴ Marie-Rose Moro, interviewed by Christian Lachal and Lisa Ouss-Ryngaert in Lachal (2003) p. 5. The comment made later that she is "into psychiatry and anthropology" refers to the fact that she is a pupil of Tobie Nathan, who founded a radical form of ethnopsychiatry in France in the 1980s. For an analysis of this current, see Fassin (1999).

⁵ "Tremblement de terre en Arménie: le réanimateur et le psychiatre" [Earthquake in Armenia: The resuscitation specialist and the psychiatrist]. *Médecins sans frontières. Medical News* 7, no. 2 (1998), pp. 26–40.

In this account, which has become the official version of the birth of MSF's mental health programs, and by extension, of humanitarian psychiatry as a whole, presents the process as the result of a series of reasoned observations. First comes the observation of the limitations of specialists in somatic emergency treatment: once the dead are buried and the injured treated, they have little to do. Then there is the discovery of the local population's need to speak and be heard. Finally, there is objectification through an epidemiological study and individual missions that testify to the existence of psychological problems.

This rationalist interpretation contrasts markedly with an account of quasi-mystical inspiration from one of the Armenian psychiatrists who went out to the scene:

I remember I was in Normandy, where I was leading a course for the elderly.⁶ In the morning I got a feeling of unease that stayed with me right through the morning. That night, when I went home, I turned on the TV and I saw pictures of the earthquake. I said, that was it. I'd never felt sick in that way before in my life. As soon as I saw the pictures, if I'd had wings, I would have gone straight there. I contacted SOS Arménie and Médecins sans frontières, not really in my capacity as a psychiatrist, but as an Armenian, because there was no way I could stay here when I knew my place was there.

At the scene, his activity was given meaning by a very personal experience. The coordinator of the on-site team also remembers something like a turning point in the course of the mission, which the Armenian psychiatrist recalled in visionary style:

At the time I was motivated more by my own history, what my people had lived through, than by my psychiatric thinking. One day a physiotherapist came to see me. She said, "Listen, I've got a little boy with a hyperflexed wrist who's had his thumb amputated. I'm supposed to do rehab with him. But the moment I touch him, he yells." I went into the hospital room where the kid lay. I asked him his name. He said, "Ardagh." That was the name of an Armenian prince who sacrificed his life for Christian Armenia in 461. As soon as he said the name, I saw my ancestors facing the Persians, I saw that first war of resistance where a people said no to the superpower of the time, I saw the dead bodies, the sickness, the mutilations as an enemy army that was attacking us, and this little boy as a victim. But he could also be the hero. I said to him, "You've got muscles of steel in your arm, and that's because with this arm, just like Ardagh threw the enemy out of Armenia, you're going to throw out everything the

⁶ Interview with an Armenian psychiatrist conducted and transcribed by Estelle d'Halluin on February 13, 2002. A longer version appears in our report (Fassin and Rechtman 2002, pp. 120–123).

earthquake did to your body. But for that, you need the physiotherapist, you need her help.” And from that point on, he allowed her to massage his arm.

Identification with a national hero appeared to have vanquished the child’s resistance. After this first contact, the psychiatrist came every day to monitor his young patient’s progress.

One day, he continued, I said to him, “I don’t understand why you always walk on two feet and one hand.” Everybody was so focused on the problem with his wrist that no one had paid any attention to the fact that he walked that way. When I asked him, it was as if I was waking him up from something. He answered, “I was with my grandfather when I felt the house moving. He said, ‘Ardagh, run!’ I said to him, ‘What about you?’ And he said again, ‘Ardagh, run!’ I ran and the house collapsed.” I had the sense that the earthquake was inscribed in his body: he had become totally still. Then, in a flash of inspiration, I said, “Ardagh, come here.” I took him in my arms and said to him, “Remember the war? Now, the enemy is the ceiling that’s falling down. You’re not alone, I’m with you.” I don’t know what took hold of me, but I took him by the shoulder and stood him up. It was as if he was my son. As if I had given him life. Events overtake you. You see unimaginable things happening before your eyes. After that, it was like a miracle. Not in the religious sense. But a few days later I came back to the hospital, and I was told that the night nurse wanted to see me urgently. I went up there. She asked what I’d done to Ardagh. I explained. She said, “You know, since the earthquake, he’s never even closed his eyes. After you saw him, that was the first night he slept.” It was as if all his suffering had been resolved at once.

This narrative reads almost like a catharsis. The past reemerges in the present, the earthquake reanimates the epic, the history of a people is incarnated in the paralysis of a child—and speech liberates the patient from trauma. Although the Armenian doctor dismisses the suggestion of religious connotations, his instruction to the paralyzed child, “Ardagh, come here,” clearly echoes “Lazarus, take up thy bed and walk” in the Gospels. The psychiatrist’s emotional reaction is a Christ-like experience of transcendence.

These two accounts—the objective analysis by the French director of mental health services and the subjective remembering of the Armenian doctor—seem to be stark opposites of one another. But on the basis of factors we identified in documents and interviews with MSF and MDM workers, it is possible to recognize a link between the rationalism of one and the mysticism of the other. So what were the beginnings of humanitarian psychiatry, as far as they can be reconstructed?

Let us look first at Médecins du monde, which sent emergency aid in the days following the disaster. An MDM administrator of Armenian origin, aware of observations of psychological distress that were being reported back from the mission, appealed to a friend who was a member of the Institute of Psychosomatic Medicine in Paris, and together they organized an exploratory mission.⁷ The Armenian psychoanalysts and psychiatrists sent over by MDM carried out an evaluation that rated subjects according to the results of a free-ranging interview or, for children, a series of drawings. The study revealed that about 40% of people in the disaster zone were suffering from trauma neurosis, and 60% from post-traumatic depression; by comparison, the levels were respectively 30% and 10% in the regions not directly affected by the earthquake.⁸ On the basis of this study it was decided to roll out a long-term mission (planned to last three years) strongly structured around the work of Armenian and French psychoanalysts,⁹ and including the creation of networks of Lacanian psychoanalysts in Armenia.

At the same time, Médecins sans frontières was replacing its emergency aid missions with resources to care for chronic conditions, such as renal dialysis machines and orthopedic equipment (the latter in partnership with Handicap International, which also had personnel in Armenia). MSF's team was a large one, comprising up to sixty people, about twenty

⁷ The School of Psychosomatic Medicine was founded in 1962 by Pierre Marty. It was inspired by the work of psychoanalysts such as Groddeck and Ferenczi, but above all by F. M. Alexander, the founder of psychosomatic medicine in the United States. A clinic was set up in Paris in 1968, and in 1972 this became the Institute of Psychosomatic Medicine. Staff there included a psychoanalyst of Armenian origin, who was to become the linchpin of the first mission. See the special issue "Etats traumatiques, états somatiques" [Traumatic states, somatic states] of the *Revue Française de Psychosomatique* 2 (July 1992), particularly Diran Donabédian's article "Note à propos des effets du traumatisme chez l'enfant à l'occasion du tremblement de terre en Arménie" [Note on the effects of trauma in children following the Armenian earthquake].

⁸ These figures may be compared to the statistics produced on the basis of systematic clinical examinations carried out eighteen months after the earthquake by a group of researchers from the Trauma Psychiatry Program at the University of California in Los Angeles (UCLA), in collaboration with the Armenia Relief Society Clinics in Gumri. Using rating scales, they observed 50% suffering from post-traumatic stress, 28% from depressive disorders, and 26% from anxiety. Goenjian et al. (2000).

⁹ The European School of Psychoanalysis played an important role in setting up a network of Lacanian-influenced psychoanalysts between France and Armenia, following the MDM mission to Leninakan and its surrounding area. It culminated in the opening of a psychological rehabilitation center in Yerevan, the creation of a French-Armenian Association for Psychoanalysis Research and Inquiry in 1993, and the organizing of the Institute of the Freudian Field's first seminar in Armenia in 1996. See "Moments d'histoire entre la France et l'Arménie" [Historic moments between France and Armenia], <http://www.nls-cfap.com/historique>.

of whom were of Armenian origin. All of them experienced both profound distress and highs of elation.¹⁰ The few psychiatrists present had come as medical doctors, rather than on the basis of their mental health qualifications (which no one considered to be of any use at that time). When the on-site team coordinator asked MSF's head office in Paris to send psychologists and psychiatrists, the medical director initially refused.¹¹ It was only after a battle of wills, and by stressing the prevalence of psychological disorders, that the team leader managed to get the head office to send over a psychiatrist of Armenian origin, then a French psychologist who gave up her holidays to set up a counseling unit, and finally a permanent team. Clearly the sequence of events was not quite as straightforward as suggested by Marie-Rose Moro, the director of humanitarian psychiatry programs; but it was also more down to earth than the Armenian psychiatrist's account. Both of their stories contribute elements of the whole, however.

Thus there are two distinct origins. *Médecins du monde* came together with a psychoanalytic institution, and this led rapidly to the establishment of a mission, followed by a mental health program, through the impetus of "French-Armenians," as one MDM human resources administrator put it. But *Médecins sans frontières* had few professionals with the relevant skills, and this explains the relative delay in that organization's sending out psychologists and psychiatrists; their eventual deployment was the result of "a chance encounter," in the words of the mission director, referring specifically to the case of young Ardagh, which had touched her deeply. In other words, for MDM mental health was a more central element in the initial intervention; for MSF it was more circumstantial. However, in both organizations, professionals of Armenian descent played a decisive role in recognizing psychological problems, which were not yet described as traumatic. From this point on, the involvement of psychiatrists and psychologists in aid missions gained increasing legitimacy. We will turn now to the question of why psychiatry and humanitarianism first came together in Armenia, and why it occurred at that particular moment.

¹⁰ In an interview we did with her in September 2001, the on-site coordinator of the program recalled, "It was MSF's first international mission. There were people from the Netherlands, Belgium, Spain, France. We really did amazing things. We organized holiday camps with skiing for child amputees. We imported Swiss chalets to make survivors' centers. There were projects on a grand scale and enormous enthusiasm. Head office in Paris just let us do what we wanted."

¹¹ In the interview he gave us in October 2001, he clarified: "When the first request came in from the field, I remember refusing it. Or rather, I asked them to back it up. The mission coordinator argued, 'These people are suffering, it's no good just getting them to make collages, we need to give them psychological treatment.' But we had never worked in mental health. We had no experience, except for two MSF psychiatrists who had undertaken a

IN THE BEGINNING WAS HUMANITARIANISM

Into the social arena of disaster and conflict, humanitarian psychiatry introduced new definitions and new descriptions, new players and new structures. It opened up the possibility of seeing and naming, diagnosing and treating the suffering brought about by tragedies such as the Leninakan earthquake and, subsequently, a whole series of other events, including war, exile, massacres, and forced displacement. In as far as it is reasonable to assume that the psychological disorders following these events existed before they were recognized as such by psychologists and psychiatrists, it could be said that humanitarian psychiatry was a social innovation. It created new questions about old problems. As we shall see later, the reformulation of questions transformed the problems in return, but we should begin by asking what made this possible.

The issue is not an idle one. In an interview shortly before his death, Stanislas Tomkiewicz, a psychiatrist who survived the concentration camps and spent most of his life trying to understand and treat people who had suffered extreme violence, asserted that in 1963—soon after the Evian agreement which acknowledged Algerian independence and brought about the release of twelve hundred Algerians being held prisoner in France—he, together with “a group of young doctor friends from the Algerian National Liberation Front (FLN), ‘invented’ psychological care for victims of persecution.” According to Tomkiewicz, this constituted a first attempt at what later came to be called “humanitarian psychiatry,” and, he added, referring to the “informal psychotherapy” offered in France ten years later to people who had been tortured under the dictatorships in Chile, Argentina, and Uruguay, “‘humanitarian psychiatry’ as a concept really emerged with the events in Latin America.”¹² Here were two milestones, neither of which was recognized at the time. The history of scientific advances is littered with similar episodes, where a discovery only gains meaning, and sometimes a name, much later, once theoretical underpinnings are in place that bolster its legitimacy.¹³ Here, however, the problem is different, and the period between this “discovery” of humanitarian psychiatry and its naming was not due to a period of scientific gestation. We do not propose to examine whether what Tomkiewicz refers

more or less clandestine mission to the Soviet Union a couple of years earlier to gather information on dissidents in psychiatric hospitals.”

¹² See the preface, in the form of an autobiographical testimony, that he wrote for the volume edited by Lachal, Ouss-Ryngaert, and Moro (2003). Speaking of his regrets, he says, “If I could have my life over again, I would have done more of what you call humanitarian psychiatry.”

¹³ Canguilhem (1977).

to was really humanitarian psychiatry, whether it can be invented without being named (as in the case of care for Algerian prisoners), or whether it is enough to name it in order to invent it (as in the treatment offered to Latin Americans). We shall confine ourselves to observing that what everyone now concurs in calling “humanitarian psychiatry”¹⁴ was not constructed on the basis of these early efforts (or others, equally edifying, such as the care offered to Cambodian refugees by French psychiatrists in the early 1980s). It is a different history that we have to recount here—one that begins not with the prisoners persecuted during the Algerian war, nor with the victims of the dictatorships in Latin America, any more than it began with the survivors of the Nazi concentration camps. It was in the ruined cities of northern Armenia, among the survivors of the 1988 earthquake, that humanitarian psychiatry was born.

Allow us to digress for a moment. The 1995 earthquake in Kobe, which left 5,500 dead and 320,000 injured, was the greatest disaster to hit Japan since the Second World War. The expression used to describe psychological care for trauma victims after the quake was a neologism: *kokoro no kea*. Literally translated it means “care for the heart.” However, Joshua Breslau, who studied the use of the term in this context, remarks that “*kokoro*” has broader significance than simply the notion of heart. It incorporates ideas of intention, emotion, thought, and ultimately of subjectivity, as opposed to “*seishin*,” which represents the spirit and psyche more specifically and is a root of the word that translates as psychiatry. Thus, a less technical term than that used by doctors was coined to mark that place in a person where the experience of the disaster is imprinted. A renowned Japanese psychiatrist who was open to international trends in his discipline took over the term by assimilating it to “PTSD”; then, a North American public health specialist introduced a Japanese version of the rating scale used for the syndrome. According to these authors, *kokoro no kea* and PTSD were one and the same: the first term could be translated by the second and was thus subject to the evaluation tools and treatment techniques tested in North American psychiatric institutions. Close examination might suggest that, whatever its effects at the therapeutic level, this intervention by the two specialists resulted in an artificial reduction of two distinct concepts, one moral and the other medical, into a single notion, with the latter in some sense absorbing the former. But a finer discernment is needed in analyzing the history of humanitarian psychiatry. In Armenia it was concern for the other, a characteristic of the humanitarian ethos, that came first—not the diagnostic category, which belonged to psychiatric practice.

¹⁴ As can be confirmed by an internet search using the keywords “humanitarian psychiatry” (18,000 results on Google, May 3, 2005).

This statement can be applied more generally. In a classical analytical perspective, an innovation can be seen as a fortuitous meeting between new configurations of knowledge, action, and society. Knowledge offers tools for understanding reality. Action allows the tools to be applied. Society can be more or less welcoming to new elements of knowledge and action. Thus with regard to humanitarian psychiatry, which really took off in 1989, it is tempting to suggest that, in chronological order, the identification of post-traumatic stress at the beginning of the 1980s first offered a new tool (designated PTSD in DSM-III), that the Armenian earthquake then furnished the opportunity for psychiatrists to use this new diagnostic category (with its range of treatments, primary among them debriefing), and finally that favorable attitudes toward humanitarian causes provided receptive social conditions (both in the area of the disaster and in the countries supplying aid). However, this logical linear progression does not quite reflect the realities. All interviews with psychiatrists and psychologists working in aid during this period confirm that they did not make use of the concept of trauma or of its various incarnations as set forth by the North American mental health establishment. In fact, for the most part, they were unaware of these notions. When they had trained in departments of medicine or human sciences, the concept of trauma was not even taught, except for combat shock which merited only brief mention (and was hardly relevant to students not planning to enter military psychiatry, which in any case followed a different curriculum).

In this regard, the initiator of psychiatric programs at MSF is absolutely explicit: "I didn't go over to treat trauma. I went to treat psychological suffering resulting from violent events, what in France we called reactive pathology. I had no thought of PTSD. I hadn't any particular knowledge of it, and I hadn't tried to put it together as a diagnosis. When I went to Armenia I was unaware of the literature on the subject." Even the Armenian psychiatrists were not using this diagnosis, she recalls: "They belonged to the French school, where there was no particular emphasis on the category of trauma. Our intervention wasn't based on that diagnosis. All the links to it were made after the fact, but they're of no historical value since we weren't thinking along those lines at all." In fact it was only with the first mission to Palestine that trauma as such became a concern for MSF, first among Palestinian psychiatrists, who made extensive use of this diagnosis, and then among French specialists in military psychiatry, who had published widely on the subject: "We invited Crocq to come out specially, asked him to refine aspects of the diagnosis and contribute his direct experience of these problems." One of the pioneers of psychiatry in MDM echoed this account: "Before 1996 I had never heard of psychic trauma. It was during the first war in Chechnya that we began to work with it." She even remembered specifically the first time

she received training about this condition, in a hospital in the south of France where she was working at the time. It was Crocq, once again, who was coordinating the establishment of the French emergency aid network: "Crocq came to give a workshop on the pathology of disasters when the emergency clinical psychology units were set up in our region." In other words, for both MSF and MDM, the category of trauma appeared on the aid scene some time after volunteer psychiatrists had already entered the field, and it simply served to support their intuitions and legitimize their actions. The victimologists who had been working in military psychiatry were the vehicles of this retrospective recognition, but when MSF and MDM workers encountered them, the trauma concept was already spreading rapidly along the international psychiatric grape vine and was finding wide acceptance. The victimologists merely speeded what was an inevitable encounter with the concept.

Thus it was the ideal of moral commitment—loyalty to the "spirit of the 'French doctors,'" as one of the founders of MDM put it—rather than any appeal to professional reasoning or to the validity of the DSM, that drove the psychiatrists in these two organizations to act. For many, it was an abrupt awakening to a particularly dramatic and shocking situation somewhere in the world that prompted them to contact the aid organization they worked with, whether it was Romania and its orphanages, or the war crimes of Bosnia and Kosovo. The same sense of outrage drove them to take part in future missions—in Chechnya after the second Russian invasion, in Palestine during the second Intifada. We detect a parallel with the Armenian psychiatrists who maintained that they had gone not as psychiatrists (and indeed, they were working as general practitioners), but as Armenians, called by their ancestral homeland.

In this sense, it could be said that humanitarian psychiatry belongs more to the humanitarian epic than to the history of psychiatry.¹⁵ Moreover, it became much more solidly established as a field among aid organizations (we need only note the recent proliferation of mental health missions throughout the world, and the increasing number of expatriate psychologists) than within the discipline of psychiatry. In academic psychiatry it had only a marginal presence (as a part of the curriculum for a diploma in transcultural psychiatry), and all those who practiced it did

¹⁵ In his apologia for this new practice, Christian Lachal (2003, p. 33), writes: "Humanitarian psychiatry is a branch of humanitarian medicine. Humanitarian medicine naturally finds its place in the field of humanitarian aid, and psychiatry its own place within the domain of humanitarian medicine." He adds, "Humanitarian psychiatry is a branch of psychiatry. We can speak of humanitarian psychiatry just as we speak of infant psychiatry. In both cases, these are specific fields of psychiatry which developed gradually." Of these two definitions, the first seems a more accurate description of an empirically observed reality than the second.

so alongside a public or private practice completely separate from their international activity. Humanitarian psychiatry was much more a practice of psychiatrists engaging in humanitarian activity that gave added meaning to their work,¹⁶ than it was the work of specialists in what would later be dubbed humanitarian psychiatry (in contrast to military psychiatry). Moreover, the first steps in humanitarian psychiatry involved much improvisation and experimentation, do-it-yourself methods combined with inventiveness. The director of mental health at Médecins du monde recalls, "We weren't afraid of anything. At our first meeting we were all ready to set up 'Psychiatries du monde.' At the time we joked about it. Now things have turned around a bit, as they have in society also. Twenty years ago, if I said to someone, 'You need to go and see a psychiatrist,' they would have been offended. Now they take it as sensible advice." And indeed, members of both organizations testify to the initial reticence of the newly arrived psychiatrists. The head of mental health at Médecins sans frontières told us:

I got a call from the director of programs. She said to me, "What are we going to do? We've never sent psychiatrists before. We don't know how to manage them in the field. We don't know how they're going to work with the others. Wouldn't it be a good idea for you to go on an exploratory mission?" I said, "Why me?" Her answer made me laugh: "For the first trial with psychiatrists, it's better if it's someone who won't frighten the medical workers." I don't know if that's a compliment for a psychiatrist.

But within a few years, psychiatrists found their place. This was partly because they were also medically qualified. In this they had a marked advantage over psychologists. A psychologist remembers how, during the 1970s, her intuitions had met with a rebuff from the aid organization she now works with:

I'd contacted them to say that while there would be medical needs to tend to, there were also psychological needs. For me it was obvious that psychologists had their place within humanitarian medicine. I was told that this was a medical organization and that only doctors, nurses, and logistics experts were taken on as volunteers. But I could make a donation if I liked. And I did!

This ambivalent relationship between doctors and psychologists was already apparent in the prehistory of humanitarian psychiatry. And it persists. In field teams today the directors of mental health programs are

¹⁶ Véronique Nahoum-Grappe (1996, p. 266), writes: "The use of psychiatry in the contemporary humanitarian aid program derives from the impossibility for everyone, including medical aid workers, of facing the totality of horrific events which they witness as they are happening."

psychiatrists, and those who implement them are psychologists. While the former will go out on one- or two-week visits once or twice a year, the latter generally stay in the field for between six months and a year, sometimes longer. Underlying this distinction are issues of credibility (the higher status of the medical doctor), but also, incidentally, of employment opportunities (the large number of psychologists on the job market). Thus we should remember that despite what the term “humanitarian psychiatry” suggests, it is practiced mainly by psychologists.

We see then that the introduction of mental health care into aid work did not derive as we had thought from a scientific advance (the recognition of trauma as a valid medical diagnosis) that opened a new field of knowledge. Rather it was an ethical shift that was responsible, the recognition of a new locus of engagement (suffering as a moral category). At the 1992 conference on “Mental Health, Societies, and Cultures: Towards a Humanitarian Psychiatry” in Bucharest, the director of mental health programs at MDM recalls that there was virtually no mention of trauma: “It was more focused on all the extreme situations—war, disasters, poverty, refugees—all the things that result in strain, rupture, or distortion of the social fabric, and thus cause psychic suffering.” MDM’s publicity campaigns took up this idea a few years after Armenia, with the slogan “We also treat invisible wounds.” Or, as the title of an article in a *Médecins sans frontières* publication put it, “Silent Pain Also Needs Care.”¹⁷ The fact that the focus was on “suffering” rather than “trauma” (in both clinical practice and public relations), and that the word most often used by those involved to explain what motivates them is “empathy,” clearly indicates that we are in the realm of humanitarianism rather than the pure psychiatry of trauma: “Treating psychological wounds means first of all putting the unspeakable, the ordeals, and horrors that people have undergone, into words,” writes Béatrice Stambul in *Médecins du monde’s* journal.¹⁸ Making a link between violence inflicted on the body and the violation of human rights is intrinsic to the humanitarian project. Here it is extended to the deepest, and thus least visible, traces of tragic events:

¹⁷ The article formed the introduction to the *Medical News* special issue on psychology: *Médecins sans frontières. Medical News* 7, no. 2 (1998), p. 2. In her interview with us, the director of mental health programs at MSF acknowledged, “Around 1994, Médecins du Monde mounted a huge campaign which basically said, ‘We take care of the suffering that can’t be seen.’ And that was humanitarian psychiatry, psychological suffering. At MSF we recognized how apt that wording was: ‘They’ve put their finger on it.’ We were almost irked that we hadn’t thought it up ourselves. We thought they’d created a very discreet but really well made campaign. And I remember huge posters in the metro with black-and-white photos, nothing flashy. It was beautiful. It was aesthetic. It wasn’t miserabilist. It was really well done. We said, ‘They’ve got it.’ ”

¹⁸ P. Stambul, “Pas de santé sans justice” [No health without justice]. *Médecins du Monde. Le journal destiné aux donateurs* 56 (1999) p. 7.

"Therapeutic work extends to and includes compensation, which involves recognizing psychological suffering on an equal basis with any physical disorder." Thus humanitarian psychiatry derives from the recognition of psychological suffering rather than from the identification of mental illness; it manifests as a stirring of empathy rather than a call for clinical evaluation.

According to Jan Goldstein, "console and classify" are the two founding principles of modern psychiatry, from the end of the eighteenth century on. The first of these grows out of a religious tradition, the second from a scientific process.¹⁹ Humanitarian psychiatry placed much more emphasis on consolation, and showed comparatively less interest in classification. It was an ethical practice, at the service of victims, before it became a medical discipline presupposing a diagnosis. Trauma was not the reason for intervening: at most it justified the intervention in retrospect, albeit with a degree of reticence on the part of many psychiatrists who disputed the frequency of post-traumatic stress disorder. It is clear that we need to reverse the accepted chronology: in the beginning was humanitarianism.

ON THE MARGINS OF WAR

While the devastating tragedies of earthquakes—from Armenia in 1988 to Turkey in 1999 and Iran in 2003—punctuate the history of humanitarian psychiatry, it was war zones that soon became the heart of the practice. This is a crucial shift. On the scene of earthquakes, disaster was anonymous: suffering was caused by the forces of nature, and there was no need to take sides. In war zones, on the other hand, the issue of partiality immediately raised its head. Here suffering is caused by human violence—and it is rare for the two sides to be treated equally. Both in international opinion and among aid organizations, there is a perception of the attacker and the attacked, of oppressors and the oppressed. Once it was the Soviet army and the Afghan people, Iraqis and Kurds, Ethiopians and Eritreans. More recently it was Russians and Chechens, Serbs and Croats, Bosnians, or Kosovars. In other words, conflicts call for moral evaluation as much as for political analysis. What is judged good and what is judged evil generally depends on shared public opinion within the world to which aid organizations belong. The Russian persecution of the Chechen people,

¹⁹ Although in her book *Console and Classify* she emphasizes her divergence from Foucault's *History of Madness*, by highlighting these two elements, Goldstein paradoxically engages with the material of both *Omnes et Singulatim* ("console") and *The Birth of the Clinic* ("classify").

following on the Soviet invasion of Afghan territory, was widely condemned in the West, despite the Realpolitik that prevailed in government circles. Successive waves of Serbian violence against the Croats, Bosnians, and Kosovars were denounced and then countered with varying degrees of commitment by Western powers, and ultimately became the subject of legal proceedings within the framework of a recently established international justice system. It is relatively easy to intervene on one side while proclaiming neutrality. We are on the side of the victims, say the humanitarians.²⁰ Politics be damned, this is about ethics.

But this apparently clear distinction can become blurred—or at least be exposed for what it is, a politically contextualized moral evaluation—when disagreements arise within the humanitarian movement. This is uncommon, since usually those involved share not only the same moral values, but also the same political perspective. In opposing the Russian government in Chechnya, the Indonesian government in East Timor, the Sudanese government in Darfur, humanitarian morality comes together with international law and, above and beyond this, with a sense of injustice that is widely shared in the West. Matters were not so simple in the former Yugoslavia. When NATO forces were used against the Serbs in 1999, MSF and MDM, like many other organizations, set up camps and clinics for Kosovars fleeing the bombardment. Later, when the air strikes were over and the return of the Kosovars had been organized, they continued to support them, principally in the area of mental health care. But during the conflict the Greek section of MSF, which took the view that Serb civilians were equally victims of this violence, decided to organize an exploratory mission to Belgrade, despite opposition from other national sectors within the organization. This initiative reflected the fact that in Greece the moral evaluation of the situation in Kosovo was based on different political premises, linked to ancient affinities with the Serbian people. This mission resulted in the expulsion of the Greek sector from the international movement—something that had never happened before in the history of MSF.²¹ Over and above the shock wave sent out by this unprecedented sanction, the discord revealed a more general aspect of work in a war zone: there might be different ideas about who the victims

²⁰ Rony Brauman (2000, p.65), in reference to the debates that spread throughout the humanitarian movement as the Vietnamese fled communist repression in 1979 (a debate that formed the background to the split in Médecins sans frontières in 1980), writes: "Victims, all victims, deserve a fraternal hand, extended irrespective of ideological differences."

²¹ The international MSF movement was not the only organization that refused to accept the politics of the Greek section. The director of mental health programs at MDM remarked, "We had some problems with the Greeks. It was the Orthodox connection. They went to the aid of the Serbian victims of the NATO air strikes; they didn't recognize the concerns of the Kosovars."

were. Moreover, this split made it clear that absolute neutrality was impossible, and that humanitarians were always implicitly taking sides. As we shall see, the Israeli-Palestinian conflict took this dilemma to its most extreme.

There is, however, nothing surprising in the fact that war has become the preeminent locus of operations for humanitarian psychiatry. It was, after all, on the battlefield that humanitarian organizations (from the Red Cross to Médecins sans frontières) did their first work, and it was on the battlefield that military psychiatrists had their first clinical experiences of trauma. In France, specialists like Claude Barrois, François Lebigot, Guy Briole, and particularly Louis Crocq, all professors of psychiatry at the Val-de-Grâce military hospital in Paris, could be found in conflict zones long before humanitarian mental health specialists arrived.²² As we have seen, these clinicians were the descendants of a long line of military psychiatrists who had been identifying, classifying, treating, and publishing on cases (long grouped under the title "traumatic neurosis") since the First World War, and who had extensive experience of soldiers returning from the front. In discovering war zones and their victims, humanitarian psychiatry was unwittingly reconnecting with an already well-established tradition, as those involved realized only later. But it was based on different premises: it focused not on combatants, but on civilians. It highlighted empathy rather than clinical criteria. More than simply treating, it also bore witness. In these three aspects, humanitarian psychiatry was writing a completely new page of history, distinct from that on which military psychiatry had been set down for nearly a century. It was only later, and coincidentally, that it came into actual contact with military psychiatry, through exchanges with military doctors such as General Crocq, who had ties with MSF and MDM. For military psychiatry, trauma was primarily a diagnostic category that led the way to clinical treatment. For humanitarian psychiatry, it was first and foremost a lived reality that offered a window onto an experience of suffering. It is this experience that we must now attempt to delineate.

After Armenia, where it first emerged, it was in the Balkans during the 1990s that humanitarian psychiatry began to evolve. In the interim there had been Romania, with its prison-like orphanages and decrepit nursing homes where disabled children and mentally ill patients stagnated in squalid conditions—an important revelation, particularly for Médecins

²² See in particular their monographs, which all bear remarkably similar titles: *Les Névroses traumatiques* [Traumatic neuroses] (Barrois 1988), *Le Traumatisme psychologique* [Psychological trauma] (Briole, Lebigot, Lafont et al. 1993), *Les Traumatismes psychiques* [Psychic traumas] (De Clercq, Lebigot 2001), and *Les Traumatismes psychiques de guerre* [Psychic traumas in war] (Crocq 1999).

du monde, which ran programs in the country. But the context here was the psychological consequences of chronic destitution, rather than a traumatic event. It was the exceptionally violent break-up of the former Yugoslavia that turned humanitarian psychiatry into a wartime clinical practice. In Croatia, then in Bosnia, and above all in Kosovo, a practice at least, if not a politics, was being defined. The language and tools of a new speciality were coming into being. People began to refer more and more to trauma, or even PTSD; charts and scales were beginning to be used to recognize the signs. But the move towards full recognition of this diagnostic category and its language was nevertheless a gradual one.

Consider for example the report on MSF's first mental health project relating to the conflict in the former Yugoslavia. The project took place in France, starting in November 1992, and it involved sixty Bosnian Muslim civilians who had been liberated from the Serbian camps in Bosnia-Herzegovina and were being housed in a Sonacotra²³ hostel in the Saint-Etienne region. The report gave a detailed description of the psychological consequences of their detention experience. But the "clinical practice of trauma" presented in the report mentions virtually none of the symptoms used as criteria for post-traumatic stress disorder. The report speaks of "loss of habitual points of reference underpinning identity," "destruction of subjects' capacity to anticipate," "difficulties in adjusting to physical, psychological, and behavioral changes caused by deprivation, maltreatment, and torture." In an explicit reference to French ethnopsychiatry, there is mention of "the loss of the habitual cultural context, supports that underpin the group, and language and social rhythms." It is only at the end of the list of symptoms that reference is made to "the painful entrapment of refugees in a cyclic time that brings back the faces of torturers as well as the cherished images of family, soiled, humiliated, and profaned"²⁴—a phraseology far from the standard formulae of DSM. The vocabulary is still largely that of traditional psychology, although for the first time mention is made of a "PTSD questionnaire," albeit one which is used "flexibly and adaptively."

Thus, the words and the tools existed, but relatively few as yet subscribed to the ideas they represented. The vocabulary and the syntax were being established, less in order to treat Bosnian survivors (since the scope for humanitarian volunteers to offer therapy was limited by the fact that patients were supposed to be treated by licensed psychiatrists) than to

²³ Sonacotra (National Society for the Construction of Housing for Workers), the main French organization providing accommodation for immigrant laborers.

²⁴ See the article by Yves Gozlan and Pierre Salignon (1995), who set up this project and later worked with other Bosnian former detainees in a transit camp in the former Yugoslavia.

put together documentation of the atrocities committed by the Serbian military (in order to understand better the realities of ethnic cleansing). "The task of the team leading the study was not to offer medical treatment," note Gozlan and Salignon. "The reports drawn up at this time were meant to be included among the working documents of the Investigation and Prosecution Committee of the International Criminal Court." "Study," "report," "commission"—the focus is first and foremost on evidence gathering, a process that is deemed to have a therapeutic function of its own: "Where trauma had broken links, we encouraged construction, where trauma had resulted in devastation, we encouraged putting it into words." This first experiment—protected to some extent by the French environment in which it took place, more comfortable than the camps and centers where the team was later to work in the former Yugoslavia—nevertheless fed into subsequent developments in humanitarian psychiatry. Médecins du monde was seeing the same process of evolution, as the director of its mental health programs suggests: "In Croatia and Bosnia, we had psychiatric teams working around reconstruction and reparation." The main project was the Duga Center, set up for "children traumatized by the conflict." Hence, in this context, where the effects of the conflict on the psyche were all the more marked because ethnic cleansing and concentration camps reawakened the spectre of Europe's darkest days, days that everyone thought were safely behind them—the 1990s were a period of apprenticeship in war for humanitarian psychiatry (although interventions at the scene of natural disasters also continued). The decade ended with a final jolt that definitively established the discipline.

In Kosovo, humanitarian psychiatrists and psychologists had been working in the field since the start of the conflict. They were thus in a position to treat trauma at the very moment when it arose, without waiting for the long-term effects to emerge. This is emphasized by what MDM's director of mental health programs told us: "In Kosovo, we arrived before the event. There's all this debate about the issue of humanitarian monitoring of situations. You have to acknowledge that if there ever was a war that could have been predicted in advance, this was it." The team on site, in what was then still the Federal Republic of Yugoslavia, left Kosovo hurriedly the day before the NATO air strikes began. As soon as the processions of families fleeing the violence, or more frequently driven out of their homes, arrived at the border, teams were ready to intervene in Macedonia, Albania, and later in Montenegro. Everyone saw the implementation of mental health programs as a priority. "It wasn't a random decision," the director continues. "It was really [she hesitates] . . . everything happened in this way that [she hesitates]. . . . Tens of thousands of people were arriving in dribs and drabs, with the wild eyes of people who have just seen their homes burned, their livestock slaughtered

before their eyes. We heard terrible tales of torture, brutality, executions.” In such conditions psychiatrists and psychologists felt themselves useful, and they were perceived as useful by their fellow volunteers. As the MDM director admitted in our interview, “It’s true that there were really simple things that had amazing results. Talking in groups helped people feel calmer. We could identify those who were developing a full-scale trauma neurosis and those who were simply traumatized, who could be helped by talking. We did debriefing. There was a lot of psychological intervention.”

The intervention began in the camps, and ended with major support for the reconstruction of the country’s mental health services.²⁵ In the interim, MDM learned a great deal about the timing of trauma. For the first time, humanitarian psychiatrists and psychologists were intervening not in the aftermath of the event, when people were beginning to show symptoms, but almost simultaneously with the event. Today they describe themselves as having practiced the then unnamed technique of “emergency psychiatry.” According to an MDM psychiatrist, this was also the first time that a clinical evaluation tool was systematically used to identify patients who required further treatment. This was the “Crocq scale,” which had been adapted for humanitarian use during a mission to Chechnya.

Médecins sans frontières had also set up mental health programs among refugees in the three countries bordering Kosovo, complementing their traditional medical aid programs. But most of the organization’s energies during the period of the NATO air strikes were focused on chronicling the violence suffered by Kosovars. What interested them was not so much trauma as what produced it—events rather than their consequences. They therefore produced a report combining epidemiological data with narrative accounts that confirmed the existence of a Serbian deportation policy. The publicity generated by this report helped to legitimize NATO’s military operation.²⁶ Once the refugees had returned to their homes, a program was set up to train teachers to lead support groups and doctors to conduct psychological interviews. The French psychiatrists working in Kosovo, who were not particularly keen on the DSM’s evaluation tools, which they found “too based in North American practice,”

²⁵ However, reports from MSF focused on “the wounds of the soul,” notably in the special issue of MSF’s journal for donors, which bears this title and is almost exclusively devoted to trauma: “The Wounds of the Soul,” *Médecins du Monde. Le journal destiné aux donateurs* 56 (1999).

²⁶ Significantly, the document *Kosovo: Accounts of a Deportation*—which made the front page of French daily *Libération* on April 30, 1999, under the headline “Kosovo. L’enquête des humanitaires” [Kosovo: The humanitarian study]—contains no psychological data testifying to the Serbian government’s “crimes against humanity.” Trauma features neither in the statistical study nor in the narratives included. It had not yet found its place in testimony.

relied more on their "clinical experience" and offered, among other things, home visits for people suspected of being at risk of disorders. However, specializing in trauma was limiting and often frustrating, given the many forms of mental disability they confronted. One psychologist explains as follows:

The most difficult thing for me was seeing people where you realized that actually they weren't traumatized, they had been ill for a long time. We were meeting people who needed an enormous amount of help, and we weren't there for that. We had to say to them, "I'm sorry, but we can't treat your child."

This experience was shared by all the aid organizations. Above and beyond trauma, everyday mental illness gradually emerged as the major problem, aggravated by the shock of war, interruptions in treatment, and the break-up of the health services—but these disorders were outside the realm of humanitarian psychiatry, and it was time for the volunteers to return home. The emergency was over.

THE FRONTIERS OF HUMANITY

Croatia, Bosnia, Kosovo—but also Armenia after the conflict with Azerbaijan, Chechnya during the second Russian invasion, and Palestine during the second Intifada. A geography of humanitarian psychiatry was gradually being drawn and the map revealed a cruel gap: the African continent. The 1990s were a decade of particularly bloody wars in Africa, from Sierra Leone to Sudan, from Liberia to Congo, peaking with the Tutsi genocide in Rwanda in 1994, which took place under the very eyes not only of the international community (from the UN on down), but also of aid organizations which were present but powerless to intervene. Foremost among them were Médecins sans frontières and Médecins du monde. For many of those who lived through the days of terror in Kigali, when several hundred local aid workers employed by these organizations were massacred, when those who risked going out into the streets of the capital were presented with the spectacle of piles of brutally mutilated corpses, when the wounded who managed to reach the hospital were caught and killed there, when Hutu soldiers did everything they could to block treatment of the wounded, this mission was certainly the harshest ordeal they had ever faced.²⁷ When an uneasy peace was restored, the

²⁷ The most poignant testimony in this regard is that of René Caraviehe, a member of the MSF team in Kigali, entitled *Ou tout ou rien. Le journal d'un logisticien* [Either all or nothing: A logistician's journal] and self-published by the author. He recounts how the first of the wounded were received: "In my career as an aid worker I've seen mutilated bodies, but never anything like this." He also quotes from a letter from one of his colleagues:

almost unimaginable scale of the psychological consequences, wrought by the brutal extermination of almost a million people, paralyzed the mental health specialists. And this despite the fact that at this time, in other parts of the world, they were using treatment methods more and more centered on trauma. It was not until 1996 that the first MDM program was set up, and even that was at the initiative of a public health specialist rather than a psychiatrist. Médecins sans frontières, which had been expelled from Rwanda after the organization condemned a massacre in a refugee camp, showed a similar reticence, although in 1996 its Belgian section organized a series of meetings on the issue of psychological support. How can this delay, even reticence to undertake work that was being done with fervent conviction at the very borders of Europe be explained? The question is difficult to ask. The answers are even more complex, and they also prove to be extremely painful.

Michel Dechambre, a child psychiatrist, recorded his reflections upon his return from an exploratory mission to Rwanda he undertook for MSF in 1995 to evaluate the appropriateness of a mental health program. His case against sending the mission, which he stated with remarkable honesty, may help to explain the attitude of psychiatrists at the time.²⁸ It was based on five arguments. First, the number of potential victims was far beyond the capacities of mental health specialists: "We were not talking about individuals—dozens, hundreds, or even thousands. There were tens of thousands of children wounded to the core of their heart, sensitivity, and memory." Second, the kind of intervention needed was the opposite of what the aid organization was designed to accomplish. They "put out, through a high-level media campaign and outspoken statements, an image of efficiency, rapidity, and rigor," but what was required in Rwanda was "an extended, lasting intervention, making use of the few local structures still in existence." Third, the very nature of the trauma made any psychological approach extremely delicate. This was not a natural disaster or even a war between two countries. As the survivors themselves put it, "We were forced to kill each other because we were persuaded to do it,

"Rwanda was not my first mission or my last, but in the space of twenty-two hours it made me a traumatized man who, out of pride, carried that pain for six years before I went to a psychotherapist." The therapist who had diagnosed him with "PTSD, or cumulative stress," took his own life shortly afterwards.

²⁸ These observations are reported in a brief article by Dechambre, "Bilan d'un échec. Mission exploratoire au Rwanda (Avril 1995)" [Account of a failure. Exploratory mission to Rwanda (April 1995)], *Médecins sans frontières, Medical News* 7, no. 2 (1998), pp. 64–66. Bernard Doray (2000, p. 124), who was involved in setting up a National Trauma Center in Kigali with the support of UNICEF in 1995, is equally clear, if less brutal: "On the one hand, there were no Rwandans able to treat the trauma of the survivors, and on the other, foreigners who came to Rwanda could not establish delicate relationships with traumatized people whose language and culture they did not share."

we who had been brothers," with the result that many of them now had the sense of belonging to a nation of "wild beasts." Fourth, the prospects for peace were not yet certain, so it was too early to embark on self-examination, which required "reestablishing a sense of security on the emotional as well as the material level." Finally, relations between expatriates and local people remained too strained to sustain therapy that assumes "trust between the therapist and this despair." Significantly, according to Dechambre, the only action that seemed not only possible but also necessary was "offering a listening ear to the emotional experience" of the expatriate workers, so that they could recount the ordeals they had witnessed and their own experience of them.

As so often when a large number of obstacles are cited, the real underlying reason may be found by reading between the lines. It seems clear that this was the case here. The thread that runs through Dechambre's five arguments is an attempt at justification that conceals a weakness deeper than any of those explicitly listed; namely, the awareness of a difference that is presented as insurmountable. This difference is first and foremost cultural, even geopolitical. "Western media coverage" presented the Rwandans as "monsters." Aid workers were described as "Westerners" who were poorly prepared to operate among them. Ultimately it was "impossible to offer them real support on a Western basis." But this difference soon came to be expressed in racial terms: "I discovered that a white person could have difficulties in understanding a 'black consciousness,' 'black' revelations, and a 'black truth' that is not ours." It is unusual to hear the issue expressed in this way, but it articulates a deep truth of humanitarian psychiatry.

In order that the different parties involved may recognize the reality of the traumas, anthropological otherness first has to be eliminated. It has to be possible to imagine the other, the victim of violence, as another self, with the same psychic structure and capable of the same reactions to the event and the same suffering of the loss. But he or she must also be credited with a trust for the person offering a listening ear. By accepting the support offered, the victim gives a sign that a level of intimacy is possible, sufficient to allow the sharing of confidences. Here it appears that these two conditions were not met. Western aid workers saw the Rwandans as fundamentally different—by virtue of their color, their history, and their numbers—and unwilling to open themselves to Westerners who would not understand them and might even betray them. This radical otherness was rarely explicitly stated, but it was everywhere apparent. In January 2000, a team from MSF sent to Sierra Leone stated the need for a mental health program for victims of the country's civil war. After long discussion, the project was abandoned. "One argument that was often put forward," explains psychiatrist Christian Lachal (who sees the argument as

unfounded), “was doubt as to the possibility of constructing a program of psychological care among a population whose traditions and system of thought were so different from ours.”²⁹ In March 2001, an MSF program director expressed surprise that no major mental health projects had yet been implemented in Africa. “You’d think that only Europeans could benefit from mental health care. But I really want to show that it’s also needed in Africa.”³⁰

This difficulty in establishing mental health programs on the African continent (where cultural differences were thought to be too great) is paradoxical, given that those who introduced humanitarian psychiatry into MSF also promoted ethnopsychiatry in France, a discipline that by definition is based on acknowledging these differences. When we put this to the coordinator of mental health programs, she recalled the failure of a number of exploratory missions in Africa—in Rwanda and Sierra Leone, and also in Mozambique: “I think there are different reasons, which are related to the particular situations, but maybe there is also something structural.” In other words, cultural. But the place we really need to look for this “something” is not in the culture of others, but in the culture of humanitarianism. As the nurse who served as coordinator of the MSF team in Armenia explained to us, in an interview conducted ten years after the earthquake that occasioned the first steps in humanitarian psychiatry, “We don’t have mental health programs in the refugee camps in Africa. We should. But everyone thinks that it’s too complicated—that it’s cultural.” Attempting to explain what happened in Armenia, she said, “There was something magical there. So many things that were communicated just through eye contact. It was as if they were European. I’ve worked a lot in Africa, and it was the first time I worked in a country where the people were so like to us.” This similarity which she so frankly evokes is actually ontological: it is what allows people to be included in

²⁹ See the article cited above, “Mettre en place une mission de soins psychologiques. Pourquoi? Quand? Comment?” [“Setting up a psychological care mission: Why? When? How?”], available at <http://www.clinique-transculturelle.org/pdf/lachal.pdf>. While Lachal maintains that the “ambient culture” must be taken into account and that it may even be necessary to resort to “transcultural psychiatry,” he focuses particularly on war itself as culture, and asks, “What is more difficult to imagine, the way child soldiers are created using psychological conditioning techniques that are often extremely modern, or the way children are treated in purification ceremonies which represent traditional forms of therapy?”

³⁰ At the MSF board of directors’ meeting on December 22, 2000, where Marie-Rose Moro, the coordinator of mental health programs, gave a public presentation, one of the directors remarked, “I am surprised there hasn’t been a program in Africa.” Moro replied, “So am I, I have long been troubled by this gap, but I think we’re responding not only to the needs of people, but also to how far it is possible to integrate this aspect of care into MSF teams.”

the same circle of humanity. And Africans have long been relegated to the margins of this circle.

It would be wrong to see our statement as polemical. On the contrary, it articulates a reality of the field, problematic for those involved, and one of which they are often aware but rarely able to name. Humanitarians act in the name of humanity, in the sense both of a species (all human beings) and of a value (a form of concrete humanism). And so, when the language of trauma is used to describe and to testify to extreme violence, our sense of exposing forms of inhumanity is reinforced, and this raises ontological dilemmas. These questions are of course raised by all war situations, but the brutality³¹ of recent conflicts in Africa renders them acutely pressing today. Yet in the field the ubiquitous reference to trauma to describe the horror of these wars has not been translated into concrete programs that could help alleviate the consequences. Why should such inhumanity distance us from African subjects more than European subjects? We may find an explanation in the history of the radicalization of the otherness of Africa, as Achille Mbembe points out:

The theoretical and practical recognition of the body and flesh of "the stranger" as flesh and body just like mine, the idea of a common human nature, a humanity shared with others, long posed, and still poses, a problem for Western consciousness. But it is in Africa that the notion of "absolute otherness" has been taken farthest.³²

When it comes to trauma, the otherness of the body and flesh extends to the soul and psyche, as the reluctance of aid organizations to engage in caring for these aspects of the person in Africa indicates. In other words, the ontological difference which those involved identify is also (at a less philosophical level, we might say) an anthropological difference. The issue has not gone unnoticed by psychiatrists and psychologists themselves, who express disappointment that, owing to pressing medical needs, only minimal resources were available for psychological treatment in the only African MSF program that included mental health care: the project designed to help women who had been raped during the civil war in Congo in 2000. Prescribing antiretroviral drugs to prevent AIDS among the women took precedence over post-trauma counseling, they bitterly comment; and the lone Congolese psychologist on the program

³¹ The expression used by German historian George Mosse, whose book *Fallen Soldiers: Reshaping the Memory of the World Wars* (1990) was highly successful in France. Thus the term we have transposed to Africa was coined to designate a violence historically situated in Europe.

³² *On the Postcolony* (2001). Mbembe adds, "Whether in everyday discourse or in ostensibly scholarly narratives, the continent is the very figure of 'the strange.' It is similar to that inaccessible 'Other with a capital O' evoked by Jacques Lacan."

staff received support from an expatriate psychiatrist only for a short period, with the result that in total only fifty women were seen.³³ Nevertheless, in the conclusion of a report on the project, the team members expressed satisfaction with their initiative: "This approach to men and women in terrible situations can only be adopted in the name of a precise ethics, which does not constitute a new humanism, but is contained in the terms 'console, care and testify.'" ³⁴ In Congo, albeit under difficult and limiting conditions, Africans were included in this moral community, which they thus shared with the humanitarian workers, for the first time. This very belated step forward reveals the dimensions of the gap between values defended and actions taken, between the abstract humanity championed by humanitarianism and the individual human beings that humanitarians come into contact with. Significantly, it was the recognition of trauma as a universal experience that made this development possible.

How are the three principles of this new ethics (console, care, and testify) put into practice? And what is the place of trauma within it? In order to answer these questions, we shall now examine the most emblematic—if not the most typical—project of humanitarian psychiatry: Palestine.

³³ The difficulty and delay in implementing a first program of psychological care in Africa are admittedly particular to the history of MSF, but Rémy Lomet's article (in the report *Du lien au soin* [From link to care], pp. 44–55, <http://www.medecinsdumonde.org>) describes a very similar experience at Médecins du monde, albeit in less stark terms: "After the 'events,' for various reasons, primarily the murder of 'intellectuals,' the number of 'Rwandan psychs' could be counted on the fingers of one hand; the language and culture barrier made direct intervention by expatriate 'psychs' unrealistic."

³⁴ Asensi, Moro, and N'Gaba (2001).

Palestine

THE DAYS FOLLOWING Ariel Sharon's September 28, 2000 visit to the site in Jerusalem that Palestinians know as the Noble Sanctuary saw the beginning of the second Intifada, also known as the al-Aqsa Intifada. Médecins sans frontières and Médecins du monde had little difficulty in establishing a footing on the ground. They had already been in the area for a number of years, working primarily in mental health care. Humanitarian psychiatry was, consequently, the principal field of activity for both organizations. Médecins sans frontières set up its first project in Palestine in 1988, and six years later developed its first mental health program in the Jenin refugee camp, following the Washington peace agreement that put an end to the six-year first Intifada. The project involved working in partnership with a local team to set up a psychological care unit for people deemed traumatized by the years of conflict. After three years the unit was closed, but other projects were established, working among ex-detainees coming out of Israeli prisons, and with mothers whose children were suffering from malnutrition in Hebron. Médecins du monde had been present in the Palestinian territories since 1995, providing medical treatment programs. In 1998, MDM began to extend its activities into mental health care, working in collaboration with a Palestinian NGO to set up a project among young drug users (in East Jerusalem) and running short training courses for local health professionals to raise awareness of psychological problems (in the West Bank). In other words, some, albeit limited, experience of intervention around trauma had already been gained, a degree of knowledge of the context had been built up, and institutional links had been established with local groups. However, the second Intifada was to see a complete reorientation of the activities of both organizations.

Their first response to the resumption of open conflict between Israelis and Palestinians, with its toll of dead and wounded (mainly inhabitants of the Palestinian territories), was to return to their traditional modes of action. What was needed, it was assumed, were surgeons, anesthetists, and doctors to support Palestinian teams. But exploratory missions showed that this was not the case. There were plenty of skilled Palestinian professionals, and the hospitals were well equipped, said the humanitarian workers: in other words, traditional health needs were already cov-

ered. At a MSF board of directors' meeting on October 27, 2000, one of the board members reported:

I've just come back from Palestine, where I hadn't been for four years. Things have changed a lot, in terms of surgical work we don't have much to do, because the Palestinians are now very well equipped and organized. But we need to be there in case the situation deteriorates. There's such frustration and despair among the Palestinian people!

In fact there had already been discussions with two MSF psychiatrists, resulting in a decision to build up the mental health program, as the Paris coordinator of the Palestine program explained. Three days later, a team consisting of a psychiatrist and a psychologist arrived in the Gaza Strip. The two specialists returned to France with clinical observations made in two Palestinian families (where they noted "post-traumatic stress") and with specific proposals for a project involving a "mobile clinic system."¹ A few months later the director of Middle East programs came to the same conclusion: "In the Palestinian territories they've got a well-equipped hospital system with skilled staff. You can't bring any added value. In countries where there's a well-developed health care system, the last sector to be addressed is mental health." The aid mission therefore also ought to be focused—almost exclusively—in this domain, more particularly around the issue of "psychotrauma," as he termed it.

However, the point in time at which humanitarian psychiatry arrived on the scene was new—it was no longer some time after the violent event, but almost immediately afterwards. In the former Yugoslavia and even in Ingushetia, several weeks or months had usually elapsed between the events of war and the psychologists' intervention (although in Kosovo this time had been shortened); they were therefore operating in the more or less usual clinical conditions in which PTSD is identified. But in Gaza and the West Bank, mental health specialists were on the spot just a few hours after the destruction of a house, the death of a child, the shooting of civilians, the bombing of a district. There had not yet been time for PTSD to arise. This was an unconventional situation, although there were some recently reported instances of similar experiences in clinical practice with "acute stress," as well as in the history of "trench psychiatry."² As MSF's director of mental health programs put it:

¹ See the report by Karine Pillerte and Christian Lachal, *Mission exploratoire de santé mentale à Gaza Strip* [Exploratory mental health mission to the Gaza Strip] MSF, October 30–November 1, 2000. The authors write: "There is a double trauma, with a reactivation of traumatic events they have experienced in the past, either at a very young age, during the first Intifada or, more generally, during periods of tension."

² According to an MSF psychiatrist who went out to Palestine and gave us an interview, "Military doctors are familiar with acute stress and know how to treat it. The three basic principles are: immediate treatment, on-the-spot treatment, and (questionably) returning

Up to that point, we always intervened after the emergency was over, because we usually let the doctors and surgeons go in first, and the zone also had to be made safe before we could treat psychological suffering that had not disappeared spontaneously. But later, a number of US and UK studies demonstrated the importance of early intervention, before clinical symptoms arise and a post-traumatic disorder has become established. So we could envisage being at the front line, where events were actually happening.

In contrast to the situation we noted in earlier missions, starting with Armenia, it seems in this case that the need for psychiatric clinical intervention was the initial justification for humanitarian action. But this shift from "after" to "before" had repercussions beyond the clinical. From now on psychiatrists would work squarely in the middle of humanitarian missions. They, too, would venture to the front lines to work with the wounded, rather than remaining behind the lines, in both time and space.

One persistent question remained. What was their reason for "being there"? The answer given by MDM's director of Middle East programs was as follows: "To put it in high-flown terms, one of our founding principles is 'to treat and bear witness.' And it's true that psychic wounds are more easily adapted to the mode of bearing witness. The proliferation of mental health operations is probably not unrelated to that." Given the conditions on the ground in the more troubled areas where there is no possibility of implementing normal treatment procedures, it is easy to understand why the focus shifts from treating to bearing witness. In the work carried out in Palestine, the "added value" of humanitarian psychiatry is probably manifested more in testimony than in care. Or rather, the significance of the intervention rests entirely in showing solidarity in two very distinct ways: at the local level, demonstrating a concern for individuals encountered; at the international level, bearing witness to the conflict in the public arena. As one member of the MSF team in Gaza said, "From the strictly medical point of view, our visits are more a show of solidarity and a sort of limited ad hoc psychotherapy than a response to urgent need." This is put even more clearly by the directors of the program, who emphasize the "complex interrelation between bearing witness and medical intervention," the former as justified in its own right as the latter:

This is field testimony, factual, fed by daily contact between doctors, psychologists, and families. In the face of their suffering, our responsibility is to describe the effects of war on them. Our task is simply to recount what we witness in the Palestinian territories. On the therapeutic level, this is particularly important for families.

the soldier to combat. Military psychiatrists work practically at the front line. We're not military doctors, but we've retained the first two of these principles."

Thus bearing witness becomes the ultimate *raison d'être* of humanitarian intervention as a political gesture—and as a clinical act.

THE NEED TO TESTIFY

The medical humanitarian movement was born on the battlefield of Solferino in 1859, out of the spectacle of wounded men dying without medical care. The first era of humanitarianism was personified by Henri Dunant, who, in 1863, founded the International Committee for Relief to the Wounded (renamed the International Committee of the Red Cross in 1875). It was an era characterized by care for the victims of war, initially soldiers, and later civilians as well. Throughout the twentieth century the movement faced obstacles and had to make compromises—particularly in the Soviet Union and above all in Nazi Germany. Negotiation was preferred to condemnation, for the sake of maintaining access to victims everywhere, under all regimes. During the war in Biafra, a group of French doctors employed by the Red Cross became outraged by the organization's secret bargaining for the right to bring aid, and they decided to set up the Committee Against the Genocide in Biafra. It was a split over exactly this issue, the issue of bearing witness, that led to the second era of humanitarianism, which was spearheaded by Bernard Kouchner and took institutional form in *Médecins sans frontières* in 1971 and *Médecins du monde* in 1980.

"To act and to speak, to treat and to bear witness, these were to be their watchwords," writes Rony Brauman, who also shows that from the outset the attempt to combine these two activities was not without its contradictions.³ *Médecins sans frontières'* charter vows "strict neutrality and impartiality," which is hard to reconcile with the denunciation of crimes and their perpetrators. At the organization's 2001 General Assembly, the issue of whether it was appropriate to retain the term "neutrality," when it bore little relation to actual practice, provoked a major debate. Even today, the greatest tensions in MSF center around maintaining a balance between its two aims. Not only can bearing witness (often brought center stage in major disasters) be counterproductive, jeopardizing the continued provision of care (as occurred when MSF was expelled

³ In fact, as Rony Brauman rightly notes (2000, pp. 55–56), this was the era of speaking out against the ills of the world, but it polarized around two paradigms, the "third-worldists" and the "sans-frontiéristes." The former favored long-term projects to influence collective behavior and public criticism of an international order they saw as reproducing, in rejuvenated form, the structures of colonial domination; the latter favored short-term action limited to alleviating individual suffering, combined with media campaigns to raise public awareness of distress in faraway countries.

from in Ethiopia in 1985), but, on a more insidious and mundane level, speech can become a substitute for action (a risk frequently highlighted and denounced by successive presidents of the organization). The increasingly frequent use of the term "first-aid workers," a voluntarily modest and restricted term, to refer to MSF's members serves to recall the historical origins of humanitarianism. Similarly, public recognition of affinities with the Red Cross demonstrates a return to the founding principles of the movement, and this is one of the major paradoxes of this development. Médecins du monde, which emerged from a disagreement within MSF centered around Bernard Kouchner, who championed the *droit d'ingérence* (right to interfere), has always seemed readier to combine bearing witness with the provision of care. But whatever the problems, variations, and divergences that characterize bearing witness, it remains the most characteristic feature of the second era of humanitarianism.

Of course, this feature is set within a historical context that goes beyond the sphere of humanitarianism. Contemporary societies have now entered the "era of the witness."⁴ By this expression, Annette Wieviorka means the enormous amount of eyewitness testimony from Nazi camp survivors that is preserved, in particular in recordings stored in the Fortunoff Archive (Yale University) and in the Spielberg Jewish Film and Video Archive (an offshoot of the director's film *Schindler's List*)—in other words, on the accounts of the victims themselves, and sometimes of their persecutors. But in this second era of humanitarianism, the figure of the witness is being radically transformed. In the testimony produced by humanitarian organizations, the voice that is generally heard is not that of the victims, but that of their self-appointed spokespeople.⁵ In other words, Médecins sans frontières and Médecins du monde replace the first-hand witness, who speaks of his or her direct experience, with second-hand testimony by parties who report what they have seen and heard. They were of course at the scene with the victims who confided in them, and for whom the fact that there were people prepared to speak on their behalf was no doubt important, but this kind of testimony is not without its shortcomings. On the one hand, the witnesses have only partial knowledge of the experience (the part they have grasped from a conversation usually lasting no more than a few minutes, held under difficult conditions, and which in any case was prejudiced by what the victims felt they should say, given what they knew of humanitarian organizations). On the other hand, these surrogate

⁴ See her book *The Era of the Witness* (2006). She cites Nathan Beyrak, director of the Israeli satellite of the Fortunoff Archive, who states the aims of the project as follows: "To rescue the individual out of the mass number—intimacy as a central concept of oral history." This is the function of humanitarian testimony as well.

⁵ For a discussion of the humanitarian witness as compared to the survivor witness, see Fassin (2008a).

witnesses only make public the parts they think make sense (in terms of the general idea they have both of the local situation and of their own mission). These problems are common to all proxy testimony, but they are complicated by conditions of emergency and danger, and by the moral stance that is characteristic of humanitarian intervention in war zones. Moreover, as Dominique Mehl has shown, the media, particularly television, have forged a strong relationship with their audience around suffering and misfortune, in which a “protocol of compassion” (on the part of the broadcasters) interacts with a “surge of compassion” (on the part of the receivers).⁶ Mehl’s observations of the way the intimate has been opened to public view can be extrapolated to humanitarian action and its work of bearing witness, where use of the media means simplifying causes and above all giving them emotional color. The Biafran crisis was the starting point: television acted as intermediary, showing starving children and presenters pleading for aid, the huge geographical and cultural distance between the two artificially eliminated. Through the image on the screen, faraway victims came close to hand. Reducing a complex political reality to a purely emotional plea was the price that had to be paid in order to galvanize public opinion.⁷ But this focus on end results is also humanitarianism’s great strength. If we view the last quarter century of humanitarian intervention in Palestine from these two perspectives, that of the strengthening of the figure of the witness and that of the popularization of humanitarian causes through media attention, it becomes clear that testimony was more central to humanitarian work in Palestine than traditional medical assistance. And this for at least two reasons.

The first of these is the sentiment behind the commitment of the two organizations, or rather of the individuals within them. It was indignation, more even than compassion, that prompted them to go to Palestine. The Israeli army’s occupation of the Palestinian territories, illegal under international law, the imbalance of power between the teenage stone-throwers and soldiers firing real bullets, the systematic destruction of homes and uprooting of olive trees, the daily humiliation of the population at military checkpoints, the indiscriminate killing of combatants and civilians, adults and children, men and women, and finally the feeling of powerlessness among those opposed to this program of oppression—all

⁶ Mehl 1996, *La Télévision de l'intimité* [The television of intimacy]. Her analysis focuses mainly on the emergence of the phenomenon of individuals speaking in public about their private lives. But it is clear that the practice of generating emotion through testimony applies more widely.

⁷ On the role of the media in humanitarian crisis, see Jonathan Benthall (1993, p. 3). Benthall is interested in “the harrowing details of actual human suffering,” but also “in how they are refracted by modern marketing techniques, broadcasting politics, the cultural styles of national humanitarian movements.”

these factors awoke a sense of injustice among humanitarians in many parts of the world. Indignation was intensified by the fact that power seemed to be so unequally distributed between the occupier and the occupied, the aggressors and the victims—and unalterably so. In addition, the high media profile of the Intifada gave a sense of closeness, which facilitated identification with the protagonists on both sides. There is probably no theater of war that has ever been subject to so much international public attention for such a long period. Indeed the second Intifada marks the culmination of a half-century long process that took place within the history of the Middle East, but was also bound up tightly with Europe's past. From this point of view, the death of little Mohammed el-Doura, killed alongside his father in the middle of the street on October 4, 2000, marks if not a turning point, at least an episode that is vividly emblematic of this spectacle of violence.⁸ The indignation felt by humanitarians found much more of an outlet in the denunciation of the situation than in the provision of treatment. "Our patients voice the hope that we will bear witness to what we see and hear. Clearly, the Palestinians feel abandoned and forgotten. They ask, 'Do people where you live really know what we're going through?'" wrote a member of MSF in the field journal of the psychomedical team in Gaza, on November 26, 2000.

The second reason for the central role taken by testimony is the supposed absence of any need for the activity which had comprised and legitimized humanitarian action since its inception more than a century earlier: aid to the wounded. In Palestine there were relatively few wounded, and they benefited from efficient local health services backed up by established links with the Arab countries of the region for severe cases. Neither surgery nor medical treatment was in short supply. The only need that remained was for bearing witness.⁹ The phrase "we have to be there," which is probably the slogan most often heard among humanitarian organizations, is given its full two-fold meaning here, for the task is to "be there"

⁸ All the more because the spectacle of this "living death," broadcast throughout the world, also had real political impact since, in the last attempt to restart negotiations between Yasser Arafat and Ehud Barak in Paris in early October 2000, Barak had accused French president Jacques Chirac of allowing himself to be influenced by the images and even of contributing to the failure of the meeting: "You cannot base policy on television programs," he said, the following day. See the editorial in *Le Monde* headlined "Une erreur diplomatique" [A Diplomatic Error], October 8, 2000.

⁹ This duty to bear witness can be felt by other kinds of field workers, particularly anthropologists. In her book on infant mortality in Brazil, Nancy Scheper-Hughes (1992, p. xii) argues, "The act of witnessing is what lends our work its moral (at times its almost theological) character. So-called participant observation has a way of drawing the ethnographer into spaces of human life where she or he might really prefer not to go at all and once there doesn't know how to go about getting out except through writing, which draws others there as well, making them party to the act of witnessing."

both in order to speak of what one is witnessing and to demonstrate one's solidarity. In the "Reflections on Humanitarianism" posted on its Web site, MSF offers this explanation for its work: "When the impact of medical action is limited by the contradictory effects of the violence suffered by the population, and humanitarian aid contributes to masking this violence, or worse, reinforcing the power of the aggressors, MSF members raise public awareness of the distress they are witnessing or of breaches of international conventions on the protection of persons, and thus give an account of their own actions."

So the mission is to bear witness. But to what? Humanitarian organizations must be able to define the boundaries of what their members may and should say. And these boundaries should be determined less by the risk of being sent back to one's own country, as Pascal Dauvin and Johanna Siméant argue,¹⁰ than by the efficacy of one's message. The measure of this efficacy is one's legitimate right to speak on a given topic. Humanitarians are not the only visitors to scenes of violence: journalists, lawyers, politicians, and religious leaders also lay claim to the role of the witness. Humanitarian organizations therefore have to define the arena of their testimony precisely, in order both to remain credible and to be heard. Médecins sans frontières and Médecins du monde have different, and even opposing policies on this issue. Médecins sans frontières sees its competence and hence its authority as lying strictly within the domain of medical assistance. The organization's statutes state: "The aim of the association is to inform and raise awareness of situations of distress encountered by the medical teams." Médecins du monde sees the denunciation of violations of human rights as part of the organization's prerogatives, justifying their intervention. This is clearly expressed by the strap line of their journal: "We treat all sickness, even injustice." During the 1990s, disagreements became increasingly heated between organizations that could be described as "first-aidist" (Médecins sans frontières and the International Committee of the Red Cross) and those that could be termed "human-rightist" (particularly Médecins du monde and the European

¹⁰ In their study on the humanitarian milieu (2002, pp. 222–223), they write: "There is an inevitable choice to be made between the decision to maintain an NGO's presence in a country and the act of bearing witness, for example, to violations of human rights in that country. Whatever the organization's motto and its stated position on bearing witness, testimony usually comes after a mission has been withdrawn because it could no longer work in satisfactory conditions." While the consequences of speaking out on a mission while still working in the field are always taken into consideration, testimony given after a team has left the country, such as MSF published on its work in Ethiopia, Madagascar, and Iraq, are the exception rather than the rule. In such cases the causal logic is generally reversed: the team does not leave because it wants to speak out freely; it is because they are forced to leave that they speak out publicly in order to explain the decision, whether taken by them or the government of the country they have left.

Commission's Humanitarian Aid Office), although the political allegiances sometimes associated with these two parties are not apposite in the case of Palestine. In his book on "humanitarianism in crisis," journalist David Rieff argues that the "human rights" approach represents a serious threat to the humanitarian movement, and that the situation can only be redeemed by a return to the "first aid" ethos.¹¹ In spite of this criticism, the remarkable fact remains that in the Palestinian territories humanitarian psychiatry makes it possible, if not to reconcile the two approaches theoretically, at least to bring them together practically. In effect both MSF and MDM are bearing witness to psychological distress. Trauma becomes the medium that makes it possible for them, from a strictly humanitarian perspective, to give an account of the violence of war, not of its causes but of its consequences, not of politics but of suffering. Trauma becomes the medium that makes it possible, from a strictly humanitarian perspective as the two organizations see it, to give an account of the violence of war. Trauma then offers not a last resort in the absence of physical wounds, but a significant added value in the construction of testimony.

THE CHRONICLES OF SUFFERING

The following words come from the French daily *Libération*, reporting the experience of children and teenagers in the Palestinian territories:

The medical term for it is enuresis. In everyday language, it's "wetting the bed," and it's one of the most common disorders suffered by young Palestinians since the beginning of the Intifada. The youths who throw stones at Israeli soldiers by day, displaying more aggression than adult males, often wet their beds in the night, expressing in this way the fear they repressed just hours before. The symptom is discovered by their mothers, who have confided in psychologists sent out by humanitarian organizations.¹²

Journalist Alexandra Schwarzbrod followed the work of an MSF psychologist, who told her that the youths are suffering from enuresis because, as she explains, it is "their way of showing that they are still children," while the women are "exhausted by stress," and the men "feel something like a narcissistic wound mixed with guilt because they are prevented from

¹¹ In this polemical and well-documented work (2002), David Rieff, a former *New York Times* correspondent, finds no words too harsh for what he considers a political deviation, of which MDM is the example and MSF the exception.

¹² This article appeared in *Libération*, on March 9, 2001, under the headline "Les maux de la peur à Hébron. Avec une psychologue de MSF dans la ville palestinienne sous couvre-feu" [The disorders of fear in Hebron: With an MSF psychologist in the Palestinian town under curfew].

working and can no longer feed or support their families.” We see a new kind of language being used in the public arena, a different way of approaching the conflict and its consequences, a new perspective on the protagonists and their experience. These bold teenagers who defy the Israeli army during the day “often wet the bed in the night,” we are told. They risk their lives to present a heroic image to the world (when the article was written, five months into the second Intifada, 102 young people under the age of eighteen had died from the effects of the conflict, 101 of them Palestinians), but the reality of war is just the reverse: a pitiful picture of frightened children exhibiting psychopathology. Anthropologist John Collins, who worked in the Palestinian territories with the generation of the first Intifada, writes:

The emergence of young people as political actors can generate a diverse field of discourses, opening up new possibilities for representing the relationship between the nation and its children. At no time was this more evident in Palestine than at the beginning of the Intifada; while sophisticated analysis of the role of young people was lacking at that point, it seemed virtually everyone felt a need to comment on the activists who quickly became known as the “children of the stones” (*atfal al-hijara*). For every Israeli government official who argued that Palestinian children were being sent out into the streets as cannon fodder by cowardly parents, there was a young refugee camp resident who expressed a sense of empowerment and insisted on his or her own agency. And for every psychologist or educator cautioning about the long-term ramifications of children’s loss of “respect” for adult authority, there was a musician or poet lauding the heroic exploits of the young stonethrowers.¹³

Thus trauma is seen not as the unique or definitive truth of violence, but as one of several possible perspectives—and it is interesting to note that in this text the psychologist is placed in opposition to the poet, and loss to heroism. Trauma constructs a different landscape, where we see neither martyr nor combatant, nor even ordinary people, but rather the intimate suffering of victims. This is an interior landscape, but through it readers and donors see the external landscape, the reality of the occupation.

Narrating war in the language of suffering, treating the psychological effects of military brutality, translating the conditions of oppression into wounds of the soul: this is the role of humanitarian action in Palestine, and more specifically the role of bearing witness that is at its heart. On November 20, 2000, an MSF press release announced:

¹³ Analysing the literature on Palestinian children produced by foreign organizations, Collins (2004, p. 44) remarks on “the impressive amount of . . . research on children . . . in which the empowerment of young people is regularly acknowledged, but almost always subordinated to what is seen as the larger moral imperative: the need to document, in as much detail as possible, the victimisation and suffering of Palestinian ‘children.’” Publications by humanitarian psychiatrists shows the same pattern.

Faced with the trauma of the people most exposed to violence, MSF is setting up a medical and psychological support mission in Gaza. The closure of the territories and the constant surveillance, the obstacles to travel, the witnessing of confrontations or violent incidents, as well as the daily exposure to gunfire and shelling, have seriously eroded the conditions of everyday life for families living in the Gaza Strip. "This situation generates states of acute psychological stress that require rapid and specific treatment. The current situation is more serious and more traumatic for everyone than the first Intifada," explains psychiatrist Dr. Christian Lachal.

After reporting the story of a young pregnant woman who had breathed in tear gas fumes from canisters thrown into her home and since then had presented classic clinical symptoms of paralysis, the press release went on:

Such events cause both physiological and psychological problems. A doctor can identify and treat the physiological disorders. At the same time, a psychologist can begin therapeutic work enabling patients to express their fear, treat their trauma, and reduce their levels of stress. In view of the serious trauma suffered by the population in the zones subject to violence, psychological care for families has been identified as an urgent need.

The focus is entirely on the areas where MSF considers it legitimate to intervene (physiological and psychological problems, with the latter given much greater weight), and which in turn legitimize its intervention (the sending out of ten MSF volunteers). Bearing witness to violence is always an act of condemnation at the same time as communication. The witnesses speak of what they are seeing as well as of what they are doing. The same is true of the "information campaign on mental health in Nablus" launched by MDM on December 2, 2004. The press release has a familiar polemical tone:

A population exposed to distress. "The checkpoints, the repeated incursions, the occupation and destruction of houses are traumatizing events," explains Emmanuel Digonnet, director of the mental health mission in Nablus. 90% of children have already lost someone close to them, and many are suffering from psychological distress manifested in the form of bed-wetting, nightmares, and behavioral or personality disorders. Adults, faced with unemployment and the impossibility of predicting what the next day will bring, also suffer from mental disorders such as depression. This situation causes family problems which are expressed through the loss of references or domestic violence.

But MDM's intervention takes an original form:

Treating mental illness is difficult because of the negative image of these disorders held by both the public and professionals. There is a very strong cultural

prejudice against speaking of psychological illness. In order to combat this stigma, MDM has launched an information and awareness campaign around mental health, directed at both the public and professionals. This initiative will be accompanied by the introduction of psychological treatment in the near future.

We see here a shift from treating patients to educating the public and training professionals, in other words from psychological care to psychiatric proselytizing. The aim is to promote understanding of the categories and tools of this new form of humanitarian action. In order to be socially effective, the work of translating violence and oppression into suffering and trauma must begin by disseminating information.

The richest collection of testimony to emerge from this dual task of translating and informing is undoubtedly *The Palestinian Chronicles*, published by MSF in July 2002 (individual parts of the work had previously appeared in successive issues of the organization's in-house journal).¹⁴ For a period of one year, from November 2000 to October 2001, medical and psychological teams in Gaza and Hebron noted their observations, their impressions, and their analyses in "field journals," creating "a daily account of intervention among the most vulnerable Palestinian populations." The result is a collage of narratives, usually in the first person plural, sketches combining description and interpretation, situations and symptoms, tragic anecdotes and probable diagnoses, factual observations and personal remarks.

Deir el-Balah, November 21, 2000, after a night of bombing: A nine-year-old boy spent the night in a state of acute stress. The boy could not calm down. His mother says he wouldn't leave her for a second. He couldn't sleep in his room with his brothers and stayed with his parents, praying for daybreak. Only then did he begin to calm down.

Khan Yunis, December 4, 2000, in a district under pressure from gunfire and tanks: A woman followed by her children called out to me. She showed us one of the children, saying he had problems and needed help. I went with her and spoke with the child. He is ten years old and explained that after being at home when his house was bombed and fired upon, he has had panic attacks every day at the same time, reexperiencing the terror he'd felt at that moment. . . . We also met the director and teachers from the Netzarim elementary school. They need someone to listen to and advise them. While we were talking, a burst of gunfire broke out. I thought my heart would stop on the spot. The children, as well as the school personnel, live with this every day.

¹⁴ The sixty-four-page report combines photos with text written by members of the psychomedical teams. Published in several languages and accompanied by a traveling exhibition, it provoked debate throughout Europe, and also in Palestine and Israel.

Gaza, January 6, 2001, following the demolition of houses: I returned to the place we visited on Wednesday, where I took the picture of the bulldozer. The house is gone and we met the family that lived there. They describe their distress at what has happened to them. They understand what the loss of land and home can mean for their emotional health. It's as if they've lost a part of themselves.

Even in this very fragmented form, which leaves out many more facts than it includes, the event seems to overpower the traces of trauma. It is as if the testimony, which limits itself to describing psychological distress (albeit in very sketchy terms) is straining to express something greater.

In effect the accounts swing between two poles. On the one hand, they aim to testify in psychiatric language, where humanitarian authority is greatest, but then there is danger that clinical concerns will diminish the impact of the testimony to the extent that its power of demonstration is lost. On the other, they aim to communicate raw experience, what they have seen and heard of the violence, but they do this at the risk of exceeding the legitimate bounds of humanitarian authority.

Visit to a house the day after a bombing raid: The second patient is a man with visible problems. His face is contorted and he twists his fingers compulsively. His older brother explains that the man has severe attacks, including catatonic states in which his body stiffens, he pulls his hair and hits his head against the wall. His throat closes up and he can eat only yogurt. He does not sleep. This began ten years ago. The problems occur intermittently, and the brothers agree that they increase when he is faced with difficulties as he is now, given the events. The young man was seriously mistreated during the Intifada, when he was twenty-two. He was arrested and beaten by the IDF. His problems apparently began following this abuse. The description suggests PTSD (post-traumatic stress disorder) with psychotic features. . . . Apparently, this man has not undergone any psychotherapy. If there is still time, it could be useful to suggest that he do so. We must first confirm that there are no underlying psychotic problems.

In this observation, made under difficult conditions and reported in summary form, the tenuousness of both the diagnosis and its etiology clearly emerge: the elements described would appear to suggest a psychotic condition aggravated by violent events, rather than the classic form of post-traumatic stress disorder, and the attachment of the current symptoms to the past episode of violence represents a retrospective rationalization that would probably not be accepted in other circumstances. Thus, bearing witness through trauma involves stretching clinical observations in order to make them say what they do not necessarily say so unequivocally, in order to establish causal links where caution is more normally the rule.

Indeed, the more the clinical data is fleshed out—in other words, the more the witness plays psychiatrist according the strict rules—the more the testimony on the effects of the war loses potency. The two extracts below offer illustrations.

In a Bedouin village at Erez: We are scheduled to conduct a personal interview with a thirty-nine-year-old man about problems he's had for three years but which have been revived by the current situation. The long, in-depth interview reveals that he suffers from post-traumatic stress resulting from past experiences, some of which certainly date to his childhood, and which may or may not be related to the political situation.

In a district of Hebron: A mother has come for a consultation with her nine-year-old daughter. A few weeks ago, a tear-gas bomb fell in her courtyard. She rushed to find her children, who are sent home from school when there are clashes. But she fainted and fell, had to be hospitalized, and spent four hours in intensive care. Her current fragile state has revived long-ago traumas, including the death of a baby eight years ago (for which her in-laws blamed her) and her father's death, when she was six (her mother was accused and then imprisoned).

In these two cases, as in many others, once the clinical exploration goes deeper it blurs the link between war and trauma, revealing the aftereffects of past violence, the intimate everyday suffering of personal histories. The testimony is thus less to the psychological effects of the conflict than to the individual tragedies that the situation makes it more difficult to live with and sometimes brings painfully back to life.

The mental health specialists were not fooled, but they preferred to step outside of their professional role to give an account of what they saw and heard, rather than offering diagnoses which restricted them to a fairly limited nosography that could provide little in the way of proof. They prioritized emotion over precision, the power of demonstration over accurate diagnosis. Thus their chronicles can be read in the opposite light to that in which they are presented, as an attempt to say more than trauma psychiatry practiced according to strict guidelines would allow them to say. The testimony certainly gains in power of persuasion what it loses in clinical rigor. In the following narrative, the psychologist begins with an account of a consultation with a little boy and then moves very quickly into a description of his family's living conditions:

The same day, I make another first visit, this one to the home of a nine-year-old child who is unable to sleep, cries out for his mother at night, and has become agitated. His mother doesn't know how to calm him. She welcomes us with a thin smile on her drawn, sad face. She immediately describes the nightmare she has been living for the last five months. Her house is occupied and

Israeli soldiers are stationed on her roof. When we arrived, we noticed weapons standing between sandbags. When there is shooting, everything shakes; cracks can be seen in the walls. The roof is considered a military zone and access is prohibited. The family is only permitted to go up there every ten days to perform essential tasks. Two shifts of soldiers take turns day and night, coming and going by the only door to the house. When it rains, the soldiers set up in the hallway and the inhabitants must leave their bedroom doors open at night. "In the beginning, we were terrorized and we couldn't sleep," the mother says. "Then we arranged things so that one of us stayed awake while the others slept. The soldiers leave their mess behind, they urinate in front of our windows; some are more disgusting than others and even expose themselves in front of our daughter, harassing and upsetting her."

Significantly, the narrative shifts around the word "nightmare." The reader initially assumes that it is to be understood in the literal sense, since the first reference is to the child's sleeping problems, but then realizes that the word is used figuratively, to describe the everyday experience of the child's family, as recounted by his mother. Examples of this kind abound in these chronicles; in the production of testimony by psychiatrists and psychologists without borders, the description of symptoms serves as a pretext (and often literally a pre-text) for a phenomenology of everyday violence in the Palestinian territories. And this is indeed the way these accounts have been read by commentators.

THE EQUIVALENCE OF VICTIMS

"Contrasting diagnoses. While Médecins sans frontières still continues to attack Israel and Tsahal in its 'Palestinian Chronicles,' Médecins du monde's latest report condemns the violence of Palestinian armed groups against Israeli civilians. Two politically different approaches to the same conflict." This headline of the July 30, 2003 edition of *Actualités juives hebdomadaires* [Jewish Weekly News] contrasts the two organizations' ways of bearing witness.¹⁵ After quoting an extract from the MSF journals (another description of the life of a family in a house whose roof is occupied by soldiers), the journalist, who maintains that this extract depicts "the Tsahal soldiers as more cruel than the Nazis," continues:

¹⁵ The two organizations' reports are often used to support opposing theses, with the champions of the Palestinian cause referring to the *Palestinian Chronicles* and the defenders of the Israeli state citing *Les Civils israéliens victimes des attaques des groupes armés palestiniens* [Israeli civilians under attack from Palestinian armed groups]. See, for example, the use of these reports by the protagonists of the debate provoked by Derek Summerfield's article in the *British Medical Journal*, available at <http://bmj.bmjjournals.com/cgi/letters/329/7474/1110>.

When they were asked about how they put their narratives together, the MSF chroniclers stuck to their position. "We write what we hear. We tell the stories that are told to us by Palestinian patients," the program assistant explained to us. Did they check the truth of what they were told, verify the criticisms of the military? "No, of course not, we're talking about suffering, we're not going to check up." But MSF reports little—in fact nothing at all—on Israeli pain. We asked them what their aim was in publishing their Palestinian chronicles. "MSF has to justify its fieldwork to its donors by describing the suffering that exists and that it is trying, as best it can, to alleviate."

Médecins du monde, on the other hand, finds favor in the eyes of this journalist on the grounds of its "even-handedness" in balancing a first report on Israeli army violence with a second one on the effects of Palestinian attacks. "The victims are among the most vulnerable in Israeli society; it is the whole of Israeli society that is concerned, first of all symbolically, as it is the survivors of the Holocaust who are the victims of these attacks." In this polemical article, the focus on the issue of "measure" is remarkable (the journalist evokes the necessary "even-handedness" in the evaluation of suffering on both sides). The word needs to be understood both in the sense of comparative quantification (giving the measure of facts on the one side and the other) and of relative moderation (offering a measured interpretation). This issue is central to all debates on the Israeli-Palestinian conflict, where the two sides set their victims off against one another, highlighting their own side's suffering and trauma.

For Médecins du monde it is a matter of principle. "There are no good or bad victims," declares the strap line of their double report *Israeli and Palestinian Civilians: Victims of an Unending Conflict*.¹⁶ The authors return to the slogan in their introduction: "This was our watchword at the time of Médecins du monde's founding mission to the Vietnamese boat people in the China Sea in 1979. The phrase is key to the identity of our organization." And they go on to list the empirical proofs of their asser-

¹⁶ The report *Les Civils israéliens et palestiniens victimes d'un conflit sans fin* comprises two parts: "Opération 'Mur de protection,' Naplouse" ["Operation 'Protective wall,' Nablus"], Joint MDM-International Federation of Human Rights study mission, July 2002, and "Les Civils israéliens victimes des attaques des groupes armés palestiniens" [Israeli civilians under attack from Palestinian armed groups], *Médecins du monde*, July 2003. The focus in the first report is on legal issues; in the second it is medical and psychological. The difference in approach is apparent even from the maps of the region included at the front of each report. The first includes two maps that immediately make clear, through contrasting colors, the complex division and the tight enclosure of the Palestinian territories and particularly of the so-called autonomous zones. In the second, the map shows only the sites of Palestinian attacks, against a white background with barely noticeable dotted lines marking the borders. For an analysis of this report, see Fassin (2004b).

tion, to demonstrate that the decision to include the two documents in this report is nothing out of the ordinary:

In countless conflicts, MDM's history has been marked by the concern to testify to the ordeal lived by civilian populations; from the early 1980s in El Salvador and Afghanistan, to today in Chechnya, and including both Iraqis and Kurds, Hutus and Tutsis in Rwanda, the Croatian, Serbian, Bosnian, and Muslim communities in Yugoslavia, the Albanian majority and the Serbian and Romany minorities in Kosovo. There are no good or bad victims. These words are equally true for the civilian populations of the Israeli-Palestinian conflict.

The emphasis, and the list, are there for a reason. While the first report, on the situation in the Palestinian territories, was well received both within and outside the organization, the second, on the attacks on the Israeli population, created deep divisions within the organization and risked being misunderstood outside of the organization as well.

Humanitarian organizations customarily condemn the ordeals suffered by the weakest, the oppressed, the dominated. The reality of the Israeli-Palestinian conflict, to say nothing of the way it is represented in the global public arena, does not make it easy to justify a testimony that places the two sides on the same level. Within Médecins du monde the preparation and the publication of the document on the effects of the Palestinian attacks on Israeli population thus gave rise, probably for the first time in the organization's history, to accusations of sectarian allegiance: some important administrators were suspected to have ordered the report because they were Jewish. The rifts were less painful in Médecins sans frontières, but tensions arose during the early months of the second Intifada, when some criticized the organization for not speaking out publicly; here again, accusations of sectarian bias were leveled against a number of senior figures in the organization. Contrary to all the evidence of their opposition to Israeli policy, their position was assumed to be determined by their Jewish identity. Identity-based accusations are of course particularly troubling to humanitarian organizations that profess neutrality and reject all sectarianism. In this case the disagreements reflected conflict between some of those working in the Palestinian territories, who were daily witnessing the Israeli attacks, and the central administration, which was responsible for maintaining the organization's policy of impartiality. Their concern was particularly with regard to their Jewish donors, some of whom were threatening to withdraw funding in view of what they saw as positions too biased towards the Palestinian cause. No other conflict in the world has had such an impact on the world of humanitarian organizations. But it has to be acknowledged that this conflict occupies a very particular place in international political consciousness, and particularly in France.

The principle of the equivalence of victims, explicitly proclaimed by Médecins du monde, is widely shared by humanitarians. Ultimately, it simply reiterates the principle that has justified their intervention on the scenes of war for one hundred and fifty years. But the debate provoked by MDM's report relates to the interpretation of this principle. Can the same standards be used to assess the Israeli and Palestinian situations? Humanitarians are invariably faced with this question, as we saw in relation to Kosovo where, with the exception of MSF's Greek section, all the humanitarian agencies involved considered that sending aid to fleeing Kosovar Albanians, and not to the Serbians being bombed in Belgrade, did not refute the principle of "balanced assistance." With regard to the second Intifada, Médecins du monde does not question the imbalance of power, the illegality of the Israeli state's occupation, or the violent oppression of the Palestinian population; rather, the organization focuses its condemnation purely on the suffering of victims on both sides. In this respect the denunciation of the war is strictly humanitarian, relating solely to its medical and psychological consequences. As Jean-Hervé Bradol, president of Médecins sans frontières, points out, this denunciation also forms part of the rhetoric of the protagonists in the conflict: "In the management of this conflict, talk about victims—victims of Palestinian terrorism on one side or of Israeli colonization on the other—is central to war propaganda, resulting in the creation of two emblematic figures, the eternal victim, and the victim of the eternal victim." The balanced argument that the MDM report presents is intended to counter this exploitation of victims by belligerents on both sides, in the interests of promoting peace. And indeed, meetings between parents of children killed in the conflict have often been offered as an example of the local initiatives most likely to encourage reconciliation between the two sides.

However, given the realities of the conflict, on what can the symmetry of analysis, the "balance" that some demand, be based? The first document produced by Médecins du monde focused on violations of humanitarian law and human rights in the Palestinian territories; it was drawn up in collaboration with the International Human Rights Federation (FIDH) and was essentially legal in content. The report dealt with "obstacles to first aid," "poor treatment of the wounded," "attacks on life and bodily integrity," "the use of human shields," "mass and arbitrary arrests," and the "destruction of goods and property." Responsibilities were clearly established, on the part of both the Israeli state and individuals, and the persecutions were described as "war crimes" subject to the jurisdiction of the International Criminal Court. The second document was drawn up by MDM alone, as FIDH had refused to be associated with it, and while it presented statistics of the dead and wounded, most of the text consisted of a series of "testimonies" of victims and analyses

of the "medical consequences" of the attacks. The "effects on mental health" were reported at length, on the basis of only brief reports; they primarily took the form of "post-traumatic stress disorder" affecting not only survivors but also witnesses, emergency workers, police, journalists, and "society in general." Ultimately, this analysis allows for terrorist attacks to be described as "democide"—a neologism with no legal validity, as the authors themselves recognize. Nonetheless, they called for recognition of this new form of crime against humanity, directed at a particular population.

Thus the symmetry between the two texts is only superficial, since the arguments are constructed on completely different premises. This is easily understood: political analysis would not offer any support for such symmetry; a legal interpretation would be no more appropriate in comparing the persecutions of a state with attacks perpetrated by individuals; death statistics could be used, but the manifest imbalance in the figures would be likely to weaken the parallel. In effect, only the presentation of psychological effects and individual post-traumatic stress can allow a symmetry to be established—all the more effectively when the entire population of both sides can be presented as victims.¹⁷ Independently of any political evaluation, which would be outside the legitimate scope of humanitarianism and liable to provoke dispute, psychology allows the two nations to be brought together in common misfortune. At the boundary between psychiatric diagnosis (the all-embracing clinical category of post-traumatic stress) and popular thinking (the experience of being traumatized by a serious incident), trauma ultimately becomes what testifies to the universality of suffering and thus to the equivalence of victims.

In an interview, a psychologist teaching at Bir Zeit University and working for the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) remarked that a number of mental health programs had been set up in the territories since the first Intifada: "In particular, with the al-Aqsa Intifada, NGOs have set up a huge number of programs around trauma. It's an approach donors like," she added. The reasons are not far to seek: not only is psychology generally a much easier vehicle than surgery for translating the compassion generated through international media focus on the Palestinian situation into action, but trauma also allows for a sort of consensus around the victims. Who would think of denying that children who witness the murder of their playmates, whether by Israeli bullets or a Palestinian bomb, share the same suffering? However, in reality this attempt to "depoliticize" con-

¹⁷ We see here an extension of the notion of trauma from the individual to the collective, as Anne Kaplan (2005) has noted in relation to a number of events, primarily 9/11 in the United States.

frontations between the two sides fails at least in part because, depending on which side of the conflict the trauma is presented (Palestinian in the case of MSF, Israeli in MDM's report), the account will be welcomed by one side and condemned by the other—and this despite all disclaimers, proofs of impartiality, and demonstrations of good faith.

Foreign aid organizations are not the only parties, nor even the first, to work in trauma care. Local teams, both Palestinian and Israeli, are also involved. The Gaza Community Mental Health Programme was set up in 1979.¹⁸ Its founder, an Oxford-trained psychiatrist, conducted a number of studies, primarily epidemiological, that used questionnaires and rating scales (and hence statistics) to evaluate the proportion of individuals, and specifically of children, affected by post-traumatic disorders. The Natal Israel Trauma Center for Victims of Terror and War is a more recent initiative, set up in 1998.¹⁹ Its members gather accounts from the victims of attacks, but also from soldiers recalling their traumatic experience of war. Thus the testimony of both organizations, as provided on their respective Web sites and also in articles and lectures, demonstrates their common conviction that it is possible to read events through the trauma they produce.

However, the presentation and interpretations offered by the two groups differ. While GCMHP offers studies backed by statistical data, Natal reports mainly individual case histories. For example, reading the GCMHP documents we learn that “in a random sample of 944 children, 94.6% had been exposed to funerals, 83.2% to gunfire, 61.6% had seen friends or neighbors wounded,” and 97.5% showed acute, moderate, or mild “PTSD.” Natal's texts show us individuals, often soldiers, like the man who recounts, under the heading “Nightmare in a Village,” the terror he experienced when he found himself trapped in his vehicle, surrounded by stone-throwers, on a dead-end street in an Arab village. Referring to the incident, he writes, “Part of me died three years ago.” Moreover, while GCMHP always situates the trauma in the long historical context of the tribulations of the Palestinian nation, Natal sets it in

¹⁸ GCMHP is first and foremost a mental health care organization bringing together professionals working in four community centers. It is described by its members as “carrying out traditional psychological work” but “setting its therapy firmly within a culturally sensitive, community-based approach” in order to “adapt Western approaches to the Palestinian reality.” See the organization's Web site at <http://www.gcmhp.net>.

¹⁹ The word “Natal” is itself the acronym of a Hebrew expression meaning “victims of national psychotrauma.” The organization cares for groups of people who have faced Palestinian attacks, in “groups of victims of terrorism” that are organized after attacks using a telephone hotline that offers “immediate and specific aid to victims of national trauma.” It receives major funding from Jewish organizations in the United States. See its Web site at <http://www.natal.org.il>.

the immediate present of the violence facing the Israeli population. Thus on the Palestinian side the chronology of the conflict goes back in time, sometimes as far back as the mythical age of Abraham, but more often to the series of tragic events that began with the expulsion of 1948 and led up to the second Intifada in 2000—violent events that stand out against a background of “everyday stress, frustration, and humiliation with their effects on the mental health of the population.” On the Israeli side, by contrast, the drama is presented in the instant present of the “terrorist attack,” as for example in the account of the attack that occurred on the port of Ashdod on March 14, 2004, “at the shift change.” Objective statistics versus subjective accounts, historicization of suffering versus the immediacy of violence: trauma can be read in various ways, depending on the political purposes it serves. Testimony makes use of it as a resource, its precise definition subordinated to the presentation of a cause. As some have pointed out in criticism of MSF and MDM, in a war situation the concept can only be superficially neutral. The strategy of using it to establish an equivalence of victims is constantly undermined by the tactics of those who do so. Nevertheless, trauma still opens new horizons in our understanding of the world.

HISTORIES WITHOUT A HISTORY

“Really? Palestinians Suffer from Trauma and Anxiety?” a headline in the March 25, 2001 issue of Israeli daily *Ha'aretz* asked ironically. The writer, reporting on the activity of psychologists and psychiatrists working with Médecins sans frontières told of an incident in which Palestinian children and youths, some throwing stones, others playing peacefully near their homes, had been mortally wounded by real bullets fired deliberately at them by Israeli soldiers:

At first sight, it seems that people have accepted the fact that their life is constantly in danger, since wherever they are they are within range of Israeli weapons. Their facial expressions, the jokes they make about the situation, and their ever-present smiles reveal neither fear nor panic, and testify to their incredible capacity to adapt to all situations, however crazy. That was why a psychologist serving as a military reservist in the IDF was so surprised to hear fellow psychologist Hervé Landa say that Palestinians suffer emotionally from long days under fire from machine guns, tanks, helicopters, and mortars aimed at their homes. “I was convinced Palestinians didn’t suffer from trauma and anxiety,” he said. The two psychologists had met by chance at a checkpoint in the Gaza strip and had begun talking. Landa works for a French humanitarian organization, Médecins sans frontières. Recently, following interventions in

Chechnya, Bosnia and Kosovo, the organization realized that it was not enough to send medical teams to treat physical injuries. Emotional stress was frequent and no less disabling.

Thus the presence of humanitarians has an unexpected effect—that of bringing the protagonists in the conflict together, at least in their ability to understand that one side is as capable of suffering trauma as the other.

The revelation that this conversation brought to a naïve—or cynical—Israeli psychologist, that Palestinians also suffer, might by itself serve as a justification for humanitarian psychiatry. The shift in the picture we see of the youths, who move from being bold stone-throwers to children who wet their beds, transformed from intrepid combatants into traumatized individuals, could ultimately rehumanize the enemy by blurring his or her otherness. While less heroic, these traumatized youths would seem emotionally closer and more familiar, because they too suffer. In general it can indeed be affirmed that in situations where aid organizations intervene, psychologists and psychiatrists have altered the image of the protagonists, restoring their individuality through the recognition of their personal suffering. Trauma has this virtue of universalization, even if, as we have seen, the virtue remains largely a theoretical one, difficult to put into practice. However, the conclusion of the *Ha'aretz* article reins in the optimism. Describing discussions between inhabitants of the territories and MSF psychologists, the journalist writes: “K., a teacher at the school in Rafiah, wonders whether these intimate conversations help, when things around them—the causes of the trauma—do not change. He asks what can really change when every day children continue to be injured and killed.” Humanitarians are themselves well aware of this: they are there to alleviate suffering, not to end the war—even if they would like to help end it by speaking out.

However, since the possibilities for medical care are so limited, the question is not only, as this teacher wonders, what they can change in the life of Palestinian children. If testimony is such a prominent part of their activity, the primary question is: what are they changing about people's ideas of the conflict? Or rather, we might see the two questions as essentially one: what meaning is given to events and their consequences when the language of trauma, or more broadly of psychic disorders, is introduced into care and testimony? This question can be answered on two levels: that of the individual, and hence of the processes of subjectification in operation, and that of the collective, and hence of the logics of representation.²⁰ We need to grasp the added significance conferred by the testimony

²⁰ Estelle d'Halluin's report (2001) offers useful understanding and reflection on this issue. She compares humanitarian agents' own views of their activity with the views the Palestinians have of the humanitarians.

of humanitarian organizations—and also, as we have seen, of local institutions—that highlight trauma in their care for individuals and in their pronouncements on situations. Let us then consider this dual perspective, individual and collective.

First, at the individual level, mental health specialists tend to validate, or even to impose, from within the range of possible ways of interpreting the experience of a conflict, one interpretation that brings together three fundamental features: it personalizes the history of the individual in a unique, albeit incomplete account; it explores the psychological dimension, focusing on those aspects that best express the individual's relationship to the violence of the situation; it emphasizes the emotional aspects, highlighting elements likely to prompt empathetic reactions. Everything the inhabitants of the Palestinian territories live through is related to the trauma they experience and the suffering they feel, both of which are portrayed as undeniable. The aim of humanitarians is, through symptoms and affects, to attain to the incontrovertible truth of their patients' condition, one that could not be challenged because it is based on testimony that is by definition impossible to refute or to reinterpret for political or partisan ends.

However, people exposed to various forms of oppression and terror, domination and dispossession, have different, complex, and polysemic experiences. In the case of the Palestinians, they may see themselves as combatants rather than as victims, a description that many youths reject. They may think of their daily life in terms of resistance rather than submission, political violence rather than psychic suffering. Moreover, their experience is not totally bounded by the war. Their representation of the past and their expectations of the future are not fixed in the landscape of trauma.²¹ When psychologists and psychiatrists ask their clients to talk of their suffering, they not only force them to recite their troubles yet again (and some specialists condemn the pathogenic effect of this process), they attempt also to make them believe—because the specialists are themselves convinced—that this is the only, or at least the most effective way to make their story heard in the international arena.

The humanitarian movement tends to channel the many different forms of experience that are possible into one voice that delivers a unified message, thus reducing a cause to simple and consensual expressions. In order to be heard they have to highlight those aspects that evoke compassion and bring facts related to what are considered legitimate concerns of the

²¹ Compare the type of experience recounted by adolescents and youths when they present themselves to psychologists as suffering from psychic distress, and when they speak with anthropologists of their rituals of resistance, in Julie Peteet's study (1994) of the first Intifada.

organization. Hence the suffering body and, increasingly, the suffering soul. Given that trauma has become part of the *Zeitgeist*, this reasoned argument nevertheless gives rise to some surprising excesses, as evinced in this interview with a psychologist who has been working in Palestine for a long period: “NGOs responded to the situation impulsively and organized debriefing, which involved making systematic visits to families affected by the events. If a mortar falls on my house, I’ll get ‘counselors’ from such-and-such an NGO coming round and asking me, ‘What happened?’ And I’ll tell them my story. Two days later, another NGO will come knocking at the door. And telling the story is not enough to make people feel better, especially if it means telling it for the fifteenth time.” This inflation of trauma and its specialists on the market of suffering is not the only problematic issue; there is also the paradoxical incapacity of humanitarians themselves to articulate the facts to which they wish to testify through the pathological symptoms they invoke (which remain as imprecise as they are non-specific) and the clinical vignettes they publish (with a psychological reading well short of their own understanding of matters). Despite their efforts to deliver a testimony that is above suspicion, they fail to speak the truth of the scenes and the people about whom they wish to bear witness.

In the field, volunteers are aware of dissonances that they find difficult to interpret and which make the facts on the ground not so much contrary to as somehow subtly different from the version underlying the ethos of humanitarian psychiatry. Thus in the chronicles written by the MSF teams we read that a young man “speaks without sadness” of the death of his friend the day before, and insists that “it not be said that he felt fear,” which leaves the psychologist “troubled.” We also learn that in one camp the refugees are in a “worked up state,” with “laughter, shouting, over-excited children,” clearly surprising the visitor, who describes their mood as “hypomaniac.” But these reactions appear to be rare. In the main, the Palestinians adapt to their interlocutors. To psychologists they speak of their suffering, to aid workers they expose their misery.²² In fact no one knows how this presentation of oneself and one’s misfortune modifies psychic subjectivity—though certainly it will differ from one individual to another. However, it is clear that it affects people as political subjects. The image a people create of themselves and of the way others view them, as well as the translation of this reality into political terms, are affected

²² Refugees not only develop practices to counter their condition being defined in this way by humanitarians; they also, in a more subtle and everyday way, construct social relations that contradict descriptions of them as victims, as Michel Agier (2004) has shown in other camp contexts. In this they are activating “a politics of a life of resistance.”

by the fact that they realize they are seen purely as victims, and that often their identity is reduced to this one aspect.

At the level of society, the process follows a similar logic—all the more given that the boundary between individual and collective sometimes tends to become blurred, at least in local organizations (humanitarian organizations generally separate the individual from the collective). Thus Natal speaks of “national trauma,” while GCMHP declares that the “impact on the psyche, on individual lives, and on the community as a whole” are indivisible.²³ Not only does this rhetoric straddle the boundary between the individual and the collective, it also vacillates between psychological theory and common sense, and it is thus easy for terms such as “trauma,” “suffering,” and “stress” to be used in both vocabularies, ordinary speech contesting these terms with scientific language. This double ambivalence, between individual and collective, and between psychological theory and popular opinion, is a key to the success of the post-traumatic paradigm and its variants.

The three processes of personalization, psychologization, and production of emotion that we have described at the individual level are encountered as well at the collective level, but augmented by a further dimension. The intervention of humanitarian psychiatry effectively results in a form of reification of social facts whereby the history produced by human beings tends to vanish, replaced by rigid scenarios in which persecutors and victims are strictly confined to the roles assigned to them. For example, a psychologist who has been working in the Palestinian territories for several years recounts her anger at the role playing introduced by GCMHP in schools after the death of little Mohammed el-Doura: one plays the child, another the father, and 1,500 pupils are the Israeli soldiers, each repeating his or her part like a robot. “When I saw that I was horrified,” she says. “I thought: to think a psychologist did that!” This is certainly an extreme case, but the “vignettes” on the Israeli-Palestinian conflict produced by psychologists and psychiatrists clearly show that the roles

²³ Not all psychological theories giving an account of the conflict and its effects refer to trauma. Thus, the interpretation of the second Intifada offered by MSF’s two coordinators of mental health programs in Palestine, Marie-Rose Moro and Christian Lachal (2003, pp. 222–224), derives from a different paradigm. According to these authors, the situation of the Palestinians can be understood in the light of the “double bind” theory of the Palo Alto school, which assumes two agents, a primary repetitive experience, a primary negative injunction involving punishment, a secondary injunction which comes into conflict with the first, and a tertiary negative injunction which prevents the victim from escaping the situation. “Double bind situations are powerful for both populations. The solution is war, which transforms the double bind into confrontation and permits psychic survival.” However, Moro and Lachal concede that “to say that the al-Aqsa Intifada is a solution of this psychological or psychosocial type is of course an exaggeration, if this is the only explanation offered.”

are not only assigned to each participant, but also are fully taken on by all concerned. Historical processes elude analysis, which is replaced by emotion or sometimes by narrative frameworks that turn the past into myth.

In short, what the testimonies written by humanitarian psychiatry offer are histories without history—either individual history or collective history. Biographies and personal experiences culled from both sides of the conflict, fragments shuffled to suit the needs of humanitarians, to fit the message they wish to communicate. What is retained of the contexts and circumstances that underlie these constructs and that could help the protagonists to understand their position, is above all the events likely to lead to post-traumatic reactions. There is nothing surprising in this, given that the diagnostic category instituted by DSM-III in 1980 aimed precisely to eliminate all trace of the cause, recognizing only the effects: survivors of disasters or war wounded, victims of plane crashes or sexual abuse, Vietnamese civilians or US soldiers, all shared the same symptoms and hence the same clinical diagnosis. Thus the recognition of trauma represents, in the strongest sense, the abolition of experience in its simultaneous uniqueness and commonality, set as it must be within an individual and a collective history. Of course humanitarians recognize these limitations. They themselves, as we have seen, tend to produce testimony that oversteps psychological categories. Rather than trying to fit Palestinian accounts into a rigid diagnostic framework, they focus on communicating fragments of life and moments observed. But the power of collective evidence of these psychological categories has become so strong, in local societies as well as in the international public arena, that it is increasingly difficult to escape them.

“Ultimately what justifies the humanitarian movement is that its members are on the spot,” writes Luc Boltanski. “Presence on the ground is the only guarantee of effectiveness and even of truth.”²⁴ But is claiming an authority that derives merely from one’s presence on the ground—as ethnographers would do with fieldwork—enough to guarantee efficacy and truth? Today, humanitarian psychiatry assumes that efficacy of intervention and the manifestation of truth operate through a testimony that speaks of violence in the language of trauma and suffering. But what is gained in familiarity, by bringing those experiencing violence closer to the

²⁴ In his book *Distant Suffering*, Luc Boltanski (1993, pp. 258–261) describes “humanitarian society and its enemies,” those who criticize it not for “its actions on the ground” but for “the media representation . . . of suffering endured by those to whom the members of humanitarian organizations wish to draw the public’s attention.” As the reader will have understood, our position is that this distinction is illusory, and that the work of representation *is* action in the field. We are studying a practice, not an ideology.

public whose awareness is to be raised, making the cause of the former less abstract and more accessible, is lost in terms of a genuine understanding. The social effectiveness of trauma does not necessarily produce the historical truth of the victims.

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Thus, within less than twenty years, a new domain has become established on international scenes of suffering: humanitarian psychiatry. From the Armenian earthquake of 1988 to the South Asian tsunami in 2004, from the Romanian orphanages to refugee camps in Kosovo, this discipline offers a new language for articulating the ills of the world. Contrary to what might be imagined, it was not born from the discovery of trauma and its psychic effects at the sites of disasters and conflicts, where today the vocabulary and semiology of trauma are taken for granted. Rather, psychic suffering was first identified through the reaching out to the other that characterizes humanitarianism, and only later was this suffering interpreted as being of traumatic origin. Moreover, before the others could be ascribed the capacity to feel the same affects and share the same symptoms as oneself, they had to lose the burden of their radical otherness and become in some way another self. In effect, the volunteer psychiatrists and psychologists initially saw cultural distance as an ontological distance—a distance that survivors of wars and genocides were the last to see eliminated, when it was recognized that they too could be victims of trauma and in need of psychological care.

Faced with common suffering humanity thus reconstituted, humanitarian psychiatry created a new imperative for itself. Of course it must still console and provide treatment, but the practical conditions for this clinical work—carried out in emergencies, in tents, under bombardment, and in demolished houses—meant that operational possibilities, and especially the ability to do effective therapy, were severely limited. A different path, entirely new to mental health professionals, therefore opened in conflict zones: the task was to bear witness, specifically on the basis of those affects and symptoms that humanitarian psychiatry alone could reveal as the indelible traces left in the psyche by violence. The expertise of humanitarian psychiatry was placed at the service of victims—all victims, as humanitarians like to emphasize—and trauma became an exhibit for the defense of the oppressed, and an argument for the prosecution against the oppressors.

In this campaigning work of rewriting causes through psychiatric testimony, an important part of the individual experience and collective history of the victims for whom humanitarian organizations speak has

been lost. However, rather than deploring this fact, we need to focus on the way in which the victims have reappropriated this representation themselves, how they are taking it over or diverting it, depending on their situation, how they claim it or reject it. As a tool of a politics of humanitarian testimony, trauma contributes to constructing new forms of political subjectification and new relations with the contemporary world.

PART FOUR

The Politics of Proof

ON NOVEMBER 9, 2002, members of a number of organizations providing medical and psychological aid overseas, and for immigrants to France, met just outside Paris. The purpose of their meeting was to attempt to find a common position on a problem they had been confronting for some years: the increasingly pressing demand for clinical psychological certificates attesting to the authenticity of torture suffered by individuals seeking political asylum in France. This demand came either from those seeking refugee status themselves, from lawyers or organizations supporting their applications, or from institutions responsible for judging whether their claims were grounded—the latter being the Office français de protection des réfugiés et des apatrides [French Office for the Protection of Refugees and the Stateless, OFPRA], which examines cases in the first instance, and the Commission des recours des réfugiés [Refugee Appeals Commission, CRR], which hears appeals of requests that have been refused. Once again, it seemed that new conditions for asylum were to be imposed that would further erode the ethics of hospitality.¹ The meeting, which was not open to the public, was attended by representatives of three organizations: the Comité médical pour les exilés [Medical Committee for Exiles, Comede], the Centre Primo Lévi de soins et de soutien aux personnes victimes de la torture et de la violence politique [Primo Levi Center for Care and Support of Victims of Torture and Political Violence], and the Centre de droit et d'éthique de la santé [Center for Rights and Ethics in Healthcare] in Lyons. The Françoise Minkowska Center, which specializes in caring for the mental health problems of immigrants, had also participated in the discussions begun some months earlier, but none of its members were able to attend the meeting. The other NGO that specializes in the mental health problems of people who have suffered persecution, the Association pour les victimes de la répression en exil [Association for Victims of Repression in Exile, Avre], was not invited.

From the start of talks tension between the organizations was evident, despite the fact that for several years they had been united in their struggle

¹ In the fifth of his seminars on hospitality, Jacques Derrida (1997) exposes this contradiction: "There is an antinomy, a non-dialectizable antinomy, between, on the one hand, the *law* of unlimited hospitality (to give the new arrival all of one's home and oneself, to give him or her one's own, our own, without asking a name, or compensation, or the fulfilment of even the smallest condition), and on the other the laws (in the plural), those rights and obligations that are always conditioned and conditional, as they are defined by the Greco-Roman and even the Judeo-Christian tradition, by all of law and all philosophy of law." The demand for medical certification, and the increasing prominence of trauma in medical certificates, are set in the context of this contradiction.

to defend the rights of refugees in a context of increasingly restrictive asylum policies.² The discussion focused on the problems posed by the increase in demand for clinical psychological assessments. For a start, providing expert reports diverted professionals from their primary mission of care. "Administrative logic is incompatible with therapeutic logic," a member of Comede asserted. "Certification disrupts the care relationship," added a psychologist from the Primo Levi Center. Second, it forced organizations into the ambiguous role of expert witnesses for public authorities. "My work is therapy, and so I place myself in that context," a member of the Primo Levi Center protested. "Refusing to draw up certificates is a political statement. It means refusing to act as a dispensary." One of his colleagues in Comede responded, "Are we going to call the entire legal system into question? How much of this debate is actually about medical expert reports or psychological expert scrutiny?" Finally, there was doubt about the efficacy of certificates: "We know they don't do any good," a psychologist from the Primo Levi Center declared. "How many of those we give certificates to are granted asylum? Legally we're nothing. We don't have the same weight as a real expert witness." One of the directors of Comede nevertheless seemed more hopeful about the value of their opinions: "I can't let it go that easily. I have the sense that the certificate is useful in some cases. That's what we're told by patients, by lawyers, and by refugee associations." But all came back to the same question: Why aren't the patient's words enough for the OFPRA or CRR officer, when they are enough for the doctor who listens to him or her? Beyond the problematic nature of the certificates themselves lay the further question of whether these organizations should continue to issue them. This question had troubled the activists for more than ten years: there was a powerful tension between resistance to being used as a tool by the authorities and concern to maximize asylum seekers' chances. In fact the question had never really been decided: suspending certification had often been suggested, but the threat remained an empty one. Taking that step would mean a leap into the unknown, both with respect to the public authorities who contributed a substantial proportion of the organizations' funding and in relation to the asylum seekers who would be likely to suffer from the decision.

However, that night the organizations became even more sharply divided. The representatives of the Primo Levi Center wanted to adopt a common strategy of confronting public authorities: "We are a care center," one explained. "We have had a political discussion around whether we should continue with certification or not. The question

² The meeting, which took place at Comede's offices and was attended by Estelle d'Halluin, is reported in more detail in an article (Fassin and d'Halluin 2005).

arose because of the increase in requests. We felt more and more manipulated. Our position now is that we will not issue them." Another explained the intention behind this decision: "We have to do more than just say we are not going to issue any more certificates. We have to combine this decision with a political declaration from all the organizations that wish to denounce the myth of proof and promote the right to asylum. But obviously we have to explain our position to OFPRA, to our partners, and to our patients." However, the other organizations present at the meeting were more reticent. A doctor from the Center for Rights and Ethics in Healthcare hedged: "In spite of everything, you feel it's a way of helping them, don't you?" One of his Comede colleagues agreed: "Our justification for issuing certificates is that there's always a possibility it could help." In the end, nothing was decided. After some heated exchanges—one participant even walked out of the meeting in protest against the failure to take a common position against certification—the members of the three organizations dispersed. At the time no further meeting was planned. It seemed that the positions of the two sides were irreconcilable and that each would go its own way. But a few months later, it was learned that none of the organizations had actually stopped issuing certificates. The threat was not carried out. There was still disagreement, but a split had been avoided.

The debate around certification has resurfaced periodically and insistently over nearly twenty years, but recently a new element has been introduced: the invocation of psychological sequelae in clinical reports. Interestingly, trauma has become such a commonplace to those involved that this fact has gone unnoticed. For a long time the issue in certification was to authenticate the marks left on bodies by torture, testifying to the scars. Now it relates also to the traces left in the psyche: signs of post-traumatic distress are sought by experts as evidence of persecutions endured. The role of psychologists is therefore strengthened and redirected towards this new semiology, which reveals not mental pathology but psychic suffering that is considered normal in light of the violence the refugees have suffered. Organizations have been created of specialists who lay claim to competence in this new field, through which mental health is being redefined beyond pathology. The authorities charged with adjudicating requests for asylum consider it perfectly natural that doctors or psychologists should explain to them in a certificate that they have identified psychic symptoms which in some way constitute evidence of violence endured.

This kind of proof is increasingly present in applications for asylum, and is moreover demanded by the applicants' lawyers. Let us consider the following letter as just one example among many:

Dear Sir:

Following our meeting at my office on 16.11 last, I note that you were going to consult a specialist in order to obtain a certificate confirming the compatibility of the scars on your body with the ill-treatment you suffered. I also note that your regular doctor has recommended a psychological examination relating to this ill-treatment. I advise you to approach either Comede or the Primo Levi Center, or a forensic physician.³

Thus, like the physical scars, the psychological effects of violence can authenticate the account of an asylum seeker. The causal relationship established by an expert between the signs observed and the alleged persecution offers proof that this persecution did indeed occur. It gives the OFPRA officers or Appeals Commission judges the confirmation they need to decide on the truth of the applicant's claims. In a context of growing suspicion towards asylum seekers over the last twenty-five years, trauma has become part of the test of truth. This change in the way evidence is administered occurs simultaneously with an inverse change in public policy and practice regarding refugees. More credit is given to medical and psychological expert evidence, but increasingly less credence is given to political asylum.

No one doubts that victims of torture may suffer traumatic sequelae, both physical and psychological, from the ill-treatment they have undergone. And no one is surprised that doctors, psychiatrists, and psychologists devote their efforts to better understanding and caring for the suffering resulting from such persecution. The remarkable fact that we wish to emphasize is that today trauma, properly certified by mental health specialists, has become a customary and expected element in the application submitted by the asylum seeker to the OFPRA protection officer or the Appeals Commission evaluating judge. Twenty years ago it played no part in the assessment procedure; now it forms an integral part of the proof that French institutions demand from candidates for refugee status. Clearly trauma has once more enlarged its field of influence within society. Of course, psychiatrists and psychologists working with organizations supporting asylum seekers or, more specifically, the victims of torture and persecution, continue to offer mental health care for their patients. They see therapy as the core and ultimate purpose of their work, the rightful application of their skills. The fact that they are called to bear witness, asked to draw up reports attesting to the psychological traces of ill-treatment, transformed into auxiliaries of the institutions responsible for granting asylum, is problematic for them. However, even as they condemn

³ Letter from a lawyer's office dated November 16, 2001, relating to the application of an asylum seeker whose case was to be heard by OFPRA. (From the files of Arnaud Veisse, director of Comede).

this diversion, they continue to produce an increasing number of official documents authenticating trauma and serving as evidence for asylum seekers or for the lawyers and organizations defending them. We need to assess this change in the administration of evidence on at least two levels.

First, we shall try to understand the conditions in which a new domain of mental health—partially autonomous, and particularly segmented—has emerged, a domain that has crystallized around the politics of asylum and the question of torture, and which we might call the psychotraumatology of exile (although there is no officially recognized term for it). It is a field in which the professional and the activist overlap, and it revolves around the new social figures of the asylum seeker and the torture victim—not new in themselves, to be sure, for hospitality and violence have always existed, but for what they represent and for the way in which they are represented. The meeting described above is indicative of the central issues in this field, in terms both of the discussions between the participants present and of the relationships that may be surmised with those who were not present.

Second, we shall attempt to gain a detailed understanding of how trauma has come to be incorporated into the medical certification procedure, focusing specifically on an examination of certificates issued to asylum seekers over the last two decades. Changes in the role of psychological evaluation and modifications in clinical language will provide keys to the way in which signs of violence find their place in the ordeal of truth that forms the basis for granting refugee status. However, our concern is not to prejudge the efficacy of what is often seen by those involved as a key to opening the doors of asylum (despite the fact that empirical study shows its limitations when it comes to actual judgments). Ultimately, far from following a single, linear path, the journey to establishing trauma as part of the regime of truth emerges as an uncertain, ambiguous process, full of contradictions that say much more about moral and political stakes than they do about clinical and diagnostic issues.

The Psychotraumatology of Exile

ON APRIL 30, 1996, a lawyer attached to the Court of Appeals in Paris wrote to a doctor on the Medical Committee for Exiles in connection with the case of an asylum seeker who was to appear before the Refugee Appeals Commission. Aside from seeking specific evidence to support his client's claims in this individual case, the lawyer wondered about the possibility of developing a more systematic structure for psychological expert reports:

Lawyers are very surprised by the Appeals Commission's responses to the narrow scope of the medical certificates you produce. Of course we are only indirect witnesses of what are often complex situations, and I appreciate that your medical certificates cannot unequivocally confirm or deny the truth of certain facts. But would it not be possible to set up a medical structure that would allow for a psychological examination of the claimant's account followed by a statement as to the likelihood of a legitimate claim to asylum?

Drawing a parallel with another area of the law, he described what he was envisaging in more detail:

In criminal law, there are a number of experts in psychology and/or psychiatry who offer judgments on matters even though they were not eyewitnesses. These doctors' analyses relate essentially to the credibility of the account given by the individual under investigation. So I'm wondering whether it would be possible, alongside a medical examination proper, to conduct a purely psychological examination to assess the credibility of the applicant's account.

Recognizing the dangers of contributing in this way to the adjudication of cases, he concluded: "Unfortunately there is no solution that does not involve risk, but it seems to me that a psychological examination could give some of your medical certificates more weight in the judicial process."

This letter does not raise the issue of trauma, and for good reason: the concept had not yet reached the arena of adjudication of asylum claims. But while lawyers did not yet have the language of trauma at their disposal, they were already thinking in terms of proof and beginning to see the role that psychiatrists and psychologists could play in providing that proof. What is being proposed here, quite explicitly (and this letter is

valuable for the way it expresses what would later be implicit) is what might be called a new regime of truth in which the expert in the psyche would confirm or invalidate an account. However, this proposal is unclear as to whether the subject of the report should be the personality of the claimant (in order to establish how much confidence can be placed in his or her account), or the sequelae he or she presents (to determine whether they are consistent with the violence described). Recent developments might suggest that the latter hypothesis is more likely, and that the inquiry relates to psychological sequelae indicative of persecution. But there is a substantial body of recent writings by psychiatrists and psychologists that demonstrates inconsistencies in asylum seekers' memories and seems to suggest that evaluation of the likely validity of their stories is called for on some level. However this may be, the target of investigation today is certainly trauma, probably beyond the hopes of the lawyer cited above. The letter below, sent by a member of the Ecumenical Mutual Support Service Cimade to a hospital doctor a few years later, is revealing:

Mrs. D came to see us. Although her request for territorial asylum has been lodged, the outcome is not guaranteed. It needs to be backed up with evidence. It would be good if she could consult a psychiatrist. In addition to helping her, he might be able to give her a certificate confirming psychological trauma.

Many more examples could be found of similar requests addressed to mental health specialists with the aim of obtaining evidence to support claims. Within less than ten years, the demand for psychological expert reports, which was no more than a working hypothesis in the Paris lawyer's letter, has become routine practice, a gesture taken for granted, a standard expectation. Evidence of trauma is now sought as conclusive proof, and a new field of expertise has grown up around this need: the psychotraumatology of exile. However, the emergence of this field can only be understood in the light of the history of the structures catering to the medical care of immigrants.

THE IMMIGRANT, BETWEEN NATIVE AND FOREIGNER

The psychiatry of immigration began to develop in the 1950s, between two historical eras dominated by two images of otherness: the native, in the colonial era (whether resident in the colonies or the metropolis), and then the foreigner, in the post-colonial world (whether this foreigner had official status or not, and whether he was seeking work or requesting asylum). Between these two figures stands another who links them chronologically and sociologically—the immigrant, a product principally of the demand for labor in the French economy, and in Europe as a whole.

During this period of transition from one figure to another, interest in the mental health of these immigrants emerged both on the margins of the rejuvenated field of general psychiatry and among those who had worked in colonial psychiatry.¹ On the one hand, in France, the universalist model of the French mental health system and the dominant psychopathological paradigm rejected a priori any idea of ethnic or cultural singularity. Mental health care for immigrant patients would require neither a special clinic nor different kinds of treatment. This refusal to make a distinction was reinforced by an indifference in French society to the condition of these marginal groups. At best the "overseas-born" proletariat might benefit indirectly from the medico-social treatment developed in progressive psychiatry circles. On the other hand, in the colonial empire a policy and practice of psychiatry had developed that were strongly marked by cultural and racist prejudices. Attempts to identify specific traits of the "African personality" or the "Muslim mentality" inevitably resulted in interpretations that revealed more about the colonial mindset than about local psychopathology. A radical reaction against these interpretations did arise during the period of decolonization, but it related more to the ideological project of colonial psychiatry than to the essentialist theory of the colonized mental patient. Although mental health specialists—who were later to take an interest in the cases of immigrants—rarely mention this aspect of their discipline's history, the contrasting landscape of colonial psychiatry and its critics is always there as a backdrop to their thoughts and activity. Let us look in detail, then, at these two histories which throw light on the development of the psychotraumatology of exile.

At the end of the Second World War, French psychiatry was profoundly affected by the discovery of the extreme state of deprivation in which the discipline had left mental hospitals under the German occupation: 40% of the patients housed in them had died of starvation and neglect.² Reacting to this tragic abuse of the asylum as an institution, leading psychiatrists, including François Tosquelles, Lucien Bonnafe, and Georges Daumazon, engaged in a collective critique of the practices of psychiatry. The winds of reform that blew through the discipline led, ten years later, to the first experiments heralding a new psychiatric sector established in the early 1970s. At this time the focus was on taking professionals out of the hospital and designing a care structure that would bring them closer to patients, in contrast to the asylum which represented the archetype of

¹ For an analysis of the psychiatry of immigration, and more particularly of the tension between universalism and culturalism, see our article (Fassin and Rechtman 2005b).

² On this history, see Robert Castel's book (1976) and articles by Jean Ayme (1996) and Max Lafont (2000).

Erving Goffman's "totalitarian institution."³ This questioning of psychiatry, its practices of classification and internment, and its collaboration with the dominant power and the established order, took place in a context of fundamentally universalist thinking. There was no place for a differentialist approach which would have produced a special, or perhaps simply retooled, clinical practice to treat first the natives in the colonies, and later immigrants. At the margins of French society, in their camps, hostels, and shanty towns, these invisible workers came to the attention of psychiatry only when mental pathologies were discovered while they were being treated for work-related injuries. It was with these cases that *sinistrosis*, which as we have seen was born a half-century earlier, came into the limelight.⁴ In a period in history when immigrant labor was essential to the economic development of the country, absence from work through illness was all the more suspect and unwelcome if the patient related his alleged symptoms to his conditions of work. Thus the illegitimacy of the pathology made explicit the illegitimacy of the immigrant, who not only was no longer socially useful, but also demanded financial compensation. Apart from this particular condition, which was otherwise relatively marginal within psychiatry, otherness was only acknowledged insofar as it signified experience of otherness as mental disease. The cultural other did not exist.

The situation was very different in colonial psychiatry, which had developed around the notion of a radically other colonized subject. Rather than the African mental patient, it was the African *per se*, even when mentally healthy, who was presented as the paradigmatic figure of otherness.⁵ An eye-opening study of this period is the report by British psychiatrist John Colin Carothers, who, at the request of the World Health Organization, undertook an analysis of the "African mentality in health and illness."⁶ On the basis of clinical data, electroencephalograms, and anatomo-pathological data, he developed theories on the inferiority of African subjects, which he ascribed to "frontal laziness" that caused them to behave like lobotomized European subjects. In the French empire, it

³ See Erving Goffman (1968) on the condition of mental patients in American asylums and his theory of what he calls "total institutions," but which, in the political context of the time, translators chose to render in French through a term meaning "totalitarian institutions."

⁴ See the section on *sinistrosis* in Abdelmalek Sayad's chapter "La maladie, la souffrance et le corps" [Illness, suffering, and the body] (2004), translation of a 1981 article.

⁵ On this history, see the articles by René Collignon (2002) on French colonial psychiatry and Richard Keller (2001), who compares the French and British empires. The most important reference however is the latter's recent book on "colonial madness" (Keller 2007).

⁶ See the report by Carothers (1954) and the analysis by Jock McCulloch (1995) of Carothers' psychiatric work and its political implications for the Mau Mau rebellion.

was the Algiers School that in the 1920s applied this differentialist approach to the "North African native" and constructed a paradigm of "Muslim psychiatry."⁷ According to Antoine Porot, founder of this school, the "psychic formula of the Muslim native" was characterized in particular by "mental weakness" linked to a lack of intellectual stimulation, and by "a low level of affective and moral life" revealed in a lack of respect for human life; the two elements combined explained the "criminal impulsiveness" of the "native." For both Carothers and Porot, otherness was ultimately less cultural than racial, since it derived from biology (poorly developed frontal lobes according to Carothers, a prominent *diencephalon* in Porot's version), and moreover the differences were understood less as cultural traits than as signs of inferiority (Porot links magico-religious representations of illness to mental underdevelopment, while Carothers ascribes them to a lack of conscience). The virulence of the criticism leveled at colonial psychiatry by Frantz Fanon, for example, is easily understood. As he reminded readers, it was taught in faculties of medicine and schools of health for decades, including in both the British and the French empires.⁸ Thus this emergent "ethnopsychiatry," as it was beginning to be called, was far from being the meeting between psychiatry and ethnography that Franck Cazanove, the chief medical officer for the colonial troops posted in Senegal and the author of illuminating texts on mental patients in French West Africa (published as early as 1912)⁹ had called for. Instead it was based, from the outset, on an extreme notion of otherness, essentialized, and racialized, that left no place for genuine recognition of the other.

In these parallel traditions of general psychiatry and colonial psychiatry, which took contrasting approaches to otherness although they never came explicitly into conflict, the place each gave to war trauma is particularly significant. When it came to war, Africans suffered doubly, sustaining heavy human losses both far from home, serving in the armies of the European powers during the two world wars, and then at home, during the colonial conquest and the struggles for independence. As to general psychiatry, the most remarkable fact is the virtual absence in the literature of references to infantrymen and other colonized subjects engaged in wars on the European continent. To judge by the psychiatric literature, shell

⁷ See in particular the articles by Antoine Porot (1918 and 1932), and René Berthelier's analysis (1994) of the Algiers School, its offshoots, and its critics.

⁸ "Algerian medical students received this training and imperceptibly, after accommodating themselves to colonialism, the *élite* came also to accommodate themselves to the inherent stigma of the Algerian people," writes Fanon (2002), in reference to the racist explanations of psychological peculiarities identified in colonized subjects.

⁹ "A meeting between psychiatry and ethnography could produce illuminating and fertile results," Cazanove notes in a medical article (1912).

shock, the subject of so much discussion particularly among French and German psychiatrists, apparently affected only European soldiers. When disorders were observed in soldiers from the colonies they were interpreted as psychotic manifestations (dismissing any possible causal link between event and symptoms), and patients were sent back to their country, thus evading the issue of compensation and hence of secondary gains around which the debates about European soldiers centered. In other words, African soldiers were apparently not affected by trauma, although it is known that they had more than average exposure to the violence of the conflicts. Conversely, colonial psychiatry offered a wealth of interpretations that aimed to characterize the colonial response to war situations. The various forms of ethnopsychiatry developed in this context explained psychological disorders in terms of malingering. The malingering of these non-Europeans differed, however, in three significant ways from that of European soldiers: their duplicity was evident and left no room for doubt; the incidence of malingering was widespread, affecting all soldiers and thus it was ultimately no longer pathological; and finally, it was manifested in crude ways because it had not been processed through dreamwork. Opposition to the colonial order, expressed either through signs of stupor or conversely through violence, was ascribed by these clinicians to individual psychopathology, sometimes augmented by psychoanalytic factors. In one example of this psychologization of political situations, the refusal to eat was described as the negativism and stubbornness characteristic of the colonized mentality, rather than being linked to hunger strikes and hence the practices of resistance.¹⁰ In other words, in contrast to general psychiatry, in colonial psychiatry there was an over-abundance of interpretations of the manifestations of war trauma.

Between denial hiding under the cloak of medical universalism, and over-interpretation based on colonial racism, we can see that the psychiatry of immigration, as it began to emerge between the end of the Second World War and the beginning of decolonization, developed amid the contradictions and ambiguities of the Republican model of color-blind universalism and egalitarian integration regularly invoked even by those

¹⁰ We could cite Antoine Porot (1918) at length on this theme. After noting "the frequency of, and readiness to slip into accidents and pithiatic reactions" (in other words, malingering), he continues: "When applied to war traumas, this cast of mind has incalculable consequences and creates legions of exaggerators and perseverators. The Muslim native has a remarkable propensity for passive life. His rather crude, one-track mind applies all of its inert mass to the initial trauma and the immediate functional incapacities." Later, describing what happens when these normal proclivities are amplified by pathology, he writes: "As for the psychopathies proper observed in Muslims in time of war, they present in simple form: some confusion, with stupor, almost always; dreaming, in the Muslim, is rare and results only from infection or intoxication."

who most strongly rejected it. Whether it took up these traditions or reacted against them, the emerging psychiatry of immigration was strongly marked by this history. It was also, however, remarkably diverse, and it developed largely in the context of support organizations, on the margins of public health services. We shall examine the psychiatry of immigration in more detail by looking at the treatment of refugees—in other words, of those whose experience adds the memory of violence to the suffering of exile.

THE CLINICAL PRACTICE OF ASYLUM

The first psychiatric care facilities catering specifically to immigrants in France were set up by a psychiatrist whose personal history is itself emblematic of the upheavals of the early twentieth century.¹¹ Born in Russia, raised in Poland, and educated in Germany, Eugène Minkowski came to Paris during the First World War. In 1951, in the face of a growing demand for psychological support from emigrants from Eastern Europe, for whom the public system was unable to offer appropriate assistance, he set up a mental health clinic in the offices of the people's community clinic in Paris (opened by Doctor Tiomkine during the Second World War to offer treatment to the needy). Ten years later, Minkowski's clinic became part of an independent association funded largely through the support of a number of private organizations specializing in aid to refugees, but also receiving public money. The focus was on treating patients, often children, by taking into account their history, and in their mother tongue. However, the clinical practice was built not around a culture (that of the native country), but around an experience (that of exile, and sometimes of the tragedy and violence that had led to exile). The phenomenological approach to mental illness developed by Minkowski emphasized universal models rather than individual interpretations. The use of the patient's own language represented a simple adaptation to the conditions of the treatment relationship, which was furthered by the fact that rather than using translators interposed between therapist and client, the clinicians were Russian, Polish, German, and French psychiatrists who shared the same culture as their patients. Each clinic was identified by the language

¹¹ For a description of the Minkowska Center, see the Web site <http://www.minkowska.com>. Our account is also based on interviews with staff of the center. Initially financed by the Service social d'aide aux émigrés [Social services for the assistance of emigrants], the center was subsequently supported by Cimade and Secours catholique, by the Paris city authorities, the Caisse d'épargne bank, and the Service d'hygiène mentale [Mental Health Services] in Paris. Since 1985 it has been funded by the Caisse nationale d'assurance maladie [National Health Insurance Fund].

it used. In 1965, new practices were opened in response to demographic changes in the migrant population, first in Spanish and Portuguese, then in Arabic and Turkish. Others focused on regions of the world rather than language areas, for immigrants from sub-Saharan Africa, for example, and Southeast Asian refugees. Thus the structure was adapted to changes in the immigrant population while maintaining the flexible universalism that characterized the spirit of the first clinic. It is worth noting that although the first patients were suffering from experiences directly related to war, and some of the subsequent waves included people who had been persecuted in their countries of origin, trauma was never the focus of the psychiatric clinical practice, which was on the contrary based on a generalist approach to the “mental health of migrants” (as indicated by the organization’s current mission statement). In the view of the psychiatrists working at the center, it was exile, rather than trauma, that defined the experience of these patients who were caught between two histories, between two worlds.

The Centre d’orientation médicale pour les demandeurs d’asile [Center for Medical Advice to Asylum Seekers, Comede] was born out of a similar response to an emergency. In this case the trigger was a the sudden surge in applicants for refugee status, particularly from Southeast Asia, which resulted in the creation of a network of health professionals willing to offer them free consultations, a network supported by two human rights organizations.¹² This was in 1979, when large numbers of Cambodian victims of the Khmer Rouge were fleeing their country. The chartering of the *Ile de Lumière* hospital ship brought their tragedy to the attention of the French public, and the refugees’ cause gained popularity, largely based on a wave of emotion. Three years later, the aid center became the permanent organization Comede, Medical Committee for Exiles, with its clinic in the Kremlin-Bicêtre Hospital south of Paris. The historical context was completely different from that in which the Minkowska Center was set up. The great political upheavals of the period after 1968 were waning, and new forms of activism were emerging, less radical and more targeted. Within psychiatry (which had also weathered fierce controversies during this period), a current critical of France’s colonial heritage—denouncing

¹² For an analysis of Comede, see the organization’s journal, *Maux d’exil* [The ills of exile], and its annual report, on its Web site, <http://www.comede.free.fr>. We also conducted a series of interviews with members of the management team and the medical-social staff. Comede was set up by Groupe accueil et solidarité [The Welcome and Solidarity Group, GAS], and funded by Cimade and Amnesty International, which are members of GAS. Today Comede is largely publicly funded, mainly by the Population and Migration Directorate, the General Health Directorate, the Ile-de-France Regional Health and Social Welfare Directorate, the Ile-de-France Regional Health Insurance Office, the European Fund for Refugees, and the United Nations Fund for the Victims of Torture.

in particular the pathogenic conditions in which foreigners lived—had developed in the field of immigration, and this current had crystallized around the Comité médical pour la santé des migrants [Medical Committee for the Health of Migrants]. Comede had a specific focus (on asylum seekers), and its aims were concrete (to provide treatment to people excluded from the health care system). As one of its first presidents, Philippe Magne, put it, Comede catered not to “the star dissidents, but to the foot-soldiers of exile.” Paradoxically, as the organization became more professional, moving from relying on volunteers to paying its staff, and more institutionalized, supported by public subsidies, it gained an increasingly public profile, particularly in the Coordination française pour le droit d’asile [French Coordinating Committee for the Right of Asylum], an organization that coordinated the efforts of twenty groups that opposed increasingly restrictive government policies on asylum. Comede offered medical/social services that aimed to answer the full range of human needs, including—from the start—psychological and psychiatric treatment. This service, initially run by Latin American refugees, was continued by other mental health professionals, mainly of African origin, who had come through the rapidly growing university training in ethnopsychiatry. Comede specialized in assistance to asylum seekers (unlike Médecins du monde which, during the same period of the 1980s, focused much of its work on illegal aliens at its pioneering community clinic on the rue du Jura, in Paris), and increasingly found itself facing the specific problem of victims of torture. Should these patients, who were in the minority at the clinic, be singled out from other applicants for refugee status on grounds of the nature of their traumatic experience or, conversely, should they be treated like the others in order to avoid creating moral distinctions in suffering and hence also a sort of implicit hierarchy among asylum seekers? This difficult question led to a split in the organization.

The Association pour les victimes de la répression en exil [Association for the Victims of Repression in Exile, Avre] was formed in 1984 in response to the idea that “victims of torture are not patients like others and require a very special kind of care.” The following year, the organization established a clinic in the Croix-Saint-Simon hospital in Paris.¹³ Its founder, general practitioner Hélène Jaffé, had been working with Comede where she argued in favour of different treatment for people who

¹³ On the history of Avre, see the brief outline on its Web site, <http://www.avre.fr>. We have also drawn from documents produced by the organization, notably its quarterly newsletter *Havre* (Haven) and from interviews conducted by Estelle d’Halluin with staff of the organization, which was primarily supported by public subsidy from the Fonds d’action sociale [Social Action Fund], the European Union, and the United Nations. Its president collaborated with the government on several programs. The organization was dissolved in 2006 after the retirement of its charismatic leader.

had suffered torture, but found no support for her position. Her conviction of the distinct nature of their problems was strengthened during a mission she undertook for Médecins sans frontières to Guinea-Conakry following the death of President Sékou Touré in 1984, to treat those released from camps and prisons. On her return, she set up Avre with a small team of doctors and psychologists. In addition to providing treatment, backed up by teacher training aimed at facilitating the integration of asylum seekers into French society, Avre worked in a number of other countries. Financed principally from French and European public funds, it developed a close collaboration with the French government, even chairing a Ministry of Health working group on victims of torture. In general, Avre's political activity was oriented more towards the international arena, where it brought civil prosecutions against former dictators, than the national context, where it took no part in campaigns for asylum rights. But the most remarkable paradox in the organization is its position on trauma. On the one hand, it was the first organization in France to suggest that the experience of victims of torture and the psychic "sequelae" left by the ordeal were unique. On the other, it was systematically reluctant to engage with psychologists, whom it regarded as ill equipped to deal with this unique condition, whereas medical doctors who had worked on such cases had a genuine capacity to "listen" to patients. Trauma was rarely evoked in Avre: the preference was for drug treatment rather than psychoanalysis. Relegated to a subsidiary role and mistrusted within the organization, the psychotherapist members left Avre.

Thus it was yet another split that led to the formation of the Primo Levi Association in 1995, created by a group of seven ex-Avre members who initially set up a small structure they called Trêve [Truce].¹⁴ With the support of Médecins du monde, Amnesty International, Juristes sans frontières [Lawyers without Borders], and Action des chrétiens pour l'abolition de la torture [Christian Action for the Abolition of Torture], Trêve set up the Primo Levi Center. Funded initially by these private organizations, the Center increasingly won public subsidies, and by 1995 received 80% of its budget from public funds. While patients who came to the Center's clinic were offered medical treatment and social assistance, the core of its work was psychotherapy. Specializing in trauma, the work of course included "care and support for victims of torture and political

¹⁴ On the history of the Primo Levi Center, see the Web site <http://www.primolevi.asso.fr>. We also conducted interviews with several members of the organization, attended two of their conferences, and consulted their public journal *Mémoires*. The Primo Levi Center receives 80% of its funding from French public institutions (the Prime Minister's Office, the Population and Migrations Directorate, the General Health Directorate, the Ile-de-France Region, the City of Paris, as well as several national and international bodies), but also receives funding from a number of NGOs, including MDM.

violence," as the organization's name implies, but it also offered help to persons exposed to the spectacle of this violence through their work (the staff of aid organizations, for example) or to the narration of it (such as members of legal support organizations). This justified the provision of "debriefing"—psychological support aimed at preventing post-traumatic sequelae. In addition to caring for patients, the organization campaigned publicly in defense of the right to asylum and to raise awareness of the suffering of those "psychically traumatized by torture." In the late 1990s the Center established links with the Association de langue française d'études du stress traumatique [French Language Association for the Study of Traumatic Stress, ALFEST], founded by military doctor Louis Crocq, the originator of psychiatric victimology and a latecomer to the field of humanitarian psychiatry. Thus the evolution from the psychiatry of immigration to the clinical treatment of trauma came to its completion with the establishment of the Primo Levi Center. But this shift extends beyond the French context. The European Network of Treatment and Rehabilitation Centres for Victims of Torture and Human Rights Violations brings together thirty-eight organizations. Sibel Agrali, director of the Primo Levi Association and one of the French members of this network, explains its mission: "Victims need more than just care related to their ill-treatment. On top of all their difficulties in building a new life and getting their past recognized, they remain haunted by what they have experienced, traumatized by their journey and by exile. There is no official training specific to these traumas. And you can't offer a listening ear to a victim of torture without yourself being affected, shocked. You have to learn to withstand and manage these situations. And it is not a matter for specialist doctors: torture is not an illness. The solution is not a question of cure." Torture and trauma, then, go hand in hand. Both call for specialized treatment; both are more a matter for psychology than for psychiatry; and both have become targets of coordinated action at the European level.

We see that in the history of medical and psychiatric care for refugees over the last half-century in France there has been development on two levels. On the one hand, there is a progressive redefinition of the client group: while the Minkowska Center caters to immigrants, Comede, in the late 1970s, turns its focus to asylum seekers; and from the mid-1980s Avre, followed in the 1990s by the Primo Levi Center, are dedicated exclusively to victims of torture and persecution. We see both a diversification in care provision and a degree of specialization around extreme situations. On the other hand, there is a shift in the time frame that treatment covers: at the Minkowska Center, although there is an acknowledgment of past suffering, clinical practice is centered around the experience of exile. At Comede a division between the before and after of emigration begins to be constructed around the issue of political violence, but this creates ten-

sions. A split occurs with the emergence of Avre, which aims specifically to establish a distinction between patients' relation based on the kind of violence they have experienced in their country of origin. However, it is with the Primo Levi Center that trauma *per se* becomes the central focus of care. Thus, while the suffering of exile (a present cut off from the past) is not denied, the legacy of violence (a past inserted into the present) becomes the new object of treatment.

We are not, of course, suggesting that one type of patient is being replaced by another, or one time frame by another; rather, we are attempting to show a shift of focus to asylum seekers and the question of violence, at the same time as an accretion of successive layers of clinical challenges. Far from thinning out, the organizational landscape becomes richer, and the professional field more complex. This dual shift, from migrants to victims of persecution, and from exile to trauma, marks the emergence of what we may call a psychotraumatology of exile. We use this term to point both to an increasing specialization around asylum seekers and victims of torture, and to a persistent tension between a focus on exile and the exposure of trauma.

A CHANGE OF PARADIGM

"The external and internal worlds of voluntary immigrants are vastly different from those of refugees and asylum seekers," writes psychiatrist and psychoanalyst Vamik Volkan¹⁵ in his introduction to the first book devoted exclusively to the trauma of "war and torture victims." However, the distinction is more complex than it appears. On the one hand, "there are also common elements that underlie the psychology of both the 'normal' immigrant, who leaves his or her homeland voluntarily, and the traumatized immigrant, who is forced to flee by circumstances. . . . Since moving from one location to another involves loss—loss of country, friends, and previous identity—all dislocation experiences can be examined in terms of the immigrant's ability to mourn and/or resist the mourning process." But on the other hand, in the case of refugees and asylum seekers, "their mourning processes are complicated due to actual traumatic experiences. One has to deal with the effects of the actual trauma before the individual can become like ordinary, 'normal' immigrants." This contrast between the mourning of exile and the trauma of violence—which, Volkan suggests, gives rise to fundamentally different experiences and hence demands different treatment strategies for the "normal" immigrant vs. the "forced" displaced person—is now common currency. Today, the suf-

¹⁵ Volkan (2004).

fering of the immigrant cannot entirely encompass that of the victim of persecution: there is in the latter something that the former does not contain, which is termed trauma. This notion is the fruit of social evolution, the progress of which is revealed by the history of clinical practice as it relates to the issue of asylum. Clinics shifted only gradually from a model of mourning to one of trauma, and trauma did not replace the mourning paradigm; rather it enriched and partially overlaid it.

The founders of the Minkowska Center focused on emigration—and therefore exile. The very use of the term “émigré” [emigrant] instead of “immigré” [immigrant], which then had pejorative connotations, is significant. It implies not only a higher valuation of the migrant (rather than being a surplus person “here,” he or she is a person missing from “there” and who misses “there”), but also an attachment to elsewhere. The émigré must not only settle “here” but also must detach him or herself from a “there” that continues to have meaning. The very name of the organization Comede (Medical Committee for Exiles) points to this link. The treatment Comede offers foreigners who make use of its services still incorporates both the “before” and the “here,” distance and presence, the pain of separation and the difficulty of settling in. For the Minkowska Center and Comede, a refugee is primarily a person within the complex and many-faceted experience that is exile. This does not mean that the personal suffering of the individual victim of persecution is not taken into consideration, but it is considered as an individual history within a universal framework. There is an apparent paradox in the emergence, in the 1950s, of a clinical approach to the experience of exile that is not built on the model of trauma neurosis, even when it was dealing with patients from Eastern Europe, many of whom had direct or indirect experience of the barbarity of World War II, the inhumanity of the Nazi camps, or Soviet repression. But rather than a contradiction or a denial, what we see here is the assertion of an ethical stance that refuses to see distinctions between levels of suffering or, more generally, between forms of experience.

The creation of Avre ushered in a different model. According to Avre members, living through torture, or through political violence more generally, produces an individual experience irreducible to any other, and usually incommunicable. They argued that this ineffable experience merited clinical intervention as well as intuitive compassion—in other words, psychotherapy. And with the establishment of the Primo Levi Center, the unique experience of the victim of persecution and psychologists’ recognition of trauma were brought together for the first time in the field of immigrant mental health. A name had thus been put to this irreducible fragment of life, which was henceforth no longer incommunicable, because it had become the target of psychotherapy. What is new in this

approach is the isolation of the actual moment when the persecution took place as the root cause of the trauma. Today this seems to go without saying. However, it too is evidence of a significant shift in viewpoint whereby the experience of political violence takes precedence over all other experiences, all other forms of suffering that the concept of exile, by virtue of its very imprecision, so flexibly encompasses. This model was neither a hypothesis that could be tested and validated, nor was it the product of a prejudice that would lead to predetermined misunderstandings in other areas. Rather, it was an operational postulate that found its meaning entirely within the concrete activity of Avre and the Primo Levi Center.

When patients arrive at these clinics they are initially passed through what amounts to a triage to identify those whose cases are suitable for treatment. At Avre the selection is very strictly based on the criterion of torture. According to one of the organization's doctors, "We only treat people who are or who claim to be victims of torture. We're entering into an ideological debate here. As I see it, people who've witnessed massacres, whose loved ones have been tortured in front of them, are victims of torture. But from the organization's point of view, that's debatable: fearing for your life is not torture." Clearly, this distinction in terms of what actually happened effectively constitutes a rejection of the notion of trauma, for which the nature and even the truth of the violent event are not diagnostic criteria. At the Primo Levi Center, by contrast, patients are accepted on the grounds that they are suffering from trauma. One example would be the case of an Algerian patient aged around thirty, who was referred to the organization by a hospital. He had applied for territorial asylum, on the grounds that his life was in danger in Algeria. He had been a police officer, had been threatened by armed groups, and, having resigned from his post because he disagreed with what he was asked to do, he also feared military reprisals. Serious psychological disturbance had brought him to the center. At the end of his first appointment, it was revealed that prior to the recent events the man had been under psychiatric care in Algeria for alcoholism that was ascribed to an underlying neurosis. For this reason, he was referred on to the public psychiatric service. The aggravation of his clinical condition by the political climate and the persecution he had suffered, was not taken into account, because the prior existence of symptoms made it impossible to identify post-traumatic signs clearly.

To sum up: in the history of psychotraumatology in France, recognition of torture as a reality particular to refugees preceded the identification of trauma as the mark left by the violence suffered. In the 1950s and 1960s, neither torture nor trauma was at the heart of the Minkowska Center's therapy. In the early 1980s, debate over whether victims of tor-

ture should be given special treatment caused a rift in the organizations concerned. Those in favour of differentiating these victims from the others argued that their experience of violence was so extreme and unspeakable as to call for distinct treatment, independent of the general notion of trauma. By the early 1990s, tensions centered around the role that should be taken by psychotherapists in the treatment of victims of torture, but trauma was still not a widely accepted concept, since the model being put forward was one of empathic listening and social support. It was only with the creation of the Primo Levi Association that a link was made between torture and trauma: a special report on the history of the Center in the December 31, 1997 issue of *Le Monde*, titled "Les psychotraumatisés de la torture" [The psychic trauma of the torture victim], gave weight to this development, which was gaining ground rapidly. A few years later, when experience of care for victims of persecution was beginning to be exchanged at the European level, trauma had become a commonplace in the clinical assessment of asylum seekers and refugees by all organizations. The reality of trauma was recognized by all, particularly by psychotherapists.

This change of paradigm—from the experience of exile to that of violence, which also marks a transition from mourning towards trauma—nevertheless occurred within the same world of ideas. Whether the talk was of the suffering of exile or of the aftermath of violence, it was placed in relation to a universally recognized way of thinking. However individual the history of each migrant or victim of persecution, whatever its inscription in a collective history and, hence, in a particular culture, addressing the mourning of exile or the trauma of violence presupposes a common psychic world within which these concepts acquire a meaning and call for a response. This notion of a common psychic world does not of course preclude historical and cultural variation in the expression of symptoms, any more than it precludes variation in the psychotherapies that constitute society's response. But the experience is potentially universal. The corollary of this implicit presumption of a common world are forms of empathy or countertransference that have been described by psychotraumatologists such as John Wilson, founder of the International Society for Traumatic Stress Studies: "The accounts of survivors are always variants of the universal trauma archetype."¹⁶ In the view of those who support the post-traumatic stress diagnosis, and more generally of those who made use of the concept of psychic trauma, these categories describe a suffering without borders, a suffering that knows no cultural barriers.

Hence, despite their differences, the diverse approaches developed over half a century, from the Minkowska Center to the Primo Levi Center,

¹⁶ Wilson (2004).

derive from what we may call a universalist reading of the experience of migration and violence. Their intellectual lineage differs profoundly from that of contemporary ethnopsychiatry, which is based on a differentialist reading. We saw the emergence of this discipline, with Antoine Porot and especially John Colin Carothers attempting to create a science that would align psychology with culturalism (not without racist prejudices), and provide a scientific justification for the colonial order. In the 1980s and 1990s a different ethnopsychiatry grew up around Tobie Nathan at the Georges Devereux Center in Saint-Denis, where the focus was not on treating “natives,” but on immigrants or even second-generation immigrants. Breaking with Devereux’s “complementarist ethnopsychanalysis,” the new ethnopsychiatry proposed an essentialist approach to otherness that rejected both the possibility of a common experience of suffering (since each culture, ethnically defined, constituted a closed entity) and the idea of a shared sense of citizenship (since each group, identified by origin, was to be preserved and separated from the others). The influence of this current in mental health practice, and also in social work and even in the legal profession, had its effect on the emerging field of the psychotraumatology of exile.¹⁷ Many of the psychologists and psychiatrists who work with Comede, Avre, and the Primo Levi Center have passed through this school or have at one point or another identified with its approach to culture. However, most have since distanced themselves from it and now call for an approach that insists on the common experience of exile and trauma and denies that communication is impossible between the cultures in which the experience takes place. In an interview recounting her professional career, a psychologist who followed Nathan’s teaching explained to us: “As I see it, ethnopsychiatry is allowing culture to speak rather than the subject. There is no subject, just an object of research called the patient.” She contrasts this with the psychoanalytic approach she now uses: “This approach highlights the patient’s connection with his own personal history, his own past, and also with other patients. This allows the patient to become aware that she can locate her own history within a much broader historical context than that of the culture that failed to predict what happened to her.” Thus it is the individuality of the person that forms the basis for the universality of the experience.

These theoretical—even ideological—differences between universalism and differentialism did not preclude compromise. The boundaries between the two apparently irreconcilable worlds proved to be more permeable than might have been expected. Individual bridges were created be-

¹⁷ For an analysis of the work of Tobie Nathan and his influence in the scientific field, the media, and public action, see Fassin (1999 and 2000).

tween psychotraumatology and ethnopsychiatry, the most significant being the path taken by Françoise Sironi, who was a member of Avre and subsequently one of the founders of the Primo Levi Center, before she became director of the Georges Devereux Center. Hybrids of the two approaches were also developed, such as the psychiatric service at the Avicenne Hospital in Bobigny, where the team led by Marie-Rose Moro practices and teaches both the clinical treatment of trauma and transcultural psychiatry; the "trauma group" is led by the same psychiatrists and psychologists as the collective sessions that bring together "co-therapists" of varying national origins. The way in which issues of the mental health of immigrants—in this case refugees—form part of a debate between universalism and culturalism, between the clinical treatment of exile and radical ethnopsychiatry, is a historical phenomenon specific to France which can be observed in several areas, but which is most sharply expressed in this articulation between the theme of immigration (hence otherness) and the domain of psychotherapy (hence subjectivity).

This uniquely French trait was reinforced by the state's ambivalence about this issue. On the one hand the authorities promulgated a universalist model through a system of care that was oblivious to the problems of migration, and on the other, they favored culturalist approaches by supporting institutions that focused on difference. Thus the field we tentatively term the psychotraumatology of exile was constituted on the margins of the public health care system, through initiatives of private, not-for-profit organizations. However, this distinction between the public and private sectors does not fully explain the dynamics of the relationship between government policy and nongovernmental practice. First, the proportion of the private organizations' funding coming from public funds—whether through direct financing of their activities or through support of patients under social welfare programs—is increasing, until it amounts sometimes to virtually the entire budget of the organization. The value of the proportion raised privately through members' subscriptions and grants from other organizations (themselves often recipients of public subsidies) is more symbolic than substantial. Second, state institutions increasingly collaborate with private organizations; public hospitals often refer patients to private health care centers, to the extent that some, like the Minkowska Center, become as it were complementary to the public health care system; private organizations draw up documents at the request of government bodies, such as the guide to care of immigrants produced by Comede; members of private organizations sit on ministerial working groups (Avre, for example, contributed to the working group on torture); and the government grants prizes to private organizations, for example awarding the Human Rights Prize to the Primo Levi Center in 2004. Thus psychotraumatology—and through it, mental health care for

immigrants, particularly the most vulnerable of them—has been the scene of complex interplay between the state and private organizations, with the latter taking the initiative, but with the state following by supporting them and thereby deeming itself absolved of responsibility for the humanitarian management of the plight of victims of persecution. This relationship became particularly problematic when the government began to implement stricter immigration and asylum policies, at the same time as it was funding nongovernmental organizations caring for those who would bear the brunt of these policies. For their part, the organizations united in protesting against the action of public authorities whose subsidies enabled them to continue operating. Nowhere were these tensions so apparent as in the controversy over medical certificates.

THE EVIDENCE OF THE BODY

“Do you need a piece of paper to prove torture?” asked the authors of a special issue of *Mémoires*, the quarterly newsletter of the Primo Levi Association.¹⁸

Asylum seekers, faced with the increasingly strict criteria of OFPRA and CRR, are turning in desperation to doctors to obtain a medical certificate testifying that the marks left by the torturers are compatible with their stories. The phenomenon is reaching worrying levels. What is happening? Why are these men and women, who have already been through unspeakable ordeals, chasing after a piece of paper drawn up by someone who is a stranger to their past life, a retrospective witness who saw nothing of what they lived through, someone who, while ready to listen and possessing established medical skills, cannot by definition know better than the applicant him/herself what happened, and how it came about? Today, the asylum seeker who has no certificate feels less confident of being granted residence, thinks that he or she has less chance of being believed.

This pressure for evidence from the body was exerted directly on the care organizations. The Medical Committee for Exiles (Comede), for example, which sees around five thousand patients a year, has seen rapid growth in the number of expert reports it draws up. In 1984, 151 clinical psychological certificates were issued; in 1994, the figure was 584. By 2001, the number had risen to 1,171. Since the overall activity of the care center increased over this period, we must also compare the number of certifi-

¹⁸ This was the title of the report, which included an interview with Dr. Joseph Biot, a member of the Center for Rights and Ethics in Healthcare. The extracts are cited from the main article, “The Impossibility of Proof.”

cates issued with the number of consultations, in order to measure the actual workload: between 1984 and 2001, the ratio of certificates to consultations multiplied five-fold. This gives an indication of the increasing proportion of a doctor's day taken up by the writing of expert opinions: 28% of their work related to certificates confirming the sequelae of violence and torture, and this does include the 19% of their time spent testifying to serious illnesses that justify granting asylum on humanitarian grounds. The number of certificates issued decreased in 2005 only because the center adopted a policy of limiting them to five per day. The inevitable repercussion of this ruling was that asylum seekers were waiting longer and longer for an appointment to request a certificate. In the face of these delays, asylum seekers now tend to use their notification of appointment as a way of proving that the procedure is under way when appearing before OFPRA officers or the Appeals Commission judges; the latter sometimes give them the benefit of the doubt.

Thus, within two decades a clinical psychological certificate has become the key to the door of asylum. At least this was how a range of participants in the process see it—especially lawyers, for whom this document has become one of the exhibits they must to gather in order to defend their clients. Witness this letter from a lawyer, addressed to an asylum seeker:¹⁹

Dear Sir,

In a telephone conversation with the Appeals Commission, I was informed that the Commission would take its decision only when it receives a medical certificate proving that the marks on your body are consistent with your account. To obtain this you need to make an appointment with a doctor at Avre and with a doctor at Comede as soon as possible. When you have the certificates from these two doctors, please fax them to me as soon as possible so that I can pass them to the Appeals Commission.

In this letter, as in many others, the focus on the precious document, on the urgency of obtaining it, and on need for duplication of proof through consultation with two doctors, reveals the lawyers' over-investment in medical certification. The consequence for the asylum seeker is clear: no certificate, no salvation.

At the same time, the bodies responsible for assessing cases were increasingly requiring certificates, so much as to give rise to repeated protests to the director of OFPRA, the President of the Appeals Commission, and even to the Council of the *Ordre des médecins*.²⁰ For example, follow-

¹⁹ Letter dated December 7, 2001. This is one document from a file of similar requests collated by Doctor Arnaud Veisse, director of Comede.

²⁰ Order of Doctors, the French doctors' professional association.

ing “pressure which runs counter to the ethics” of the organization, the chairperson and director of Comede wrote to the director of OFPRA complaining about its officers:²¹

Some telephone Comede themselves to get a quick appointment for a certificate: patients often tell us that they have been told that they will only be granted residence on presentation of a certificate; sometimes even if they have a medical certificate, often from an eminent specialist, they are asked to get it validated by Comede.

For both Comede and the Primo Levi Center objective complicity with the bodies responsible for accepting and rejecting the applications of asylum seekers became untenable, despite the fact that the requests for certificates demonstrated the high regard they enjoyed with OFPRA officers and the judges of the Appeals Commission. The relationship between institutions responsible for implementing an increasingly restrictive policy on asylum and organizations whose mission it is to defend the rights of refugees, is clearly problematic.

The difficulty becomes all the greater when what is to be demonstrated is often invisible. Physical traces of torture can disappear quickly. According to a UN handbook:²²

The expert must proceed to a medical examination of the presumed victim. In this regard, the time factor is particularly important. A medical examination should be undertaken whatever the time elapsed since the torture, but if it is alleged to have taken place less than six weeks before, the examination should be made as soon as possible, before the most obvious traces have disappeared.

But virtually all the asylum seekers seen in France are seen months or even years after their ordeal. The “psychological proof” referred to by the UN High Commissioner on Human Rights therefore becomes all-important. As these experts suggest, “almost all those who have undergone torture suffer from depressive conditions,” but these symptoms, while they justify treatment, do not constitute proof of violence suffered. Conversely, while they argue that “the simplistic and erroneous belief that post-traumatic stress is the principal effect of torture” should be challenged, this less frequent symptomatology should excite attention because

²¹ Letter dated May 5, 1994, to which Francis Lott, the director of OFPRA, responded on June 15, 1994, in memo no. 392, reminding his agents that they are forbidden to “interfere, for whatever reason and in whatever way, in the work of Comede” and of the need to “restrict requests for a forensic medical certificate to exceptional cases where a doctor’s opinion is essential to understanding the case, as a complement to and not a substitute for the applicant’s words, nor as a substitute for an in-depth interview with the OFPRA officer.”

²² *Handbook for Effective Enquiry into Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN High Commissioner on Human Rights, Geneva, 2001.

it can help to establish that the condition is due to persecution. Ultimately, it is the most subjective trace, the trace that remains in the psyche, that will testify, virtually indefinitely, to an event of which the body no longer retains the marks.

Here the psychotraumatology of exile, whose gradual emergence around asylum seekers and torture victims we have explored, acquires new social significance. The discipline was born out of a recognition of the unique nature of the experience of persecution and the need to provide special treatment for trauma. It became a tool for evaluating the truth of accounts, useful to the authorities responsible for adjudicating refugee status. The doctors and psychologists who had committed themselves to this humanitarian cause had done so with the purpose of providing care. Now they were required to testify. Most of those working for the non-governmental organizations involved in asylum issues were unhappy with this new role, for which they were not prepared, seeing a fourfold danger in this diversion of their activity.

First, testifying to torture implies a retrenchment of the principle of the right to asylum. Under Article 1 of the 1951 Geneva Convention,²³ a refugee is defined as a person who, "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." The idea of fear—provided it is justified—is thus central. The person does not need to have been tortured to benefit from refugee status; the threat of persecution is sufficient. And the proof sought by means of the medical certificate essentially consists of physical scars left by torture as such. Limiting proof to these scars means restricting the very spirit of asylum by excluding people who feel they are in danger and are trying to escape violence. Some in the aid organizations ironically term this the "torture bonus." Psychological experts can help to open the door to asylum a little wider by identifying signs of suffering that relate to the fear of persecution; but experience shows that little use is made of this potential.

Second, the certificate also breaches the separation between the role of the physician as therapist and expert witness. According to Article 105 of the French Code of Public Health,²⁴ "no one may act as both expert

²³ Convention relating to the Status of Refugees, adopted on July 28, 1951, UN High Commissioner on Human Rights, <http://www.unhchr.ch>.

²⁴ "Exercice de la médecine d'expertise" [The practice of medical expert opinion] (article R4 127-105), *Code de la santé publique*, 19th edition, Dalloz, Paris, 2005, p. 1331.

medical examiner and doctor treating the same patient. A doctor must not accept a request for expert opinion in cases involving his own interests, or those of any of his patients, close relatives, friends, or a group that habitually uses his services." We would point out that there is also a third interested party, besides the medical expert witness and the treating doctor: namely the activist doctor, who may not be strictly objective in assessing the situation. But to restrict ourselves to the terms of the debate as it is posed by the NGOs, what is at stake is less the expert's impartiality than his or her "instrumentalization" by the asylum seeker, who takes advantage of the care offered to obtain the precious document and thus misses out on the opportunity for receiving genuine treatment. Doctors, and still more psychologists, express their frustration at this situation, which diverts their patients from the therapeutic relationship: once the certificate has been provided, the patient does not return. In fact, in order to avoid this potential diversion of the organizations' mission, certificates are now virtually never issued at the first appointment. Before obtaining the document, the applicant has to "prove him/herself" once more.

Third, the certificate acts as a substitute for the asylum seeker's own words. A member of the Primo Levi Center told this story:²⁵ "One day, an OFPRA officer called and told me, 'If you tell me this woman was raped, I'll grant her asylum.' But why did *I* have to confirm that she'd been raped in order for her to be allowed to stay?" This case is significant in that rape, except in rare cases, fortunately leaves no physical traces after a few weeks. Psychologists are therefore expected to provide evidence to confirm the truth of the account, to find in the psyche the trace left by the invasion of the body, to recognize the trauma that is proof of the violence suffered—even though it is well known that the psychological consequences of rape can vary widely in form and seriousness, and moreover that women often remain silent about what happened to them. But beyond this particular case, asking an expert to provide corporeal proof of the violent or degrading treatment suffered by the person means reminding the applicant that her words are of no value, that her truth counts for nothing. In agreeing to testify, through an expert report, that the applicant's account conforms to the evidence, the doctor or psychologist "vouches for" the asylum seeker, thus involuntarily confirming the devaluation of her word.

Finally, many see the certificate as useless or even pernicious. On the one hand, at the individual level, its efficacy is far from established. The doctor or psychologist may feel that he is giving the asylum seeker a better

²⁵ A similar case was reported in a letter from Comede to OFPRA a few years earlier, suggesting that this suspect figure has a symbolic value for those involved.

chance through this authentication of her account, but the figures do not necessarily confirm this. There is no relevant French study, but a Swedish study of fifty-two cases found no statistical correlation between the provision of an expert's report and the decision taken by the commission responsible for determining status;²⁶ even the identification of post-traumatic stress disorder, observed in three-quarters of the applicants, did not improve their chances. The authors conclude: "The CTD (Center for Torture and Trauma Survivors) examinations of alleged torture are meant to give reliable and unbiased information to the Swedish authorities involved, but the certificates provided are apparently often ignored." On the other hand, at the collective level, the practice of certification suggests that distinctions can be made between those asylum seekers for whom clinical psychological truth can be established, and those whose account cannot be verified one way or the other. Given this, the certificate could paradoxically be seen as contributing to the growing suspicion of asylum seekers and thus to the reduced legitimacy of their cause. This is a matter of concern for two senior members of the Primo Levi Center:²⁷ "The doctor who ventures into the terrain of proof becomes the tool of an ideology. Requiring proof that is impossible to come by allows the state to remove those not wanted by the social body." Ultimately, certification is a no-win situation.

Given these four criticisms—which we would categorize respectively as political, deontological, ethical, and evaluative—it might seem surprising that those who articulate them continue to issue the certificates they so disparage. But there are three reasons for this. First, one cannot refuse a certificate to a person who has a right to ask for it (although this stipulation applies more to doctors than to psychologists). Second, providing the certificate shows the person that his or her account is believed, and many attach a therapeutic value to this support. Third, in each specific case, everyone still hopes that this document will, despite everything, contribute to a happy outcome for the asylum seeker: hence the applicant is given the benefit of the doubt. Thus, despite the frustration and anger it arouses, those who condemn psychological certification continue to practice it. Not all are equally critical of it, however. While Comede and the Primo Levi Center are most inclined to denounce the uses and abuses of the certificate, the Minkowska Center and Avre have never made it a bone of contention.²⁸ One of the psychologists at Avre explained:

²⁶ Forsman and Edston (2000).

²⁷ Henriques and Agrali (2005).

²⁸ This is also the position of others, such as the "trauma group" at the Avicenne Hospital in Bobigny, where the psychiatrists, who are also members of Médecins sans frontières, go

I started by drawing up certificates for some patients, and now I issue them to almost all of them. Once a patient has committed to the therapeutic relationship and is really investing in it, I don't see any problem with certification. I think it has advantages given the anxiety, phobia, and trauma that the relationship with the OFPRA officer can generate, and I don't think it's a bad thing to . . . not direct, but alert the officer that the patient's attitude isn't a lie or an avoidance, but is really about suffering.

A psychiatrist at the Minkowska Center put it even more explicitly:

What I write in my certificate relates to what I have identified as a condition that justifies treatment. It's quite vague. But I know that I am required to use the standard form of words. That wording doesn't bother me because it helps to validate my methods, just as an element of the signifier helps to validate a meaning. If, as a citizen, I think my certificate, while remaining legal and respecting what is ethically required of a certifying doctor, can be used by lawyers or the person him/herself to confirm something, it doesn't bother me one way or the other because first, I'm working here in my capacity as a psychiatrist and second, I'm a psychiatrist who understands the society within which she's operating. It's the certificate or death.

In both cases, there is neither institutional reflection on nor individual criticism of certification. These professionals are saying that where there is psychological distress, it should be testified to, and there is even a sense that they are rendering a service to the asylum seeker, going beyond the expert witness role to become an activist committed not to a cause, but to a person.

Thus the field of psychotraumatology of exile in France can be described along two axes. On one axis, two currents emerge: one links clinical practice with politics and could be called politically committed (Comede and the Primo Levi Center); the other focuses purely on clinical practice and could be described as distanced (the Minkowska Center and Avre). On the other axis, two positions can be distinguished: one, which we may call totalizing, sees the experience of exile as indivisible (Comede, Minkowska Center); the other, which we shall call specific, singles out the experience of trauma (Avre, Primo Levi). Thus four combinations are possible, depending on level of involvement, on the one hand, and recognition of subjectivities, on the other. These two axes could be plotted on

as far as to say, "The attitude sometimes taken of systematically refusing to issue medical certificates to these patients seems to us unjustifiable. The psychiatrist treating the patient should at the very least ensure that a colleague can undertake to issue the certificate." The criticism is clearly directed at the Primo Levi Center, which is known to be linked to *Médecins du monde*. Baubet et al. (2004).

a chart on which the figures of the immigrant and the foreigner have been replaced by those of the asylum seeker and the torture victim, where mental health has become the tool used to regulate the flow of refugees, and where trauma emerges as a higher proof of truth, while the significance of exile declines. Proof through the body's scars must now be sought in the psyche.

Asylum

THE FOLLOWING MEDICAL CERTIFICATE is one of the thousand or so similar documents issued in 2002 by the Medical Committee for Exiles (Comede):¹

I the undersigned, being a medical doctor, certify that I have today examined Mrs. G, born on . . . of Turkish nationality, for the purposes of drawing up a medical certificate which the person concerned intends to attach to her request for asylum. Mrs. G, a Kurd from the district of Varto, alleges that she and her husband were involved in the armed struggle for the liberation of Kurdistan. Her husband is said to have been arrested and tortured in 1998 after a meeting, and to have disappeared a few days after his arrest. She claims that shortly afterwards she was beaten up and raped by soldiers in front of her children. The birth of a daughter is said to have been a result of this rape. Clinical examination revealed a sutured longitudinal scar on the inside of the left wrist, consistent with a wound inflicted by a bladed weapon, and an extensive scar on the right groin consistent with a violent blow to the abdomen. This patient also presents a post-traumatic neurosis characterized by a depressive disorder with major anxiety, which requires psychological care and long-term psychotropic treatment. Taken together these observations are consistent with Mrs. G's account. Certificate drawn up at the request of the person concerned and delivered into her hands.

These few lines bring together elements of evidence that the applicant for refugee status can submit to the OFPRA officer or to the Appeals Commission judge adjudicating her case. The account, succinct to the point of dryness, enumerates the facts without narrating them. The indirect speech ("claims that she was beaten up and raped," "is said to have been arrested") communicates the expert witness's required distance from the facts reported to him. The physical examination, reduced to its simplest expression, records bodily traces ("a longitudinal scar") cautiously linked to the alleged violence ("consistent with a wound inflicted by a bladed weapon"). The psychiatric diagnosis, comprised of a series of diag-

¹ This certificate is among two hundred documents we sampled at random from Comede's archives, taking fifty for each of the years 1987, 1992, 1997, and 2002, to which we added a small number collated for the year 1983. Comede Archives, file no. 2002/04-PC2 (34).

nostic categories ("post-traumatic neurosis," "depressive disorder with major anxiety"), concludes with the need for treatment ("psychological care and long-term psychotropic treatment"). The conclusion is both clear-cut and measured ("Taken together these observations are consistent with the account"). The clinical psychological certificate becomes a copy-book exercise in style, revealing a progressively acquired mastery of the rules of expert report writing. The wording of the certificate conforms to standards patiently defined by the organization issuing it and testifies to the writer's effort to meet as closely as possible the imagined expectations of the bodies responsible for adjudicating the case.

One of the assessors at the office of the UN High Commissioner for Refugees, who is responsible for evaluating appeals against rejected asylum applications, commented, with regard to this type of document: "At the Appeals Commission all proof, evidence, and other material is admissible. Afterwards the judge forms his personal opinion, primarily on the basis of the coherence, credibility, and contradictions of the account, which remains the core element; after that, a bit like an admission of guilt in a criminal case, the certificate provided by the lawyer and the applicant for asylum is more or less seen as the supreme proof."² But he immediately corrected himself: "That's true, but not always: it depends on the individual case. A certificate is never enough on its own. If the account is not credible, if it is not consistent, it's extremely rare for a certificate to alter the balance. If the account is credible and coherent, and if the medical certificate supports it, that's a plus. Ultimately, if there is doubt, the medical certificate will weigh on the applicant's side."

However, not all certificates have the same value: "The judges do take into account who drew up the certificate. We have more confidence in some of the organizations that the Appeals Commission has been working with for years than in a general practitioner from the suburbs. And it also depends on the wording of the certificate. Some are better worded than others. There are some that say, 'The physical sequelae are consistent with the account.' We don't know if the doctor heard the same account as we did." And he concludes: "The problem is that we are working in an area where there is little written evidence. Usually the judges have to base their decision exclusively on the applicant's claims. So if there is a written document that supports his account, it's nice to be able to fall back on it. We have less of a feeling of passing judgment a void."

This comment is significant on several levels. First, it confirms that to lawyers and asylum seekers, the certificate has become a kind of fetish,

² Interview with an assessing judge at the office of the UN High Commissioner for Refugees sitting on the Refugee Appeals Commission, conducted by Estelle d'Halluin on August 5, 2002.

valued well beyond its true efficacy. Second, it indicates the relative value of the certificate in the process of assessing applications. It supports claims but does not substitute for them; it may confirm judges in their opinion but it does not determine their decision. Finally, it reveals the social investment in this document, both in the care with which it is drawn up, which implies that rules of writing have been established, and in the credit acquired by the organizations, which gains them a degree of legitimacy in defending their clients. Thus the medical and psychological certificate as object represents much more than just a text written on an official letterhead: it is a fragment of history—that of the asylum seeker, of course, but equally that of the contemporary world.

In order to understand how this new method of establishing proof emerged and how these new mental health competencies have been used, we need to look at the history of asylum in European countries, at the reasons for the growing presence of trauma in certification, and finally at the anthropological questions raised by this procedure.

THE ILLEGITIMATE REFUGEE

The reason that demonstrations of trauma and, more broadly, of the scars left by violence, have become so crucial in assessing the validity of requests for asylum is that refugee status has lost much of the legitimacy it enjoyed in earlier times. In order to understand this incessant quest for proof through the body, we therefore need to understand the source of the suspicion that now shrouds Western societies' relationship to asylum seekers. "From its inception the experience of a refugee puts trust on trial," write Valentine Daniel and John Knudsen.³ "The refugee is mistrustful, and excites mistrust. In a very profound sense, one becomes a refugee before ever fleeing the society in which one lives, and one continues to be a refugee even after receiving asylum in the new place where one is received." But individual lives are here set in the context of a collective history.

The history of refugees is both long and short. As Michael Marrus, who has devoted a lengthy historiographic study to the administration of those he calls "the unwanted," writes:⁴ "Refugees, people obliged by war or

³ In the introduction to their edited collection, significantly titled *Mistrusting Refugees* (1995), they differentiate this tragic experience of mistrust that is a constant in refugees' experience from the cultural mistrust that may characterize some societies.

⁴ In *The Unwanted* (2002), Michael Marrus notes that the word "refugee" in the sense that we understand it today only appears in the 3rd edition of the *Encyclopaedia Britannica* (1796). Until that point, the term was used exclusively for Protestants who had fled the persecution of the French king in the late seventeenth century.

persecution to leave their dwellings and seek refuge abroad, have tramped across the European continent since time immemorial. Yet only in the twentieth century have European refugees become an important problem of international politics, seriously affecting relations between states." Marrus notes three features distinguishing contemporary refugees from those of earlier centuries: their presence in vastly greater numbers than the world has seen before; the fact that they are so dramatically and uniquely removed from civil society; and the extraordinary duration of their displacement. We should probably add a fourth essential characteristic: whereas before they had low political visibility, being for the most part transients with no real legal status and therefore dealt with primarily by local authorities or charitable organizations, over the course of the twentieth century refugees have become a crucial element in the make-up of national and international political entities. Although marginal by virtue of their situation and their numbers, they are at the heart of the definition of the world order and the debates it raises.

The very existence of a large number of populations rejected by or fleeing their homeland and requesting the protection of another country puts to the test the model of the nation-state as constructed in Europe and, more broadly, the legal foundations of the world community of states. As Alexander Aleinikoff writes: "The concept of refugee both reflects and problematizes the modern construction of an international system of states. That system is premised on an understanding of the world as divided into legally equal, sovereign states. . . . In such a world, individuals need to belong to a state both to ensure their protection and acquisition and to permit the system of states to ascertain which particular state has responsibility for (or control over) which persons. . . . In short, the modern world operates under the motto of 'a state for everyone and everyone in a state.'"⁵ The transnational movement of refugees not only disturbs this order, it shakes its very foundations. Hence the mistrust or even hostility directed at those who seek asylum outside their country. Similarly, Giorgio Agamben argues:⁶ "If the refugee represents such a disquieting influence in the order of the nation-state, this is primarily because, by breaking the identity between the human and the citizen and that between nativity and nationality, it brings the originary fiction of

⁵ See Aleinikoff (2005). From his legal perspective, "refugees represent a failure of the state system, a 'problem' to be 'solved.' As 'involuntary migrants,' refugees evidence a breach of the state of origin/citizenship relationship. The result appears to be a logical contradiction: 'solution' of the 'refugee problem' within the existing system of states threatens a first principle (state control over admissions) of the system."

⁶ In an article entitled "Beyond Human Rights" (2000), he maintains: "Inasmuch as the refugee, an apparently marginal figure, unhinges the old trinity of state-nation-territory, he deserves instead to be regarded as the central figure of our political history."

sovereignty to crisis”—sovereignty understood here as the idea that birth within a particular nation makes the subject a sovereign being. The refugee no longer shares in the sovereignty of country where he is persecuted, and yet does not share in that of his country of arrival, from which he hopes for protection.

In this context of a political image of the refugee as now threatening, now pathetic, the twentieth century institutionalized assistance to refugees, spurred by the dual purpose of, on the one hand, safeguarding the nation against this potential threat, and, on the other, protecting the increasingly numerous victims of persecution. The first step was the creation, in 1921, of the High Commission for Refugees, under the aegis of the League of Nations, principally to deal with the flood of Russians fleeing the Soviet Union. Remarkably, until that point the League of Nations, the institution charged with coordination between states, had not been deemed to have the authority to take on this role, which was instead left up to private generosity. The League of Nations only agreed to take on the responsibility under pressure from a number of philanthropic organizations (particularly the Red Cross) and a few governments (notably the Swiss), and almost against its will, for it did not see the issue as a problem within its jurisdiction. Subsequently, the United Nations Relief and Rehabilitation Administration (UNRRA) was set up in 1943, with the mission of caring for war refugees and later concentration camp survivors—often in competition with the armed forces, to whose authority it eventually acceded. At the end of 1946, UNRRA was replaced by the International Refugee Organization, set up by the recently constituted assembly of the United Nations and charged with providing humanitarian aid to the “last million” of those administratively designated as “displaced persons” in the aftermath of the war. Until that point, however, the issue of refugees had been Europe-focused in terms of the people involved in these forced migrations and, more broadly, a Western matter in terms of the states involved (given the growing role of the United States). After the partition of India in 1947 and the expulsion of the Palestinians from their territories in 1948, it became a worldwide issue, though of course in both these cases—in Southern Asia and in the Middle East—Europe’s ties to the affected regions are crucial to an understanding of the international interest in the two tragedies. In other words, even at a time when it was emerging as a worldwide demographic problem in terms of its geographical spread (and today the majority of the populations involved are in the Third World), the issue of refugees was still seen from a Western perspective, defined from the point of view of a constitutional state and a relationship to powers historically located in Europe and North America.

The creation of the office of the UN High Commissioner for Refugees in 1949 (resulting in its establishment in 1951), and the signing of the

Geneva Convention on refugee status in 1951 (which came into force in 1954), have to be understood in the new context of the unequal distribution of refugees through the world. These two actions institute what we may call the contemporary politics of asylum. The first confirmed the authority of the UN with regard to the protection of refugees; and indeed, the HCR's field of intervention has continued to expand. From a simple structure providing financial support to private organizations, it has become an agency operating in the field in over one hundred countries. The Geneva Convention defined the criteria for obtaining refugee status and the rights associated with it, in a text that would serve henceforth as an official reference point, although it was subject to contradictory interpretations—usually restrictive on the side of governments, liberal among organizations campaigning for human rights. Thus, by the early 1950s, an international institutional and regulatory framework for asylum had been firmly established, although the constant political threats to its existence and the practical restrictions it is subject to are evident to all. The deep wounds of World War II left European countries with the sense of a debt owed to victims and a responsibility for survivors, and this structure bears the imprint of that debt.

However, the humanism of those who drew up the 1951 Convention, which gave this historic initiative an appearance of generosity towards all peoples, represents only part of the reality. The position of the French government during the preparatory negotiations foreshadowed, at least in spirit, many aspects of the current debates. Anxious to preserve the sovereignty of the state in relation to the UN, the French sought in vain to have not only the rights of refugees enshrined in the text, but also the restrictions that would be incumbent upon them. They argued for measures to control the circulation of refugees, using entry and exit visas. Above all, they campaigned for limiting the definition of refugee to Europeans, and for excluding persecution that took place prior to January 1, 1951. The Geneva Convention acceded to the latter demand, but allowed individual countries to choose how refugees were to be defined in terms of their origin. As was to be expected, the French government (going against the vote of parliament), retained the most limiting, European definition. Moreover, it refused to differentiate between refugees and other foreigners in employment, where preference was at that time given to French citizens.

Thus, contrary to what is popularly assumed, it is clear that reasons of state and the even more narrow reasons of perceived national interest are at the core of the contemporary system for protection of refugees. At the time when OFPRA and the Refugee Appeal Commission (the two mechanisms for assessing requests for asylum) were voted into being, even at the time when French diplomats were involved in drawing up and then

ratifying the Geneva Convention, France was the country that took the toughest stance, adopting a European limit on the definition of refugees, as opposed to a universal model of asylum, giving preference to French workers in hiring, and introducing strict control measures. These decisions stemmed from two trends which were to persist in years to come: suspicion of refugees, who were considered competitors in the labor market, and subordination of asylum policy to the economics of immigration. In the period of growth which lasted up to the mid-1970s, these trends were not so evident because refugees, who were effectively conflated with other foreigners, were contributing to the production of national wealth. It is even probable that many potential applicants for asylum bypassed the application process by obtaining residence through an employment contract. From 1974, France put into effect the first measures to block economic immigration, and asylum became progressively more circumscribed by an increasingly strict policy aimed at controlling the flow. In fact, the rise in requests for asylum was used as an argument for more and more restrictive structures. In 1974, just over 2,000 cases were processed; two years later, the figure had reached more than 15,000. The rise continued, reaching a peak of 61,000 applications in 1989. At the same time, the ratio of applicants granted leave to remain was falling, from 90% in 1974 (and as high as 95% in 1976) to 28% in 1989. The hunt for "bogus refugees" became a leitmotif in public discourse, used to justify the increasing harshness of adjudications. During the 1990s this process became even more entrenched: despite a drop in the number of applications, down to 17,000 in 1996, the percentage of applications granted continued to fall, to 20%. In the early years of this century a new rise in applications was accompanied by an increase in the number rejected: in 2003, out of 52,000 cases assessed, the ratio of acceptance was no more than 10% at the initial, OFPRA assessment stage, and 5% after petitions to the Appeals Commission. Thus, over a period of twenty-five years, hospitality towards refugees has decreased in spectacular fashion: the rate of acceptance of applications has fallen from 19 out of 20 to 3 out of 20.

It is clear, therefore, why the assessment of proof has become so crucial a part of the asylum process. Twenty-five years ago, applicants for refugee status were *a priori* considered credible. Today, they are objects of suspicion, suspicion which appears retrospectively justified by the adjudication decisions of the assessing bodies. As Gérard Noiriel has shown, asylum policy has always rested on a bureaucratic machinery designed to establish the validity of claims.⁷ Even as early as the 1930s, special border

⁷ Noiriel (1991): "The absence of probative written evidence explains the weight given to the accounts of asylum seekers. The archives of these institutions demonstrate the zeal with which officers seek to restrict the truth of these testimonies."

agents were given evaluation criteria and interviews were introduced in which applicants had to justify their claims. From the 1950s onwards, OFPRA refined its mechanism for verification, placing an increasing emphasis on the applicants' accounts. In the absence of written evidence, applicants attempted to demonstrate their sincerity by means of a harrowing and detailed narration of their stories. Up until the end of the 1970s, evidence provided directly by the asylum seeker retained a high value. When more restrictive policies were introduced, it became necessary to reduce the credibility of the applicants' testimony. Their narratives were systematically questioned; their body was therefore summoned to testify. As their word was less and less heeded, asylum seekers required a mediator to speak for them. The clinical psychological certificate linked these two processes: it verified the scars on the body and established the expert witness as spokesperson.

On close examination, however, the physical body has little to say. We could even say that it speaks less and less. Exhaustive enumeration and detailed descriptions of scars are both tedious and offer little in the way of proof. They speak of injury, but usually without confirming its origin. Many certificates appear unconvincing to the assessor and hence frustrate those issuing them. But we can probably go further, and say that torturers now tend to leave fewer and fewer traces of their work. Either they use techniques that leave no marks, or they see to it that the bodies disappear completely. But whether they choose disposal of their victims or more sophisticated methods, persecutors are concerned not to leave evidence of their crimes. Torture is even more effective if it can also be denied by those who commit it. Not only are they protecting themselves from possible prosecution, which, although rare, is a risk, but they redouble the violence exercised on their victims by rendering their suffering mute and their word suspect. Where previously it was presented as a spectacle, torture has become secret. Where before it was imprinted on bodies, now it is transformed into mental torment. From this point of view, the Place de Grève⁸ is the opposite of Abu Ghraib, and the execution there of would-be royal assassin Damians is the antithesis of captivity in Guantánamo. Ultimately, the survivor of these new forms of torture retains few scars of his treatment at the hands of his torturer: the humiliation, the degradation, the spectacle of loved ones raped or killed leave no more mark than electricity applied to the genitals or submersion in water to the point of near suffocation. Talal Asad has shown that while this evolution corresponds to changes in the practice of torturers (the development of more refined techniques), it also reflects a change in our sensibilities which has reduced our capacity to recognize forms of violence that we do not see

⁸ Site of public executions in France until the Revolution. —Trans.

(acts defined as attacks on dignity).⁹ In any case, the tortures that are being invented by torturers leave very few visible traces that can be authenticated by a doctor. There is thus a cruel paradox in the juxtaposition of the increasing demand for proof through the body and the gradual disappearance of physical scars.

In the context of this new reality, trauma comes into its own, becoming an essential element in the administration of proof. For what the physical body no longer shows may be revealed by the psyche. The traces that doctors find it difficult to detect can be recognized by psychiatrists and psychologists. Precisely because it is immaterial, the memory of violence is all the deeper and more lasting. While physical injuries may heal without leaving marks, psychic wounds are indelible and, though buried, they yield up their secrets to those who have learned to search them out.

RECOGNIZING THE SIGN

The exhibition *The Ills of Exile*, organized by Comede in 2000, comprised a collection of black-and-white photographs and a collection of personal narratives.¹⁰ The two were not linked, thus preserving the anonymity of the interviewees, if not of the faces. Two of the photos showed scars: one, round, on the back of an Algerian who lifts up his shirt to show it; the other, long, on the neck of another Algerian who raises his head to reveal it. We know nothing of their history, but their scars say everything about the violence they suffered and about the instruction given them to expose those scars to the viewer. The stories are presented as fragments: a Rwandan who was tortured by Hutu soldiers, then condemned to death by a Tutsi court, tells how his wife was raped and that he does not know what happened to his five children, but his request for asylum was turned down; an Angolan fighter with the MPLA, who recounts how he was imprisoned, tortured, and raped in UNITA jails, also had his request for asylum rejected; there are many others. All the refugees have to tell is their stories, which the officers responsible for assessing their cases evidently cannot hear. With the recognition of post-traumatic signs, however, there is renewed hope that the truth might yet be heard.

Nevertheless, it was a long time before trauma found a place in medical testimony. Take, for example, the following certificate, issued in 1987 in relation to a thirty-five-year-old Chilean man:

⁹ In his article "On Torture, or Cruel, Inhuman and Degrading Treatment" (1997), Talal Asad writes: "The category of torture is no longer limited to applications of physical pain: it now includes psychological coercion."

¹⁰ See the catalogue for the exhibition *Maux d'exil*, photographs by Olivier Pasquier, narratives collected by Jean-Louis Levy, Comede/Bar Floréal, Kremlin-Bicêtre, 2000.

Mr. D was seen at Comede several times for chronic somatic pain and problems with memory, concentration, and sleep, which he ascribes to having been beaten up when he was arrested a number of times in Chile from 1979 onwards. Over the course of a number of sessions, it proved difficult to pin down the circumstances of the violence described, as Mr. D appeared very disturbed by his difficulty in remembering. His anxiety about various somatic pains had led him to request many X-rays, which he showed us. They showed no traces of radiographically visible fractures at this time (cranium, nasal bones, hands, wrists, spine, knees, right ankle). Nevertheless, a slight nasal deviation consistent with an old trauma is clinically observable. At the same time, Mr. D saw the psychologist several times in order to explore all approaches to the problems he complains of. These latter are a group of symptoms frequently observed in subjects who have experienced detention and particularly harsh abuse (headaches and problems with memory, concentration, and sleep), despite the fact that each one alone does not indicate any specific condition. We propose a course of combined psychotherapeutic and medical treatment for Mr. D.

This document is significant on at least two levels. On the one hand, it illustrates the silence of the physical body and the vain efforts of the asylum seeker and the doctor in their quest for proof: Repeated X-rays reveal nothing of the torture undergone; the only indication is the deviation of the nasal septum, a condition so common that it offers little in the way of proof. Significantly, it is only in describing this deviated septum that the word "trauma" appears in the document, with an explicitly physical meaning. On the other hand, we note the wealth of the psychic semiology, which is empirically ascribed to violence suffered but is not formally validated. Although the doctor indicates that these symptoms are frequently associated with detention and torture, because the syndrome they constitute is not named it is difficult to establish a causal link, as the doctor himself stresses. The term "trauma" is not used, although the clinical picture is roughly consistent with post-traumatic stress disorder.

We can compare this with another certificate, issued fifteen years later in the case of a twenty-two-year-old man of Turkish nationality:

Mr. Y claims that he was persecuted by the Turkish authorities because of his alleged links with the PKK. He says that he was placed in detention on two occasions, for five days in December 1998, and for fifteen days in January 1999. Mr. Y describes in great detail the torture he suffered: cigarette burns, electric shocks to the penis and the toes, multiple beatings to the whole of the body and the face, beating on the buttocks after being forced into the inside of a tire, beating on the soles of his feet. He also says that he lost consciousness. Mr. Y complains of chest pain on the left side, palpitations and nausea, and sleep problems, which include difficulty getting to sleep, nightmares, and night waking. Clinical examination reveals two round scars on the back consis-

tent with cigarette burns, and several scars on the anterior face of the thighs. There is also a trauma neurosis with panic attacks that requires clinical psychological treatment. These observations are consistent with the traumas recounted by Mr. Y.

This time the body has retained a few marks that support part of the account. But more importantly, the subject retains the trace of violence in the form of psychic symptoms described as traumatic. The word itself has value as testimony, linking the signs to the torture and establishing the truth of the latter.

By following the wording of certificates issued over two decades, as we have done in our study, it is even possible to trace the semantic changes in the word "trauma." In the 1980s and into the 1990s, it always signified a physical ordeal: the trauma was the physical blow suffered. A Cameroonian man,¹¹ a member of the political opposition, who was "beaten and punched," is described as presenting "marks of trauma to the vertebrae and pelvis." A Zairian man who was "arrested and beaten up" is reported as showing "multiple osteopathic lesions, which may be related to traumas," and, notably, a "post-traumatic syndrome" that bears no relation to the psychologically defined stress condition, as it is related to a "cranio-sacral displacement." A Sri Lankan man who suffered physical torture in prison presents "deafness attributable to cranial trauma;" another Sri Lankan suffers from "sensory problems in the radial nerve consistent with an old trauma to the wrist." In all these certificates, issued in 1992, trauma is understood as a physical phenomenon, in the sense of orthopedic trauma. Significantly, describing the case of a Turkish man who was tortured during interrogation, the doctor notes that his "complaints" include "that he can no longer sleep and is haunted by nightmares," but in his conclusion does not refer to these symptoms, focusing only on the physical signs of abuse: "The fine scars suggest trauma with a bladed instrument. The oval scars on the legs suggest trauma with a blunt instrument with crushing of the tissues." Nothing is said of the psychic sequelae, as these were deemed of little use as evidence. One particular nosographic form in cases of violence consists of a set of symptoms known as "subjective cranial trauma syndrome," an ill-defined diagnostic category that disappeared from medical documents shortly afterwards: it referred to imprecise symptoms including headaches related to a shock to the head and without objective evidence; this description is close to *sinistrosis* and thus highly suspect. The following account is given of a Turkish man beaten about the head with a rifle butt: "The temporal scar is consistent with the

¹¹ The following extracts are taken from the Comede archives for 1992, from case numbers 34.156 (1), 36.911(7), 36.246(46), 31.549(50), 35.820(38), and 35.411(37) respectively.

origin claimed. The headaches of which he complains suggest subjective cranial trauma syndrome, which can persist many years after the initial trauma." This formulation, including a didactic explanation, resurfaces in a number of certificates.

The descriptions of psychic symptoms that a mental health specialist would today most probably ascribe to post-traumatic stress disorder are vague, and they are usually attributed to depression or anxiety. For example, again in 1992, an Angolan man¹² recounts "having been burned with cigarettes, kicked, punched, beaten with sticks, hit in the face with a plank of wood, and having lost consciousness on several occasions" during an interrogation; he describes "problems sleeping: when he goes to bed, he relives his arrest and the torture he suffered" and "his guilt about his sister who was arrested because of him;" however, like many others, his diagnosis is of "reactive depression in response to events experienced in his country." This diagnosis is unspecific and will not help the person to authenticate his story; in some cases the doctor may also ascribe the condition in part to the unstable circumstances in which the asylum seeker is living, blurring even further the causal link with the violence suffered. In the same year, a Zairian man reported that he was "arrested during a demonstration," and that in prison he was "bound by his wrists and ankles and brutally beaten until he lost consciousness;" the doctor notes that he "expresses distress and great anxiety," that he "has become very emotional, has nightmares, is frightened," that he "cannot talk of the his experiences in Zaire without weeping," and that he suffers from "problems with memory and concentration." The conclusion cites "reactive depression in response to traumatic events experienced in his country." In other words, the psychiatric "post-traumatic" semiology is present, but the diagnostic category is missing. The adjective "traumatic" is used here in the popular sense and not in that of the specialist's vocabulary. It is also worth noting that the ascription of the symptoms to depression leads to explanations in terms of mourning, guilt, and shame—terms that occur frequently in certificates from this period—and thus constructs a picture of suffering which is not yet that of trauma.

Ten years later, the interpretation offered, and the reading of the signs proposed, is different. A Tamil man who "claims to have been persecuted by the Indian and Sri Lankan authorities" and to have been beaten with rifle butts and truncheons, and who "complains of headaches which prevent him sleeping" and are extremely incapacitating, has his problems analyzed as "symptoms of post-traumatic neurosis (agoraphobia, insomnia, nightmares) requiring psychological care." The headaches are no

¹² The following extracts are taken from the Comede archives for 1992: 34.985(30) and 38.310(21), and for 2002: 74.333(12) and 70.457(19).

longer due to “subjective cranial trauma syndrome,” nor are the insomnia and nightmares diagnosed as manifestations of “reactive depression.” Now clinicians are seeking out signs that might suggest the sequelae of trauma. A new psychopathological landscape is being drawn. On occasion the term “post-traumatic” is omitted, but the description is clearly informed by this clinical category. In his account of the case of a Bangladeshi woman who was beaten, burned, imprisoned, and raped by the police in Bangladesh, a doctor notes: “She complains of frequent headaches. She experiences psychological problems that include difficulty sleeping, frequent nightmares, and recurrent thoughts of the events she and her family lived through.” However, the conclusion indicates dispassionately that “the psychological problems she describes are consistent with her claims.” Insomnia, painful dreams and recurring memories delineate a clinical picture that is not named, but is easily recognizable.

We should not, however, make the mistake of thinking that psychology has become the keystone in the certification process, or that trauma has become a guaranteed route to refugee status. Of the fifty certificates issued by Comede in 2002 that we studied, only seven (14%) mention a psychological element, and of those only three refer to “post-traumatic neurosis,” while the other four merely cite symptoms such as “nightmares.” By way of comparison, in 1992 six psychiatric diagnoses were offered, mostly of “reactive depression,” and thirteen complaints were reported, generally “difficulty sleeping” (38% of the total). Ten years later, only 6% of the people seen were explicitly recognized to be suffering from post-traumatic sequelae (although a study of the 1,119 cases seen during the year indicates a “psychic trauma” level of 22%), and only 4% of patients were seen by a psychologist, who in Comede would not normally be authorized to issue certificates (whereas 14% of the certificates in our sample mention psychological problems). In other words, although nearly 25% of the people seen at the clinic were assumed to suffer from post-traumatic sequelae, only one in six of those was seen by a psychologist, and one in four had the diagnosis noted in his or her certificate.

Many medical certificates offer a striking contrast between the applicant’s summary of his or her experience and the total absence of any psychological assessment. Even today, the following description is given of a twenty-nine-year-old man of Turkish nationality: “This Kurdish patient alleges that he is a victim of repression. He claims he suffered arbitrary beatings, torture, and sexual abuse on several occasions. He claims he was forced to collaborate with the PKK and, when he could not supply enough information, his wife was raped. He alleges that he too was raped and tortured.” There is no mention of any manifestations of suffering, and no psychological opinion is sought. The clinical account simply de-

scribes six cutaneous scars. The conclusion is as impassive as it could be: "Taken as a whole these observations are consistent with Mr. S's claims." Given what we know of the consequences of such violence, we are far from what Allan Young, working in a psychiatric clinic for Vietnam veterans, describes as the "diagnostic technology" for recognizing post-traumatic stress disorders.¹³ These certificates show that trauma has as yet had relatively little impact on medical expert opinion in asylum cases.

Indeed at Comede relatively little attention is paid to the psychological dimension in medical reports. It is as if the organization did not fully believe in it, as if this evidence was not quite evidence, as if the physical body was still more convincing in bearing witness than the psyche. This would appear to be confirmed by the remark of an assessing judge at the Appeals Commission: "In general, judges place more faith in physical than in psychological observations. I don't know why, maybe they seem more tangible. Maybe the judges find it easier to appreciate how they are consistent with the account." We have also noted that Avre is markedly reluctant to use psychologists, who play virtually no part in their expert reports, and that the Primo Levi Center had strong reservations with regard to clinical psychological certificates, which they threatened several times to stop issuing. There is thus a striking paradox in the recent emergence of psychic trauma in asylum applications: those involved are prepared to recognize it on an abstract or non-specific level, but they mistrust it in specific cases. France is probably not unique in this respect. Since the beginning of the twenty-first century the thirty-eight member organizations of the European Network of Treatment and Rehabilitation Centres for Victims of Torture and Human Rights Violations have complained repeatedly of the failure to give due consideration to trauma in adjudications by national authorities.¹⁴ In both senses of the word "evidence"—that which is evident, and that which offers proof—we could say that society's application of psychic trauma in the case of asylum applications is marked by a strong belief in the concept in general, but a low level of faith in the category at the specific level. Those involved in the process, particularly assessing officers and judges but probably also lawyers and doctors, are persuaded that torture and violence do give rise to trauma—a fact taken for granted in popular thinking—but little inclined in practice to use this argument as a basis for their rulings, often feeling that it has insufficient value as proof.

¹³ Young (1995).

¹⁴ The study by Cécile Rousseau et al. (2002) of decision-making processes at the Immigration and Refugee Boards in Canada shows a similar tendency, emphasizing both the limited weight given to trauma in medical and psychological certificates and the ignorance of the issue of trauma among administrators responsible for assessing cases.

THE TRUTH OF WRITING

For the last twenty years the entire focus in psychological certification has been on making certificates more effective—in other words, conforming better to the assumed expectations of OFPRA officials and Appeals Commission judges. The support organizations have set explicit or implicit rules. Ethical codes have been voiced or actually drafted. Here, for example, are the standards proposed by three British specialists for the “role of the clinician in the legal process,” in order to improve “credibility” with those assessing asylum applications:¹⁵

The key here is to ensure that the clinician restricts the opinion to clinical issues. The first principle for the clinician, in the legal arena, is always to stay within the bounds of clinical knowledge and expertise. It might be tempting to add extra comments about countries of origin or about the legal system, but there is nothing that undermines a report by a health professional more than extraneous observations. . . . Experts need to make an effective contribution where their knowledge makes this appropriate and to avoid comments when they have nothing of substance to add.

Thus the task for doctors, psychiatrists, and even psychologists is to rein in their strong convictions when providing reports on grounds for asylum applications. Here the best is enemy of the good. Even if they are convinced by the individuals’ accounts and familiar with the situation in their country, the health professionals must not allow this to color their words. The only assertion a professional can legitimately make is one based exclusively on their area of expertise: namely, that they have noted the existence of psychic scars imputable to the violence experienced.

However, in many cases the treating clinician, who is often, as we have seen, an ad hoc or somewhat reluctant expert witness, oversteps the bounds of her competence to comment on history or politics, to bear witness through her own belief in her client’s truthfulness. This is evident in the conclusion of the following certificate, issued in 1987:

Mr. B’s account of the circumstances of his arrest and the abuse he suffered at the time, and of his time in N prison, is particularly detailed, coherent, and sometimes tinged with emotion. The clinical evidence is relatively limited. However, the combined elements are such that the truth of the facts alleged can be believed.

¹⁵ See Herlihy, Ferstman, and Turner (2004), who distinguish between two “very different” roles: that of the clinician treating an asylum seeker and that of the clinician brought in to prepare an expert report, although they note that the boundaries between the two are today becoming blurred.

Both testimony to a commitment and an admission of powerlessness, this declaration focuses more on the applicant's truthfulness, which is outside the doctor's expertise, than on the clinical symptoms, where his knowledge could make a difference. He references affect (that of the asylum seeker) and belief (that of the expert). Ultimately, he is testifying to his own conviction rather than to the validity of the grounds for asylum. He is vouching for the authenticity of the asylum seeker's word. But this is not what is required of medical or psychological experts. In this context a diagnosis carries much more weight than a narrative. This is the point where certification reaches the limit of what it can do, usually because "the clinical evidence is relatively limited." And it is precisely here that the concept of trauma, if it is used (which is far from always the case, as we have seen), can be effective: although an outline of the post-traumatic clinical picture is much more vague than the marks left by a physical scar, and its capacity for convincing OFPRA officials and Appeals Commission judges more limited, it does offer proof of violence. An impression left on the skin or evidence of a healed fracture can always leave a doubt as to whether it is the result of persecution or of an everyday accident, but post-traumatic syndrome, with its nightmares and flashbacks, its avoidances and hyper-vigilance, testifies to a causal event. At least, such has been the case for a number of years.

The situation of expert witnesses in psychic trauma in asylum cases is, in many respects, diametrically opposed to that of their forbears who provided expert reports on trauma neurosis in soldiers or *sinistrosis* in workers. For one thing, the military psychiatrists and forensic doctors were happy to offer their expert opinion, whereas the health professionals who work with refugees today are by and large reluctant to take on this role. Moreover, the military doctors were generally unconvinced by the patients they saw, while modern health professionals feel committed to supporting their patients. Finally, in earlier times clinical symptoms evoked suspicion, while today they tend to buttress the authenticity of the account. Thus, in the area of asylum, expert opinion on trauma, which was thought to be no longer necessary given that the concept had become generally accepted in popular thinking, is coming back in force—but in a new way that rests ultimately on a misunderstanding. The doctors, psychiatrists, and psychologists who work in organizations that support asylum seekers and victims of persecution consider themselves first and foremost committed caregivers, professionals who place their clinical skills at the service of a cause. The increasing suspicion of refugees, and the consequent increase in the demand for certification, has put them in a difficult position. They joined the organizations to care for patients, and

now they are summoned to act as expert witnesses.¹⁶ They saw themselves as activists, but have become, in a sense, forensic specialists.

In order to fulfil their new role, however little they relished it, they had to learn the rules of report writing. At Comede a committee was set up in the early 1990s to draw up policy on expert reports. This process of collective reflection examined both the “technical aspect of certificates”—how should they be worded?—and the “meaning of certificates”—should the organization continue to issue them, and if so under what conditions? The result was a series of recommendations, relating particularly to writing style: it was important to “transcribe the complaints in simple, non-medical terms” and to “link the facts related by the patient to the traces of abuse observed as closely as possible;” above all, the writer is cautioned to avoid pointing out “missing elements,” for it had been noted that applications could be rejected on the basis of this medical judgment even though the absence of evidence obviously did not indicate there had been no persecution. Gradually a draft template was built up, following the standard formula for any other medical report: personal data were followed by the “declarations” or the “account,” necessarily couched in terms of reported speech; then the “complaints” or “reported problems,” always briefly outlined because they offered little in the way of proof; next followed a very detailed “examination” identifying physical signs and sometimes psychic symptoms; and finally a “conclusion” addressed the compatibility¹⁷ of the various elements, particularly of the clinical data with the narrative elements. In its driest form, this standardization results

¹⁶ This development in expert opinion runs parallel to the movement we described above in psychiatric victimology. The clinicians who championed the cause of victims were initially expert witnesses who testified to the reality of trauma. They became specialist caregivers only as a secondary development. In this field expert opinion played a “therapeutic” role, which derived from the recognition of the trauma, but also because it was a tool in the hands of the support organizations. In the case of asylum, the process is reversed because the “order” for an expert report comes from the public authorities.

¹⁷ This term was preferred to “imputability,” which was considered a “legal” term. As Elisabeth Didier (1992) writes in an article which is referred to both within and outside the organization: “The term ‘consistency,’ habitually used by doctors, lies within the framework of a probabilistic process. This process has nothing in common with the legal process, which consists in evaluating whether a causal link has been established (proof). The doctor provides clarification to the judge, but in no case does he make decisions on matters of the law.” The reluctance of specialists in asylum to enter into the logic of expert opinion is evident. That this stems as much from a concern to maintain their independence vis-à-vis the judicial system as from a desire not to harm asylum seekers, is indicated by the following passage: “The fact that the doctor establishes consistency between the sequelae and the allegations does not mean that the applicant is telling the truth; nor does the fact that he establishes no such link mean that the applicant is lying.” This double syllogism aims to protect both the word and the truth of the asylum seeker, in a situation where both are threatened.

in texts like the following report issued to a thirty-seven-year-old Sri Lankan asylum seeker:¹⁸

Mr. G complains of having been beaten by the military in his country. He claims he was arrested several times: in March 1984 (23 days), October 1988 (3 months), and from July 1999 to February 2000. He alleges that one of his sons was killed by the army in December 1999, and that his wife was tortured and raped. He alleges that one of his brothers and his brother-in-law were also killed. He claims that he was punched in the left ear, burned with cigarettes on the right thigh, and injured with pincers on his left arm. He complains of a reduction in hearing on the left-hand side, liquid exudation from the left ear and pain on that side. Clinical examination revealed a number of scars: one round, 3 cm in diameter, under the chin; one oval scar, 4 cm in diameter, on the front of the left arm, which the patient attributes to the pincers; and a round burn scar, 2.5 cm in diameter, on the front of the right thigh. The left eardrum is perforated, with subsequent local infection and exudation. The clinical examination is consistent with the patient's account.

The noncommittal reporting of the man's words ("alleged," "claims") and the minutely detailed description take the concern for neutrality and the spirit of professionalism to extremes.

Under these conditions, it was difficult for psychological or psychiatric assessment to find a place. As we have seen, until the early 1990s the problems reported were unspecific and rarely linked to an experience of violence in the past, and hence they contributed nothing or were even counterproductive in expert reports for asylum applications. In the case of a black Mauritanian¹⁹ who had suffered violence and humiliation in prison, the psychologist observed "a state of distress and psychological torment manifested particularly in serious insomnia, recurring nightmares, and incapacitating headaches," but he did not go further in seeking out the characteristic elements of post-traumatic stress disorder. In the case of a Sri Lankan woman, a psychiatrist noted "serious anxiety-phobic problems" with "a set of somatic symptoms associated with distress," and had no compunction in interpreting them as due to a "probably hysterical personality with an expectation of secondary gains." It is easy to imagine the devastating effect this diagnosis must have had on the OFPRA officer's decision in the case. These certificates certainly did not follow the writing instructions being laid down for doctors at that very moment, any more than they respected the implicit moral codes of the organizations working to support asylum seekers. What they reveal most strikingly is a failure

¹⁸ This extract is taken from the Comede archives for 2002, case 72.736.

¹⁹ The following extracts are taken from the Comede archives for 1992, cases S.B. and H.K., unnumbered.

to recognize trauma and a mistrust of victims of persecution—and this more than ten years after the introduction of PTSD had marked the end of the era of suspicion. They also show, as we have seen at other points in history, how much the credibility accorded to symptoms is influenced by the status of the individuals involved.

A few years later, trauma had entered French nosology, and victims of violence gained in credibility. “Psychological” elements began to be introduced in support of “somatic” symptoms in expert reports. The standard formula for reports increasingly followed the medical format. In the case of a twenty-nine-year-old Angolan man²⁰ who had been arrested, “thrown into a ditch filled with thorns and left barefoot,” who “alleges he was kicked in the head and shoulders, and whipped for several hours until he lost consciousness,” and who “has lost any clear perception of reality, suffering from hallucinations and delusions,” the certificate concludes: “Mr. D experienced a major psychological trauma from which he has not yet recovered. It is very probable that Mr. D has suffered from delirium secondary to the abuse suffered.” Here the term “trauma” is used in the commonly understood sense, but the professional establishes a relationship of probability between the current symptoms and past violence. In the case of a forty-one-year-old Bangladeshi man, “persecuted for many years because of his political activity,” who was attacked by militants from an opposition party, “stabbed all over his body and left for dead,” the doctor states that he is suffering from “a reactive depressive state with panic attacks, insomnia, headaches, stomach pains, and a permanent sense of unease,” which is then described as “a state of post-traumatic stress related to long-term persecution of himself and his family.” In this document trauma appears as part of a clinical diagnosis, no longer simply as a term in common usage, and thus allows the doctor to testify to a link with the violence suffered. This statement would prove all the more useful since the application for asylum had already been rejected by OFPRA and the applicant was having to petition the Appeals Commission. Thus, the refined diagnosis gradually came to attest to the validity of the declarations of those claiming to be victims of persecution. Through the mental health professionals’ learning process in both clinical diagnosis and report writing, trauma had become established in medical certification.

However, while the question of format was beginning to be resolved, the issue of meaning remained: of what use were the certificates? What was the point of issuing them? What benefit did they offer the individual, and what political use did they serve? These questions came up in different

²⁰ The following extracts are taken from the Comede archives for 1997, cases 44.204 and 54.306.

ways in the different support organizations, particularly at the international level. At the fourth meeting of the European Network of Treatment and Rehabilitation Centres for Victims of Torture and Human Rights Violations, on March 30–31, 2006, in Paris, the problem of clinical psychological expert reports was the focus of debate. It emerged that among the thirty-eight organizations present at the meeting, the position taken by the French representative, the Primo Levi Center, was unusual, if not unique. While all expressed concern about the increasing demand for reports, only the Primo Levi Center made it an issue of principle. While British organizations exhibited a firm pragmatism, asserting that if the report was useful and trauma served as evidence, the only issue was the quality and hence the efficacy of the documents issued by clinical psychology expert witnesses, and while Greek representatives even asked their colleagues for a supporting reference they could present to the authorities in order to ensure that their—often challenged—expertise in trauma was respected, the French continued to worry about the dangers and problems of expert reports in themselves. Did an individual have to be traumatized in order to be given refugee status? Could the diagnosis of a psychologist or psychiatrist serve not only to testify to the truthfulness of an account, but to speak the truth of a story? We need to reconsider these questions, which were both ethical and political.

THE MEANING OF WORDS

With time, the medical reports issued by Comede became shorter and more narrowly clinical. Those drawing them up no longer included narrative or commentary. At the same time, the word of asylum seekers had lost its credibility: not only the assessors, but also their lawyers and doctors, were finding descriptions of the abuse stereotyped and repetitive, prompting disenchanted remarks or barely concealed doubts as to their truthfulness. There was no longer any space where the substance of their experience of violence could be expressed: it had no place in the doctor's reports, and the words spoken by the refugees themselves were not believed. Two extracts from expert reports issued by Comede in 2002 offer examples.²¹ The first is that of a Tamil man: "This patient, a nurse and computer programmer, politically active, says that he was arrested in 1998. He alleges he was subjected to abuse, being beaten, punched in the face and all over his body, and tortured. He claims that he was once again

²¹ These extracts are taken from the Comede archives for 2002, cases 71.919(4) and 74.148(43). The subsequent quotations are taken from cases 74.010(10) and 72.188(5), in 2002, and 37.406(10) and 35.989(29), in 1992.

arrested and tortured in 2002.” The second gives an expert opinion on a Mauritanian man: “Mr. S alleges he was imprisoned by the authorities. He says he suffered torture: multiple blows from a truncheon, punches and blows from a rifle butt, particularly on his right shoulder.” In both cases a precise description of the scars, and a declaration of consistency with the individual’s claims, follow. What do these reports tell us of the political violence suffered? What do they reconstruct of the climate of terror surrounding these acts? In his study of victims of the “dirty war” in Guatemala, Marcelo Suárez-Orozco (1990) discusses the dialectic of “speaking of the unspeakable” and “giving a voice to the voiceless.” Medical expert reports could bridge this gap. Often, however, they fall far short. They say nothing of the unspeakable while at the same time depriving the voiceless of their voice. Thus they bear witness—sometimes effectively, in terms of the hoped-for result of winning refugee status—without expressing anything of the asylum seeker’s truth.

Words have little power to speak of torture. What does the word “blows” in the extracts above tell us? “When we speak of torture, we must take great care not to add to it,” writes Jean Améry in his account of his arrest by the Gestapo in July 1943.²² And yet we read, in a medical certificate: “He alleges he was imprisoned in an army camp from May 28 to June 2, 1996, and beaten all over his body on several occasions.” Another one reads: “In April 1989, when he was deported, he claims he was abused by soldiers, beaten with a truncheon and a wooden board, and stabbed.” To grasp what these statements are really saying, we need to return to this paragraph where Améry describes the “first blow” he received in his Belgian prison:

The first blow brings home to the prisoner that he is *helpless*, and thus it already contains in the bud everything that is to come. One may have known about torture and death in the cell, without such knowledge having possessed the hue of life; but upon the first blow they are anticipated as real possibilities, yes, as certainties. . . . Not much is said when someone who has never been beaten makes the ethical and pathetic statement that upon the first blow the prisoner loses his human dignity.

Even if expert reports describe post-traumatic symptoms, and perhaps especially when they do, they articulate nothing of this experience.

Another medical report reads: “He alleges that he was stripped, humiliated and beaten. He claims he was attached to a grating by his wrists for

²² Améry, a philosopher of Austrian origin, migrated to Belgium in 1938 and became a Belgian citizen after the war, changing his name from Hans Maier to Jean Améry. He provided one of the few subjective analyses of torture (1998), based on his own experience in the Breendonk concentration camp.

three days without food." In another case: "He claims he was hung from his bound wrists or ankles, and repeatedly beaten with a log. He says he was beaten 'like an animal' until he lost consciousness on several occasions." In order to understand the meaning of these descriptions, we need to return to the passages where Améry recounts how he was suspended with his hands bound behind his back, until his shoulders were dislocated:

My own body weight caused luxation. . . . I . . . now hung from my dislocated arms, which had been forced high up behind me and were now twisted over my head. At the same time, blows from the horsewhip showered down my body, and some of them sliced cleanly through the light summer trousers I was wearing on this 23rd of July 1943.

It would be totally senseless to try and describe here the pain that was inflicted on me. . . . Since the *how* of the pain defies communication through language, I can at least approximately state *what* it was. It contained everything that we already ascertained earlier in relation to a beating by the police: the border violation of my self by the other, which can be neither neutralized by the expectation of help nor rectified through resistance. Torture is all that, but in addition very much more . . . only in torture does the transformation of the person into flesh become complete.

Tamil or Mauritanian, Kurdish or Angolan asylum seekers are not likely to speak of torture with Améry's eloquence. They do not have the words, and even if they had, there is neither time or place for them to make their statement. They stand before an OFPRA officer (where only one case in two goes for interview) or before the judges of the Appeals Commission (where cases are heard one after the other). The officials are distracted, caught up in the routine of assessment and the litany of accounts. In fact even if the asylum seekers had the time and the place in addition to the words, they would not be believed.

We can therefore posit the following hypothesis. Where an experience cannot be expressed in words or given voice through speech, the body can, up to a point, provide access to some measure of that experience. It may mean nothing to say that a man "alleges he was beaten," even if the instruments used and their physical point of impact are enumerated, but a series of scars or traces of fractures incarnate the violence, even if they do so at the price of reducing the experience to its barest expression. But a double limitation is very soon encountered: on the one hand, the marks left on the body disappear quickly, and on the other, for those that remain the link with the alleged facts is at best a matter of consistency rather than demonstrated causality. At this point the psyche seems to offer a terrain both reassuring and uncertain: reassuring because it is assumed that the traces that violence leaves in the psyche are likely to be both permanent and relatively specific, but uncertain in that the signs are tenuous, subject

to interpretation, often buried and invisible. Herein lies the ambiguity of using trauma as evidence. It says something of the suffering undergone, the dignity trampled, the violation of the self—all the elements Améry evokes and which the victims themselves are unable to make heard. But at what price?

A thirty-two-year-old Mauritanian woman recounts the following facts, reported by the doctor (the date is 1992, when medical reports still included narrative):²³

Mrs. S states that her soldier husband was arrested during the events of April 1989, at home, by white Mauritians. She describes terrifying scenes she witnessed in Nouadhibou. She saw Beydanes cut the throats of children, women, and men. She saw babies thrown against walls and mothers screaming as their breasts were cut off. She alleges that she herself was also arrested with her four very young children and taken to the police station. She claims that she lived through a nightmare during her six-day detention, in which she was tortured, scalded with boiling water on her feet, beaten, and stabbed. She emphasizes particularly the rapes she was subjected to in front of her children, who were screaming with fear. She attempted to resist and was again stabbed repeatedly. She says that she and her children were treated like animals, food was thrown on the floor, she suffered terribly from thirst, insults, and humiliations.

Note that here, at a time when the standard procedure was to limit the certificate to clinical expert opinion and a doctor's conclusion, an effort is instead being made to convince the reader by recounting the facts of what happened:

Mrs. S's account is very coherent. It is still very painful for her to describe what she experienced, and she does so with deep distress. She states that she has never been able to speak directly to OFPRA, nor to the Appeals Commission, about her history, and that simply remembering the events she lived through overwhelms her. The observations made during the clinical examination are indicative of serious abuse. All the scars are consistent with the causes cited and with the alleged torture. Above all, Mrs. S presents very worrying psychic sequelae. She is suffering from a state of traumatic shock related to the terrifying scenes she witnessed and the events she suffered, particularly the rapes in front of her children. The psychic sequelae of her experience are a source of acute emotional suffering. This state is related to the torture and violence suffered, which she was unable even to speak of during her first appointments with Comede.

²³ This extract is taken from the Comede archives for 1997, case 50.757. The details of the account suggest that the woman is a Haratin (black), while the torturers are Beydanes (white).

Expert reports on the existence of psychic sequelae of violence do more than provide evidence intelligible to French government officials and judges. They speak the words the individual cannot utter. Thus the clinical psychological certificate does not simply stand in the place of the asylum seeker's voice: it also makes her silence possible. Trauma, and the traces of it identified by mental health specialists, bear witness to the unspeakable.

. . .

Over the last twenty-five years, political asylum has gradually lost the sense of protection consecrated by the 1951 Geneva Convention in the aftermath of World War II. From an anthropological point of view, in the tension created by asylum—between hospitality and hostility, between generosity and suspicion—it is the latter that wins out. Once seen as unfortunates suffering from the disorder of the world, refugees are today suspected of cheating and abuse. While for a time asylum policy was spared the increasingly restrictive and repressive attempts to control transnational migration, it has now fallen victim to the same economic and ideological issues as plague immigration policy. Asylum seekers were cast as potential frauds, who, if they wished to join the fortunate minority awarded refugee status, had to prove themselves, or rather to prove that they indeed deserved the protection they claimed. The more the asylum seekers' accounts lost credibility, the more they had to look to their bodies to provide testimony to the violence suffered. The more their word was devalued, the more they had to rely on the expertise of doctors and psychologists.

Thus, on the margins of a public mental health system that had little interest in defending the rights of immigrants and foreigners—beginning with the right to equality under the law—a constellation of associations grew up to provide psychological care to these groups. As an effect of demographic changes (the fall in economic immigration and the growth in the demand for asylum), but also as a consequence of changes in awareness (with greater attention focused on problems related to political violence and psychic suffering), the issue of torture and persecution gained more public prominence. European networks were established and they gained the support of international bodies. Trauma then emerged as the nexus of this new configuration, linking violence and suffering, politics and psychiatry, experience and care, memory and truth. The field of the psychotraumatology of exile inherited the earlier concerns of clinicians working with immigrants, but it reinvigorated them by developing therapeutic techniques specific to victims of torture. This gave rise to a new therapeutic field, albeit one partially inspired by earlier work with post-trauma patients who had survived wars and disasters. However, the

new clinicians, victims of their success, found themselves called on not as caregivers but as expert witnesses. Unwittingly, they had forged a new link with that long hunt for lies and malingering with which the history of trauma is, as we have seen, closely bound. As before, when it was the veracity of wounded soldiers and injured workers that was in doubt, so now clinicians held the keys to the truth about refugees. The refugees' own words were no longer sufficient to establish the truth of their accounts, but doctors could find in bodies, or better (in the case of psychologists and psychiatrists) in the psyche, the scars left by the alleged violence. Some embarked on this new course with enthusiasm; others were much more reluctant; but ultimately, psychic disorders, the signs of trauma, came to bear witness to the facts that had produced them. At least in principle.

For if we look carefully at what those whose job it is to assess applications for asylum actually say and do—both OFPRA officers and Appeals Commission judges, both lawyers and clinicians—it seems that the principle that political violence has damaging effects on the psyche is much more generally accepted than the proof of that damage in individual cases (the fact that the torture of a given individual can be confirmed by indisputable symptoms). It is easier to think that people are traumatized by serious and painful events than to believe that they are suffering from post-traumatic sequelae that establish the authenticity of those events—especially when they are *a priori* assumed to be flouting the law. Thus, as has been the case since it first emerged, psychic trauma speaks only that truth about the victim that society is prepared to hear.

CONCLUSION

The Moral Economy of Trauma

OVER THE LAST TWO DECADES, OUR RELATIONSHIP TO TIME HAS CHANGED. Once confident, almost arrogant, it has become painful and anxious: in the words of W. H. Auden, we live in an "age of anxiety."¹ Our sense of history—that is, of both our collective history and our individual histories—has also changed profoundly. From being the story of the victors, it has become a "historiography of the vanquished," as Reinhart Koselleck predicted.² Our gaze on the past was once a celebration of days of triumph, when memory spoke of grandeur and glory, of which the bicentenary of the French Revolution was the apogee. Today we look back with wounded eyes, remembering the slave trade and the effects of colonization, playing and replaying the debates that revolve around old wrongs. Not so long ago our attitude to the present was buoyed up by the liberation of the last colonies and the emergence of young democracies, in a context where some argued that the fall of European communist states heralded the end of history. Today we have lost some of that assurance, we have renounced our certainties, and quietly, almost daily, we are falling further and further into an anxious reliance on security policies and precautionary measures. Our view of the future, once full of hope grounded in the invocation of a new world order, has turned to disenchantment. The world we see is a world full of dangers, dangers which we understand as the long-term consequences of domination and oppression that we thought could be forgotten, but which were only buried, ready to re-emerge.³ Thus we live time differently, even if we have only rarely taken the measure of it. Our relationship to history has turned tragic.

In this new context, where our historical setting, and especially the way in which we think about it, has been fundamentally transformed, trauma has come to give a new meaning to our experience of time. It marks both the psychic and the metaphorical trace of what has passed: a psychic trace

¹ W. H. Auden (1991). The long poem *The Age of Anxiety* was written between July 1944 and November 1946.

² R. Koselleck (2002). In the German historian's view, while in the short term history is made by the victors, in the long run it is the history of the vanquished that becomes the accepted version.

³ Contemporary forms of treatment of time relate less to the logic of sites of memory (Nora 1997) than to the problematic of the integration of history (Fassin 2006a).

to which trauma neurosis, and more recently post-traumatic stress disorder, bear witness, giving grounds for the intervention of psychologists and psychiatrists; a metaphorical trace that is invoked in the demands of descendants of slaves and native peoples, victims of massacres and genocides, calling for legislation or for reparations. We would be tempted to call it an ineffable trace, since this memory is as insistently present as its imprint is fleeting, if there were not some researchers in biomedicine who are now claiming that it has a material reality inscribed in neuronal connections and regions of the brain.⁴ But this terrain, where the cognitive sciences come together with clinical psychiatry, is not our focus.

Psychoanalysts may identify the neurotic symptoms of a “psychic wound” and neurophysiologists may discover cortical lesions responsible for the construction of an “emotional memory,” and either of these factors could be manifested in sleep problems and anxiety disorders. In other words, trauma may be understood figuratively (the immaterial trace) or literally (the physical scar). But this is not what we have attempted to understand and interpret in this volume.⁵ In contrast to the many works that psychiatrists and historians, philosophers and anthropologists have devoted to this subject, we believe that the truth of trauma lies not in the psyche, the mind, or the brain, but in the moral economy of contemporary societies. The fact that trauma has become so pervasive a factor in our world is not the result of the successful dissemination of a concept elaborated in the scientific world of psychiatrists, and then exported into the social space of afflictions. It is rather the product of a new relationship to time and memory, to mourning and obligations, to misfortune and the misfortunate. The psychological concept, trauma, has enabled us to give a name to this relationship.

We are therefore claiming to contribute not to a history of psychiatric knowledge but to an anthropology of common sense. In our view, trauma is a “floating signifier” which, as Claude Lévi-Strauss noted in relation to

⁴ International trauma specialist Bessel Van der Kolk (1996), a psychiatrist at the Harvard School of Medicine, has put forward a synthesis of the neuroendocrinological and psychobiological data on PTSD. On the basis of brain imaging in individuals affected by post-traumatic stress disorder and electrical stimulation of laboratory animals, he posits the existence of an “emotional memory” that becomes “indelible” as a result of cortical lesions. Although he makes no reference to this work, Paul Ricoeur (2004) also speaks of the “cortical trace” of memory.

⁵ Cathy Caruth (1995) believes that recent neurobiological discoveries, Freudian theories, and clinical observations can be reconciled: she goes as far as to suggest that the anatomical underpinnings of trauma help us to understand its contradictory symptoms. Ruth Leys (2000), on the other hand, argues that this literal and materialist reading misses the meaning of the traumatic experience: in her view, rather than a unified whole, trauma is a set of contradictory paradigms which call for pragmatism on the part of therapists rather than modeling.

the Melanesian *mana*, “is the disability of all finite thought . . . although scientific thinking is capable, if not of staunching it, at least of controlling it partially.”⁶ It speaks to us of our era—the spirit of the age, we might say. It expresses a range of the concerns, values, and expectations of this era. We can of course highlight the diversity of signifieds to which this single signifier refers, and we might wonder if it is reasonable to group in the same category the adult who was sexually abused as a child and the earthquake survivor, the veteran who committed war crimes and the civilian whose family was massacred, the descendant of the captive rediscovering his or her history and the political activist tortured under an authoritarian regime. But we believe that the fact that all of these realities are today subsumed under the heading of trauma is an important indication of the way in which the tragic is understood in contemporary societies—not clinically, as North American psychiatrists asserted when they established the diagnosis of post-traumatic stress disorder on the basis of the similarity of symptoms observed in all these situations, but anthropologically, for the simple reason that all of these individuals are thought of in similar terms. Both misfortune and violence are understood to be phenomena that leave traces of the past in the present, and that may even require immediate treatment in order to ensure they do not burden the future. From this point of view, while it is important to speak of “trauma culture,” as does Anne Kaplan, or “cultural trauma,” to use Ron Eyerman’s term (both evoking the traces left by dramatic events in individual histories and collective accounts),⁷ we need at the same time to look at what it means that the concept of trauma has given us this unprecedented ability to talk about—and hence to experience—the violence of the world.

According to Michael Herzfeld, “social and cultural anthropology is ‘the study of common sense,’ ” that is, of “the everyday understanding of the way the world works.”⁸ By this definition, the ambition of the present volume is indeed anthropological. What we have aimed to do—contra the popular assumption that trauma is self-evident and that those who speak of it are simply revealing a reality—is to understand what is at play when we interpret the world and its disorders through this concept, which has moved from clinical psychiatry into everyday parlance. We must shift our point of view in new and unaccustomed directions in order to grasp how categories are constructed and used, how representations not only describe reality but transform it, how practices not only follow from

⁶ Lévi-Strauss (1987). In his view, the contradictions and variations of “mana” can be resolved if we accept that it has a “symbolic value of zero,” which the speaker can fill.

⁷ See Kaplan (2005) and Eyerman (2001). Both focus on understanding the collective forms of trauma, on the basis of the memory of colonization and slavery, respectively.

⁸ See Herzfeld (2001), who also defines anthropology as “a critique of common sense.”

a priori reasoning but justify it in retrospect. We have not sought to discover whether trauma is real or whether psychological treatment of it is a good thing, but rather to understand what the choice to read violence in these terms produces in the social world and in the moral sphere. Thus our approach necessarily proceeded from a critique of common understandings, not in order to refute them but rather that we might better analyze the assumptions behind them and their consequences. As we have shown, the ideological revolution produced by the concept of trauma changed the status of the wounded soldier, the accident survivor and, more broadly, the individual hit by misfortune, from that of suspect (as it had been from the end of the nineteenth century) to that of entirely legitimate victim. We have described this spectacular reversal that allows the soldier to claim his rights, even on the very basis of crimes he has committed, and the person who claims to have suffered sexual abuse to gain recognition of her suffering on the basis of her word alone, as marking the end of suspicion. This development both establishes and reinforces a new figure, one that is central to an understanding of contemporary society—the figure of the victim.

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Today, particularly in France, when victims of apartheid, colonization, or the slave trade call for recognition, it is considered good form to condemn “competition between victims.” Similarly, when addressing the issues of women suffering sexual harassment from colleagues or superiors at work, young people experiencing discrimination in employment on the grounds of their skin color or family name, and more generally those who transform their demands into complaints it has become usual to mock the tendency towards “victimization.”⁹ We, however, reject this reading, which is ultimately simply a sophisticated but classic way of denying injustice, inequality, and violence. In our view, this type of analysis only adds a moral evaluation to the study of our moral economy, by suggesting that some victims are, from the point of view of the speaker, more legitimate than others. Rather than drawing up an honor roll of victims, we prefer to focus on the way in which contemporary societies “problematize” (to use Foucault’s term) the questions facing them.

⁹ The expression “competition among victims” comes from Jean-Michel Chaumont (1997): since the publication of his book it has become widely used and has taken on polemical connotations, being used to invalidate the historically based claims of descendants of slaves and native peoples. The term “victimization,” more specifically in the French context, is more fluid, having initially been used, particularly in studies of violence and crime, simply to describe the fact of considering oneself victim of a phenomenon, before taking on a more

In the case of trauma, we are not dealing with an inert object, any more than victims are passive subjects. As we have established through our case studies, victims of industrial accidents, backed up by victimological expert reports, make use of the argument of trauma to obtain insurance payouts; the inhabitants of the Palestinian territories, taking arguments from humanitarian psychiatrists, use trauma to champion their cause in the court of world opinion; asylum seekers, assisted by specialists in psychotraumatology, attempt to gain recognition of the reality of their persecution through trauma. Thus the politics of reparation, testimony, and proof demonstrate three practical ways in which trauma is applied in the field of action. In each of these cases, the focus is less on exciting empathy (although this intention may be present) or of representing oneself as a patient (although the expectation of treatment is not excluded) than on simply claiming one's rights. Thus, while trauma emerges in the context of an ethos of compassion that is characteristic of our era, it is also a tool used in a demand for justice.¹⁰ But we would go further. There is no way we can know whether victims necessarily consider themselves as victims. Survivors of the accident in Toulouse may equally view themselves as residents relegated to a disadvantaged housing project; young Palestinians may see themselves as heroes of their people's cause; asylum seekers may consider themselves political activists. We know nothing, or almost nothing, of their subjectivity—or interiority—as victims. Survivors of disasters, oppression, and persecution adopt the only persona that allows them to be heard—that of victim. In doing so, they tell us less of what they are than of the moral economies of our era in which they find their place.

To be more specific: while the subjective experience of victims remains inaccessible to us, the public recognition they are accorded in the name of trauma provides the key to an anthropology of the subject—an anthropology definitively freed from the illusion of the unfathomable depths of the individual and fully attentive to the political processes of subjectification. In focusing our critical gaze on common meaning at the same time as avoiding the irony of sitting in judgment, the issue is thus to analyze these moral economies without falling ourselves into the trap of moralization. But is it possible to escape normative reading entirely? Is it even desirable to place oneself at such a distance that values no longer operate? Our answer to both of these questions would be no. Just as we believe that there is no apolitical opinion, we argue that there is no point of view

negative connotation, as for instance in the work of Olivier Mongin (2003), who sees it as a contemporary obsession.

¹⁰ The concept of the ethos of compassion (Fassin 2006) can be used to designate cultural codes that pay extreme attention to suffering and show a special willingness to listen.

entirely separate from morals.¹¹ It is clear that the most decisive attack on morals, that put forward by Nietzsche in his *Genealogy*, is still a moral act. But equally, we are convinced that the attempt to avoid the moral dimension of anthropological work is an intellectual abdication. Would it be possible that the price Wittgenstein paid for his radical deconstruction of moral philosophy was to end up unable to speak of the moral world as it is seen and lived by its members?

Thus, if we accept these two premises, if we believe that it is neither possible nor desirable to eliminate all moral understandings, our task is not to distinguish between good and evil, but to critique the actual conditions that produce social realities. For example, to take the founding issue that led to the creation of PTSD as a diagnosis, we do not say that there are “good” and “bad” victims and that the concept of trauma makes it impossible to distinguish one from the other (North American war criminals and the Vietnamese survivors of their massacres being essentially brought together in the same psychic suffering). Instead we ask what the recasting of war crimes as traumatic experience means for the perpetrators (social recognition and financial compensation) and for the American nation as a whole (reconciliation and redemption). For us, this critique of the ways in which victims and their causes are produced, which replaces judgment of the victims themselves and of the validity of their cause, is fundamental. Rather than distinguishing on the basis of moral criteria between the survivors of the Toulouse accident and the factory workers, the Palestinian residents of destroyed houses and Israeli witnesses of bomb attacks, tortured asylum seekers and their torturers, we instead examine what the failure to distinguish between them in the mental health system—or even beyond the medical context in the popular use of the concept of trauma—obscures about social relations, historical realities, and political situations. Let us make this crucial point more explicit.

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Most social science research on trauma and on victims adopts an empathetic point of view with respect to victims. This is easy to understand. The violence of the events experienced affects even the researchers studying it, and the pain and suffering it produces exert a sort of fascination for them. For these reasons, few researchers distance themselves sufficiently to avoid taking trauma for granted and seeing victims as what they profess to be. Our critique neither refutes—nor confirms—either the diagnosis of trauma or the status of victim. But how can we avoid reduc-

¹¹ See Fassin (2008b) for a plea to consider morals as a legitimate object of anthropological research, which implies a reflexivity on the anthropologist’s moral position.

ing analysis to empathy, without falling into an excess of condemnation? In our attempt to achieve this goal, our method has been to shift the terms of the question. While scientific practice tends to examine a reality for what it is, we have studied what it is not. To be precise, we have focused on two aspects of the process of production of trauma and victims that most research leaves out: what does this process not allow to be said, and who are those whom it makes it possible to leave out? In other words, while trauma is a language that appears both neutral and universal in its account of victims, it significantly fails to throw light on certain signifieds and certain agents. Identifying these gaps gives us the means to grasp the figure of the victim delineated by trauma.

First, trauma obliterates experiences. It operates as a screen between the event and its context on the one hand, and the subject and the meaning he or she gives to the situation on the other. By reducing, whether in clinical terminology or in common language, the link between what happened and what was experienced to a set of symptoms, or even of predefined representations (the fact of being traumatized), it obscures the diversity and complexity of experiences. It conceals the way in which experiences take on multiple meanings in a collective history, in a personal life story, in a lived moment. Having lived through an explosion at a factory in Toulouse, the destruction of one's home in Palestine, the persecution of one's family in Sri Lanka, or any other event, does not necessarily imply that one's experience is circumscribed by this event, or even that one desires that it be reduced to this event. Indeed, this is what victims—defined as such by others—often say as they adjust as best they can to this obligatory label which will afford them the status of recognized victims. The fact that, in given circumstances, they must pass through this process of recognition in order to win financial compensation, public awareness of their plight, or refugee status does not imply that they agree with this process or this image.

Nor can we be satisfied with trauma as a society constructs it, whether or not it is verified by psychological tests and psychiatric observations. Both before and after the tsunami, the survivors in Aceh were already victims of political domination, military repression, and economic marginalization. Both before and after Hurricane Katrina, the people of New Orleans were already victims of poverty and discrimination that reinforced class inequalities through racial distinctions. Trauma is not only silent on these realities; it actually obscures them. As a focus of consensus, it eliminates individual features. We can therefore understand that it is claimed by victims themselves, that is, by members of society who define themselves as victims. Trauma offers a language in which to speak of the wounds of the past—of slavery, colonization, or apartheid. Claimed by the protagonists themselves, trauma becomes once again an argument in

struggles for recognition of the plurality of memory—even if this violates historical reality. Hence we understand why such recognition is selective.

Second, trauma—or rather the social process of the recognition of persons as traumatized—effectively chooses its victims. Although those who promote the concept assert that it is universal, since it is the mark left by an event, study reveals tragic disparities in its use. After the industrial accident in Toulouse, residents of the district where the explosion occurred, and by extension the entire population of the city, were seen as victims of trauma, justifying the intervention of mental health specialists. The factory workers, however, stigmatized by the disaster, and the mental patients in the psychiatric hospital, simply forgotten, were not fully accorded this status. While humanitarian psychiatry is practiced everywhere in the world, it has long been more readily accepted as a treatment for the suffering of the Armenian, Romanian, and Croatian people than for that of Rwandans, Liberians, or Congolese; and while it attempts to care for the victims on both sides of armed conflicts, tensions may arise around distinctions between those who are suffering, depending, for example, on whether they are Kosovars or Serbs, Palestinians or Israelis. And while organizations that specialize in caring for victims of torture and persecution strive to treat them without discrimination, they are regularly faced with the question of what attitude they should adopt towards former torturers or accomplices now seeking asylum. And, in a less morally conflicted situation, they are also sometimes required to refuse patients who have suffered political violence but are considered as presenting prior pathologies that require ordinary psychiatric treatment.

In noting these tensions, and even contradictions, we are not condemning practices, but simply emphasizing the lines of moral demarcation that always operate in the context of trauma. It was clear to all that the international mobilization, including action around trauma, was much greater after the tsunami in Thailand than after the earthquake in Pakistan, principally because the tsunami affected Western tourists who were immediately offered support by the clinical psychology units made available to them, while no Westerners were involved in the earthquake. Recognition of trauma, and hence the differentiation between victims, is largely determined by two elements: the extent to which politicians, aid workers, and mental health specialists are able to identify with the victims, in counterpoint to the distance engendered by the otherness of the victims. Cultural, social, and perhaps even ontological proximity matter; as does the *a priori* valuation of the validity of the cause, misfortune, or suffering, a valuation that obviously implies a political and often an ethical judgment. Thus trauma, often unbeknownst to those who promote it, reinvents “good” and “bad” victims, or at least a ranking of legitimacy among victims.

However, if the metaphor of trauma is so taken for granted today, this is also due to the fact that it allows a subtle distinction to be made between the individual and the collective, between the governmentality it imposes on the former and the cohesion it provides for the latter. Compensation, testimony, and proof, although they are unarguably subsumed by this metaphor of trauma, are not identically distributed among different places, events, and people. Thus, even though the concept of trauma asserts the equal humanity of all suffering people, even though it proclaims that collective memory is now a product of the fate of each individual and that it necessarily implies reparation, testimony, and proof, the use of the concept in fact makes it the basis for a new division between human beings. The nature of events deemed traumatic, the value accorded in advance to the life of those suffering, the need to protect some social groups at the expense of others determines which of these three paradigms—compensating, bearing witness, or certifying—will take priority in the therapeutic process.

In reparation, the lawful right accorded to each individual, independently of any procedure of authentication, derives from the need to preserve the illusion of collective unity, which the event—itself incontestable in cases such as bomb attacks or the explosion in Toulouse—threatens to break apart. Here, reparation comforts the whole of the collective because it is guaranteed to each individual—with the notable exception of those who are marginalized. Conversely, in the case of testimony, the collective cause to be defended is fed by the individual unit of each testimony, with the sum of the units producing the narrative of a collective fate. Here, the collective ideal to be defended using the concept of trauma blurs personal experiences, and individuality becomes subsidiary. Finally, in the certification of refugees, scrutiny of the reality of the facts in individual cases can signal doubts or even denial of what entire populations or specific groups are collectively exposed to on other continents, and this can signal an abdication of international responsibility. Here, the uncertain fate of each individual is emptied of all reference to the collective history, this time in the name of a higher interest, that of protecting the supposed national community of the receiving country.

Clearly, the uses made of the concept of trauma adapt remarkably well to these multiple nuances, and even contrive to render the inequalities they reveal almost invisible. This is no doubt also their strength.

. . .

Trauma was born in the late nineteenth century as a psychological category constructed on analogy to the medical notion of a corporeal injury, and it bears traces of this lineage still today, for one can speak as readily

of a psychic scar as of a physical scar. Its reemergence at the end of the twentieth century, within a reworked psychiatric nosology, was for some time restricted to clinical practice. Indeed it both extended the territory covered by clinical practice (by including persons who were not necessarily sick, but who had experienced an event deemed traumatic) and refined the clinician's diagnostics (by establishing a minimal phenomenology of post-traumatic stress). The new reality thus described even appeared to avoid any moral prescription since, as it was based purely on symptomatology, it ostensibly eliminated judgment of either the facts or of their perpetrators. It was symptoms that defined the syndrome; rape, torture and accident were not distinguished from one another; neither was the perpetrator distinguished from the victim or the witness. All that counted was the mark left by the event.

But this was an illusion. The door may have been shut against moral judgment, but it found its way in through the window. Or rather, it never really left the scene at all. In fact trauma enjoys its current status more as a moral than as a psychological category. The trauma of the survivors of the Toulouse accident, of Palestinian youths, and of political refugees is universally acknowledged, and it confers a form of social recognition before it is ever validated by any psychologist or psychiatrist. Moreover, when mental health professionals are called on to attest to the diagnosis, they decline to give an opinion or even deny the relevance of the category, noting that it is relatively rare and of limited validity. Rather than a clinical reality, trauma today is a moral judgment.

We can thus understand why the boundary between collective trauma and individual trauma is as difficult to discern as is the passing of historical trauma from one generation to the next. There is no need to explore how we move from one to the other (perhaps even by returning to Freudian speculations on the founding murder in the sociodicy of the Jewish people). The validity people are willing to accord to trauma in order to relate the experience of descendants of survivors of the Holocaust, of the Armenian or Rwandan genocide, of victims of slavery or apartheid, is not the validity of a clinical category but rather of a judgment—the judgment of history. In other words, trauma today is more a feature of the moral landscape serving to identify legitimate victims than it is a diagnostic category which at most reinforces that legitimacy. It speaks of the painful link that connects the present to the past. It identifies complaints as justified and causes as just. Ultimately, it defines the empirical way in which contemporary societies problematize the meaning of their moral responsibility in relation to the distress of the world.

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THE EMPIRE OF TRAUMA

TODAY WE ARE ACCUSTOMED TO psychiatrists being summoned to scenes of terrorist attacks, natural disasters, war, and other tragic events to care for the psychic trauma of victims—yet it has not always been so. The very idea of psychic trauma came into being only at the end of the nineteenth century and for a long time was treated with suspicion. *The Empire of Trauma* tells the story of how the traumatic victim became culturally and politically respectable, and how trauma itself became an unassailable moral category.

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