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FORFEITING THE PARADIGM OF VICTIMHOOD[1]

ABSTRACT
This paper is a philosophical meta-discussion of the current culture in psychiatry and psychotherapy that focuses on trauma as the source and predominant determinant of a large number of psychiatric complaints. Such a culture leads to increasing, rather the decreasing, the destructive role of traumatization and victimization throughout the life experiences of those affected, and (as culture) is exemplified by increasing calls by influential psychiatrists to expand the interpretative role of trauma to virtually all our experiences of social inadequacy and personal hurt. We argue here, from a philosophical and psychiatric point of view, that the transactions, semantics and affects that psychiatry and psychotherapy are concerned with in cases of trauma and victimhood are negatively affected by the culture of using trauma as an alibi and a kind of universal explanation of psychological dysfunctionality and suffering. We also argue that, contrary to the current culture of a sort of idolatry of trauma, more consistent and philosophically informed approaches to psychiatric and psychotherapeutic intervention, based on a different interpretation of less-than-radically adverse life experiences, might in fact reduce both the clinical occurrence of traumatization and the actual adverse impact of self-perceived victimization and traumatization on the prospects for achieving the goal of 'the good life'.

KEYWORDS
trauma, intentionality, mental states, expression, the mind, psychiatric intervention, psychiatric culture, language, attention, resilience

Setting the Stage

Numerous principled, mainly ethical, controversies mar modern psychiatry and psychotherapy. Most concern the actual understanding and use of psychiatric and psychotherapeutic knowledge, primarily in the form of trying to endow it with pseudo-scientificity and impose it on other individuals and the

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society as a whole in the form of obligation, social norm, or ideological doctrine. However, other ethical controversies of the helping professions involve the actual substantive assumptions which have become so deeply entrenched in psychotherapeutic and psychiatric practice that they are now matters of informal political correctness. One of them is the uncritical predication of victimhood as a paradigm. This is an assumption that invites philosophical interpretation focused on values, specifically with a view of maintaining a clear picture of the value structure of the normative relationship between the individual and society.

One of the problems with victimhood in psychotherapy is that it is almost entirely an ideological assumption: people can be victimized by other people, by circumstances, and by broader life events, however this does not make them victims in terms of their identity. The uncritical paradigm of victimhood of women (by men, who are often considered 'generally' violent, unforgiving, abusive, etc.), of one life partner (by the other partner, or by any other person associated with the life partnership), or political leaders (who 'sacrifice' themselves for their grassroots supporters, for their nation, for their collective, all along profiting majorly from the sacrifice) is so useful that it has become stock part of modern psychotherapy. Even legal texts depict individual persons as 'victims' (e.g. 'a victim of domestic violence', in cases where no actual violence has been established, but the person is still continually legally referred to as 'the victim').

One of the challenges in the process of forfeiting the paradigm of victimhood is a clarification of the relationship between victimhood and trauma. While trauma is a very real source of dysfunctionality and pathology, but also of personal growth and integrity, victimhood. like fear, is almost singularly the source of misdirected therapy and the resulting loss of life time, self-confidence and a sense of identity in so many clients of psychotherapy and patients of psychiatry.

Victimhood as a Transaction

The transactional nature of victimization and traumatization arises from a general transactional subtext of all our life experiences; it is theoretically couched in the view that our relationships with significant others, and with society at large, represent a fundamental structure which determines both our identity and the processes which lead to our subjective metabolizing of our life experiences (Ragland 2015). The theoretical perspective which makes the transactional view of psychological processes philosophically intelligible and, in fact, partly foundational for the philosophy of psychiatry, in fact comes from the philosophy of law. Specifically, it was the Chicago judge and legal philosopher Richard Posner who most recently championed the idea that all our normative relationships are in fact reducible to transactions according to the liberal market principle that any good, or any object of exchange (including emotions, relationships, and other values), under ideal conditions of exchange, ought to end up in the hands of those who value them the most. For example, in a simple

market exchange, like an auction, a particular masterpiece will end up owned by the person who values it the most and is, consequently, willing to pay the highest price for it. The same principle, according to Posner, applies to all our social life, and can be extended to the point of contemplating a reduction of criminal law to the law of torts (civil law), where the wrongs and legal rectifications of those wrongs would be conceived in terms of damage and compensation (Posner 1995; Posner 2008).

Posner's considerations encapsulate the general principles of social structure in terms of transactional interactions between members of society and suggests a way to understanding the most optimal outcomes in most contested situations, or more precisely, situations of contested exchanges. It formulates the general principles on which, somewhat earlier, the psychotherapeutic theory of transactional analysis had been founded by the psychiatrist Eric Berne, who liked to describe himself as 'a phenomenological philosopher' (Berne 1961). It is unclear why Berne believed that the transactional view of human interactions was in any important way based on phenomenological philosophy. In fact, there is little evidence that Berne was even familiar, to any great extent, with that type of philosophy, however his understanding of the transactional nature of human interactions is far more in line with the later 'economistic' tradition in understanding human relationships, including the one exemplified by Posner's writing.

The fundamental assumption of transactional analysis is that every choice or action taken by a person undergoing therapy ought to be examined against the assumption that such choices 'pay off' to the person on some level, whether the person is aware of this payoff or not; thus, the choices and actions are not accidental, even when they seem so, and they always serve some kind of desire, which might be repressed from the conscious mind. Transactional analysis suggests an elaborate system or internal economy of satisfactions, which it calls a structure of 'strokes', that allow the person to maintain an energy balance over longer periods by acquiring positive 'strokes', or affirmations from the significant others, and by keeping them in reserve and using when necessary to assure self-worth and functionality in challenging situations when the person is disapproved off by one's community or important others. The idea behind the transactional view is that our focus in articulating our experiences is primarily directed outside ourselves, to the significant others who make up the community which provides the context where we establish our social identity. Thus, what Searle called 'intentionality' as the property of the mind to 'strive' to something, to always be driven by something, by a target somewhere outside the persons or, sometimes, inside the person (as in self-examination) is governed by a transactional logic (Searle 1983; Searle 1969; Searle 1979).

In Searle's context, the transactions are described primarily in linguistic terms, in line with his view that language expresses the structure of the mind, and he thus analyzes the transactional humanity, or what Agamben would later call 'sociality' (*Socialitas*), in terms of expressions that we exchange in our social interactions (Agamben 2013). Searle makes a number of distinctions between

the various classes of expressions, and of the mental states that are expressed by such statements, perhaps the most salient of which for our discussion here is that between beliefs, which are expressed in 'whole propositions', and emotions (in Searle's words: mental states 'such as love and hate'), whose expression may not require a whole proposition (Searle 1989: 6).

The way in which mental states are expressed is not merely a semantic organization of psychic experience, but also a mnemonic device which helps formulate the trace of that experience for future reference: thus the language we use not only expresses what we feel, or what becomes revealed in our psychic representations from the realms of our subconscious mind. The use of language and expression in general helps cement the nature of our memory of the particular experience. We will remember the experience in the form in which we have expressed and formulated it. This is how it will be kept in our psychological records as a trace of our life events. That is where the language of transactions starts playing a key role in understanding, preventing and treating trauma. At the same time, it is the point in which it becomes clear why trauma is a fundamentally philosophical category which cannot be successfully treated psychotherapeutically without at the same time focusing on its conceptual formulation and philosophical interpretation, both of which contribute to its final expression in the person's mind. Without a critical, discoursive processing of trauma, it may be an insoluble problem for the entire civilization, which sees its psychological troubles increasingly in terms of earlier traumatization, and is therefore advancing towards justifying and legitimating ever greater personal social inadequacies and dysfunctionalities by reference to unresolved, and often unresolvable, trauma. Again, Gabor Mate, mentioned subsequently in greater detail, is perhaps the best-known modern champion of this entire culture of seeing trauma as the unavoidable and pervasive part of human experience which fundamentally turns most of us into victims, whether we are aware of our own victimhood, or not (Mate 2022).

One of the most functionally effective forms of social capital, generated by quality transactional relationships, is that of trust. Fundamentally, problems of trust illustrate the dynamics of creation of organic communities which play healing roles both in terms of the constitution of personal identity and in addressing psychic complaints ranging from neurotic to psychotic. Trust is at the same time a source of power to control one's life events in a way which conveys satisfaction onto the level of overall life experience, and a source of organicism in social structure, namely it facilitates further transactions without the need for institutional or procedural guarantees (Seligman 2000). Historically, the evolution of trust conforms to a process of individuation as it moves from a mental state associated with the honor of performing (well) certain specifically assigned social roles, or exercising a rank in society, to mental states associated with conscience, and, more narrowly, conscientiousness. This is a move from a more group-based emanation of trust to a more person-centered emanation that emphasizes individual relationships, the social structure in the sense relevant to psychotherapy:

> [...] the transformation of the terms of confidence from those based on group affiliations (and so encompassed by some ideology of honor) to contracts between individual selves – as the self becomes the locus of moral order – engenders both the possibility of trust and perhaps also its growing necessity as whole arenas of human interaction can no longer be encompassed by externally attributable patterns of behavior (i.e. by role expectations). (Seligman 2000: 54).

Trust in this social evolutionary sense plays a key role in the therapeutic endeavor generally, and consequently also in the treatment of trauma and victimhood. Importantly, however, the counseling (including the philosophical counseling, or integrative counseling) treatments of victimhood and trauma alike involve both the 'diagnosis' (in this case, the adequate analysis, interpretation and formulation of the experience, which then becomes the mnemonic device by which the person later accesses the same experience), and the use of trust between the counselor and the counselee (included in the broader context of 'transfer' – again a transactional relationship) to address and edit the memory of trauma and the experience that memory elicits in the person once it is consciously accessed. The manner in which the actual interpretation and formulation of the experience unfolds, and thus seals the character of the experience as victimizing or traumatic (even when it is not radically or drastically such in any immediate appearance) depends on a cultural environment which, in the present culture, strongly favors, rather than avoiding, the solidification of traumatization and victimhood.

The Culture of Victimhood in Psychiatry and Psychotherapy

One of the most general philosophical problems with modern psychiatry, psychology and psychotherapy as allied helping professions concerns the limits and nature of their burden of trauma and their ideological infection with the uncritical use of the concept of victimhood. The use of victimhood is highly political in the sense that the social reception of victimhood governs even the individual articulation of a personal sense of being victimized. This results in the worrying situation where victims of highly personal traumas are only able to express their sense of victimization and the impact of victimization on their personal lives along the lines of the accepted social narrative of victimization, which thus deprives them of the opportunity to articulate their own narrative.

The authentic, personal sense of victimization is a source of general dysfunctionality and potential psychopathology, however the question to ask earnestly in addressing the conceptual controversies of psychotherapy is how much authentic trauma is actually encountered in the ordinary psychotherapeutic experience, and, correspondingly, how many 'real victims' we actually see.

The current culture of conceptualizing the psychotherapeutic situations is dominated by the so-called 'depot trauma', or 'pan-trauma', as a cultural expectation in modern psychotherapy is to seek the roots of most dysfunctionality, personal, emotional and social inadequacy, in potentially traumatizing antecedences, typically in childhood, but also in early adult life.

The ideological positioning of victimhood has reached a critical level both in psychotherapeutic and in the more general social discourse, to the extent that almost all entry diagnostic criteria for victimhood have been abolished, resulting in the general spreading of an 'aura of victimhood' as a socially acceptable form of self-presentation and presentation of others. The prevailing normative expectation in many western societies is to have been a victim at least at some stage of everyone's life, and the most difficult social position appears to be one where one does not see or present oneself as a victim. This tendency is further facilitated by politics through a proliferation of psychosocial projects, pseudo-scientific and pseudo-therapeutic techniques aiming to generate a 'total therapy' for society. The result is a mass 'recycling of trauma' as opposed to working through trauma. This is an outcome predicated by the value assumption that removing trauma is neither necessary, nor desirable; rather it is the processing of trauma so that its hurtful nature is reduced, while its cognitive and value-significance and presence in the person's life is preserved, because it is socially desirable and provides various benefits to the person in their social interactions, and especially in the more favorable valuations of their social transgressions.

The ethical consequences of the above social and psychotherapeutic trends and problematic conceptualizations of victimhood lead to an 'epidemic of innocence', where personal and collective irresponsibility and lack of success in social transactions are routinely medicalized and attributed to the paradigm of victimhood. Freud's proclamation that even psychosis cannot be an excuse for the abandonment of ethics, and that a psychotic patient remains ethically responsible, has thus been abandoned in practice, although the principle is reaffirmed in the most authoritative modern textbooks of psychotherapy – thus Paul Verhaeghe remarks that however severe a psychosis, 'even insanity has ethical limits', and insists that 'the field of clinical psychology and the field of jurisdiction and normativity – must be clearly separated' (Verhaeghe 2008: 13).

Part of the reason for the creation and perpetuation of the culture of victimhood lies with a particular professional and corporate interest of psychiatry. In many states, psychiatry has been a factual part of the repressive apparatus, and has been involved in labelling political dissidents and other persons considered a threat to the state. Policies in such systems had not been too concerned with victims up to the moment when the leaders realized that turning the person into a victim made her easier to manipulate. This has led to entire policies of representation of collective, ideological or ethnic victimhood as a depository of the conflictual potential of collectives. Such manipulative depositories of conflict today are the distorted ideologies of 'patriotism', but also group activist ideologies of militant feminism, liberalism or anti-liberalism, or of ethnic emancipation. The revival of the public use of concepts such as 'fascism' clearly suggests the history of the use of group ideologies to preserve animosity and derogatory potential for the revival of negative attitudes about significant others, those one disagrees with. Political institutions in various states have created narratives of victimization within most social phenomena and have

placed complete control over the institutions of forgiveness and reconciliation as the terminal phases of the individual recovery of every victim. Thus the processes of forgiveness, rather than being organic and authentically individual, are turned into protocols; they are even considered inadequate if they do not conform to technologies controlled by institutions, including psychological assessment supported by psychometrics, technologies or forgiveness and closure, etc. (Worthington 2016). The political authorities across the western world have thus created a situation where it pays to be a victim according to protocol. Victims are stimulated through various kinds of reparations, and they are encouraged to stay within their victimized status by psychotherapists who seek and find trauma as the defining event in their identities. The identity of a victim thus remains profitable and stimulated in a variety of ways, because being weak psychologically provides both excuses for individual inadequacies, and at the same time favors the political government, which finds its constituents who define themselves as victims extremely prone to political manipulation. The described trends leave victims poorly motivated to 'get well'. The conceptualization of victimhood as socially desirable naturally leads to re-conceptualizations of therapy, not as a process that ought to enhance resilience, but contrariwise, as one that will make even those individuals who do not perceive themselves as victims of trauma 'more aware' of just how 'traumatized' they might actually be. Perhaps the most prodigious work in this vein today is that by Canadian psychiatrist Gabor Mate, who tries to develop a culture of trauma, where all kinds of striving as described as 'addiction' and the negative experiences associated to failures in striving are achieve particular social and personal values as 'trauma' (Mate 2022).

Part of the problem with the ideological promotion of trauma and traumatization is connected with the way trauma is built into modern psychiatric diagnoses. Any diagnosis is always a set of protocols, and includes therapeutic assumptions. However, everything that contains social normativity is in some way subject to political influence. Psychiatric diagnoses are particularly susceptible to ideological influences because they are less exact and empirically verifiable than diagnoses in physical medicine, and the way in which psychiatrists are formed as professionals highly depends on the politics, ideology and values of the social system within which they are educated and gain their initial experience. The value systems of psychotherapeutic practice are often different from personal value systems of psychiatrists: they tend to evolve into self-sufficient ideologies which command authority to individual psychiatrists, where this authority arises from general practice. One of the facets of such practice has long been that psychiatrists are taught to seek in every interpersonal relationship the signs of traumatization and aspects of trauma. This leads to a generalized perception of most relationships as potentially pathological and victimizing. Closely connected is the tendency by psychiatrists to consider every person who fares weaker in some power relationship as a victim, without a prior responsible assessment of the mental capacities of the participants in the relationship. Such an approach leads to individuals embracing

their victimization as a way to re-establish an equal relationship of power, in other words to increase their social power, and that is one of the most dangerous consequences of the ideology of trauma and victimization.

Not every relationship is a trauma, and not every negative experience in a relationship qualifies the subject of that experience as a 'victim'. Many victims are in fact the primary actors of their own negative experiences, but if they belong to certain categories that are generally considered victimized in society, they are easily proclaimed to be 'victims'. An obvious example is that of women who undergo negative marital or partnership experiences, where they are almost automatically qualified as 'victims of psychological abuse' if only they say that they feel that they have been abused. However, this removes the ethical distance and, when combined with the lack of interest by psychotherapists to work with the other side in the same relationship and hear their part of the experience, it is nothing short of low-quality psychotherapy. On a philosophical level, such practice poses serious ethical questions aiming at the very purpose and social utility of psychotherapy if it merely reproduces social stereotypes instead of questioning them in light of a more fundamental set of therapeutic insights.

The above tendency in psychotherapy has largely redefined psychotherapists as trauma investigators, and the easy and uncritical conveyance of pseudoscientific status to the assumptions of primary, secondary and tertiary traumatization has given legitimacy to what is today an almost completely irresponsible public debate about trauma as the core phenomenon of psychic suffering. This has removed the basic principle that Verhaeghe and other Lacanian psychoanalysts insist on, namely that the truth has crucial ethical, rather than factual, ramifications and that the ethical bounds of mental disorders provide a framework within which the curing of these disorders is possible in the first place (Moskowitz, Dorahy, Schäfer 2008). Trauma is not an ethical category; it does not exonerate the victim from moral transgressions and non-conscientious behavior that militates against her own and the well-being of her close ones, the behavior that makes up so much of the symptomatology of 'trauma victims' in so many therapeutic situations.

The Concept of Anxiety and the Role of Victimhood in Cultivating Anxiety

The primary inhibitor arising from trauma is the anxiety which becomes associated with a particular experience, action or choice. This anxiety becomes the threshold which the person cannot cross in order to engage in activities, relationships or other experiences which account for important aspects of one's life, yet which seem fraught with potential pain. Thus, discussing anxiety in the context of trauma appears to be of utmost practical significance, and at the same time as an important philosophical and conceptual connection, which may shed further light on the meaning and potential interpretations of the concepts of both anxiety and trauma.

If anxiety is understood as the alarm that something out of the ordinary or something undesirable might occur to the person, then anxiety must be seen as an inevitable part of everyday experience and cannot be factored into accounts of trauma as its defining element. However, if anxiety is seen as an existential condition which is connected with our values, philosophy of life and our approach to social structure, namely to relationships with important others, then anxiety may be part of trauma, and may also be the critical element of it whose treatment determines whether trauma will lead to growth or it will stifle personal and identity development of the person or entire group.

The issue we wish to address here is to what extent anxiety is associated with intuition, whether it is a manifestation of intuitive cognition associated with the fear of a potential outcome, and how far it is rooted in the body, namely whether the body is the primary source of the feeling of anxiety. The two issues bring us to the energy-perspective in psychotherapy and open up an inroad into a particular view of the psychotherapeutic understanding and healing of trauma, which is based on establishing or repairing a psychic energy balance.

A view of psychic processes that takes account of bodily sensations during what we customarily experience as psychic experiences shows that most feelings manifest as bodily sensations; in fact, this is so much so that we would likely be unaware of our own 'anxiety', 'depression' or 'fear' were it not for the bodily chemistry and somatic sensations. When patients describe their 'symptoms' which designate anxiety or depression they typically describe bodily processes: heightened pulse, nausea in the stomach, tremors, sometimes uncontrolled movements (tics), etc. It is through their inability to control their bodily reactions and body movements that patients become aware of their anxiety: the disturbed sleep pattern, inability to concentrate manifested in bodily unrest, difficulties in breathing, etc., are typical complaints which describe anxiety. The language used to describe a phenomenon reveals the key features of that phenomenon, and the language we use to depict anxiety is predominantly physical.

Conversely, the strategies to calm anxiety which start from the body have proven effective in most cases. Physical exertion, breathing exercises, meditation focused on bringing physiological processes into alignment, are all beneficial in cases of anxiety. Thus, while modifying thought patterns through Cognitive Behavioral Therapy type of interventions is essential in addressing the anxiety disorders as prolonged patterns of anxiety, it appears that the very feeling of anxiety lives in the body and becomes awakened by thoughts. What the modification of thought patterns achieves is not a removal of the feeling of anxiety, but the avoidance of triggering of anxiety in the body through the triggering thoughts. This positions anxiety in the realm of bodily cognition and leads to the question of whether anxiety is associated with intuition as the bodily equivalent of rational and properly 'mental' cognitions. Clearly intuition circumvents rational reasoning and offers insights into aspects of reality that are unreachable by 'mind alone'. The fact that bodily, intuitive cognition cannot be explained in rational terms does not make it any less a cognition, though it is structurally different from rational thought and reasoning. Following

the bodily sensation with regard to potential future outcomes of our decisions has many forms, and one of the more extensively discussed in psychoanalytic literature has been the interpretation of dreams as fundamentally bodily sensations which occur during the physiologically dormant state of the body, allowing the person access to what Freud and Jung considered the unconscious collective knowledge, or anticipation, of future events (Freud 1913; Jung 1963).

Assuming that anxiety is rooted in the body and detected from the body, as experience appears to suggest both introspectively and based on complaints in psychotherapy, which refer to bodily manifestations of anxiety, it would seem that anxiety as an alarm which relates to the memory of trauma, when trauma is the reason for anxiety, represents a bodily record of a trauma. We experience this recollection mentally, but our primary reactions which make the recollection traumatic are physical. They are fundamentally physiological: inability to sleep, the tremors, a sense of physical weakness, difficulty breathing, etc. The contraction of our sense of time which occurs in anxiety is triggered by trauma, however it appears that the fixation of anxiety to a particular experience is what makes that experience trauma. In other words, it seems that it is anxiety that makes an experience into a trauma. As anxiety is fundamentally a neurotic mental state which becomes fixated at the interface between our perception of reality and the 'raw experience' of the reality itself, the train of thought appears to play a key role in fixating anxiety. While, on the one hand, anxiety triggers thoughts, including the obsessive, repeated and intrusive thoughts which often lead to psychic dysfunctionality, on the other hand the thought current fixes anxiety to certain experiences in the first place. This is the reason some people will be traumatized (or, at least unconsciously, 'decide to be traumatized') by some events which other people will overcome; the latter will not fix their anxiety to those experiences and will either successfully forget them, or 'archive' them into memory without the precursor of trauma.

There are, of course, ground-shattering events in individual and group lives which do represent trauma, where it would almost be unnatural for a person or group not to be traumatized, such as the painful death of close ones or major episodes of violence and devastation. However, the borderline between what is justifiably considered trauma in a society and what we are encouraged to regard as trauma while, otherwise, such events would not be legitimately considered to be trauma, must be drawn somewhere. The culture of canceling all borders and boundaries in traumatization is a culture of inhibition and debilitation of large numbers of clients in psychotherapy, because it blurs not only the conceptual distinctions between trauma as a major, stifling and anxiety-ridden experience, on the one hand, and simply adverse events which call for a mobilization of personal resilience, but also the difference between the person and the person's outside world. The assumption of the outside social worlds serves as a check on our entirely subjective qualifications of experience which we share with others: this is where certain standards and classifications of what type of experience legitimately meets what kind of emotional reaction becomes a part of normalcy.

If Lacan's position is true that it is socialization that makes us 'normal' or 'abnormal', namely our ability to internalize values and norms from the society and informal communities wherein we are raised, then consequentially our understanding of traumatization and the value which we assign to experiences in terms of their traumatizing capacity and meaning are also learned, or socialized. The process of socialization in its critical personality-formation aspects takes place during childhood, however socialization in general does not end there. Even adults become re-socialized through the internationalization of new or changed social norms. The psychotherapeutic process is a form of resocialization in the sense of mental health as measured through socialization. This is where Philippe Pinel, the founder of the modern psychotherapeutic clinic, concurs with Lacan. Pinel conceived psychotherapy as a form of 'moral re-education', based on the idea that by correcting socialization that has misfired somewhere along the way of a person's affective development the mentally disturbed person would thereby be cured and made 'normal' (Charland 2010).

The process of socialization, or social learning, accounts for most of the fixations of affect to certain experiences: as affect regulates behavior and choices, at least on a very general level, socialization teaches the individual what to feel and when, especially when social emotions are concerned (empathy, solidarity, shame, pride, etc.). When the affective behavior goes awry and becomes disconnected with socially desirable emotions and reactions, this is diagnosed as 'dissociation' (dissociation of affect and cognition, or affect and experience), and is considered one of the key symptoms of psychosis. Thus, a consensus on appropriate affect is a key element of our standards of normalcy, one that psychiatry has consistently abided by through its concepts of 'realistic' (in fact, shared with the rest of society) and 'functional' (understandable and supportable by the rest of society).

An important consequence of this learning theory of affects which is embedded in the history of psychiatry specifically, and of psychotherapy and the allied practical humanities more generally, is that we also learn what is structural trauma, or trauma that is couched in our socially significant relationships (Lacanian concept of 'structure'). Most traumatization that is the subject of modern debates are relationship-related traumas: experiences of loss, abandonment or violence encountered within otherwise close and emotionally significant relationships. It is not controversial whether someone who has survived genocide has been traumatized: that is obvious from the magnitude of the experience and the consensual reaction which makes it clear that everyone else would also feel traumatized in such circumstances. The controversial traumas are those that are declared to be traumas, yet ones which need not be regarded so, nor would most people experience them as major trauma. Gabor Mate has been one of the champions of that mass resocialization where people are told by experts that they are traumatized, that they have had difficult childhoods or youth, that they are 'unaware' of just how deeply traumatized and suffering they are, to the extent that all causation of mental difficulties is at least putatively attributed to trauma. Thus, trauma becomes the main and automatic suspect

in every dysfunctionality. At the same time, it becomes a powerful, universal alibi for what would otherwise be considered socially inapt behavior. The discourse of mental health has thus been reduced to trauma and resilience as two complementary forces which govern our lives: according to the main assumptions of that discourse, which, again, Mate exemplifies particularly obviously, we are all systematically abused by the traumatizing social practices that we all live within, and our resilience as a reaction to trauma is constantly tested. The consequence is that mental illness is the reaction of a healthy individual to unhealthy social conditions (Mate 2019). Thus, social conditions are to blame for dysfunctionalities, which is a seductive idea, because of course the society does influence our well-being in innumerable ways, however if the boundary between personal responsibility for a degree of resilience and ability to accept loss, stress and rejection and the society's responsibility is abolished and all the responsibility is left with society, mental health as we traditionally conceive it disappears as a concept. That is perhaps why Mate insists that 'normalcy' is a myth, where only the society can be diagnosed with serious pathology that then carries over into personal dysfunctionality.

There are at least two levels of discussion here. One is the need to address social pathology, a topic that has been seriously neglected in the philosophy of psychotherapy and even in the philosophy of psychiatry for decades. This is a separate topic that we cannot address with due care in this discussion, however one whose importance we acknowledge and one of us has dealt with it elsewhere (Fatić 2020: 397–450).

A different level of discussion is whether the internalization of a culture of trauma, which is emanated by social elites, institutions and authorities, such as Mate, and which provides an alibi for all kinds of mental and social disabilities, while encouraging wide swaths of the populations of developed western societies to consider themselves mentally disordered and traumatised to the point of partial social dysfunctionality, is a part of that very social pathology. Could it be that the social pathology that Mate writes and speaks about, that pathology which allegedly traumatizes and scares us into extreme vulnerability and ultimately mental illness also contains the very ideology of trauma? After all, if health is ideally defined as a near perfect state of mental and physical wellbeing, then all those social influences which degrade health in the sense of the organism's ability to handle stress, to recover and regenerate, including toxic ideologies, are pathological. This logic, then, entails that the toxicity of the ideology of traumatization as a universal alibi and at the same time a tool for extreme psychiatric reductionism (where psychiatrists, as we mentioned at the beginning, are reduced to 'detectives of trauma' rather than being full-fledged therapists) is a par excellence example of social pathology that needs to be addressed in the interest of public health.

The above circular reasoning of the advocates of trauma as the universal social ill and the almost all-encompassing phenomenon that overarches most mental disorders and dysfunctionalities has not so far been pointed out in the philosophy of psychiatry, nor in the theoretical encapsulations of methodological

arguments for modern psychotherapy. Instead, trauma has been slipped through the circular logic as a paradigm whose attractiveness and seductive charm (because it absolves the patients of any responsibility) would eventually replace any rigorous argument to establish trauma as a well-defined concept and to delineate its causal place in the etiology of so many mental disturbances that it is claimed to give rise to.

We suggest here, based on our three perspectives (the nature of the transactions, where trauma is part of the transactional cost for our social structures, or relationships, the changed and simplified methodology of psychiatry which is largely reduced to seeking the causation of most mental problems in hidden trauma, and the role of anxiety in the actual conceptualization of trauma), that when we speak of trauma we in fact speak of anxiety that is fixed to specific experiences in ways which are largely (not completely) socially engineered.

By reducing the discourse of trauma to the discourse of anxiety and the way it becomes experientially positioned, or fixated, to specific types of experiences, structures (relationships) and their outcomes, we are able to address inhibition, the wide spectrum of neurosis, and even psychosis in the traditional sense delineated by Pinel, later by Lacan and the contemporary Lacanians, as based on socialization as a normative process, and on the affective internal structuring of that socialization in accordance with personal capacities, which are not the same in every member of society.

Making General Sense of It All

In the philosophical and psychiatric thinking of trauma in three salient contexts: that of transactional social intentionality, that of the dominant psychiatric culture and practice, and that of the etiology and hermeneutics of anxiety both from a philosophical and medical point of view, we take a unified, integrative perspective as a philosopher, and a psychiatrist. This perspective suggests a particular diagnostic and treatment semantics of trauma and victimization which casts the social intentionality, exemplified in the language of traumatization and victimization, as highly directive, and to some extent oppressive, cultural norms for diagnostic and treatment transactions in modern psychiatry. The culture of treating mental issues as the likely offspring of early trauma and of focusing on the search for trauma instead of looking for more optimizing and brighter values which might illuminate one's life is a self-fulfilling prophecy where most complaints indeed become trauma: if people are taught to see their issues as results of trauma, and indeed if they are taught to formulate such a broad array of negative experiences as traumatizing, this will actually lead to the symptomatology of trauma. Philosophically, it will yield a situation where the psychiatric and more generally therapeutic culture, rather than improving the quality of life of the patients, in fact degrades it by its very language, culture and diagnostic practices, and from the point of view of psychiatry itself, such language will reduce the range of psychiatric interventions to what could basically be described as crisis-intervention.

Our view in this analysis, which takes the form of a suggestive tone which may lead to further research and interpretation of the matter, is that psychotherapy in general has much more to offer to trauma sufferers than it does now, by focusing on the 'life after' the experience which it fixates as traumatic and as the locus of one's present issues. This is a cultural and value matter that, if adequately reinterpreted, might lead to a change of the current psychiatric and psychotherapeutic culture along more optimistic, broader protocols based on value-laden interpretations that focus the content of life experiences as the potential substance of resilience and flourishing, rather than focusing on the traumatizing potential and, indeed, factual effects of the same experiences. While some radically negative life experience cannot be interpreted otherwise but as traumatizing (extreme violence and the like), they are fairly rare in the psychotherapeutic practice of trauma intervention compared to more everyday and less directly adverse experiences for the person. A different theoretical understanding, especially of the concepts of personal responsibility for the very interpretation and formulation of one's experiences, might address many of the currently self-defeating aspects of psychotherapy that has defined itself to such a great extent by reference to trauma and victimhood.

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Odricanje od paradigme žrtve

Apstrakt

Tekst je filozofska metadiskusija aktuelne kulture u psihijatriji i psihoterapiji koja se koncentriše na traumu kao izvor i preovlađujuću odrednicu velikog broja psihijatrijskih tegoba. Zahvaljujući pomenutoj kulturi, destruktivne uloge traumatizacije i viktimizacije se pojačavaju u svom uticaju na životna iskustva protagonista, ili žrtava tih iskustava, zavisno od toga kako se traumatizacija i viktimizacija posmatraju. Primeri ove vrste kulture uključuju sve češće pozive uticajnih psihijatara na širenje interpretativne uloge trauma kao delimičnog objašnjenja svih iskustava koja uključuju osećaj socijalne neadekvatnosti i lične povređenosti. U ovom tekstu, autori argumentišu da, sa filozofske i psihijatrijske tačke gledišta, transakcije, semantika i afekti kojima se psihijatrija i psihoterapija bave u slučajevima trauma i viktimizacije, dobijaju dodatni destruktivni potencijal zahvaljujući upotrebi trauma kao univerzalnog alibija i objašnjenja za psihičku disfunkcionalnost i sa njom povezanu patnju. Nasuprot toj kulturi, autori sugerišu da bi, umesto idolatrije u vezi sa traumom, dosledniji i filozofski informisaniji pristupi psihijatrijskim i psihoterapetuskim intervencijama, koji bi počivali na drugačijim interpretacijama onih negativnih životnih iskustava koja ne ugrožavaju psihičku egzistenciju radikalno ili ekstremno, mogli redukovati kliničku zastupljenost traumatizacije kao sindroma. Istovremeno, uzdržavanje od psihodijagnostičkog tretiranja traume kao univerzalnog alibija za disfunkcionalnost, smanjilo bi konkretne negativne efekte interpretacije sopstvenih iskustava kao viktimizacije i traumatizacije. Trauma kao alibi, u aktuelnoj kulturi, faktički onemogućava efektivno ostvarivanja cilja „dobrog života“ kao filozofskog zadatka za svakog pojedinca, i kao nosećeg ideala u celokupnoj psihoterapiji, jer pruža normativni predložak za posmatranje i umerenih negativnih iskustava kao trauma, i za tretiranje nefunkcionalnosti kao faktički redovne, gotovo neizbežne, posledice takvih „trauma“.

Keywords: trauma, intencionalnost, mentalna stanja, izraz, um, psihijatrijska intervencija, psihijatrijska kultura, jezik, pažnja, otpornost