Recovering the context in posttraumatic stress disorder: The psychosocial trauma in victims of political violence and terrorism

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Abstract

Throughout history, humans have frequently carried out harmful actions against one another. Often, these actions result in intensive and long lasting pain and suffering. Posttraumatic stress disorder (PTSD) diagnosis has been the theoretical tool used mostly by psychologists to understand the physical, emotional and behavioural symptoms following a traumatic experience. Due to its clinical and medical roots, PTSD diagnosis represents man in a social vacuum, a man without context, and a model of health closely tied to illness. The aim of the paper is to reintroduce the social context of human beings into trauma diagnosis, and to develop a health model that is more focused on well-being than on illness. Both points of view help us to seek a theoretical way for better understanding the psychosocial trauma that result from political violence and terrorism. Psychosocial trauma has definite roots, and destroys our inner world –the world of our most valuable meanings– infects our minds with hate against others, and breaks the social fabric we belong to.

Keywords: Mental disorder, mental health, posttraumatic stress disorder, psychosocial trauma.

La recuperación del contexto en el trastorno de estrés postraumático: el trauma psicosocial en víctimas de violencia política y terrorismo

Resumen

La historia de la humanidad está plagada de acciones violentas perpetradas intencionalmente por parte de unos sujetos contra otros de las que se ha seguido un sufrimiento intenso y duradero que viene amargando la existencia de millones de personas. El trastorno de estrés postraumático (TEPT) ha sido el concepto del que se ha valido la Psicología para estudiar las consecuencias psicológicas derivadas de la violencia política y del terrorismo. Pero debido a sus raíces clínico-médicas, el TEPT adolece de dos grandes inconvenientes: dibuja la imagen de un sujeto suspendido en el vacío, y maneja un concepto de salud muy vinculado al de enfermedad. Este artículo pretende recuperar al sujeto que somos todos: un sujeto inserto dentro de una realidad socio-histórica, y recuperar un concepto de salud alejado de la enfermedad: el bienestar. Ambos puntos de vista nos ayudan a una mejor comprensión de las experiencias traumáticas derivadas de la violencia política y el terrorismo desde una concepción psicosocial del trauma. Se trata de un trauma que tiene unas raíces situadas fuera del sujeto, una experiencia que destruye nuestro mundo interior, nuestro mundo de creencias, que llena el corazón de odio, rencor y resentimiento, y que rompe el tejido social que nos rodea.

Palabras clave: Desorden mental, salud mental, trastorno de estrés postraumático, trauma psicosocial.

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Just a few days after Hurricane Katrina destroyed the Southern coast of United States, the American Psychological Association (APA) posted papers on its website ("Managing Traumatic Stress: After Hurricane Katrina", "Managing Traumatic Stress: Tips for Recovering From Natural Disasters"; "Posttraumatic Growth Inventory") that aimed to help psychologists cope with the demands coming from victims of that natural disaster. In an electronic letter sent to the thousands of APA members, Norman Anderson wrote: "Our hearts go out to all of those affected by this unprecedented disaster, and to those with loved ones in the region. APA is strongly committed to providing significant assistance to the survivors in both the short and long term" (Anderson, 2005, p. 1). Hurricane Katrina, as well as Hurricane Stan some weeks later, has shown once again that besides the economic and political consequences, natural disasters have also a psychological face: the pain, lack of control, the social disorder, the losses, and the personal suffering people experience under such an extreme and traumatic event.

A vital and psychological emptiness usually follows an unprecedented, intensive and traumatic event that suddenly destroys our physical, social and mental landscape: this is the picture of a traumatic experience. When such an event like Katrina happens in the life of any person, she/he is close to the "angry heart" that Da Costa talked first about in 1871 in a paper published in the "Journal of Medicine and Sciences" based on the clinical observation of a soldier fighting in the American civil war (1861-1865): breast ache, racing heart rate, and giddiness were his three main symptoms. Afterwards, "traumatic neuroses of war" (Kardiner, 1941) "intense stress reaction" (APA, 1952), and "posttraumatic stress disorder" (APA, 1987) have been the different labels used for the symptoms which accompany the personal experience of a traumatic event.

Natural disasters are only one of the many sources of physical pain, mental disorder and psychological suffering we undergo throughout our lifetime. But there are a lot of harmful actions humans beings intentionally carry out against each other: These include acts of war (Marlowe, 2001; Martín-Baró, 1990; Moreno and Jiménez Burillo, 1992; Pérez, 1999), terrorism (Blanco, del Águila, and Sabucedo, 2005; de la Corte, 2006; Fullerton, Ursano, Norwood, and Holloway, 2003), torture (Amnistía Internacional, 1984; Basaglu, 1992; Böjholm, 1999; COLAT, 1982; Elsass, 1997, etc.), rape (Garcia del Soto and Hromadzic, 2005), political persecution and internal and external displacement (Hauff, 1998; Kagee & García del Soto, in press; Marsella, Bornemann, Eklad, and Orley, 1994; Sveaass, 2000), sexual assaults, robbery, and severe accidents such traffic accidents, air crashes, etc. What we know for sure is that the most common and extreme suffering mankind has experienced in his history comes from the planned actions of some human beings against other innocent human beings. And we know that those actions are aimed not only at his/her physical being, but also his/her sense of belonging (Becker, 1995), his/her political or religious ideology, and his/her worldview, and so impose a power-submission structure.

One of the more reputable European historians, Eric Hobsbawm, presents a disturbing fact: during the last century, about 187 million people died as a result of violent conflict. This includes the victims of the two World Wars, as well as various colonial and ethnic wars, political genocides, and religious witchhunts. At the time of writing, hundreds of Iraqis are caught up in a political situation that is both highly uncertain and fraught with violence. Looking at this picture, it is hardly to surprising that research in anxiety disorders had increased dramatically in the last two decades of the past century (Norton, Cox, Asmundson, and Maser, 1995).

The socio-political and ideological roots of traumatic experiences tied to political violence and terrorism is our first argument: the introduction of historical

arguments is needed if the concept of trauma is to be adapted to the current theoretical trends we are witnessing in Psychology (positive psychology, for instance), and to all suffering people, as we should.

The existential factors of symptoms

The anxiety disorders has always been a major focus in the theoretical and applied work of psychologists and psychiatrists, but in 1980 the Task Force of DSM-III decided to introduce a new anxiety category: posttraumatic stress disorder (PTSD). There currently seems to be wide agreement that definite historical events played a central role in the approval of this nosologic category (Martín-Baró, 2003; Millon, 1983; Scott, 1990). Nothing new: this can be said of many other theoretical concepts used in psychology, but this is especially so in this instance. The PTSD category was developed in response to pressure from two lobbies: the Vietnam Veterans, and the women's victims of sexual rape (Burguess & Holstrom, 1974).

On returning home, the Vietnam soldiers learned that they fought in a wrong and unpopular war. Feeling that their psychological problems were being ignored, they successfully campaigned for the right to be recognized as mental patients with an unique diagnosis – PTSD – and thus in need of psychological treatment. Such recognition allowed them the medical, social and economical benefits for having a "mental disorder" (Young, 1995; Vázquez, 1990; Vázquez, in press). As is demonstrated by its application to victims of political violence and terrorism as well as to combat veterans, the PTSD diagnosis has become the stock medical and psychological response to what are essentially social and political problems. "The advocates for the PTSD diagnosis inappropriately medicalized political dissent when they conceptualised the problems of veterans as a form of mental illness" (McNally, 2003, p. 230). Clinical fraud has been one of the consequences of this process. In a well documented book, B.G. Burkett, a Vietnam veteran, and Glenna Whitley, an investigative journalist, have shown that many studies of combat-related PTSD included subjects who lied about their symptoms (it is really easy to fake them), and the incentives for doing so are as high as $36.000 per year, tax-free and indexed to inflation, for life (Burkett and Whitley, 1998, p. 236). "Any complainant can read in the newspapers the PTSD symptoms or download them from Internet and repeat again in the evaluation sessions" (Arboleda-Flórez, 2000, p. ix). A reputable researcher in the field of mental health notes: "one should not forget the historical roots of PTSD, and the thin line between the clinical research and legal, economic, and social interests…the PTSD is a land ripe for lies and falseness" (Vázquez, in press).

The current argument is a familiar one: as with any other theoretical proposal, the psychology of trauma is not an ahistoric, value-free concept, which is hardly surprising given that psychology itself is hardly a value-free discipline. For a long time the social sciences have disagreed with Max Weber's proposition of the two different kinds of problems: the opinions or proposals coming from the politics of the time, and the scientific analysis of facts. People who come fresh into the intellectual arena should keep in mind that there are two distinct kinds of problems, on one side the verification of *facts*, on the other the answer to questions about the *value* and contents of culture and about the behaviour of people in cultural communities and in political associations (Weber, 1967, p. 213). The notion that facts and values are separate entities was also the core argument of Guthrie's APA Presidential address: "Like metallurgy, a scientific psychology consists in a new orientation toward psychological facts, a weeding out of subjective descriptions and an avoidance of descriptions colou-

red by values and prejudices that are not universally shared" (Guthrie, 1946, p. 4). It has been very easy to regret the comparison between psychology and metallurgy, and to restore the value-oriented nature of social sciences (see in particular Wright Mills' innovative conceptualization of the "sociological imagination," 1959) and in psychology (Bevan, 1976; 1980; Martín-Baró, 1998, pp. 293-341; Miller, 1969, etc.). Early on in the preface to his vital book, *Value-Free Science*, Robert Proctor, the author of one of most disturbing studies about the Holocaust, *Racial Hygiene: Medicine under the Nazis*, has noted how since the 1960s it was realized that "facts" suffer from many of the foibles once attributed only to "values" (Proctor, 1991, p. ix). In this context, it is worth noting that there is one "foible" we are interested in, namely that values and science have social origins and social consequences. This supposed foible has become an identifying mark of our discipline: as a brand of social sciences, psychology is committed with physical, social and psychological well-being of persons, groups, organizations, communities, and societies (see American Psychologist Special Issue, 1969, 24, Nº 12). Along with illness, well-being should also be a part of the framework of mental disorder, trauma and health. There is a growing literature in psychology that focuses on enhancing the positive resources of those who have experienced traumatic situations, and that emphasis the importance of concepts such as "Well-Being" and "Resiliency" (Seligman, Sheen, Park & Peterson, 2005).

A value-oriented science means that there are some "extracognitive factors" between the subject and the object of knowledge (Merton, 1973). Social and cultural factors pervade the contents of scientific paradigm: the economic structure, the group goals and interests, the wide world of ideology, the power relationships, the social class the scientists belongs to, the culture, etc. According to Merton's sociology of science, the previously mentioned surrounding historical conditions underlying the establishment of PTSD as a diagnostic category become one of the best supporting examples of the existential bases of knowledge. These existential conditions give us a realistic picture of science and of scientists: they are not entities existing in a vacuum, but men and women who select the problems they want to pay attention to; researchers who take a definite theory as starting point and examine selected hypotheses; individuals, like everyone else, who have their own beliefs, values, attitudes, etc., and who many times run the risk of interpreting reality solely from their own cognitive framework, disregarding facts and realities they are not familiar with. In this regard, the specificity of the situations experienced by survivors of political violence tends to be especially difficult for scholars to grasp, not being familiar enough with these realities. Due to his wide professional experience in traumatic contexts, the voice of Derek Summerfield should be attended to: "The largely non-western populations targeted did not ask for trauma interventions…we need to remember that the Western mental health discourse includes a theory of human nature, a definition of personhood, a sense of time and memory, and a secular source of moral authority… none of this is universal" (D. Summerfield stated this in 2005, at a WHO meeting in the post-Tsunami situation in Sri Lanka that partly inspired van Ommeren, Saxena, & Saraceno, 2005).

From among the many existential factors playing a role in the construction of science, the following two are especially important: the role played by power (i.e.: power as a source of meaning), and the likelihood that the social sciences have begun a process of "balkanization" or break-up due to the pressure of groups with vested interests, as it seems to have been the case in PTSD. From the times of Francis Bacon, one can observe the corrupting influence of group

loyalty on human understanding (Merton, 1973, p. 184). Social psychology has seen plenty of this type of corrupting influence: stereotypes which support the humiliation of people belonging to out-groups, norms which allow harmful actions against others, beliefs that justify persecution and dehumanization, leaders who encourage group polarization and destruction of the enemies, groups who make decisions solely to preserve group-cohesion (groupthink), or who are full convinced that they (the insiders) are the guardian of the truth and not allow the "outsiders" to take a hand in the matter.

Besides the historical nature of knowledge and group pressures, there is a second line of argument, an epistemological and theoretical one: PTSD as an anxiety disorder has developed according to a model of man solely based on psychological factors; a model of a man isolated from his social world, from the world of his interpersonal and inter-group relations, a world without others, and without a "generalized other" (see Mead, 1934, pp. 152-164); a model of a man without history; a model of a man from an impossible world. From the standpoint of the anxiety disorder that the DSM-III labelled PTSD, the victims and the victimizers are hanging in a vacuum: from the clinical point of view, it seems that they lack existential conditions, or that the conditions external to the victims of a traumatic event (i.e.: the surrounding conditions), and those of the victimizer lack psychological meaning. An isolated subject reacts to the traumatic event with the symptoms depicted in table I.

TABLE I
The symptoms as framework

Da Costa (1871)	**Kardiner (1941)**	**DSM-III-TR (1987)**	**DSM-IV-TR**
– *Brest ache* – *Heart rate* – *Giddiness*	– *Chronic Irritability* – *Sudden Shocks* – *Explosive Aggressions*	*"The essential feature of this disorder is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience... The stressor producing this syndrome would be markedly distressing to almost anyone, and is usually experienced with intense fear, terror, and helplessness. The characteristic symptoms involve reexperiencing the traumatic event, avoidance of stimuli associated with the event or numbing of general responsiveness, and increased arousal. The diagnosis is not made if the disturbance lasts less than a month" (APA, 1987, p. 247).*	"The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity… The person's response to the event must involve intense fear, helplessness, or horror (APA, 2000, p. 463).

According to the diagnosis criteria depicted in Figure 1, there is nothing outside the subject worth of giving psychological meaning: With regard to mental health and mental disorder, there is nothing interesting outside the dispositional factors ("behavioural, psychological and biological dysfunction", as we seen in Table II), including different ways of discrimination and prejudice against individuals belonging to out-groups (Brewer, 1999), persecution or torture for political reasons (Becker, 1995), mistreatment of the enemies following an order

coming from a religious leader, the belief in one's biological superiority, the humiliation of out-group members (Lindner, 2000), the effect of the power hierarchy (Kelman and Hamilton, 1989; Milgram, 1974), or the devaluation of victims as human beings (Bandura, 1999). A socially and culturally isolated subject with symptoms coming from some dysfunction from inside: that is the core concept of the PTSD mental disorder diagnosis as seen in the DSM-III, and DSM-IV (see Table II).

TABLE II
Mental disorder

DSM-III-R	DSM-IV-TR
"In DSM-III-R each of the mental disorders is conceptualized as clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.... Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the person" APA, 1987, p. xxii).	"In DSM-IV, each of the mental disorders is conceptualized as clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.... Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the person" APA, 2000, p. xxxi).

As a counterpart to the concept of mental disorder used in the clinical tradition, it is useful to recover the real picture of the ordinary people we are: people in cultural and historical settings (Vygotkski, 1927); people belongings to macro-and micro-social contexts (Tajfel, 1981); people inside "life space" (Lewin, 1936), etc. Therefore, it is also useful to determine the role played by all these outside variables (such as culture, religious ideology, authority, bureaucratic role structure, group pressures, norms, power structure, image of the ingroup and the outgroup, etc.) in such traumatic events like war, torture, ethnic discrimination, and prejudice against out-groups. The outside context must be taken into account when assessing the psychological dysfunction caused by exposure to traumatic events. In political violence and terrorism, this is especially important since the nature, the degree, and the intensity of dysfunction an individual can suffer can be related to outside conditions, such as the social situation in which he/she is grown up. One needs to look outside the person in order to understand what is inside: the reasons of his/her behavior, his/her ideology and thoughts, and his/her feelings. From the psychosocial perspective underlying this approach, it is not only about the person *and* the situation (the behaviour as a sum product) as reads the title of one of the most influential book in the social psychology of the second half of the past century (Ross and Nisbett, 1992); it is about the person *in* the situation: the behaviour as a result of the interrelationships between the person and his environment: "this implies that it is necessary to find methods of representing person and environment in common terms as parts of one situation" (Lewin, 1936, p. 12). The tension systems Ross and Nisbett refers to arise not only regarding both individual psyches *and* social groups, but also regarding individual psyches *in* group structure (norms and rules, power, roles, etc.) and ideology (values, beliefs, attitudes), and regarding indivi-

dual psyches inside macro-social economic structures, as is pointed out in some cases of political violence and terrorism.

In this day and age, after two World Wars, after a number of genocides against innocent people due to the colour of their skin or their political ideology, and after a baseless invasion of a peaceful country lead by a crazy dictator (Iraq), the argument that political violence and terrorism is supported by behavioural, psychological or biological disturbances intrinsic in the individuals who have taken part in it, is a pre-scientific and an immoral argument. Adolf Eichmann's history as told by Hannah Arendt (1964); the classical experiments about group pressures (Asch, 1951), obedience to authority (Meeus & Raaijmakers, 1995; Milgram, 1974), deindividuation (Zimbardo, Haney, Banks, and Jaffe, 1973), ingroup favoritism and outgroup discrimination (Tajfel, Billig, Bundy, and Flament, 1971); the more recent lines of research on intergroup bias (see Hewstone, Rubin, and Willis, 2002 for a review); the role played by emotions in intergroup hostility (Brewer, 1999; Leyens, et al., 2000; Mackie, Devos, and Smith, 2000); the disturbing historical research conducted by Hilberg (1960), Browning (1992), Goldhagen (1996), and Gross (2001); the disturbing testimonies of victims of mass violence (see Todorov, 2002, and over all Primo Levi, 1989, and Elie Wiesel, 1996); this wide empirical, theoretical, and historical evidence persuades us to conclude that terror is perpetrated by ordinary people (Fiske, Harris, and Cuddy, 2004; Waller, 2002), by "model neighbours" (Blanco, 2005), by good people (del Águila, 2005).

It is worth asking if it is possible to apply this concept of mental health (see Figure 2) to events such as military combat, violent personal assault, being kidnapped, being taken hostage, terrorist attacks, torture, and incarceration as a prisoner of war or in a concentration camp, all of which are defined by the DSM-IV-TR as roots of the PTSD. Where is one to find the behavioural, psychological or biological defects which gave rise to the wars, acts of terrorism and the many mass killing that took place over the past century? Can a person-oriented dispositional model be used to explain the executions of millions of Jews by the Nazi terror, the murder of 800.000 Hutus by the Tutsis, the terror arising from the Soviet government against political dissidents, the persecution, oppression and exploitation of thousands of people by the various military dictatorships in Latin America.

The concept of mental disorder used in DSM-III and DSM-IV underlies a model of man remote from his surrounding context: an impossible man. But this concept also underlies a model of health very close to illness. Theodore Millon was member of the DSM-III Task Force, and participated fully in its discussions from the task force's inception. He tells how Robert Spitzer, the chair of the Task Force, together with other members (most of them psychiatrists), put forward the statement "mental disorders are a subset of medical disorders" as part of the official definition of mental disorder. In February 1978 the concept was put to the test of a vote and defeated (Millon, 1983, p. 806). Millon describes it as a "pyrrhic victory," but it seems that the ideology underlying this statement (a model of health tied to illness, and a model of man isolated from his social and cultural environment), is now pervasive among mental health professionals. The first conclusion of the APA Task Force on Descriptive Behavioral Classification (whose task it was to assess the need for an alternative diagnostic criteria) was that the approach used in DSM-III was an unsatisfactory method of classification because its disease-based model was used inappropriately to describe problems in living, and the categories had been either created or deleted on committee vote rather than on hard scientific data (Smith & Kraft, 1983, p. 777). This is the point: a disease-based model of health which has hardly chan-

ged in the last twenty five years based on a solitary model of man, an universal model of knowledge, and an old-fashioned theoretical and epistemological perspective to which Vygotski (1927), Lewin (1922) and Mead (see Reck, 1964) propound a distinct alternative: a distinctive, active, mediated, and reflexive model of man.

From the theoretical point of view, it is worth pointing out that the concept of mental disorder, as it is found in DSM-III and the DSM-IV, underlies the Kuhnian notion of paradigm: an agreement the members of a scientific community had got after a long lasting process of discussions, decisions, and disagreements: in other words, after a long lasting process of cleaning (Kuhn, 1962). Before sharing a paradigm, normal science usually became involved in a type of mop-up work that made an "attempt to force nature into the preformed and relatively inflexible box that the paradigm supplies" (Kuhn, 1962, p. 24); an attempt which, as Kuhn notes, renders invisible the events or phenomena that will not fit with the core arguments of the paradigm. It is easy to prove that this is the way followed by the concept of mental disorders: the imperative cleaning task by defining a paradigm results in hidden variables that nowadays we cannot see as marginal, much less as invisibles.

The mop-up task has disregarded everything that happened before the traumatic event (the pre-traumatic situation), and does not pay attention to the victimizers or to the arguments they use for explaining and justifying his harmful actions, only briefly touching on the interpersonal, inter-group and social events that happened externally of the victims. The PTSD diagnosis only focuses on the *post-traumatic situation*, but to understand the pain, the losses and the personal suffering arisen from political violence and terrorism we need also pay attention to the *pre-traumatic situation*. It seems that the Task Force has left it solely to the person to deal with war, torture, displacement, political violence and terrorism. The well known diagnostic criteria shown by "normal science" (the DSM-III and DSM-IV-TR in this case) are re-experiencing, avoidance, and arousal, together with the emotions of pain, helplessness and horror. Indubitably, all these symptoms are meaningful reactions, but they underlie a model of man in a social vacuum (an individual-focused approach), and a model of health based on an "ideology of illness": an old-fashioned model of man and of health in need of a broader paradigm (Kagee and García del Soto, in press). A new approach should "display a new application of the paradigm or to increase the precision of an application that has already been made" (Kuhn, 1962, p. 30) because in the past the theory and the data had shown "an anomaly in the fit between theory and nature" in the interested topic. Let's compare the socio-historically bounded individual against the biomedical model of man we find mostly in the clinical tradition (see Table III).

The arguments used to lay siege to the PTSD concept that normal science (DSM-III, and DSM-IV) has proposed are as following: a) it is a insensitive diagnostic category unable to get at subtle distinctions, something very useful in diagnostic tasks; b) as already noted earlier, it is a diagnostic category which poses only post-trauma questions, and we need a category that takes the pre-traumatic context and situation into account; c) it is a context-free diagnostic category, remote from socio-historical factors. The PTSD poses only psychological questions, while from a psychosocial point of view we also need to pose social ones; d) the PTSD diagnosis disregards the context of the victim (a solitary model of man), who is understood as complete owner of his/her behaviour, of his/her thoughts and of his/her feelings; e) PTSD is a diagnosis which pays attention only to victims and touches only briefly on the victimizers and on the socio-historical context in which the traumatic event has taken place; e) last but

not least, the PTSD diagnosis does not have pay attention to the social sharing of suffering, to the effects of traumatic events on groups, institutions, communities, and societies. The PTSD diagnosis only demands information from the individuals, and we need to demand information from the collective.

TABLE III
Four models of subject suffering traumatic experiences

Biomedical subject	Social subject	Socio-historical subject	Socio-political subject
"In DSM-IV, each of the mental disorders is conceptualized as clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.... Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the person." (APA, 2000, xxix).	"The best therapy for acute stress is social: providing safety, reuniting families, creating effective systems of justice, offering opportunities for work, study and other productive roles, and re-establishing systems of meaning and cohesion-religious, political, social and cultural" (van Ommeren, Saxena, & Seraceno, 2005) .	"It is evident that mental disorders have to do not only with the person but with his set of social relationships. In doing so, we have to understand mental health as a problem arising from social, interpersonal and intergroup relationships which will seriously affects the person, in some cases the group, in some other the family, as well as the institutions and even the entire society. It is worth to say that we don't try to simplify a complex topic as of the mental health refusing his personal roots following a social-oriented reductionism. But we want to change the way to understand health and mental disorder as a process coming from outside to the inside of the individual instead of coming from the inside to the outside. The mental health and mental disorder are to seen not as a the expression of the inside functioning, but as the reflect in the person of a humanizing or alienating set of social relationships" (Martín-Baró, 2003, p. 338).	"An individual and collective process that occurs in reference to and in dependence of a given social context: it is process because of it intensity, its duration in time, and the interdependence of the society and the psychological processes. It exceeds the capacity of the psychic structure of the individuals and of the society to answer adequately to this process. Its aim is the destruction of individuals, their sense of belonging to the society and their activities. Extreme traumatization is characterized by a structure of power within the society that is based on the elimination of some members of this society by others of the same society" (Becker, 1995, p. 107).

Toward a new Psychology of trauma

Some of these arguments are similar to the ones used by Martín-Baró, a social psychologist who taught and did research in El Salvador in a climate of political violence, terrorism and war, and who was finally murdered by a battalion of the

Salvadorian Army in 1989, together with other colleagues and Jesuits priests of the "Universidad Centroamericana" (UCA).

The line of arguments used by Martín-Baró (2003) goes back to one of the core principles developed by the so-called "new psychosocial epistemology" (Gergen & Gergen, 1984; Martín-Baró, 1998; Tajfel, 1981): "the historically and culturally rooted psychological and sociological forces influencing the 'discovery' or production of knowledge" (Rappoport, 1984, p. 108), the existential bases of knowledge as we have seen in Merton (1973), and as were proposed by Marx. Arguing against a pure and abstract idea coming from the outside into the mind as delineated by the Hegelian dialectic, Marx holds that the human being defines himself and his knowledge inside a definite natural, historical and cultural setting. This is the model of man we come to propose as the one who suffer (victim) and lead to the trauma (victimizer). This model is far away from the Kantian transcendental subject, a context-free model of man against whom George Herbert Mead set the community of subjects in interaction and communication: the other, and the generalized other. A man in a definite socio-historical context, a man mediated by the conditions of his every day life: the color of his skin, the roles he plays, the groups he belongs to, the ideology he defends, the support he gets from his fellows, the power relationships which define his social relationships, etc. According to these arguments, the concept of trauma had to come out from this "phenomenological immutability" (Gergen's concept) which led to the ahistorical model of man, and the biomedical model of health underlying the concept of PTSD, and so follow the theoretical proposal of the one who can be considered the greatest European social psychologist in the last half of the 20th century: "Social psychology *can* and *must* include in its theoretical and research preoccupations a direct concern with the relationship between human psychological functioning and the large-scale social processes and events which shape this functioning and are shaped by it" (Tajfel, 1981, p. 7).

Therefore, it could almost be said that most of the critics of the PTSD construct are based on three main arguments:

1. The need to take into account the historical roots of knowledge.

2. The need to consider the social context in which the traumatic event takes place: the context before (pre-traumatic situation), and the context after (the effects on groups, communities, and even societies). Here the nature of the violence - natural disasters or socio-political struggles interact with the specificity of the context creating pre- and posttraumatic situations as diverse as Bosnia and Herzegovina, Colombia, Liberia, etc. Again, the need to consider variables such as socio-economic and poverty conditions, reasons for engagement with different factions, and gender and generational relations seem to be appropriate.

3. The need to recover a model of man tied to his social context, and a model of health remote from illness that considers also the resilient/coping capabilities of the survivors.

These were the arguments used by Martín-Baró in the early eighties, just a few years after the inclusion of PTSD in the DSM-III, to propound a new vision of mental health stemming from his theoretical thinking and vital experience in the Salvadorian civil war. Following this argument, and summarizing his proposition, the author wrote as early as 1984:

> Mental health is no more an end-problem [the posttraumatic disorder] for became a raising-problem [the pre-traumatic situation]. It is not a satisfying functioning of the person; it is about the human relationships defining the humanization ways opened for people who take part as member of groups and societies. More clearly: mental health is an interpersonal and intergroup dimension better than an individual condition, although this dimension become different in persons involved in these set of relationships making up different symptoms and syndromes (Martín-Baró, 2003, p. 336).

Mental health is seen as an interplay between the person and his surrounding environment: this is the hypothesis Martín-Baró takes as starting point. In so doing, he follows, whether he was aware of it or not, Lewin's topological way of thinking. The old-modish philosophy of differences sustaining the methodological individualism (the Aristotelian philosophy) open the way to the philosophy of relationships (the Galilean philosophy), which gives support to a socio-historical model of man. From this point of view, mental health is to be seen from an interpersonal and an intergroup dimension (as an intersection between different parts of life space, as could be said from Lewin's point of view) similar to other human behaviours the social psychologists are familiar with: altruism, aggression, attraction, attitudes, group polarization, groupthink, and many others.

Therefore, in the mental health conception devised by Martín-Baró in 1984, it is easy to find the significant thread of Vygotski's socio-historical theory: from the outside (pre-traumatic condition) to the inside (posttraumatic stress disorder). The trauma should be understood as twice social: first due to its roots; and then due to the social effects that results from it.

> [...] It is evident that mental disorders have to do not only with the person but with his set of social relationships. In doing so, we have to understand mental health as a problem arising from social, interpersonal and intergroup relationships which will seriously affects the person, in some cases the group, in some other the family, as well as the institutions and even the entire society. It is worth to say that we don't try to simplify a complex topic as of the mental health refusing his personal roots following a social-oriented reductionism. But we want to change the way to understand health and mental disorder as a process coming from outside to the inside of the individual instead of coming from the inside to the outside. The mental health and mental disorder are to seen not as the expression of the inside functioning, but as the reflect in the person of a humanizing or alienating set of social relationships (Martín-Baró, 2003, p. 338).

The subject of trauma – the one who suffers its effects and the one who perpetrates the evil – can hardly renounce his/her reflexivity (likelihood to take the role of the other), to his/her socio-cultural roots, to his/her skills to give raise and transmit meanings and symbols, (the ability to sign, according to Vygotski), to his/her inherent sociability (location in a net of social relationships) to his/her activity toward his/her inside (ability to learn) and toward his/her outside (ability to change the social context). The subject of trauma brought enough evidence against the fundamental attribution bias inside the PTSD diagnosis: the tendency to make the person responsible for his mental disorder without taking the context into account. It seems to be similar to the "ultimate attribution error" used by Hilton and van Hippel (1996) for reporting on stereotypes maintenance. From these assumptions it was easy for Martin-Baró to formulate a new concept of trauma as "a normal effect arising from a social system based on a dehumanizing net of oppressive and exploiting social relationships" (Martín-Baró, 2003, p. 295).

Like any other behavior, trauma is the outcome of an exchange process between the person and his external setting (macro and microsocial events, institutions, relationships, etc). Therefore, trauma has a dialectical element; that is to say "… not only that trauma has social roots, but that the nature of trauma is to be located in a definite social exchange setting in which the person is only a part of it" (Martín-Baró, 2003, p. 293), and sometimes is a part to be defeated.

To great extent, this was the framework used in the Latin American Institute for Mental Health and Human Rights (ILAS) since its founding in 1988: the traditional diagnostic categories (the ones used in the DSM-III at that time) were unable to account for many of the symptoms and faces of suffering. What

was needed was a type of diagnosis which could take into account the roots of trauma: "This style of diagnosis is different from the one we are familiar with, because its framework looks at human rights violations as roots of suffering, and does not allow a sociopolitical problem to hide as a psychopathological disorder. This way of giving a name to the suffering – identifying the situation which could be responsible for it – prevents the reduction of such symptoms to a PTSD diagnosis" (Lira, 1999, p. 143). The theoretical terms of the exchange process between the person and his context could give rise to the definition of a traumatic event as a human right violation, torture, sociopolitical pressure, etc. In other words: to better understand the traumatic experience, we should take into account the concrete repressive situation, and the psychological and social processes inherent in individuals, families, and groups (Lira, Becker, and Castillo, 1990, p. 40).

As we show in table II, David Becker, a psychologist who worked in Chile during the repressive and killing dictatorship of Pinochet, makes more precise the setting in which the trauma takes place: in cases as the ones represented by political violence and terrorism, traumatic experiences are a consequence of the use of suffering to regulate and control the political behavior of ordinary citizens. Often in these cases, trauma is an expression of social and political control; trauma means the use of terror against those trying to defend a "wrong" ideology: "everywhere the victimizers have argued the victims disorder for justifying his actions of cruelty and destruction" (Becker, 1995, p. 103).

Taking into account the social roots of trauma, it is unavoidable that psychology pays attention not only to the suffering person, but also to the situation in which the trauma finds support; to the ideological context trying to understand it; to the political, economical and religious structure helping the political violence gain an institutionalized status. In order to examine this, it is necessary to look "outside" the suffering person, as well as to look "before" the trauma (to the pre-traumatic conditions) since the trauma can be "a normal result of a social system based on persecution, exploitation and oppression of human beings by human beings… The psychosocial trauma takes then part of a social normal abnormality" (Martín-Baró, 2003, p. 295). This is one of the core hypotheses of the socio-historical (psychosocial) approach to the study of the psychological effects of a traumatic event. The malfunction which gives rise to mental disorder (see Table II) can be understood not only as a behavioral, psychological or biological, but also as a social one, and it may be possible to define the trauma from a socio-historical point of view, as "the expression in concrete terms of a set of dehumanizing and aberrant relationships as the one we can find in a civil war context" (Martín-Baró, 2003, p. 293) led by group polarization, by humiliation of persons belonging to outgroups, by intergroup hate based on certain beliefs or values. The likelihood of a pathology particular to groups, organizations, or even societies (Blanco, 2004; Blanco, et al., 2005, pp. 389-434) underlies a psychosocial approach to the roots of evil.

There is also another way to look for the risk dimensions such as the one used by Brewin, Andrews and Valentine (2000). The meta-analysis they conducted included data on predictive or risk factors for PTSD from 77 studies that investigated populations exposed to trauma in adulthood. Three categories of factors emerged: a) factors such as gender, age at trauma, and race predicted PTSD in some populations but not in others; b) factors such as education, previous trauma, and general childhood predicted PTSD better, and c) factors such as psychiatric history, childhood abuse, and family psychiatric history "had more predictive effects". Here again we have the ideology of illness in its pure sense. In political violence and terrorism none of the 14 predictive or risk factors reported

by the aforementioned meta-analysis plays any significant role in trauma. In these cases, the risk factors come from group membership, from subscribed ideologies, from the stigma human beings put on each other, from inter-group conflict, from the need for a positive identity, from the humiliation some people are sentenced to for the duration of their lives and from the frustration of basic needs.

The effects of trauma emerging from political violence are to be seen not only in the person *per se*, but also in his/her set of interpersonal relationships (Mollica, 1999), groups, communities and institutions within the social fabric: "The war's worst effect is the likelihood to undermine the social relationships which give rise to the historical development of the person as a psychological entity and as human community" (Martín-Baró, 2003, p. 343). There is also a supra-individual level at which trauma shows its disturbing effects, above all the trauma rooted in the political violence and terrorism: the narrowness and rigidity of social life, social polarization, the devaluation of human life, and the impairment of social relationships: all these are also effects of trauma, and are also arguments for a conceptual transition from the canonical PTSD to the "psychosocial trauma" construct. The destruction of the social nets of support and of social practices (ODAGH, 1998), the introduction of fear as means of controlling political behavior (Lira & Castillo, 1991), the harm to natural resources (ODAGH, 1998), the resentment and hate against ones who belong to the victimizers' group: there is another dimension of trauma that we cannot go over.

The aforementioned are without doubt dimensions of a "new psychology of trauma" presented in part through the definition of Martín-Baró, which played a major role in this area in the early 1980s and it seems perfectly fair to acknowledge as such. Moroever, it was Janoff-Bulman (1992) who used this label to point out that the traumatic events seriously affect the structure and content of our meanings: "the essence of trauma is the abrupt disintegration of one's inner world" (Janoff-Bulman, 1992, p. 63), the breakdown of a set of beliefs on which rest our core assumptions about the world we live in, about the self, and about others: a) the belief that the world (the people and the events) is benevolent, and a good place for living; b) the belief that the world is meaningful, "one in which a self-outcome contingency is perceived: there is a relationship between a person and what happens to him or her" (Janoff-Bulman, 1992, p. 8), and c) the belief that the self is of worth: "we perceived ourselves as good, capable, and moral individuals" (Janoff-Bulman, 1992, p. 11). The latter is also a part of Bolton and Hill's (1996) proposal that the traumatic experience has a shattering effect on the following three fundamental assumptions that every human being needs for his survival as social and psychological entity: a) the self is sufficiently competent to act (the self is of worth); b) the world is sufficiently predictable (the world is meaningful), and c) that the world provides sufficient satisfaction of needs, an interesting dimension that reminds one of Ervin Staub's theoretical proposal on the roots of evil (Staub, 1989; 1999): "difficult conditions of life in a society are one important starting point for the evolution of mass killing and genocide" (Staub, 1999, p. 182). In the last decade, Edna Foa and her colleagues (Foa, Steketee, and Rothbaum, 1989; Foa, Ehlers, Clark, Tolin, and Orsillo, 1999) proposed an emotional processing theory that suggests that "PTSD is a consequence of disruptions in the normal processes of recovery" (Foa, et al., 1999, p. 303): trauma is mediated by two basic dysfunctional cognitions: a) the world is completely dangerous, and b) one's self is totally incompetent. Taking these two cognitions as a starting point, the research groups headed by of Edna Foa in Philadelphia and by Anke Ehlers in Oxford have developed a new measure of trauma-related cognitions (the "Posttraumatic Cognitions Inventory:

PTCI") whose principal-components analysis yielded the three following factors: a) negative cognitions about self; b) negative cognitions about the world, and c) self-blame (Foa, et al., 1999).

All these proposals make concrete the "psychological emptiness" that was discussed early in this paper: the metaphors upon which people build their personal and interpersonal lives brake down noisily. Going back to Kuhn's concept of paradigm, Janoff-Bulman writes: "Within the mind of a single individual there are times when one's guiding 'paradigms' – one's fundamental assumptions – are seriously challenged and an intense psychological crisis is induced. These are times of trauma" (Janoff-Bulman, 1992, p. 51). Similarly, Carlos Martín Beristáin (2005) writes about the importance of "making sense out of violent experiences" and trusting the "strength of the people" to continue living and "making new narratives, by giving events new meanings, out of these experiences".

The Report on "Recovering the Memory of the History" in Guatemala presents convincing data about the symbolic dimensions of trauma: "Besides the socio-economic effects, many of the material and social losses are symbolic injuries: offence to the sentiments, to the dignity, to the hopes, and to the subjective meanings that are a part of the victims' culture as well as their political and social life. It has destroyed the legal and the normative system, and the moral and ethic principles of the community are completely destroyed by the power of weapons, by the murdering of their leaders and traditional authorities, by the destruction of their social organization" (ODAGH, 1998, p. 73).

"Watching behind the curtains", says Richard Mollica, is one of the four effects of any traumatic experience: the value system of victims change because of collective violence; the cultural beliefs are destroyed and replaced by new ideas about daily life, which has been destroyed by violence and torture (Mollica 1999, p. 50). Furthermore, in her dissertation Nora Sveaass glances at the systematic breakdown of meaning as a consequence of human rights violations (torture, forced disappareance, rape, etc.), and she describes these actions as "political trauma", arguing that "such events are specially destructive and traumatizing due to their contextual and intentional character" (Sveaass, 2000, p. 7).

It has hardly to surprising that traumatic events rooted in the willing action of some persons against others, as is the case of war, torture, terrorism, sexual rape, etc. result in a psychological impact that is particularly intensive and wide (Baca y Cabanas, 2003; Echeburúa, 2004; Fullerton, et al., 2003; Martín-Beristáin, 1999). Due to its rational intentionality, the suffering rooted in political violence and terrorism is not only more harmful, but usually is followed by effects more lasting than it is supposed by the DSM-IV (Garbarino & Vorrasi, 1999; McFarlane, 1995). The way in which Carmelo Vázquez (in press), a well known clinical psychologist in the realm of positive psychology, describes the trauma produced by humans against humans seems to be in agreement with the psychosocial perspective we are interested in: "In some way, these more intensive and lasting effects, which go further on the psychological symptoms described in the definition of PTSD, are related to the losing of confidence in other people, to the losing of values, and to a sense of helplessness about human nature and about justice in the world" (Vázquez, in press). The effects associated with traumatic events do not obey the short time frame that the DSM-III and DSM-IV have established (Portillo, 2005): the door to long lasting effects is wide open in the case of political violence and terrorism.

As we have previously seen, collective fear adds to the fear of personal harm (Lira & Castillo, 1991); the breakdown of security means the stimulation of a *fear memory* which leads to surviving behaviors and blocks our normal daily life

(Foa, et al., 1989); the displacement (Palacio & Sabatier, 2002; Kagee and García del Soto, in press); the aggression against the community (Hernández y Blanco, 2005, pp. 294-303; ODAGH, 1998, pp. 71-80); the breakdown of social support nets; social polarization (Martín-Baró, 2003, pp. 139-183; Punämaki, 1990) and humiliation (Lindner, 2000); the prejudice, hate and anger against one's "enemies" (Techio & Calderón 2005; Vázquez, in press); the destruction of natural resources (ODAGH, 1998); the militarism of the social life, which in some way implies the institutionalization of violence and terror, and a militarism of mind and consciousness (Martín-Baró, 2003, pp. 311-320). All these effects result in trauma creating an ominous social reality (Lira, et al., 1990, p. 35): a deep social mistrust covers with silence the social life and social relationships, as Lira and Castillo (1991, pp. 229-242) observed while working as therapists in Chile under the dictatorship of Pinochet. But this ominous silence also took place in the Basque Country (Spain) due to the criminal actions of the terrorist group ETA: "Society kept silence in bars, in working places, in the elevator, at the market place, although the attack against an innocent person took place nearby them. The accompanying fearful silence was a too-heavy flagstone. We lived anesthetized in front of the suffering of our neighbors, inside a context of moral anomie which is still here with us", writes Cristina Cuesta (2004, p. 17) whose father was murdered by ETA in 1982. All those are enough reasons to talk about an "extreme trauma" as the one whose starting point is to intentionally harm the population as a global political strategy aimed to wrestle ideological and political control (Becker, Castillo, Gómez, Kovalskys, and Lira, 1990, p. 289).

Taking into account all those arguments, we come to the following dimensions of psychosocial trauma (Table IV).

TABLE IV
The dimensions of psychosocial trauma

The pre-traumatic situation: the goals of political violence and terrorism	**The desintegration of the inner personal world: the loosing of metaphors**	**Community Hate against the enemies**	**The breaking of social frameworks**
– The facilitating context – The imposing label of a "group pathology" – The rationality of evil: the destruction of individuals and groups aimed by political violence	– Benevolence of the world (negative-positive cognitions about the world) – Meaningfulness of the world – Self-Worth (negative-positive cognitions about self) – Self-blame	– Social polarization – The construction of enemy image – Sense of humiliation, hate, avoidance, helplessness, unjustice – Dehumanization	– Impairment of social life – Institutionalization of violence and terror – Learning of instrumental value of violence and terror – The collective memory of suffering

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