A CRITIQUE OF POSTTRAUMATIC STRESS DISORDER AND THE *DSM*

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Posttraumatic stress disorder (PTSD) is one of the few *DSM* categories that was created and became widely accepted as a result of people other than psychiatrists wanting it. Even progressive practitioners tend to assume that it is essentially well constructed and benign. This article shows otherwise. The article fundamentally problematizes PTSD. It demonstrates that the category PTSD is confused, reductionist, contradictory, and arbitrary and that it pathologizes purposeful and valuable coping strategies commonly used by people who are traumatized. It demonstrates, in addition, that the category does not even serve the purpose for which progressive therapists have engaged with the diagnosis and that it cannot simply be "corrected."

Keywords: *trauma;* DSM*; antipsychiatry; feminist*

Although humanistic psychotherapists, feminist therapists, and other progressive practitioners have long been critical of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and its diagnoses (see, e.g., Colbert, 2001; Greenspan, 1983), we have

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tended to look fairly favorably on the diagnostic category posttraumatic stress disorder (PTSD). This favorable attitude stems from the origin of the PTSD conceptualization, PTSD's focus on genuine injury, its practical value, and the success of progressive practitioners in reframing the conceptualization so that more and more clients fall under its auspices. Significantly, unlike with most diagnoses in the current *DSM*, the diagnostic category PTSD was constructed at least in part because people other than psychiatrists wanted acceptance of a new "mental disorder." As Kirk and Kutchins (1997) documented, after the Vietnam War, American veterans lobbied the American Psychiatric Association to construct a diagnosis that would recognize the long-term psychological damage incurred by soldiers in combat and would pave the way for therapeutic services. The veterans proposed the diagnostic category catastrophic stress disorder or CSD. The most critical aspect of CSD was the precipitating causal event. The deliberating psychiatrists were uncomfortable having causation included. The compromise solution was the introduction of PTSD into the third edition of the *DSM* (American Psychiatric Association, 1980). The criteria specified for the new diagnosis include an initial stressor that would evoke distress in almost anyone (Criterion A), a time frame, and a list of "symptoms." With *DSM-III-R* (American Psychiatric Association, 1987), PTSD was reworked. Criterion A now stipulated that "the person has experienced an event that is outside the range of usual human experience and would be markedly distressing to almost everyone" (p. 250). More significant changes occurred as the veteran issues faded in importance and feminist practitioners took a special interest in PTSD.

Essentially, feminist therapists such as Herman (1982, 1992) saw the conceptualization as being relevant to survivors of childhood sexual abuse, women who were battered, and others routinely traumatized in a patriarchal society. After all, patriarchal violence does harm women and children; and it does have a psychological aftermath. Correspondingly, therapists wanted their clients to get the benefits that *DSM* legitimization would bring: the harm being taken more seriously, coverage in insurance policies, and women's being able to sue for damages. That being the case, feminist therapists began using the conceptualization. In addition, as documented by Kirk and Kutchins (1997), they lobbied the American Psychiatric Association to alter the definition of PTSD so that more of their clients would fall under its auspices. Although

there seems to be some shift in psychiatric practice as a result, the most obvious shift is the current formulation of PTSD in *DSM-IV-TR* (American Psychiatric Association, 2000). Unlike the initial formulation, the current formulation does not require that the traumatizing event be outside the range of normal experience; and it explicitly makes room for common events such as childhood sexual abuse. Feminist practitioners continue to use the category, to critique PTSD, and to call for change. So do transgenerational trauma practitioners such as Danieli (1998) and other progressive clinicians.

On this face of it, the developments outlined above look positive. The purpose of this article is to demonstrate otherwise. It is to demonstrate that the diagnosis PTSD is untenable and undesirable. Correspondingly, it is to show that changes made to the diagnosis in recent versions of the *DSM* make the diagnosis even more problematic. The bulk of the article argues that the PTSD diagnosis is inherently flawed and otherwise problematic. The article culminates in commentary on progressive practitioners' current engagement with this diagnostic category.

THE PTSD DIAGNOSIS

PTSD is one of a number of diagnostic categories subsumed under the larger category *anxiety disorders along with other diagnostic categories such as panic disorder without agoraphobia, agoraphobia with history of panic disorder, acute stress disorder, social phobia, and obsessive-compulsive disorder.* In *DSM-IV-TR* (American Psychiatric Association, 2000), the PTSD diagnosis consists of Criterion A, which specifies a preceding traumatic event and an initial response; Criteria B, C, and D, which articulate clusters of "symptoms"—otherwise referred to as "the disturbance"; and Criteria E and F, which function to further delimit the use of the diagnostic category. Criterion A reads,

> The person was exposed to a traumatic event in which both of the following were present:
>
> - the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others.
> - The person's response involved intense fear, or helplessness, or horror. (p. 467)

Criteria B stipulates that the trauma be reexperienced in one or more of the ways specified. Examples of alternatives provided are recurrent intrusive recollections, distressing dreams about it, and acting as if the event were recurring, whether via hallucination, illusion, or flashbacks. Throughout Criterion B, special notes are provided that essentially alter a symptom in the case of children. An example, in this regard, is "Note: in children, there may be frightening dreams without recognizable content" (American Psychiatric Association, 2000). Criterion C stipulates "avoidance of stimuli associated with the trauma and the numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following" (p. 467). Examples of what follows are avoiding thoughts or feelings associated with the trauma; avoiding activities, places, or people associated with the trauma; estrangement from others; and restricted affect. Criterion D is "persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following" (p. 428). Examples of what follows are difficulty sleeping, angry outbursts, and hypervigilance. Criterion E explicitly equates "the disturbance" with the constellation of symptoms in Criteria B, C, and D and stipulates that the disturbance must have lasted more than a month. Criterion F stipulates that "the disturbance causes clinically significant distress or impairment in social, occupational, or other important area of functioning" (p. 468).

To begin on a general level, as noted earlier, PTSD is categorized in the class of disorders called *anxiety disorders*. The nature of anxiety and of anxiety's role in the anxiety disorders are not clarified. And aside from the obvious—that each of these "disorders" includes anxiety—it is not clear what specifically makes these alleged disorders "anxiety disorders." It looks as if the anxiety itself is being understood as inherently and necessarily problematic. This understanding of anxiety is then applied to other feelings and other ways of coping that are not intrinsically pleasant. Having recurrent dreams (Criterion B subset 2 or B2) is not intrinsically pleasant. However, as every informed clinician knows, such dreams are a valid way of working through stress and problems. So, to a degree, are flashbacks (B3), which likewise are viewed as symptoms despite their functionality as described in works such as Herman (1992) and Burstow (1992). What is not pleasant becomes a symptom and, as such, pathologized.

Although a precondition is listed for this diagnosis—a traumatizing event—the symptoms are subsequently listed as if the meaning that traumatized people make of the traumatic event is unimportant and as if context and purpose are not relevant; that is, the purposive responses of stressed people are decontextualized and depicted as symptoms of a disease. A case in point is Criterion C—"avoidance of the trauma and numbing of general responsiveness." Seven types of avoiding and numbing behavior are listed, of which three must be present. Many of these so-called symptoms are, in fact, well-known and well-documented coping strategies commonly and purposively employed by people who are traumatized. It is reductionistic to ignore purposiveness and to assume that the behavior and orientations in question are the products of a disorder.

Examples are C1—"efforts to avoid thoughts, feelings, or conversations associated with the event"—and C2—"efforts to avoid activities, places, or people that arouse recollections of the trauma." There is no question but that people who are traumatized commonly respond in precisely the ways described. However, as described in Burstow (1992, (2003), one way for a person to keep from flooding—a common problem listed in B1—is to avoid conversations associated with the trauma and to avoid activities, places, or people likely to trigger memories. Although, of course, this way of coping can and does frequently lead to problems—sometimes extreme problems—it does make sense; and there are times when it is wise and even necessary. Examples of such times include when a person has been flooding and needs to ground herself or himself; when the situation being faced is particularly fraught with triggers; when there is an emergency; and when others need special attention. The point is, the behaviors described in C1 and C2 are not even intrinsically misguided, never mind symptoms of a disease. They are purposive strategies that are sometimes optimal and that make sense even when they go too far and seriously interfere with a person's other activities and intentions. By negating the person as an integral whole, that is, by isolating the behavior into discreet units covered in separate criteria, the diagnosis turns these useful and often vital ways of coping into symptoms of a disease. Moreover, insofar as they are theorized as symptoms of a disease, the stage is set for the practitioner to try to eradicate the symptoms, whether through drugs or other means, as leading

trauma therapists like van der Kolk (1996), for example, instructed practitioners to do. To phrase the problem differently, the stage is now set for practitioners to try to deprive traumatized people of necessary and vital coping skills in the name of help.

There are comparable problems with other so-called symptoms. Further examples are the alleged symptoms: hypervigilance (which is listed under Criterion D as a type of increased arousal) and feeling of estrangement from others (listed under Criterion C as a way of numbing). Like all other symptoms, both of these are constructed as manifestations of a disorder. Besides it being unclear what makes these responses symptoms of a disease, it is not even clear that these are unfortunate or unwise responses. It depends on the context.

I offer by way of example a psychotherapy client of mine who always saw her family as caring and loyal. One evening she was raped by a family member. When she told her family about what happened, the family members at first considered what she said but soon began accusing her of making up the story. Before the rape and, to a lesser extent after the rape, but before the family denial, she was very trusting and had no appreciable difficulty spending time with family members. After the rape and the denial—that is, after the traumatic events (Criterion A)—she was on the alert (Criterion D4); and she was estranged from others (Criterion C5). The diagnosis constructs this reaction as "caused by" or "part of" a disorder. A more enlightened reading is that she suddenly found herself in an unsafe universe where extreme caution and distance were in order.

What underpins this inadequate conceptualization of the response, the underlying assumption embedded in a PTSD diagnosis, and, indeed, in many other diagnoses, is that the world is essentially a safe and benign place. In this view, there is something wrong with people who see or respond to the world as if it were otherwise. Indeed, a high percentage of the symptoms are either based on or somehow connect with this assumption. This view persists despite the fact that feminists won the battle to remove the qualification that the traumatizing event be "outside the range of usual human experience" (American Psychiatric Association, 1987, p. 250); that is, the implicit assumption persists that traumatizing events are uncommon. Correspondingly, someone who acts as if such events are common—that is, someone who acts as if the world is unsafe—is seen as misunderstanding the world and responding

inappropriately as the result of a disorder. As Brown (1995) and others have pointed out, however, while the world may well look safe to White, heterosexual, able-bodied, middle- and upper-class adult males (e.g., most psychiatrists), it is not so safe for a great many others.

In this regard, as theorists such as Brown (1995), Lewis (1999), and Burstow (2003) suggested, women, Blacks, gay men and lesbians, people who are disabled, children, and much of the working class live in ongoing danger of assault. Moreover, the safe world assumed by most people (including the privileged and including the framers of the *DSM*) is not so much a reality as an inaccurate albeit serviceable construct maintained by an everyday cognitive practice: People who are not traumatized maintain the illusion of safety moment by moment by editing out such facets as the pervasiveness of war, the subjugation of women and children, everyday racist violence, religious intolerance, the frequency and unpredictability of natural disasters, the ever-present threat of sickness and death, and so on. People who have been badly traumatized are less likely to edit out these very real dimensions of reality. Once traumatized, they are no longer shielded from reality by a cloak of invulnerability. They now know that the world can get at them. What essentially the diagnostic label does is define the cloak of invulnerability as normative and define the knowledge and knowledge-based responses of the survivor as symptoms. Correspondingly, the act of labeling sets the stage for attempting to rid survivors of their knowledge, pushing them to return to a Pollyannaish view of the world that the trauma has already shown to be inadequate, and even drugging away responses that do not fit with the "norm" (see, e.g., van der Kolk, 1996). In this regard, the construction of this disorder is not only faulty, and presumptuous, but dangerous. And herein lies a significant truth about "mental disorders." While psychiatrists view the *DSM* as a neutral tool that is simply useful in assessing and helping people who are troubled, it is a tool through which a hegemonic worldview is imposed. Moreover, it so constructs people as to legitimate injury.

A number of other PTSD symptoms are likewise predicated on the assumption of safety, albeit less obviously. These include but are not limited to B1 (intrusive distressing recollections of the event) and B4 ("intense psychological distress at exposure to internal or external cures that symbolize or resemble an aspect of the traumatic event") (American Psychiatric Association, 2000,

p. 468)]. There is no question but that both of these responses are common and that they may well involve a distorted view of reality that the person constructs in response to trauma. In addition, the responses indicate a psychological problem or, minimally, a psychological challenge. However, they may also have their own accuracy, and they generally do. For example, the woman who was raped who is terrified when she walks down the street and sees men (B4) is, indeed, reacting to something that resembles an aspect of the original traumatizing event. And her current response may well impede her ability to navigate the world. However, she is not inventing the danger. While the *post* in *PTSD* creates the impression that the problem is gone and that the person is mistakenly reacting as if it were not, the problem remains. The woman is still living under the patriarchy. In other words, the social relations in the present contain the same power dynamic as those that culminated in the rape. Her fear, correspondingly, is not simply the result of an unfortunate trigger; and it is not a sign of a "disorder." It is an attunement to genuine danger. The same principle applies even where there is a dramatic shift in circumstance. For example, despite his reactions, a Jewish Holocaust survivor who occasionally reacts to people as if they were about to take him back to the concentration camp is not in Nazi Germany; and so clearly, distortion is involved and the particularity and the degree of his fear speak to the psychology of trauma. Nonetheless, he lives in an anti-Semitic world in which Jews still genuinely have something to fear. In other words, he too is attuned to genuine danger. The intense psychological distress (B4) may similarly be a kind of attunement.

On a very different level, as with other *DSM* diagnoses, the symptoms and criteria are presented as if they were exhaustive. They are not. Although, indeed, traumatized people commonly think, feel, and act in the ways described, they also commonly think, feel, and act in other ways that distinguish them from people who have never been traumatized. Having a keener appreciation of the dangers of the world is one such way, though it is hardly likely to be listed or appreciated, for it is not negative. And herein lies a further problem that this diagnosis inevitably shares with all other "mental disorders." The concept of "mental disorder" and the schemas in question force people to be looked at in negative ways. In this case, the survivor's special knowledge is unseen; and insofar as differences between survivors and nonsurvivors are seen,

the differences become deficiencies within survivors and, indeed, symptoms of the so-called disturbance.

In addition to not being exhaustive in that it excludes or obscures survivors' strengths, PTSD is not even exhaustive in its own terms, for it leaves out other possible "symptoms" and other possible "diagnostic criteria." As psychotherapists Herman (1992) and Burstow (1992) indicated, it is common for people who are traumatized to engage in various types of self-injury as coping strategies—starving themselves, cutting themselves, and so on. They may do so as a way of numbing themselves (Criterion C). However, they may do so for completely different reasons that are not covered by any of the criteria in question. For instance, as discussed in Burstow (1992, pp. 187-201), they may cut to remind themselves that they feel and that they are human. That being the case, the pretense of completeness is simply that—a pretense. The assumption that all trauma can be captured by such a schema is misguided. Correspondingly, there is something arbitrary in picking and absolutizing the specific symptoms and criteria in question.

By the same token, there is something arbitrary about the number of symptoms that must be satisfied for a particular criterion to be applied. Why three symptoms of the symptoms specified in Criterion C? Why four symptoms of the symptoms specified in Criterion D?

Insofar as the PTSD schema is looked at in terms of satisfying the requirements for a true medical diagnosis, additional problems arise. The list has nothing to do with physical problems. It overlaps enormously with such diagnoses as borderline personality disorder (p. 706), acute stress disorder (p. 469), and generalized anxiety disorder (p. 472). Indeed, the symptomology is almost identical in acute stress disorder, with the practitioner referred to the PTSD section for extra details, and with the instruction given "if the symptoms persist for more than 4 weeks, the diagnosis of Posttraumatic Stress Disorder may be applied" (p. 469). While time can have significance with real medical diseases, in no real medical diseases does one disease magically turn into another at the 4-week mark. In addition, as with the rest of the so-called mental disorders, there are no single identifying markers by which people could be said to have PTSD. Moreover, PTSD is identical in *DSM-IV-TR* and *DSM-IV*. And from the vantage point of providing a discreet diagnosis, some damaging discoveries have been made

about PTSD in *DSM-IV*. In this regard, note Kirk and Kutchins's (1997) revelations: "There are 175 combinations of symptoms by which PTSD can be diagnosed" and "it is possible for two people who have no symptoms in common to receive a diagnosis of PTSD" (p. 124).

The special instruction given with respect to children is positive from the vantage point of practitioners' understanding children and their reactions better. However, it too is problematic from a strictly medical vantage point. Insofar as the behaviors are symptoms of a disease, it is not at all clear why a number of symptoms would be different in children than in adults. In addition, some of the distinctions seem to be embedded in nothing but the framers' lack of awareness of what happens with traumatized adults. For example, Criteria B2 reads "recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content" (p. 468). The distinction between adults and children implied here is inappropriate. As is clear in Burstow (1992), Herman (1992), and Shapiro and Forrest (1997), adults who are traumatized also frequently have frightening dreams that do not have recognizable content, albeit the dreams do relate to the "trauma."

The critique of the medicalization of trauma articulated in this article so far is supported by and reinforces the more general critique of the *DSM* enterprise by critics such as Leifer (1990) and Woolfolk (2001). These critics have argued that the very foundation on which the *DSM* rests is faulty. The use of the terms *diagnosis*, *symptoms*, and *syndromes*, and *psychiatric dysfunction*, and the division into diagnostic categories they demonstrate, medicalize thought and behavior in the absence of proof that anything medical is occurring. Moreover, the terms have no obvious meaning. In this regard, Woolfolk pointed out that while we know what a heart dysfunction is, the concept of behavioral or psychological dysfunction has no clear meaning. "Syndrome" is similarly problematic. Mirowsky (1990) pointed out that syndromes are a constellation of symptoms. However, symptoms are supposed to be signs that point to something beyond themselves. All these signs point to the diagnostic categories. Now, of course, psychiatrists frequently talk as if purported "diseases," like, for example, schizophrenia, cause symptoms such as low affect. However, as Mirowsky so aptly put it, "patients' symptoms are not caused by the categories through which doctors perceive and organize symptoms except for the sec-

ondary problems arising from labeling" (p. 410). More generally, as Woolfolk and Mirowsky have argued that the purported diseases are arbitrary groupings of random numbers of ways of thinking and feeling—not natural categories. Correspondingly, in the conversion of behavior and thought into discreet symptoms, holistic integrity is sacrificed; problems in living are individualized; and the complex relationship between behavior, purpose, and context disappears.

While most of the problems discussed in the article so far relate to the diagnosis PTSD as a whole, a number have specific relevance for criteria B to D—the criteria that define "the disturbance." To zero in on the other criteria, criteria E and F present standard difficulties. Criterion E specifies that the symptoms must have lasted for more than a month. The time frame is arbitrary. Correspondingly, there is reification and lack of clarity in criterion F—"the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p. 468). What makes distress "clinically significant" besides that professionals interpret the distress as clinical and as significant? And what exactly is meant by "impairment in social functioning"?

Criterion A is the kingpin—the foundation on which the so-called disorder rests. Insofar as *trauma* and *traumatic event* are explained, they are explained here. Moreover, Criterion A has a special relationship to all of the criteria that follow. Remove it, and the disorder becomes unrecognizable. Alter it, as happened in *DSM-IV*, and the symptoms are forced to be altered accordingly. By the same token, any problems that it sets up create problems in what follows.

Criterion A begins with the stipulation that "the person has been exposed to a traumatic event." It then requires that two conditions be met, to reiterate:

- the person experienced, witnessed, or was confronted by an event or events that involved actual or threatened death or physical injury, or threat to the physical integrity of self or others.
- the person's response involved intense fear, helplessness, or horror. (p. 467)

One problem with these conditions is what they leave out. As feminists such as Gilfus (1999), Brown (1995), and Lewis (1999) showed, people are traumatized by conditions that may not fit

these criteria; yet they equally suffer the aftermath of trauma. In this regard, Brown (1995, pp. 107-108) suggested that the criterion needs to be reworked to include "insidious trauma." By *insidious trauma*, she meant the trauma experienced by peoples who are oppressed as a result of years of living under oppressive conditions—day after day hearing racist innuendoes, day after day seeing in people's eyes that you are not fully human. A more formidable challenge to Criterion A may be found in the transgenerational theorists. As is clear in transgenerational theorists such as Danieli (1998) and Duran, Duran, Yellow Horse Brave Heart, & Yellow Horse-Davis (1998), even without seeing or hearing about the "traumatic" events in question, people may suffer the type of aftermath described in Criteria B to D. As routinely happens with historical trauma, for example, profound psychological injury may arise simply from living with the traumatized reactions of others.

Another fundamental problem that becomes evident as Criterion A is scrutinized—and one that plagues the work of most progressive theorists as well—is the slipperiness of the concept of *trauma* itself. As any dictionary clarifies, the word *trauma* refers to "wounds" and to "reactions to wounds." Like almost everything else that theorizes "trauma," the *DSM* slides between the two meanings. It is often unclear whether a specific symptom is intended to be seen as a reaction to the initial event (trauma as wound) or as a reaction to the initial reaction (trauma as reaction to the wound). A1 specifies the nature of the event. A2 specifies the nature of the initial reaction. A list of symptoms follows, with it never being specified what relates to A1 and what relates to A2. In addition, no definition of *traumatic event* is provided—an interesting omission given that the entire *DSM* framework rests on definitions. Criterion A simply stipulates that the person "must be exposed to a traumatic event in which both of the following are present." Are the features specified in A1 sufficient for something to be called *trauma*? Is the response itself—A2—necessary for the event to be deemed a "trauma"? Unless such questions are answered, the nature of the diagnosis is unclear. Moreover, it is not clear that there is any way of answering these questions without examining an even more fundamental problem—the relationship between Criterion A and the rest of the diagnosis.

The question is What exactly is the relationship that is being posited between the "traumatic event" (Criterion A) and the "dis-

turbance" (Criteria B to D)? The answer to this question is anything but clear—which is itself a problem, though it is possible to inch toward an answer.

On the face of it, it would appear as if a causal relationship were being posited. And certainly the American Psychiatric Association needs that appearance if it is to avoid protest and to accomplish some of its objectives—legitimating coverage and enabling people to sue for damages, for example. However, such a causal relationship is ruled out by the definition of *mental disorder*, with which the *DSM* begins and that serves as the foundation of all that follows. Significantly, at the end of the definition of *mental disorder*, the framers stipulate that "whatever its cause," a disorder must not be "an expectable response to a particular event" (p. xxxi). Now, if the traumatic event being referred to in Criterion A is to be construed as causing the disorder, the disorder in question would be expectable, and as such, the alleged disorder would not qualify as a disorder. The foundational definition of *mental disorder*, in other words, requires that the traumatizing event listed in Criterion A not be causal. The actual name *PTSD*, in addition, is instructive in understanding the framers' intentions. There is a marked contrast between wording here and the wording of causes allowed for in the definition of *mental disorder*. What is not surprising given that the *DSM* is a biological model, while the *DSM* rules out external events as potential causes of "mental disorder," it does not rule out drugs as potential causes. So drugs appear as causes. In addition, the fact that they are intended to be seen as causal is crystal clear. An instructive case in point is substance-induced anxiety disorder (p. 483). We are left in no doubt that the substance is being posited as causal, for the words *substance induced* make the causal connection explicit. By contrast, the name *PTSD* suggests only that the disorder came after the trauma—not that it was caused by the trauma. Moreover, unlike with "substance-induced anxiety," no type of causal relationship at all is stipulated in the criterion. Criterion A simply stipulates that the person has been exposed to a traumatic event. In other words, Criterion A is being listed as a criterion that needs to be satisfied—as a sort of precondition—not as causal.

Insofar as the event or events in question are not to be seen as causal and insofar as the *DSM* is positivist, by necessity the question arises, What purportedly does cause the disorder? The *DSM* does not provide an answer. The *DSM* simply states that there are

causes to mental disorders—ones that are essentially biological and/or psychological, though external events may sometimes play a contributing role.

I have demonstrated the inadequacy of PTSD as a diagnosis, as a framework, and as an account. It is contradictory, impractical, presumptuous, pathologizing, arbitrary, evasive, confused, insensitive, and reductionistic. And it frames people's experiences in such a way as to normalize further injury. Moreover, most of the problems are not amenable to correction, for they are fundamental. They are an inevitable by-product of constructing people's problems in living as if they were actual medical disorders. Given the contradictions between the diagnostic enterprise and human existence, correspondingly, attempts at making the diagnosis more responsive inevitably result in further problems. In addition, the analysis of Criterion A shows that PTSD does not even accomplish the mission for which it was sought. Vietnam veterans and feminist therapists wanted a disorder that would demonstrate the profound harm done by certain types of events, situations, and conditions. What they got instead was a diagnosis with implicit meanings and implications that subvert the very validation that it appears to offer. Those meanings and implications include but are not limited to the following:

- Something biological or psychological is primarily responsible for the psychological aftermath.
- It is not expectable for children who are sexually abused, women who are raped, war veterans, and other survivors of trauma to continue to have psychological problems 1 month after the "event."
- The reason that people who are traumatized continue to suffer a psychological aftermath 1 month later is that something is wrong with them.
- That "something" was not caused by the traumatic event itself.

As such, PTSD is neither valid, nor workable, nor redeemable.

IMPLICATIONS FOR PROGRESSIVE PRACTITIONERS

In an article in *Violence Against Women*, Gilfus (1999) discussed feminist therapists' use of the PTSD diagnostic category and asked about the price of using it. One implication of this article is that the

price for all progressive practitioners is too high. The disorder is intrinsically problematic; and it so constructs people who are traumatized as to invalidate their ways of operating and to legitimate harm to them. In addition, as a diagnosis, it serves as an entry into the psychiatric system—a system that itself tends to be traumatizing, as shown in Breggin (1991), Burstow and Weitz (1988), and Shimrat (1997).

To varying degrees, most progressive practitioners are aware that there is a problem with the diagnosis but see progress as having been made. Seeing the possibility of further progress, some such as Brown (1995) are lobbying the American Psychiatric Association to alter PTSD to include insidious traumatization. In addition, many value the diagnosis despite problems because it is useful for legal and related purposes. This article casts doubt on these evaluations.

Feminist therapists succeeded in their attempts to get Criterion A altered so that everyday violence against women was "covered" in PTSD. However, that result is not advantageous because the diagnosis readily entails being misunderstood, being invalidated, and being subjected to further psychiatric interference. Correspondingly, despite the fact that the popularization of PTSD has resulted in greater awareness of the long-term harm of violence against women and children, the diagnosis itself turns the aftermath of the violence into a disorder and turns the violence itself into nothing but a preceding event. As such, it individualizes and pathologizes women's and children's expectable response to violence. Moreover, although the diagnosis is more sensitive to some of the complexities of trauma as a result of the changes for which feminists lobbied, the fundamental problems remain; and as described in this article, additional problems materialized as a result of those changes.

Just as the initial effort to shift PTSD was questionable, so is the current attempt to alter PTSD to include insidious trauma. Such an inclusion entails more people being invalidated and harmed in the ways described. What is particularly significant, it especially allows more and more people who are oppressed to be declared "mentally disordered." Such an outcome is frightening, especially in light of psychiatry's long history of abuse.

The one clear advantage of PTSD is that people so diagnosed can use it for legal and for insurance purposes. Although this article is not questioning the importance of people who are traumatized

receiving benefits and damages, it is questioning whether the benefit is worth the cost. What is additionally important, it is unclear how long PTSD will continue to be useful in this way. As Kirk and Kutchins (1997) demonstrated, North American lawyers are already aware of the illegitimacy and impracticability of PTSD as a diagnosis and are bringing that knowledge into the courtroom. If PTSD is made even less viable as a diagnosis by the criteria being loosened to include insidious trauma or historical trauma, the diagnosis will be able to be discredited even more readily; and so it may become of no use whatever. And herein lies a central dilemma.

This article established that as long as PTSD is a diagnosis within the *DSM*, and as long as it is posited on the understanding of mental disorder that is foundational to the *DSM*, it will be necessarily insensitive to the complexities of human existence by medicalizing problems in living. What is now coming to light, the more sensitive PTSD is to the complex and variegated realities of trauma and so the less distasteful it is to progressive practitioners, the less defensible it is as a medical diagnosis, and thus the less likely it is to continue to be of use for legal and for insurance purposes; that is, the more room allowed for differences in experiences, including experiences such as insidious traumatization, the greater the variety of experiences that qualify. The greater the variety of experiences that qualify, the more readily people with almost no alleged symptoms in common could be given the diagnosis. And the more readily people with almost no alleged symptoms in common can be given the diagnosis, the less likely the diagnosis will be accepted in lawsuits or by insurance firms. In addition, the more inclusive the definition is and so the more sensitive it is to the different ways in which human beings are "wounded," the greater the number of people who will be so labeled; and the greater the number of people so labeled, the greater the number invalidated and placed in jeopardy of further psychiatric intrusion. I see no way around these conundrums.

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