Leak Everywhere[1]:

A Critical Disability Analysis of the Conceptualizations of Trauma

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Abstract

This paper will examine how various conceptualizations of trauma are produced through specific social, historical, and political contexts, and the effects of such conceptualizations in regards to race, gender, disability, and capitalist relations of power. I will first describe the theoretical orientation of this analysis in critical theory and critical disability studies. Following Lawrence and Dua (2005), who assert that "ongoing colonization and decolonization struggles must be foundational in our understanding of racism, racial subjectivities, and antiracism" (p. 131), I begin my discussion of trauma through an analysis of how the discourse of trauma as well as healing have enabled tactics of nation-building in Canada and sustained ongoing violence against and control over Indigenous, racialized, and gendered bodies. Through a review of critical feminist and disability theorizations on reason and emotions, I then examine the historical development of trauma as a psycho-medical concept and its relationships with psychiatric categorization and knowledge. Finally, I will address the tension between the politicization of trauma and corporeal realities of distress and pain, and propose that enacting the former may open up more possibilities to care for the latter by resisting conditions that give rise to distress in the first place.

Keywords

Trauma, gender-based violence, critical disability studies, critical theory, emotions

[1] The phrase "leak everywhere" is borrowed from an untitled poem by Athena, published in a set of artist cards titled *Blossom in 2 Freedom: The Journey Within* (YWCA Toronto, 2013).

Introduction: Why Trauma?

In North America, the term trauma-informed practice has become increasingly commonplace in mental health services over the past two decades (Goodman, 2015). Broadly defined, trauma-informed practice refers to the delivery of human services that is grounded by an understanding of the complex effects of devastating events in individuals' lives (Manitoba Trauma Information and Education Centre, 2013). Moreover, underpinned by feminist politicization of violence against women in the 1970s and 80s, this practice model considers the connections between mental distress and social injustices (Goodman, 2015). However, studies on services for women who have experienced violence show that a pervasive pathologizing discourse continues to reinforce an individualist, Eurocentric, colonial, and heteropatriarchal perspective of normalcy in these services (Burnette et al., 2015; Burstow, 2003; Egan, 2016; Goodman, 2015; Koyama, 2006; Tseris, 2013; Ussher, 2011; Wathen et al., 2015). Indeed, Goodman (2015) identifies that there is a tendency amongst service providers to uncritically equate trauma-informed practice with social justice, and urges that "we critically examine the practices that are being operationalized as trauma-informed and question how and in what ways they might actually perpetuate injustice" (p. 56). Encouragingly, there is a growing body of literature that critically engages with the conceptualizations of trauma and the ways they shape practices of support. A few examples include studies and theorizations from Indigenous scholarship (Chrisjohn & McKay, 2017; Linklater, 2014; Million, 2013), mental health services (Tseris, 2013; 2016), shelter and social services (Burnette et al., 2015; Koyama, 2006), social work (Brown, 2011), and counselling and psychotherapy (Burstow, 2003; Egan, 2016; Goodman, 2015; Stevens, 2016), notably the critical reframing of historically depoliticized therapeutic methods as forms of social and collective activism (Haines, 2020).

Following the footsteps of writers and practitioners who resist individualist and pathologizing definitions of trauma, I come to this research with the experiences of surviving discrimination and psychiatrization as an immigrant racialized cisgender woman, and working over the past decade with people who have experienced violence as a mental health service provider. I have borne witness to, been devastated by, and benefitted from the colonial structures that continue to manifest in the mental health system in promoting and coercing conformity to whiteness, capitalist discipline, and heteropatriarchy. As such, my study is grounded in the belief that violence against women is produced through the widespread cultural devaluation of the feminized and racialized bodies and minds; if women seek support in mental health services for the violence and injustice they experience, then the pathologization and subjugation of women in these setting are doubly unjust (Shildrick, 1997). Feminist writers in disability studies have also long been asserting that, in heteropatriarchal societies, the subjugation of disabled people is necessarily gendered, whereby the feminine is constructed as disabled and lacking in comparison to the masculine ideal (Garland-Thomson, 2005; Wendell, 1996; Young, 1980). Wendell (1996) thus similarly postulates that disabled women are doubly rejected as signifiers of human conditions that are deemed undesirable.

This paper will examine how various conceptualizations of trauma are produced through specific social, historical, and political contexts, and the effects of such conceptualizations in regards to race, gender, disability, and capitalist relations of power. I will first describe the theoretical orientation of this analysis in critical theory and critical disability studies. Understanding that race- and gender-based violence as well as widely-accepted therapeutic practices are produced and sustained through the perpetuation of colonial structures in North America today, I follow Lawrence and Dua (2005) in asserting that "ongoing colonization and decolonization struggles must be foundational in our understanding of racism, racial subjectivities, and antiracism" (p. 131). I therefore begin the discussion of trauma on how Canada as a nation is established and sustained through ongoing violence against and control over Indigenous, racialized, and gendered bodies. Through a review of critical feminist and disability theorizing on reason and emotions, I will then examine the historical development of trauma as a psycho-medical concept and its relationships with psychiatric categorization and knowledge. Finally, I will address the tension between the politicization of trauma and corporeal realities of distress and pain, and propose that enacting the former may open up more possibilities to care for the latter by resisting conditions that give rise to distress in the first place.

Sharpening Tools: Theoretical Orientations

Following Lorde (2007), who wrote that "the master's tools will never dismantle the master's house" (p. 112), Ahmed (2017) urged for the finding and making of tools that can dismantle heteropatriarchal structures while avoiding the replication of norms within these structures. Since the 19th century there has been no shortage of psycho-medical theories of trauma (Appignanesi, 2008; Bergo, 2007; Leys, 2000); my search for theoretical frameworks to unpack conceptualizations of trauma does not follow these paths, for doing so would be to reinscribe the ideological structures already cemented by the master's tools. I therefore turn to critical theory and critical disability studies as grounding for my analysis of trauma.

Critical Theory

In his explanation of critical theory of the Frankfurt School, Horkheimer (1975) emphasizes the elimination of oppression and injustices through tracing historical contexts and understanding how "such abuses as necessarily connected with the way in which the social structure is organized" (p. 207), while being "suspicious of the very categories of better, useful, appropriate, productive, and valuable, as these are understood in the present order" (Horkheimer, 1975). Though critical theory understands capitalist systems of production as major organizing forces in modern society (Alvesson & Skoldberg, 2009), its analysis aims to expose the operations and effects of power beyond the economic realm (Meekosha & Shuttleworth, 2009). This interest in diverse social systems and relations overlaps with Foucault's (1990) theorization of power. According to Foucault, "power is not an institution, and not a structure; neither is it a certain strength we are

endowed with; it is the name that one attributes to a complex strategical situation in a particular society" (p. 93), which produces, shapes, and are reproduced by all types of social relations as well as the injustices and inequalities within them. Through this network of relations unfolds a symbiotic connection between power and knowledge, in which the "exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power" (Foucault, 1980, p. 52, as cited in Shildrick, 1997, p. 15). Thus, it is through discourse that power and knowledge operate in tandem (Foucault, 1990). Discourse is defined as both an apparatus and effect of power, and includes the constructions of meaning, the structure of language, the material practices it produces and authorizes, and the tactics that operate within networks of forces (Foucault, 1990; Shildrick, 1997). What is perceived as reality is then never accessible outside of multiple mediating, shifting, and conflicting discourses (Shildrick, 1997). This understanding of discourse thus rejects grand narratives, universal categories, and fixed binaries. Referencing past shortcomings of feminist attempts to arrive at universal categories and causal theories, Brown (2006) argues that critical theory can offer the complexity and self-reflexivity that feminism requires in reinvigorating its theoretical and political work. She highlights the Frankfurt School's commitment to critique and openness to multiple analytical frames in language, the psyche, sexuality, and thought. As "gender takes shape in and as thinking and forms of rationality" (p. 4), critical theory may be useful in addressing the question of "what produces ready compliance with prevalent gender norms, including those that circulate women's subordination" (p. 5), even in practices that claim a feminist orientation to social justice.

Critical Disability Studies

Drawing on critical theory, critical disability studies extend as well as critique the social model of disability, which has emerged through disability rights movements in Britain in the 1970s and 80s (Shakespeare, 2013). While the social model also examines the systemic subjugation of disability through capitalist relations and emphasizes emancipation (Meekosha & Shuttleworth, 2009), critical disability scholars challenge the social model's binary conceptualizations of impairment as biologically determined and disability as socially constituted (Tremain, 2006). Instead, Tremain (2006) argues that what is perceived as impairment is also socially and politically constituted as an effect of biopolitics, which refers to a strategic mobilization of power and knowledge to rationalize, classify, and regulate human experiences as population problems that require governmental management. Critical disability studies thus investigate and expose how power operates through conceptualizations of disability and impairment as well as seemingly benevolent institutional measures that regulate the subjectivities and material realities of disabled people through capitalist and ableist norms (Meekosha & Shuttleworth, 2009). Moreover, in moving away from positivistic categories, critical disability studies address the multiple, shifting, intersecting, and contradicting subjectivities and experiences of disability by urging self-reflexivity and drawing on critical feminist, legal, and race theories (Meekosha & Shuttleworth, 2009). Most notably, they advocate ongoing evaluation of movements and rhetoric that have garnered political

and economic benefits for disabled people, in order to address the concerns and agency as well as neglect and marginalization of those excluded from these movements (Meekosha & Shuttleworth, 2009). Feminist disability scholars and activists have persistently argued that women's experiences have largely been overshadowed or erased by male-centric agendas in disability studies (Meekosha & Shuttleworth, 2009), and that their experiences of psychiatric and disability oppression are inseparable from heteropatriarchal norms and gender-based violence (Frazee, Gilmour & Mykitiuk, 2006; Diamond, 2013). Further, critical feminist theories extend disability studies by investigating embodiment and the processes through which bodies are interpellated as abnormal and inferior at the intersections of gender, race, class, sexuality, and disability (Garland-Thomson, 2005). This critical engagement with difference and complexities as a shared strategy for change underpin critical disability studies' core goal of emancipation (Spagnuolo, 2016). As Graham and Jackson (2016) state, "[by] respecting this diversity and viewing it as an asset, we will emerge under many banners with a stronger voice" (p. 282, 287).

This paper takes a critical stance that refuses to accept trauma as an ahistorical, natural category that simply describes overwhelming events or people who have been impacted by them. Instead, I follow the delineation of critical trauma studies by Stevens (2016) in understanding trauma "as a cultural object whose function produces particular types of subjects" (p. 20), practices that provide explanations of realities, organizing frameworks for interpersonal and material relations, and network of meanings for understanding temporality and embodiment, through particular constructions of "overwhelming events" (p. 26). In other words, this critical examination reveals "the processes by which things that happen are denoted as trauma" (Wertheimer & Casper, 2016, p. 3). Further, in my understanding, investigating how emotions can be gendered and pathologized through discourse of trauma is an act of feminist and disability resistance. It is a way of sharpening tools: sharpening the analytical focus on unquestioned objectivity with feminist and disability knowledge (Ahmed, 2017). It is a practice of talking back, "a political gesture that challenges politics of domination that would render us nameless and voiceless" (hooks, 2015, p. 8). It is a necessary endeavour toward a less violent future.

Nation-making Through Trauma

Pain is Part of This Land

The legitimacy of Canada's constitution as a nation is necessarily built upon violence against and regulation of Indigenous peoples through a pervasive and enduring moral, gendered, and racialized discourse, which collapses "the rich diversity of Indigenous polities into a unified subject 'Indian'" (p. 6). Lawrence (2003) argues that the Indian Act operationalizes a form of normative violence, an "organizing… conceptual framework that has shaped contemporary Native life in ways that are now so familiar as to almost seem natural" (p. 3, cited in Million, 2013, p. 6). This normative

violence is operated through the hierarchical patriarchy, heterosexual norms, and gender inequalities embedded within the Act, which fundamentally alter gender relationships in Indigenous communities and have direct implications in the ongoing and unchecked violence against Indigenous women, trans people, and two-spirited people. Importantly, Million (2013) argues that sexual violence and rape "interrupts and dissolves the ontological presence of person and community" (p. 37), which is inextricably entwined with the "powers of the nation to reproduce itself, whether through child-bearing, parenting, or its spirit to endure and go on" (p. 38). Sexual violence thus occludes communities' ability to sustain a sense of health that is foundational to self-determination, while state-sanctioned gender inequities continually shape new polities that define and articulate Indigenous self-government.

The Uneven Circulation of Shame

A key component within the process of colonization, shame is defined by Million (2013) as an embodied sociality, "a social/body relationship, in part a felt analysis, an assessment of your perceived status" (p. 48) within a community. The trauma experienced collectively by First Nations communities is described as a result of "being totally stripped of the knowledges that informed you how to live in your place" (p. 163). Residential schools effectively produce shame through coerced assimilation and moral education vis-à-vis a hierarchy of race. Foucault (1995) discusses the technique of ranking as integral in producing compliance for effective population management. In his case example of the French military school, students are ranked according to "the moral qualities of the pupils and on their universally recognized behaviour" (p. 181), with the lowest rung of the hierarchy being the "shameful class" (p. 182). They would be driven by the shame of being segregated from others to endeavour rising to higher classes through "the change in their conduct" (Foucault, 1995). As such, the "*shameful class existed only to disappear*" (Foucault, 1995, emphasis added), with differences eliminated and every body behaving according to the norm. Foucault's theorization of the body as a site of disciplinary power has been critiqued for its lack of attention to how women, racialized subjects, and those whose sexualities exist outside of the gender binary are differentially constituted and impacted than his seemingly universal subject (Federici, 2014; Shildrick, 2997). For these groups, while their differences are suppressed they do not simply disappear into the ideal class. As Ahmed (2004) writes, "*we feel shame because we have failed to approximate 'an ideal'*" (p. 106, emphasis in original), often a kind of moral ideal that is "bound up with the reproduction of social norms, in particular, with norms of sexual conduct" (Ahmed, 2004). Referring to colonial education, Ahmed (2010) further explains that its goal is for the colonized to become like the colonizer but "still to inhabit a body that is markedly different from that of the colonizer" (p. 129). Given that the bodies of Indigenous peoples, particularly Indigenous women, are always already marked as deviant and threatening through a raced and gendered discourse of Indigenous sexuality, the failure to live up to the ideal of whiteness is inevitable and simultaneously "a way of taking up that ideal and confirming its necessity" (Ahmed, 2004, p. 106). Thus, shame in this context segregates those who are othered

at the same time as it integrates them back into a colonial logic that defines their identity as lack. Indigenous people's experiences of shame and its resulting devastation of personhood are therefore foundational in Canada's nation-making through moral governance.

In recent years, Million (2013) observes that shame is again evoked in the framing of colonial violence through a human rights discourse. Such framing positions Canada as perpetrator of abuse whose actions should be named and shamed; however, it simultaneously constructs the colonized subject as a trauma victim in need of healing. Such healing is often associated with the conceptualization of trauma as a psychological pathology that effectively bypasses issues of sovereignty and self-determination by focusing on "state-determined biopolitical programs for emotional and psychological self-care informed by trauma" (p. 6). This psychological and neoliberal discourse of trauma stresses personal responsibilities in overcoming individual dysfunctions for the purpose of being a productive citizen, while reconciliation between the perpetrator and victim is understood as necessary for healing. This defines healing as "a promised safety and revitalization from past colonial violence" (p. 8), thus implying that violence is no longer present and that the state is benevolent. Replicating racist ideology that justifies colonization in the first place, "[h]ealing from trauma begins to be narrated as a prerequisite to self-determination" (p. 105). Thus, "any actual political power for Canadian Indigenous Peoples is continuously deferred to a *future self-healing*" (p. 12, emphasis added). Ahmed (2004) defines emotions not as psychological states that reside within bodies, but as social and cultural practices that are shaped through relationships between bodies, which in turn produce and reinscribe relations of power and subjectivities that animate such relations. As such, it may be understood that through the discourse of trauma the state is able to express shame in apologizing and repositioning itself as an ideal, while simultaneously framing Indigenous peoples as responsible for their affective management of shame and trauma from colonial violence (Million, 2013). The apparent failure to heal and progress toward a productive liberal subjecthood may even bring about more shame. Shame as an emotion thus mobilizes the discourse of trauma to maintain a relation of custodianship and domination between the state and Indigenous peoples, with the tendency to stick to bodies that are always already marked as inadequate in order to sustain this relationship (Ahmed, 2004).

Felt Knowledge of Nation-building and Dismantling

In Million's (2013) articulation of "felt theory" (p. 56), colonialism is defined as a "felt, affective relationship" (p.46), whereby "[m]oral stigmata are produced and attached to race, gender, and sexuality as lived structures of feeling: intuited, perceived, felt, and finally, in this circuit expressed as emotions" (p. 46). A matrix of raced and gendered nuances and practices, charged with emotional meanings, generates enduring, moral common knowledge about Indigenous people as "a 'profane' figure, dehumanized and not worthy of regard" (p. 48). As such, within academia the work of Indigenous women scholars continue to be invalidated "as polemic, or, at worst, not as

knowledge at all" (Million, 2013, p. 57). She cites scholars who have endeavoured "to prove they are not already guilty of being what the state believes them to be" (p. 64) through recounting state violence, domestic abuse, systemic discrimination, as well as survival, resistance, and community reconnections. While these narratives have gained popular attention through (primarily white) feminist mobilization for women's rights and the expansion of therapeutic interventions in Indigenous communities since the 1970s, issues of self-determination and intersecting discriminations remain obscured by colonial perspectives that also permeate feminist movements, and mainstream society routinely equates social distress with individual pathology. Nevertheless, these affective narratives expose sexual violence as apparatus of colonial control, thereby disrupting the reproduction of social knowledge that positions Indigenous women's sexuality as inherently deviant, and may potentially "*displace* the very gender norms that enable the repetition itself" (Butler, 1990, p. 203, emphasis in original). Million (2013) challenges the individual-focused discourse of trauma, as well as the broader devaluation of emotions in western philosophy, by theorizing experiences of trauma as a form of *affective knowledge*, the expressions of which can "transport us to another place, compel us to look at horrors and, more importantly, enable us to imagine a new society" (Kelley, 2002, as cited in Million, 2013, p. 30). This incites a movement of emotions that can connect bodies across differences and link the affective to the political by relating community distress to the patriarchal social order imposed by colonial policies (Ahmed, 2004), as these stories have proven to be instrumental in shifting discussions about residential schools, gender norms, and colonial relations within political arenas and the social collective imaginary (Million, 2013).

Leak Everywhere: Trauma and Gendered Emotions

The dismissal of Indigenous women's affective stories as polemic or not as knowledge at all is unmistakably underpinned by the association of women with unreason and emotionality in western philosophy, and the development of trauma as a psychological concept is entangled within this gendered discourse of emotions. Following Shildrick (1997), this analysis of gender is not grounded in a fixed ontological category of women as an exclusive target of oppression, but rather on the questions of "how any body becomes en-gendered as feminine or masculine" (p. 47), and "how meaning, particularly representations of gender, are mobilized within the operations of power to produce asymmetrical relations amongst subjects" (Shildrick, 1997).

A Gendered History of Embodiment and Unreason

Tracing medical texts from the Renaissance, Shildrick (1997) demonstrates how feminine inferiority is discursively constructed through cultural and medical knowledge about the reproductive process. Evident in writings by Aristotle and Galen, the female body is positioned as a passive, empty container lacking in the "principle of soul" (Lloyd, 1996, p. 150), existing only for the active spirit of the male body to take form, reflecting Judaeo-Christian narratives of creation

(Shildrick, 1997). Through the European Enlightenment and its cementation of the Cartesian mind/body binary as fundamental to human life, men are positioned as the "self-present, self-authorizing subject" (Shildrick, 1997, p. 26) who could transcend their corporality to access pure reason that is uncontaminated by the senses. Menstruation and pregnancy are read as evidence of women's lack of control over the containment of their bodies (by leaking vital blood) and the boundaries of their selves (by simultaneously being self and other). As such, women are understood as intrinsically enmeshed with and therefore incapable of transcending their own bodies, leading to beliefs that women lack intellectual and moral agency. This gendered discourse of feminine inferiority is therefore foundational to and mutually constituting with ableism, whereby disabled people are often perceived as dependent, helpless, intellectually challenged, abnormal, and perpetually childlike, thus embodying characteristics that are constructed, devalued, and pathologized as the opposite of the masculine norm (Crawford & Ostrove, 2003; Ahlvik-Harju, 2016; Kafer, 2013). Feminist writers theorize that disabled and feminized bodies destabilize and disturb the normative understanding of corporality as controllable and self-contained (Garland-Thomson, 2005; Shildrick, 1997; Wendell, 1996). This gendered and ableist logic thus work in tandem with colonial and Enlightenment rationale to shape the hierarchical opposition between male-culture and female-nature, which justifies the regulation of nature as "wild and chaotic, but… potentially controllable" (Shildrick, 1997, p. 26). On the flipside of this logic, the white, European subject "is initiated in its subjecthood through its capacity *to affect*, and *not to be affected*" (Gorman, 2017, p.311, emphasis in original). In this binary the racialized other is presupposed as affectable, and the mad as "a failure of articulable emotion, a giving-over to affect" (Gorman, 2017, p. 311). As such, cultural processes of feminization and racialization are enabled through discursive constructions of emotions, which are positioned "'beneath' the faculties of thought and reasons" (Ahmed, 2004, p. 3), with "a much lower and animal-like condition" (Darwin, 1904, p. 14, cited in Ahmed, 2004, p. 3). The intersecting discourses of race, gender, and disability in the construction and regulation of human normalcy have deleterious effects, as racialized women and women with intellectual disabilities, for example, have historically been subjected to eugenic programs, coerced institutionalization, forced rehabilitation, involuntary sterilization and abortion, and medically unnecessary surgeries for the ease of caregiving or to normalize bodily appearances (Ahlvik-Harju, 2016; Carlson, 2010; Kafer, 2013). These can be understood as disciplinary technologies that uphold dominant norms by reinforcing the widespread belief that particular bodies and minds do not undeserve a future (Kafer, 2013).

Recovering What's Not There: Trauma and Hysteria in Bio-psychiatry

The earliest conceptualizations of psychic trauma are founded in Freud's theorization of hysteria (Leys, 2000). In the 1890s, Freud suggested that sexual violence was at the core of the "hysterical shattering of the personality consequent on a situation of extreme terror or fright" (Leys, 2000, p. 4). The historical conceptualization of hysteria reaches back to the time of ancient Egyptians and Greeks, premised on the belief that uncontrollable movements of the uterus, or "wandering womb"

(Appignanesi, 2008, p. 162), are the cause of a wide range of ailments seen in women, echoing discursive constructions of the female body as inherently lacking boundaries and control (Shildrick, 1997). With the advancement of technologies and the medical profession, the intertwining theories of hysteria and trauma emerged in the 19th century through biological psychiatry, which drew on neurosciences to explain and treat psychological conditions (Shorter, 1997). French neurologist Charcot's public theatrical displays of the hysterical trance and hypnotic cure at the Salpêtrière hospital in the 1860s played a major role in propagating the image of the hysterical woman (Appignanesi, 2008). Performed by female patients under hypnosis, these theatrical displays aimed to validate Charcot's characterizations of hysteria, including erotic gestures, intense affect such as weeping and raging, and the retelling of sexual experiences or trauma (Appignanesi, 2008). The female patient is thereby positioned as in need of rescue by the all-knowing male doctor who could wake and cure her from her own primitive state of unreason and insanity, grounded in the underlying cultural belief that women require male control to make them whole and stable (Shildrick, 1997).

In late 1890s Freud shifted away from his belief in the role of sexual exploitation in trauma, and instead reoriented his work to repressed erotic wishes, thus relegating stories of childhood sexual abuse to the realm of fantasies (Murphy, 2007). Freud was not the first to dismiss the impacts of sexual violence in the medical field. Despite eliciting and analyzing female patients' accounts of their sexual experiences, physicians such as Pinel and Charcot considered sexual violence merely as environmental factors; it was the degeneration of the female reproductive and nervous systems that persistently figured as the central cause of hysteria (Appignanesi, 2008). Following the First World War it became clear that men who experienced "combat hysteria" or "shell shock" (Leys, 2000, p. 21, 22) suffered not from organic conditions but from psychic distress. Freud then adapted his theorization of hysteria by reframing trauma "in quasi-military terms as a widespread rupture or breach in the ego's protective shield" (Leys, 2000, p. 23). This conceptualization of trauma is reminiscent of the passive, permeable female body in classical medical texts (Shildrick, 1997). It was therefore not surprising that medical interest in trauma declined thereafter, as men presenting with combat hysteria were treated with indifference or accused of malingering, likely responses stemming from the states' needs for a strong, masculine national image (Herman, 1997; Leys, 2000). It was not until the 1980s, when activism supporting Vietnam War veterans led to the inclusion of post-traumatic stress disorder (PTSD) as a psychiatric diagnosis by the American Psychiatric Association (APA), were women's experiences of sexual violence recognized and folded into legitimized conceptualization of trauma. Thus, it could be argued that women's emotional distress and experiences of sexual violence had been deemed normative and unremarkable, such that trauma gained medical and public attention largely through men's narratives of suffering, which were regarded as unusual plight given their presumed ontological stability and coherence.

Freud has consistently emphasized that it is not the event itself that is experienced by the person

as traumatic, but it is the memory of such events, rendered through psychic processes and drives, that forms traumatic symptoms (Bergo, 2007; Leys, 2000). The legacy of this theorization valourizes therapeutic efforts to recuperate an event of violence that has "occurred in a place and at a time that are, by definition, distance from here, from now" (Stevens, 2016, p. 33), which runs the risk of obscuring the ongoing violence in social life and its impacts on individuals' ways of being and community relations (Millions, 2013; Stevens, 2016). Furthermore, the understanding of trauma-in-the-past is predicated on assumptions of a linear sequence of events and a pre-trauma, "whole, pure, and mature" (Stevens, 2016, p. 35) subject, whose existence is verified and recoverable by the recounting of injuries that have damaged it. While there is an ongoing movement of feminist and anti-oppressive approaches in counselling therapy and social work that seek to politicize gender-based violence and empower survivors (Brown, 2011), therapeutic approaches to sexual assault are still commonly grounded in developmental psychology, which assumes a fully autonomous, non-abused subject who follows a set of normative stages of growth toward mature sexuality, thereby positioning women who have experienced violence as childlike, lacking in agency (Egan, 2016), "inevitably disordered" (Ussher, 2011, p. 128), and "eternally damaged" (Appignanesi, 2008, p. 469). This construction of women who have experienced violence can be understood as grounded in an ableist view of human development, whereby the masculine, autonomous adult figure functions as the norm and the ideal end of what it means to be fully human, against which the disabled person is compared and constructed as childlike, halted in development, and therefore defective (Carlson, 2010). Murphy (2007) argues that sexual violence can also be understood as a "re-enactment of sexual difference upon the bodies of its victims… that seeks to reduce those victims not to their own bodies but to a fantasized body of woman" (p. 75). As such, the feminized subject is always already interpellated as passive and vulnerable in this relation of sexual difference, in addition to emotionally unstable, irrational, and lacking in boundary (Ahmed, 2004; Lloyd, 1996; Shildrick, 1997). It then follows that, if the coherent, self-contained subject is valourized as the goal of successful recovery, then it poses an impossible quest for women and racialized others, as one cannot recover what one is assumed to have never had.

Fixing Anger: Biopolitics through Trauma

According to Herman (1997), whose book *Trauma and Recovery* is often cited as seminal in clinical trauma study, trauma entails events that "overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning" (p. 33). In popular and clinical narratives, concepts of trauma such as that which delineated by Herman exemplify attempts to make sense of events that disrupt ideology of the self as coherent, rational, with a recognizable and controllable interiority (Stevens, 2016). Conceptualizations of trauma and dominant discourse of the self are therefore mutually constituting in propagating the belief that the "self that is subject to trauma can be 'held responsible,' can be expected to respond to intervention with self-restraint or behavior modifications" (Stevens, 2016, p. 25). Stevens (2016) argues that this rubric of trauma works to cohere the affect of those who are moved to 'help' and those who are 'traumatized,' all towards

"our own admission to the global community of the healed, the cured, and the normative" (p. 29). He further suggests that medical terms produced by such notion of trauma, namely, PTSD and more recently traumatic brain injury, function "as a kind of state servant and ideological apparatus" (p. 32) in categorizing and channeling affect into state supporting practices of population control in the service of capitalist gains. Practitioners' own longings and pleasurable emotions in helping, achieving justice, and uncovering traumatic stories are shunted into the labour of managing the affects of those who have experienced violence. It is through this circuit of "bio-affective-political economies" (p. 35) that instruments of management operate in the forms of case histories, outcome measurements, and best practices, with the objectives being "the scrutinizing, the bringing under control, the calming down, the pacification of the subject of the state… through the provision of 'safety,' 'hope,' 'somatically grounded resiliency treatments'" (p. 36).

This affective circuit of biopolitics shows that power does not operate to eliminate emotions altogether, but to control them and render them productive. Ahmed (2004) theorizes that the hierarchy of reason and emotion further lends itself to "a hierarchy between emotions: some emotions are 'elevated' as signs of cultivation, whilst others remain 'lower' as signs of weakness" (p. 3). Cultivated and productive emotions are defined against unruly emotions or madness, often signaled by their inarticulability into reified 'feeling words' (Gorman, 2017). Following Scarry's (1985) theorization that pain is unsharable because of "its resistance to language" (p. 4) or "its ability to destroy language" (p. 54), emotions that flow from overwhelming violence may therefore be understood as inarticulable, unruly, and requiring management. The hierarchy of emotions is certainly a gendered construct. Ahmed (2014) references the figure of the angry wife, whose emotions are "understood as antisocial, as destroying ties of affection" (p. 115), a wandering away from the husband's will and the general social will, which assigns cheerful nurturance to women as their intrinsic duty (Lloyd, 1996). Based on its historical construction hysteria can be pictured as a raging mad woman with a wandering womb, refusing to reproduce and nurture according to their "biologico-moral responsibility" (Foucault, 1990, p. 104), thus posing a threat to the stability of the social body. The "hysterization of women's bodies" (Foucault, 1990) is therefore a strategy of disciplinary power deployed through the discourse of sexuality. While hysteria is no longer in use as a psychiatric diagnosis, it is often viewed as a predecessor to borderline personality disorder (BPD). Both diagnoses are disproportionately applied to women, both identify sexual trauma as a precipitating factor, the diagnostic criteria of both emphasize excess feminized emotions as well as emotions that defy normative femininity (Becker, 1997; Wirth-Cauchon, 2001; Ussher, 2011), and as such women labelled with either disorder are frequently viewed as "untreatable" (Sulzer, 2015, p. 85). In the current version of the Diagnostic and Statistical Manual of Mental Disorder (DSM-5) the symptoms of BPD that refer to emotionality includes: "Affective instability due to a marked reactivity of mood," "Chronic feelings of emptiness," and "Inappropriate, intense anger or difficulty controlling anger" (APA, 2013, 301.83). The diagnostic description implies that women are more prone to BPD, thus reinforcing the discursive construction of women as empty and chaotic (Shildrick, 1997). However, it is not difficult to deduce that women would be

overrepresented in a diagnosis associated with trauma when western societies are ongoingly sustained by a patriarchal social order that naturalizes the exploitation and subjugation of femininity. Moreover, feminist writers argue that since the range of socially acceptable anger is far greater for men than for women, judgements about anger as inappropriate are more likely to be made about women than men (Chesler, 1972; Wirth-Cauchon, 2001). Indeed, drawing on Aristotle's maxim, Boler (1999) argues that according to western moral traditions women are not permitted to express anger even in the face of transgression, which served to maintain women in a subordinate position. It is therefore not coincidental that both hysteria and BPD emerged during historical periods in which existing boundaries of gender roles were challenged by increased education and employment opportunities for women (Wirth-Cauchon, 2001). Further, Becker (1997) remarks that the introduction of BPD in the DSM-3 in 1980, in conjunction with a new diagnostic model that centres personality traits, has served as a way for psychiatry to maintain its supremacy against competing professions such as psychology and social work. In recent decades advancements in neuroscience, proliferation of trauma studies, and recognition of the stigma attached to BPD have led to a shift toward the use of PTSD in diagnosing women who have experienced violence (Appignanesi, 2008). In DSM-5, PTSD is also marked by a "[p]ersistent negative emotional state (e.g., fear, horror, anger, guilt, or shame)" (APA, 2013, 309.81), of which only anger is further explained as "quick tempered and may even engage in aggressive verbal and/or physical behavior with little or no provocation" (APA, 2013, 309.81). As such, following both Ahmed's (2004) model of the sociality of emotion as well as Stevens' (2016) discussion of bio-affective-politics, it can be argued that hysteria, BPD, and PTSD are but different iterations of a biopolitical apparatus that saturates the rhetoric of trauma and the traumatized subject with the emotion of anger as such rhetoric circulates through healthcare encounters, practices, and knowledge, in order to enable the ever multiplying means of systematic demarcation and regulation of normative femininity. Anger is therefore *fixed* to the traumatized subject as an inevitable outcome of trauma as well as a threat to social good that necessitates *fixing* through biomedical measures.

Through these ahistorical and ostensibly neutral diagnostic categories, anger is understood as a debilitating impairment part and parcel to the rhetoric of trauma. The naturalization of impairment in turn produces subjects who will "identify themselves in ways that make them governable" (Tremain, 2006, p. 186) and productive through regimes of rehabilitation. At the same time, sustainment of the norm also requires the conception of the impaired, as well as a prohibition of this conception by rendering it culturally unintelligible (Butler, 1990). The proliferation of trauma-related therapeutic interventions and prevention strategies that followed feminist movements had intensified the legal and medical scrutiny on women rather than on the men who perpetrated violence, whereby women were positioned as responsible for protecting themselves, which paradoxically naturalized male violence (Fahs, 2016; Million, 2013; Murphy, 2007). As such, violence in men is construed as normal, while anger in women is unintelligible except as signs of mental illness. Feminized constructions of pathology therefore obscures misogyny, with female

unreason serving to maintain the ideal of male rationality. Burstow (2003) particularly challenges the work of Herman (1997) in privileging psychiatric diagnosis and lobbying for an expansion of PTSD in the DSM. Along with Burstow, feminist scholars have argued that individualistic and deficit-oriented diagnostic criteria have reduced complex social damages and colonial violence to a list of biological symptoms (Goodman, 2015; Linklater, 2014; Tseris, 2013). Particularly, it is posited that for people who have experienced gender-based and racial violence emotions such as anxiety and rage are reasonable responses rather than signs of a mental disorder (Burstow, 2003; Ussher, 2011). Moreover, "outlaw emotions" (Jagger, 1989, p. 167), or emotions that are deemed socially unacceptable, such as anger, are reappraised as useful for feminist theorizing and activism (Burstow, 2003). Given that "'anti-normative' politics does not and cannot suspend the power of social norms" (Ahmed, 2004, p. 172), it is necessary for feminist politics to be self-reflective in examining how this move to justify anger and rage by realigning them with reason and utility may conversely reinforce binaries such as rationality/insanity, or productive/useless, thereby reinscribing the stigma of unintelligible anger and its corresponding disciplinary measures onto gendered, racialized, and disabled bodies who are always already marked for regulation.

Loose Ends: The Precarious and Necessary Articulations of Pain

What this paper has endeavoured to articulate is not so much what trauma is, but what it does in the ways that it is constructed and used. Particularly, it explicates trauma's semiotic, mutually constituting relationship with emotions, whereby conceptualizations of trauma reproduce and reinforce emotions and their underlying gendered and raced relations of power when evoked or deployed in various domains of social life, from the development of psycho-medical technologies to political maneuvers in framing citizenship and sovereignty (Ahmed, 2004; Million, 2013; Stevens, 2016). This deconstruction and problematization of the discourse of trauma do not aim to negate the corporeal realities of, or the necessity of biomedical interventions for, the injuries and pain resulting from overwhelming and devastating events (Clare, 2017). This theoretical work hopes to expose how, through dominant conceptualizations of trauma, violence is relegated to the memory of the past, and healing is configured as an ideal in the future, while ongoing violations to individuals' minds-bodies and communities *in the present* are effectively obscured (Clare, 2017). Furthermore, the promise of a cure from trauma precludes understanding of colonial, racist, and gender-based oppression that is embedded in the very foundation of this promise (Clare, 2017).

Shift from institutional care to community-based care in the Western world over the past several decades have led to new models of mental health care, such as the recovery model, which challenge medicalization of mental health and understand recovery as a social process that include access to resources and safety, as well as the recognition and reduction of ongoing experiences of discrimination, oppression, and violence in one's life (Morrow, 2013). However, Morrow (2013) observes that, implemented within a neoliberal context, an individualist definition of recovery continues to dominate mental health services that take up the recovery model, such that the framing

of recovery as a personal journey leads to the reframing of social justice and human right issues as personal health problems, thus neglecting a broader analysis of how social relations of power and systemic discrimination contribute to mental distress. As such, for "mad black, Indigenous, and people of color, the labor of narrating our distress becomes a tricky business" (Gorman, 2017, p. 312), as mad people's stories are often harnessed to showcase the neoliberal objectives of 'getting help.' Nevertheless, Morrow (2013) suggests that the recovery framework has the potential to transform the ways society perceives and responds to people experiencing mental distress by creating space for and centring stories that resist psychiatric domination and connect experiences of distress with poverty, racism, sexism, ableism, and sanism. Million (2013) describes Indigenous women's affective narratives of violence and poverty as "a canvas patiently painted with portrayals without explanations. You are there… but [the author] does not tell you what to think, what to feel" (p. 64). They are therefore affective expressions and knowledges that do not prescribe any framing in terms of their appropriateness or usefulness, and therefore "transgresses the way western knowledge works in the necessity to isolate and define" (p. 65). Similarly, Lorde (2007) writes that, for women, "poetry is not a luxury. It is a vital necessity of our existence" (p. 37). It is not a calculated strategy, but a necessary expression and sharing of the felt knowledge of social horrors as well as survival that has been disavowed, for it is through naming the nameless that visceral responses are evoked and experiences are felt, thus compelling connections and actions for change (Ahmed, 2004). There is no certainty in how these stories will be perceived or felt, or whether they will achieve the political goals hoped for, in the contexts of always shifting discourses and social conditions (Butler, 1993). Perhaps the way forward is to "proceed without assuming there is a right direction" (Ahmed, 2017, p. 197), yet grounded in the refusal "to reproduce a world I cannot bear" (Ahmed, 2017, p. 199). In the study of trauma, the rejection of a certain happy end and readymade definitions, and the tenacious excavation of the manifold operations of power within the discourses of both pain and healing, are enactments of critical praxis in pursuit of a less violent and more livable world.

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