

**Mapping the discursive spaces of trauma and
healing in mental health:
The institutional unconscious**

by

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Abstract

This research maps discursive spaces, or linguistic exchanges, that are manifested in the socio-spatial practices, based on the notions of trauma and healing within five participant mental health sites at Vancouver Coastal Health. I conducted 20 semi-structured interviews and a focus group to explore the understandings of trauma and recovery practices among both the users and the providers of mental health and addictions services within VCH. I employed qualitative methods such as ethnography, participant observation, Lacanian Discourse Analysis (LDA) and thematic analysis to explore the various perspectives behind trauma-specific services (TSS).

Theoretically and methodologically this dissertation puts in dialogue three paradigms: Psychoanalytic geography, which explores the specific socio-spatial practice around trauma and healing in the institution; clinical psychoanalysis, which explores how those exchanges are informed by unconscious mechanisms, based on language, that affect the subject's body and psyche; and the mental health field, which explores how the socio-spatial exchanges affect physical spaces, practices and interpretative frames in mental health service provision. My conceptual approach relies on a consistent shift of focus between the psychic (individual subject) and inter-subjective (social discursive) scales. I also locate two bodies of enjoyment—the subject's private body of jouissance and the social public body politic—, whose concerns are of different and often divergent nature. And finally, I rely on the Lacanian ternary of the Imaginary, Symbolic and Real registers of human experience to sustain my discussion.

I proposed two main topologies of trauma, explored various forms of trauma discourses and their social bonding, and I also discussed challenges from imaginary, symbolic and real nature in the provision of trauma services. I claim that Lacan's university discourse or *know-it-all* is the privileged social bonding in the institution, based on the master signifier "mental health evidence-based practice" (MHEBP), which functions as a hegemonic fetish that resists the complexity of traumatic suffering and simultaneously covers the anxiety of not knowing how to deal with the roots of such difficulty. By relying exclusively on biomedical and emotional literacy treatments for trauma, the institution also reduces costs in their response to the overwhelming demand for mental health services.

Keywords: Psychoanalytic geography; Clinical psychoanalysis; Trauma and healing;
Discursive spaces; Mental health institution; Lacanian topologies

In loving memory of my parents

José Fernández Hernández

and

Hilda Alvarez Ledesma,

for they are a warm light in my discourse

And to those who say here,

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List of Acronyms

3BSU	Three Bridges Mental Health and Substance Use Team
AI	Analysand followed by a number refers to a participant service user
APW	Aboriginal Wellness Program
CI	Clinician followed by a number refers to a participant service provider
EB	Evidence-based
Kitsilano MH	Kitsilano - Fairview Mental Health Team and Substance Use Team
Ld	Leadership followed by a number refers to a participant service provider in a managerial or supervising capacity
MH	Mental Health
MHA	Mental Health and Addictions
MHEBP	Mental Health Evidence-Based Practices
MHSU OS	Mental Health and Substance Use Outpatient Services
South MH	South Mental Health Substance Use
TSS	Trauma specific services
VCH	Vancouver Coastal Health



Photograph by Author.

Chapter 1.

Introduction to the research

1.1. Introduction

Trauma is an old signifier of medical origin that connotes a wound, a sort of abruptness or violent rupture, whose linguistic use extended from physical to mental suffering at the beginning of the early 20th century (Bistoën, 2016; Bracken, et. al. 1995; Young 1996), thanks to many contributions made by psychoanalysis (Freud, 1973, Ferenczi, 1949; Rank, 1929/2001, etc.). As a concept, trauma has evolved over time, and its transformations have depended on the way concrete actors historically involved in traumatic experiences, such as soldiers, hysterics, workers, accident victims, and survivors of domestic and sexual violence, have interacted with those attempting to help them (Fassin & Rechtman, 2009; Young, 1996). The use of this term, however, has experienced an unprecedented surge since the 2000s: Trauma now is used to talk about rape (Haaken, 1996; Herman, 2015); a motor vehicle accident, the death of a loved one, or physical, sexual, or emotional childhood abuse (Van Der Kolk 2014; Poole, & Greaves 2012; Degloma, 2009). Trauma can be used to identify the devastating effects of war (Kardiner, 1941; Summerfield, 1999; Kienzler, 2008; Gilligan, 2009; Davoine & Gaudilliere, 2004), the Holocaust (Levi, 1989), genocide (Dupuis-Rossi & Reynolds, 2018; Giesen, 2001; Gone, 2013; Hartmann et. al. 2019), dispossession (Fanon 1961/2004; Burnham, 2021; McKenzie-Mohr, et. al. 2012), land displacement (Ehrkamp, et. al. 2021; Sayigh, 2013; Pratt, 2017); immigration (Naraghi, 2007); racial difference (George, 2016), addiction (Proudfoot, 2019), torture (Jelinkova & Tarafás, 2020; Di Cesare, 2018), environmental disaster (Perera, 2010); or brain damage (Malabou, 2015). And trauma can be used when, in a public space, a person feels neglected by the lack of a content—related warning sign, as an explanation for why anti-vaxxers refuse vaccination against Covid19 (Maté, in Kearney, 2021), as an adjective to qualify a personal situation of heightened stressful nature, or as a click-bait for training opportunities within the counselling industry. The polyphony of trauma seems to have lost its semantic relevance: this signifier has become emptied, is itself a void, as Paul

Kingsbury & Anna Secor (2021) render it: an absence, silence or spaciousness, “an impossibility that inheres in language itself” (p. 5).

Trauma and healing affect individuals and groups alike and their scales are at times divergent. I understand the term ‘scale’ within the field of geography as follows: as a quantitative aspect of volume or size (for example, globe, nation, body or psyche); as a means by which the qualitative difference of specific entities can be contrasted—in my research subject and discourse—; and as relation regarding the position of entities in relation to each other (Sayre & Di Vittorio, 2009, p. 19). More precisely, however, I understand the notion of ‘scale’ in a Žižekian way, articulated by Paul Kingsbury and Lucas Pohl, as a parallax *qua* Real construed by fantasy (Kingsbury & Pohl, 2021, p. 207) because the way trauma affects a person or a community depends on how it is nourished by phantasmatic aspects of unconscious nature that blurs the boundaries and proportions between the subject and society and thus requires to be explored as a parallax, detailed below (c. 1.2.2).

In this chapter, I situate the context of my research and introduce the questions and the guiding methodologies of my dissertation. This empirical study, which primarily draws on concepts that inform the subfield of psychoanalytic geography, examines the notions of trauma and healing at five mental health teams within a health institution in Vancouver, Canada (Vancouver Coastal Health, VCH). The research was funded by a Team Grant from Vancouver Coastal Health Research Institute (VCHRI) and thus, an *intrinsic value* of this research consists of the fact that VCH was willing to fund a qualitative study and practice-based critique from within its own community; it is a promising gesture when an institution is open to hear from its own constituency outside the dominant research discourses.

My research is a unique and important intervention in the fields of qualitative geographical research because the variety of methodologies employed and the various paradigms put into dialogue. It constitutes a multi-level evaluation of an institution (VCH), conducted through interviews of both service users and service providers, that interrogates vital aspects in the treatment of trauma within the field of mental health. My research also contributes to the latest debates on trauma and healing practices by providing methodological approaches over how best to understand the interactions between the social and the individual embedded within the institution (Lacan, 1969-

70/2007; Kaës, 1989; Parker & Pavon-Cuellar, 2014). It hopes to inform, both conceptually and practically, policies about trauma-specific mental health services provision in VCH. Because the success of practice-based research does not depend only on the intellectual merit of the project, but on the consequent reception and the collective execution of the findings, it is my hope that the voices of the research participants can be heard.

I originally became interested in conducting this research for two reasons: on the one hand, the opacity of the term trauma invited me to *crack its voidness* by tracking its divergent and polyphonic meanings and putting the various perspectives on trauma in dialogue. In addition, my lived experience as a mental health therapist motivated me to explore some of the effects that systemic changes in service provision have produced, which parallel a global neoliberal managerial tendency, affecting the way mental health service users are implemented in the institutional spaces of VCH.

This research maps discursive spaces, understood as the embodied linguistic exchanges that occur in the practices of trauma and healing in the participant mental health sites in VCH. Discursive space is a term that emerged from the discourse theory of Lacan (1969/2007), which starts with the notion that the unconscious is structured as a language that shapes the subject's body and their exchanges with others. Mapping or tracking discursive spaces refers to analysing the various embodied positions that a participant (a speaking being) occupies, and also refers to the analysis of the signifiers and allotted meanings circulating socially and spatially among those engaged in a specific practice—in this case, mental health service provision.

Contrary to the idea that one speaks a language, psychoanalysis demonstrates that language *speaks us*, as we are split subjects between the conscious ego (secondary process) and the unconscious id (primary process – “the core of our being”—Lacan, 1954/1988, p. 43); split between what we say and what we mean in the saying. That is why the unconscious, in my research, is understood as hidden in plain sight in speech, and is thus trackable through linguistic exchanges that allow us to understand the specific form of social bonding that results from those exchanges. Yet language is always incomplete because it can't assimilate the unsymbolized and unsymbolizable and thus, as my dissertation argues and illustrates, is a central issue in trauma.

In this research study, I conducted semi-structured interviews with clients, clinicians, and institutional leaders, as well as a focus group with clinicians, to explore the understandings of trauma and healing practices among users and providers of mental health and addictions (MHA) services at five sites within Vancouver Coastal Health (VCH) that serve adult populations. The five participant sites are the following: South Mental Health and Substance Use Team (South MH), Mental Health and Substance Use Outpatient Services (MHSU OS), Kitsilano Mental Health and Substance Use Services (Kitsilano MH), Three Bridges Substance Use Team (3BSU), and the Aboriginal Wellness Program (AWP). I employed qualitative methods such as participant observation, Lacanian Discourse Analysis (LDA), focus groups, autoethnography, and thematic analysis to explore the perspectives of participants in their understandings of what constitutes trauma and healing within the context of trauma-specific service (TSS) provision.

By tracing discursive spaces within this institution, I articulate a psycho-geographic methodology to account for the entwinement of the individual subject and the social discourse, specifying the Imaginary, Symbolic, and Real spatial forces and structures. As a result of the various interdisciplinary paradigms and conceptual frames, I conceive of trauma in two different topologies of *nospace* (Lacan, 1972b, p.3): the *protruding void* and the *structural rupture*, and I instantiate each through the empirical data.

1.2. Paradigms

Theoretically and methodologically, my research puts into dialogue a few paradigms or models, that are related to my interdisciplinary training. A paradigm is a set of theories, methodologies and discourses that sustain various practices. I have studied, experienced and conducted Lacanian psychoanalysis for more than 20 years by means of my own psychoanalytic process, long years of supervision while working with people from various ethnocultural backgrounds in both private and public settings in Mexico and Canada, numerous study groups (cartels) and seminars, and ongoing public presentations and published texts that articulate theoretically my understandings of Lacanian psychoanalysis. My training in Lacanian psychoanalysis is central to my engagement with the following three paradigms involved in this research: psychoanalytic geography, clinical psychoanalysis and mental health:

- 1) Human geography explores the social, economic, cultural, political and demographic dimensions of human experience and situates its analysis in geographic space, which can range from the psyche, the body, to the city, the nation or the globe. The psychoanalytic logic is also included in human geography as it pertains to interrogations about causality, agency, structure, interrelations, network, place, emotion or movement (Elden, 2009). My empirical research, however, focuses on how discursive exchanges around trauma and healing have shaped specific socio-spatial practices that comprise the institutional unconscious, which is conceptualized from the perspective of *psychoanalytic geography* (Kingsbury & Pile 2014; Blum & Secor, 2014; Callard, 2003; Kingsbury & Pohl 2021; Nast 2000, Copjec, 1994, Žižek, 2006).
- 2) My research also draws from the field of *clinical psychoanalysis*, a paradigm informed by my training as a psychoanalyst. This paradigm allows me to track how unconscious mechanisms affect the subject's body and psyche and the challenges that the clinic of trauma poses (Freud, 1919/1973; Freud, 1920/1973; Lacan, 1964/1998; Lacan, 1959-60/1992; Lacan, 2006; Soler, 2004; Verhaeghe & Vanheule, 2005; Fink, 2007).
- 3) Finally, my research explores how unconscious socio-spatial exchanges affect institutional mental health service provision in physical spaces, practices and interpretative frames, which links my research to the vast paradigm of mental health (Morrow, M. 2007; Cook, et. al. 2017; Mills, 2014; Burstow, 2015; Pavon-Cuellar, 2014, Parker, 2005b; Lacombe, 2008; Linklater, 2014; Van Nieuwenhove et. al. 2019, Proudfoot, 2019).

1.3. Conceptual axis

In this dissertation, I explore practices of speaking, listening, writing, and spacing the notions of trauma and healing within the institution. There are four conceptual axes that accompany my research, the ternary RSI (Real, Symbolic and Imaginary), the scalar parallax, the two bodies (of jouissance, and body politic), and the concept of institution.

1.3.1. The Lacanian ternary of the Real Symbolic and Imaginary registers (RSI)

The interaction of the three Lacanian registers, Real, Symbolic, and Imaginary is central to the contextualizing and the nuancing of various concepts throughout my

dissertation because the Lacanian ternary presents the subject's experience as entwined on three different levels (Figure 1.1): Roughly speaking the imaginary is the field of the object ego, whose main function is misrecognizing the subject via the ego defenses (Lacan, 2006, p.79). The imaginary register constitutes the image of self, which for Lacan constitutes an illusory necessity that although it "determines the structuration of the subject" (Lacan, 1954/1988, p. 52), nonetheless obscures the subject's emergence, because what moves the ego is recognition rather than the knowledge of self (Lacan, 1954/1988, p. 52). The imaginary field mirrors the ego in others, and thus is the arena for semblance, erotic fascination as much as for jealousy and aggressivity "deriving therefrom in all relationships with others" (Lacan, 2006, p. 79).

The symbolic field in Lacanian psychoanalysis refers to the inherent alienation of the speaking being in language, which determines the radical social dimension of the subject immersed in discourse. The symbolic is found in speech but also in what is not spoken, such as gestures like shrugging shoulders, a smirk, a click of the tongue. Lacan proposes the aphorism "*the unconscious is structured like a language*" (p. 20) to assert the fact that "beneath the term unconscious, [there is] something definable, accessible and objectifiable" (p. 21). This aphorism emphasizes language as essential because "we only grasp the unconscious finally when it is explicated, in that part of it which is articulated by passing into words" (Lacan, 1959/1992, p. 32). This aphorism also grounds the practice of psychoanalysis as scientific because it is beyond the "ineffable" experience (Lacan, 2006, p.674), such as mystical or religious experiences. Psychoanalysis works with the Cartesian subject that doubts and asserts itself through reason, but psychoanalysis also subverts such subject with a transmissible method that recovers unconscious knowledge. The symbolic refers to the subject as determined by the materiality of a signifier because "a signifier is that which represents the subject for another signifier" (Lacan 1964/1998, p. 207). In the symbolic dimension, speech is split between the *statement (énoncé)* – the grammatical "I" that shows the signifier that represents the subject–, and the *enunciation (énonciation)* which is the unconscious "I" that produces a subject who emerges because of the speech act (Lacan, 2006, p. 677 & 730; Lacan 1964/1998, p. 139). Therefore, the subject that psychoanalysis is concerned with is the one produced by discourse. The structure of the unconscious as language also involves linguistic rules, such as metaphor and metonymy (parallel to Freud's explanation of the mechanism of condensation and displacement in the dream work,

respectively (1900/1973). Such linguistic mechanisms occur in two dimensions: the synchronic—which I read as the transversal cut of the ‘here and now’ of speech—, and diachronic—which I read as the historical longitudinal cut of language (Lacan, 2006, p. 677). The symbolic requires a primordial law of language—instantiated by Lacan through the signifier Name of the Father—which introduces the phallic function that signifies lack as such (1963/2013).

The Real refers to what Lacan called ek-sists or ex-ists, which by its etymological roots is akin to both ectasis and existence, as well as to the Heideggerian “standing outside” (Fink, in Lacan 2006, p. 798). The Real has a spectral existence in the subject’s experience of *object petit a*, and is foreign to representation, corresponding to the logical modality of the impossible and that which “always returns to the same place” (Lacan, 1974/2019, p. 89-90). But the Real is not fully outside of language because the discursive structure, which is the focal point of my dissertation, partially shapes the Real and simultaneously is shaped by it.

Although the theoretical value of this ternary consists of the equivalence and the knotted presentation of the three, to facilitate my conceptual discussion, I focus on one at a time to allow a detailed analysis of the complexity of trauma.

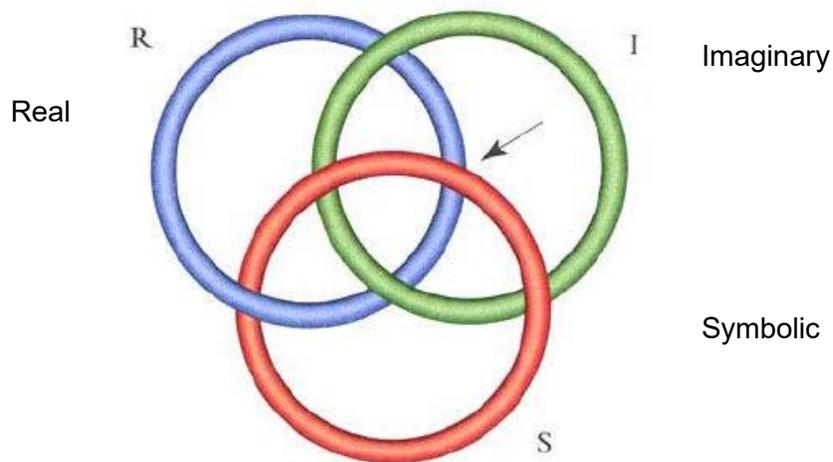


Figure 1.1. Conceptual ternary: Real, Symbolic, and Imaginary

I focus on the Imaginary register in various parts of my dissertation; for example, when I discuss environmental aesthetics of the sites involved in this research (Chapter 3) or in my *representation* of topologies of trauma, which relies heavily on topological

images to locate socio-spatial exchanges through the *imaginary depiction* of spaces such as the Moeibus band, the torus and mostly the crosscap (Chapter 5). The Imaginary register also helps me to approach in what way fantasy and the body operate (Chapter 6) and is also an important line of inquiry for healing, specifically when I discuss the reestablishment of the pleasure and the reality principle to gain somatic agency (Chapter 7).

The Symbolic level is focused on my rendition of various notions throughout this dissertation, mostly when I present different discourses, such as: the *know-it-all* or university discourse, the *protest* or hysteric discourse, as well as the capitalistic discourse (Chapter 4). The symbolic register also supports my rendition of the discourse of *victimhood* (trauma discourse) or *perpetration* (master discourse), both in Chapter 6; and finally discourse of *transformation*, which is Lacan's discourse of the analyst (Chapter 7) where I discuss the importance and paradoxes of the emergence of the subject.

The Real register is fundamental for demonstrating the impossibility of trauma via topology: the protruding void (excess) and the structural rupture (lack) articulated in both Chapter 2 and Chapter 5. The Real is also conceptually relevant when discussing the central concept of the drive in the body and anxiety in relation to object *a* (Chapter 6), as well as the symptom, *jouissance*, and surplus *jouissance* (Chapter 7).

1.3.2. Scalar parallax

The second conceptual axis that accompanies my research throughout is scalar parallax, which incorporates two terms: scale, as above indicated, expresses qualitative and quantitative levels that involve size but also perceptions of size tainted by fantasy. Parallax indicates perception of depth or movement and refers to the mechanism of alternating focus. Scalar analysis necessitates alternating of perspectives between the psychical (individual subject) and the inter-subjective (social discourse), and is useful to think how, in social linkage, the social and the individual aspects appear in alternation, as one side is seen only by the blurring of the other side. While we focus on the challenges posed by individual trauma, we blur the social aspects that cause it, and inversely, when we concentrate on the social aspects of trauma, the individual contribution can't be seen. Yet, when engaging scalar parallax through *extimate* space

we could analyze how each scale presents different challenges and at times demands divergent heuristic strategies, such as regarding memory, identification or surplus jouissance (cf. Chapter 8) and also permits a conceptual analysis of the discursive axes of representation and production, which I trace in the systemic linguistic relations that result in specific forms of social bonding in the institution (Chapter 4).

1.3.3. The Institution

The study of institutions is vast and encompasses various disciplines, which can range from private institutions, such as marriage, paternity/maternity, friendship or property; to public ones, such as the school, workplace, hospital, prison, or the political party. Institutional theories in geography at large examine the role institutions have in structuring spaces at the diverse scales or levels (such as the globe, nation, body, psyche). From a Foucauldian perspective, the geographical study of institutions can focus on mechanisms of control, cure or vigilance of “the mad, the sad or the bad” or on the historical elements that naturalize institutional practices (Foucault, 1975-76/2003, p. 8). Other institutional geographies are interested in systemic approaches to understand organizational or managerial relations, which analyze variables such as membership, networks, strategy, labour relations, communication, wages or competition and also political economy aspects that refer to the state or geopolitical relations that explain regimes of capital accumulation (Mackinnon, 2009, p. 500). In the field of human geography, institutions are understood as both formal organizations such as government agencies, corporations and voluntary bodies, as much as broader sets of rules, and values that structure people's actions. The study of institutions concerns the regulation of practices among a group of individuals, widely approached by organizational, economic, political, sociological, or anthropological studies. The term institutions tend to emphasize behaviors and practices that, once instituted, have become taken-for-granted, routine and normalized (Mackinnon, 2009, p. 499).

The field of “the institution,” however, refers to what Rene Kaës assumes as “the part of our psyche more undifferentiated” (1989, p. 12, my translation thereafter) because an individual belongs to socially organized groups that are constituted by libidinal bonds of identification, hence the institutional dynamics, as Kaës suggests, work within a narcissistic pact based on an ideal representation. The institution “is destined to secure its permanence, to preserve the law and order, and by itself constitutes a

protection against the negative, both for the subjects and for itself” (Kaës, 1989, p. 53); yet other forces within the institution antagonize “in favour of differentiation and integration of the distinct elements” (Kaës, p. 32). The dominant engagement — sameness or differentiation— chosen by an institutional constituency or body politic will “work in benefit, damage or alienation of the subject and the group” (Kaës, p. 12).

In my research, I understand the institution as the psychosocial space of an individual among others that creates social links via linguistic formations that follow certain semblance based on a master signifier. Rather than relying on the dynamics of the shared psychical functions such as identifications, libidinal pacts and ideals, my analysis is framed strictly in the structure of the language used, and thus looks for the signifier that supports the exchanges. In my psycho-geographical approach to VCH I consider the institution as the site *par excellence* where social discourses and relations repeat, materialize and become embodied through language in an *extimate* space. My research aspires to bring about difference into the institution by highlighting the various voices within it, focusing on a logic of the negative, by which I mean concentrating on what deconstructs the narcissistic ideal of the institution.

1.3.4. Two bodies

Another conceptual axis refers to two bodies—the subject’s body of jouissance and the social body politic— discussed in Chapter 6. The first refers to the private scale of the individual, whose flesh is embodied by language from the moment they enter the symbolic order and as a result generates the phenomenon of jouissance. In the body of jouissance the subject is caught by certain enjoyment whose excess leads to compulsive repetition, which constitutes a constant hurdle for the subject to emerge.

The second body is of social scale and refers to the body politic, a public collective body that sustains socio-spatial practices. Distinct from the Hobbesian metaphor of the state that necessitates an external authority as head, I refer to the body politic as constituted by the sum of one plus one, is the collectivization of desires, enjoyment and suffering, as well as flesh and language gripped by fantasy. The body politic has all possibilities for political action if it finds a way to act with the problem of the drive, mobilizing its know-how to gain power. I understand power as gaining representation by collectively generating an embodied new master signifier, liberating

the enjoyment trapped in the imposed master signifiers, as much as traversing the ideological grip of fantasy and accepting the loss of surplus jouissance (cf. 4.3.2 and 7.6.3).

1.4. Summary of results

The results of this research show that the prevailing discursive relations at VCH are structured by the master signifier of mental health evidence-based practices (MHEBP), which participates in spherical thinking; that is to say, tautological thought that disavows the unknown or the intangible. This discourse corresponds to Lacan's university discourse, which I call the 'know-it-all' discourse because it renders mental issues as transparent to consciousness, as calculated and solvable, promoting solutions through the deployment of techniques that erase the subject. A disclaimer is necessary: I believe in scientific reason and my research utilizes social science methodologies, systematic rational thought and psychoanalytic rigour. The totalizing claims of knowledge, found for example in verisimilitude or logical positivism assertions are characteristic of what Lacan called the university discourse and goes against fundamentals of scientific thought, such as scepticism, fallibility and movement and replacement of truth-claims (Preston, 2008). Given my trust in science and reliance on scientific approaches, I recognise the vital need for evidence-based research in the clinical practice of medicine, which, for example, during the crisis of Covid19 has been key in the development of preventive measures against the spread of the infection and in the development of vaccinations. In contrast, MHEBP obscure the conflictual nature of the human speaking subject—which is the supposed *object* of mental health study—resulting in an act of hegemonic fetishism, based on fantasy, that disavows the complexity of traumatic suffering and, simultaneously, tries to cover the anxiety caused by a lack of know-how in dealing with the roots of such difficulties. By relying only on the easiest and the narrowest interpretation of what constitutes MHEBP, biomedical and cognitive-behavioral discourses dominate the therapeutic landscape, which reflects the proliferation of manualized therapies, focused on measurement, rigidity of protocols, and uncritical psychoeducation. Moreover, by over-relying on the so-called MHEBP, the institution reduces costs in its response to the overwhelming demand for mental health services.

The managerial model of business enterprise has been shaping many institutions for the past 50 years (the university, schools, judicial systems) and the mental health institution is not an exception (Morrow, 2007; Barnett & Barnett, 2009; Masuda & Chan, 2016). Most services within the mental health institution(s) are psychiatric-based — medication and case management— and therapies are mainly short-term, addressing strategies for coping with affect rather than with processing histories, identities, or meaning. Some scholars who have studied this problem explore the burgeoning of the psycho pharmacological business (Morrow, 2007, p. 72) and China Mills has called this global tendency the “McDonaldization of people’s health” (2014, p. 42). The same recipe of services for all provides a slim possibility for historical redemption and exerts domination because it impacts people’s well-being. Mental health service homogenization also prevents the incorporation of the ‘case-by-case’ golden rule of singularity that any psychotherapist in good standing is required to observe as an ethical imperative that honors the complexity of the human subject. Hence, in my research I criticize the pervasive alienating effects of relying *only* on hegemonic forms of trauma discourse, rather than incorporating other discourses that contribute to a more sophisticated, realistic, and rigorous model that embraces diverse epistemologies, aids healing and facilitates social bonding.

1.5. Dissertation objectives

This research proposes a model to critically approach VCH with the purpose of understanding its symbolic and real structure, which is created by discursive relations based on linguistic exchanges among those who work or receive services in the institution. The distinct nature of the paradigms involved in my research help me to organize the following objectives: From the mental health perspective, the first objective of my research is to provide an in-depth understanding of the interpretive frames that shape how analysands experience trauma-specific services and how practitioners actualize trauma recovery. The second objective aims at enhancing and complementing the services already provided at VCH and informing policy strategies to improve service provision to those suffering the sequelae of traumatic experiences.

Based on psychogeography, my objectives are of larger scope. By engaging with the field, the third objective of my research is to clarify how the understandings of trauma and healing at VCH structure the social links of those who seek and those who provide

services for mental health and substance use. My fourth objective is to elucidate, through topological notions, the interstitial spaces in which subjects become entwined with others in language, via the unconscious, to understand how institutional practices shape certain subjectivities and exclude others.

Finally, from the perspective of clinical psychoanalysis, the fifth objective of my research is to contextualize the urgent and complex clinical challenges that pertain to the imaginary, symbolic, and real aspects of traumatic suffering with the purpose of rendering a more nuanced conceptualization of somatic and psychical suffering of those who seek mental health services in a public institution. By design, my research does not provide a *road map* to the specific implementation of practical measures to solve the complexity of trauma healing because I believe that those solutions should be developed by the body politic according to the singular needs of each specific program, drawn from collective knowledge of the practice, and informed by critical reason.

1.6. Contextual background

The empirical research was conducted at five sites in VCH, one of Canada's largest health care providers, serving a highly diverse population in the province of British Columbia (BC). VCH has a geographic catchment of urban, rural, and remote areas including Vancouver, the North Shore, Coastal Garibaldi, and Richmond, and my research focuses on Vancouver only. VCH provides services that range from acute (urgent care), primary (education and prevention at home, the clinic, or the hospital), to care of secondary and tertiary nature (specialized services), and is the main centre for clinical services, research, and teaching in BC, serving over 1.25 million people or nearly 25% of the province's population. With about 14,000 employees, spread across 86 disciplines and 112 locations, VCH is the primary provider of MHSU services, alongside the Ministry of Health, the Ministry of Mental Health and Addictions, and the Ministry of Children and Family Development.

British Columbia constitutes the third province, after the Northwest Territories and Newfoundland and Labrador, that on average spends the most per capita on community mental health and addictions (MHA) care (2017-2018), incurring an expenditure of \$146 per Canadian (CIHI 2019a, p. 18). This is a result of the challenges faced by the province, such as suicide, substance use (including alcohol and tobacco), and the epidemic crisis

of opioid-related deaths associated with the dangerous effects of opioid fentanyl (detailed in Chapter 3). In the report of 2019, BC has had a 35% increase per capita in MHA in the past two years, versus 24% of total public—sector health expenditure, spending about \$6,548 per person and forecasting a 3.4% increase in the next two years (CIHI, 2019a, p.15). However, although funding to mental health is improving, it still constitutes a very small proportion of the overall health budget. With mental health services now a provincial priority, the Ministry of Mental Health and Addictions, created in 2017, released a report in June 2019 titled *A Pathway to Hope*, outlining an ambitious 10-year vision to transform the mental health and substance abuse care system. As I conducted this research, a large institutional consultation about MHA services was underway.

I began this research project in September 2015, when I started a PhD program in the Department of Geography at Simon Fraser University (SFU). By then, I had been working for VCH for 11 years and was motivated to articulate some of my work experiences, and while conducting this research, I continued working part-time for VCH for three more years. My experience as a VCH clinician started as an outreach mental health worker in the Downtown Eastside (DTES) at the Act Bridging Program, which served hard-to-engage people with persistent mental health illnesses. After a year on the job, I found another opportunity within VCH that better fit my professional background and my interests; then, in 2005 I started working for SAFER (Suicide Assessment Follow-up, Education and Research), a counselling agency that serves people affected by the act of suicide. Within this population, the term “trauma” was often conjured up by analysts and service providers, specifically regarding physical and emotional sequelae, such as flooding of traumatic images, unbearable anxiety, inability to function, etc., in people who survived a suicide attempt or those who experienced the loss of a loved one to suicide.

For a decade at SAFER, I practiced one-to-one and some group psychotherapy within a team of about 10 counsellors, one manager, and 2 administrative personnel. This was a cohesive and supportive team; our practice was conducted in individualized offices, which reflected the personality and style of each therapist. Therapists had different therapeutic approaches, such as psychodynamic, art therapy, gestalt, or narrative, and most were familiar with CBT as well. This diversity of therapeutic approaches was indeed a strength of the team because we relied on one another’s approaches to think together about the clinical challenges we faced. As a therapist, I felt

connected to the team and felt that my approach was respected and, for me, this decade was a time of deep personal and professional growth. We had daily intake meetings, biweekly team supervision, professional developmental days, and each team member's milestones were acknowledged with a card, a cake, a delicious potluck, or flowers (i.e., for weddings, new babies, new citizenships, losing a loved one, etc.). We had heated discussions and sometimes bickering, tears, and laughs, and a sense of freedom to disagree and demonstrate our thoughts and emotions at our own levels of comfort. The agreements and disagreements were negotiated in a relational way based on a trusted relation created over time among the members of the team.

Things started to change in 2012 when the team moved to a new office model of desk rotation and open-plan generic offices, a global organizational tendency to reduce economic costs and increase the casualization of work (Voordt, 2004). This spatial transition, which I describe in Chapter 3, was a significant loss for the team, and it slowly started to be reflected in practices. As mandates started to shrink slowly, SAFER became less accessible to certain populations. Also, clinical decisions about how to best intervene with the population we attended, which was practice-based and collectively consulted, discussed, and decided, was no longer in the hands of the team, as therapeutic decisions became centralized. We were mandated to be trained in Dialectical Behavioural Therapy (DBT) which, alongside Cognitive-Behavioral Therapy (CBT), gained full domination. The mandated protocols and requirements increasingly came from outside the team and were pushed first on leadership, then on clinicians; yet the team somehow maintained its cohesiveness. I was on educational leave for two years for my PhD program when the team moved to Vancouver General Hospital (VGH) Outpatient Services in 2016, and it was in this transition that all the richness of the various therapeutic perspectives was fully lost, as well as the cohesiveness of the team. Various seasoned therapists left the organization as the hegemony of CBT was pushed with consensual coercion (Gramsci in Glassman, 2009, p. 81), and the team of 13 became a team of 50 or more people, albeit adding interdisciplinary richness, since the new team was formed not only by counsellors, but by nurses, occupational therapists, psychiatrists, and psychologists.

When I came back to work at SAFER at VGH after my educational leave, it was an altogether different environment and space. While everybody seemed truly engaged in their jobs, professional and collegial, there was no longer the connection and clinical

freedom I had experienced before. Most decisions did not arise out of consultation with other team members horizontally but, rather, were decided from the top down. CBT and DBT were the only modalities deemed worthy of employing. Other therapeutic modalities were dismissed and, increasingly, “evidence based” mental health approaches were privileged within the team, as never before. While I understand the crucial importance of evidence-based approaches in medicine, what I was seeing in mental health was a form of treatment impoverishment, as well as a lack of critical intellectual engagements. I noticed a diminution of trust in the team: if, in the past, people would have brought their frustrations to public discussion, now there was *something* preventing us from speaking up; the system and the resultant social bonding had fully changed. The workload was as heavy as it always had been, and people appeared very busy and a bit avoidant because there was little space for personal connections or conversations. It occurred to me that we were experiencing a form of *robotization* in the work environment. Despite having best friends on the team and a good relationship with the team manager and other colleagues, I felt I was losing something of my humanity there. I no longer felt as a subject with opinions and affects, but as someone of whom only full compliance was required. Being usually confident in voicing my thoughts and concerns, I found myself unable to come up with words that represented what I wanted to say, and I experienced those moments with a slight sense of paranoia because I felt I was a dissident to an apparent consensus. Various seasoned therapists complained about the rigidity of these new spaces, and some indeed left. Yet while I conducted empirical fieldwork, I realized that other teams have preserved that “homey” sense of belonging, preserving the relationality that I once had experienced.

The above are personal subjective experiences, and in my dissertation subjectivity has a role as a research method, as I will discuss below, because these experiences also provide my positionality within the context of my research project. Rather than focusing on my experience or my colleagues’ frustration or satisfaction, I am interested in connecting the ways in which institutional changes, experienced over time, affect the responses given to those burdened with traumatic sequelae. Hence, from the beginning of my project I was concerned with the services VCH provides to survivors of trauma. It is important to mention that while conducting the research, I was myself traversed by the same discourses I mapped and thus I have participated, perhaps reluctantly, perhaps with no awareness, in the things that I critique here because

discourse, as I demonstrate in this dissertation, is not about *an individual choice*. It is rather about the hegemonic framework within the institution that demands that people occupy certain linguistic positions to secure the preservation of the master signifier that structures such institutional discourse.

Due to the above context, I sought to understand how the leadership, clinicians, and analysands, conceived of trauma and healing. The explicit intention was to provide an informed critique to change policy and to propose guiding questions to rethink practices that allow subjects to feel more human and listened to, as well as to create teams that allow workers to feel truly connected to their communities. My desire to impact a system, however, would be considered a failure if it only stayed on paper because institutional practices do not depend exclusively on research knowledge but on the decision of the members of the body politic to act on it.

1.7. Research questions

A traumatic event is highly individualized and it can range in scale, settings and distribution (i.e. from physical or sexual abuse, to neglect, illness, combat experience or political persecution). Therefore, I believe that qualitative interdisciplinary research is indispensable to inform mental health policy to optimize the effectiveness of the services VCH provides for the healing of the pervasive and complex effects of trauma. Human geography provides a strong theoretical framework to understand, in a detailed way, the factual interactions between the levels of service provision (service users, practitioners, managers) within the institution. My approach considers that trauma and recovery is “an experiential and analytic construct” (Moon, 2009), not simply located ‘inside’ an individual’s head, but rather materially externalized in lived socio-spatial relations and practices (Kingsbury, 2007; Pile, 2014) that depend on the understandings that users and providers hold and share through language. Clinical psychoanalysis, on its part, allows an approach to understand what is at stake in trauma and healing, hence my interest in conducting a critical study of qualitative and descriptive nature. The following questions guided my research:

- 1) How do various discursive spaces comprised of analysands, mental health clinicians, and leadership understand trauma and facilitate healing?

- 2) How do practitioners conceptualize trauma and facilitate recovery/healing practices? How do we listen to, and intervene, to ameliorate the somatic and psychical suffering of fellow humans who seek mental health services in a public institution?
- 3) What are the divergences and intersections of these understandings and facilitations between and within these levels of service provision: analysands, mental health clinicians, and leadership?
- 4) What are the challenges and opportunities these understandings and facilitations present in trauma recovery practices within VCH?
- 5) If trauma is that which falls outside of language, if the unspeakable of trauma embodies the experience of the subject and stays in their body for whichever logical time is necessary to find a know-how to purge it, how do we intervene to stop compulsive repetition?
- 6) How do we think about the interactions of the subject in relation to the social context, and conversely how the social plays a role in the subject's experience of trauma?

1.8. Research design

To better understand the social links created around trauma-specific services at VCH, I designed a qualitative study that included the various levels of service provision, as has been done for studies on trauma-informed care (TIP) (Farro et. al., 2011; Mills, May 2015; Bassuk 2017). I examine five sites within VCH to assess the understandings and lived realities of users and providers involved in trauma-specific services. In this tiered research design, I conducted 20 semi-structured interviews with 7 clients, 9 clinicians, and 4 participants in leadership at their respective sites. I also conducted one focus group with clinicians. Table 1.1 summarizes the distribution of the 25 study participants by site and category for the semi-structured interviews and focus groups.

Before discussing the research design, I want to reflect on how I chose to refer to the service users who participated in this research. "Patient" as a term has a problematic baggage as it renders a passive person submitted to the biomedical authority, so I will avoid its use in my research. Other terms have emerged over time, coming from the fields of social justice and transformative politics, which Moon (2009) renders in this way: "healthcare as consumption and patients as consumers" (p. 40). Although I respect the struggles and achievements of those traditions, I do not want to name my participants in

this research as “clients” or “consumers” because these terms are already embedded in the mercantilist language of the neoliberal model that I precisely criticize in my research, for such socioeconomic model has brought about *subjective precarization* to global mental health services. The terms “consumer” and “client” emphasise *consumption* under a system that reproduces an inherent financial transaction for the value received. Although the health dollar is a reality and political economy constitutes, furthermore, the structure in which we live in, I want to name the service users of this research as *analysands*, for this term reflects better the position I aspire for them to occupy in my research. Analysand is the term used in psychoanalysis to refer to the person who speaks in analysis, an active position whose knowledge is the very focus of the treatment (as opposed to the supposed knowledge of the analyst). The service users in my research are *analysands* because they are not buying a service or consuming anything while we sat together in the brief time of my research’s interviews, but rather they are subjects actively responding my questions with an impetus to understand their position in their healing journey.

Table 1.1. Participants by site and category.

Participant Category	Mental Health & Substance Use Outpatient Services	Kitsilano and South Mental Health Teams	Aboriginal Wellness Program	Three Bridges Substance Use Services	Total
Individual Interviews					
Analysand	2	4	0	1	7
Clinician	1	2	1	1	5
Clinical Supervisor Leadership	1	1	1	1	4
Manager Leadership	1	1	1	1	4
Focus Groups					
Clinicians in Focus Group	2	1	1	1	5
Total	7	9	4	5	25

The number of participants was justified by the time-intensive nature of the methods of analysis (Dittmer, 2010), which I described below. Operational requirements at VCH allowed a year for the fieldwork to be completed, consequently, the size of the study and the time to complete the interviews were planned according to a reasonable amount of work for a single researcher to collect and analyze the data. The included sites were accessed through the initial responses from managers who expressed interest by answering my invitation to participate and granted access to their teams. The focus group was not only convenient regarding time but was essentially connected to the research questions of the present study, as this qualitative research method is a “strategic approach to exploring the dynamics of social discourse and social practice in relation to the construction of collective meaning” (Bosco & Herman, 2010). I did not conduct a focus group with analysands due to risks that were posed by the Ethics

Review Committee, such as potentially triggering distress, emotional reactions, or in extreme cases, activation of pre-existent post-traumatic stress disorder (PTSD).

Throughout my dissertation, I will use the following notations when quoting participants: To refer to service users, known in my research as analysands, I use the letters AI followed by the number of participant (e.g., AI1); clinicians are designated with the letters CI, followed by a number (e.g., CI1); and participants from leadership are noted as Ld, followed by a number (e.g., Ld1).

1.8.1. Recruitment

Managers in positions of leadership were first approached through an e-mail introduction by the operational manager of Mental Health and Substance Use Outpatient Services (MHSUOS) where I was working part-time at the time of recruitment. When a manager expressed interest in the study, they were contacted by phone to schedule a semi-structured interview, which was later conducted at the manager's work site. The recruitment of clinicians occurred by sending an invitation with the study description to those sites in which a manager had already consented to participate. Those clinicians who couldn't be included in individual interviews, due to the size of the study design, were invited to participate in the focus group. The individual semi-structured interviews were conducted at the practitioner's work site and the focus group was held at the MHSUOS, at Vancouver General Hospital (VGH).

Analysands were recruited through a poster (Appendix E) placed in the waiting areas of the participant sites, and after screening for criteria inclusion and competency, I arranged appointments to conduct semi-structured interviews at the sites where they received services.

1.8.2. Inclusion criteria

Adult analysands: Mental health service users between the ages of 19 and 90 who self-identified as having experienced some trauma in their lives, and who had received services for more than three months at any of the participant sites. The three month-span was chosen to grant a minimum engagement at a given team, necessary to exploring how clients understood trauma and recovery while receiving treatment at VCH.

Competency was defined as the absence of demonstrated visible emotional distress or noticeable thought disorder at the time of the first screening phone call.

Clinicians: For both the semi-structured interviews and the focus groups, practitioners (psychiatrists, counsellors, social workers, or nurses) working at the participant VCH sites who were interested in participating in this study.

Leadership: Operational managers and clinical supervisors overseeing the intended programs in which clients and practitioners interact.

Data recording, confidentiality, storage and security

After being given informed written consent, I conducted and recorded the interviews with participants on an encrypted digital recorder, with storage in hard copies and on a memory stick, both kept in a locked filing cabinet at my residence. Literal quotes of clients are presented with pseudonyms on few occasions and with no contextual content to avoid identification by anyone other than the participant and myself (who conducted the interview). For focus group and individual interviews with managers and clinicians, literal quotations were preserved without any identity mark (name or team). All data was collected in 2019 and when I produced my report for the Team Grant the quotations used were sent to each participant in an individual e-mail and none of the participants responded with any concern. I tried to maintain participants' confidentiality by not identifying any of the teams from which the quotations emanated, yet, as the focus group had five participants and overall, there was a reduced number of participants, I explained in the consent form that confidentiality could not be fully maintained. For the AWP, and according to community consultation and First Nations' OCAP (ownership, control, access, and possession), the report of my results involving the Indigenous community (cf. 6.5, and 6.6) was distributed prior to wider publication.

1.8.3. Study procedures

The questions that guided the semi-structured interviews (Appendix No. 1, No. 2, and No. 3) were informed by my clinical experience, the units of analysis draw from my use of Lacanian Discourse Analysis, and some questions were inspired by the consumer's perception of care utilized by Clark et al., 2007 (in Farro, 2011). The focus group questions were informed by the themes surfacing in the individual interviews with

practitioners. As a token of appreciation for participation, I gave each participant a 10-dollar gift card for a coffee shop in Vancouver.

1.9. Methods and methodology

The methods employed in this qualitative research were the following: participant observation, focus groups, and Lacanian Discourse Analysis (LDA). Throughout the course of the research, autoethnography, a research strategy geared to understanding how experience is created, presented as the most suitable method for approaching my experiences with one of the sites, the Aboriginal Wellness Program, which is detailed in Chapter 6. All these research methods are of qualitative nature, which Malterud (2001) describes as:

Qualitative research methods involve the systematic collection, organization, and interpretation of textual material derived from talk or observation. It is used in the exploration of meanings of social phenomena as experienced by individuals themselves, in their natural context (p. 483)

What sort of systematization, organization, and interpretation is relevant when we are trying to approach the unconscious? One first aspect refers to *immanent criticism*, which Theodor W. Adorno takes from G.W.F. Hegel and Karl Marx and opposes to transcendental criticism. According to Adorno, “[t]he procedure is immanent, because it takes the objective idea of a work, whether it is sociological, musical or literary, and ‘confronts it with the norms which it has crystallized itself’” (Finlayson, 2015, p. 1154). Therefore, immanent critique involves engaging with refutation and argumentation from the very source in which the studied phenomenon emerged. For example, counting oneself as researcher in the contradictions that the object of research presents, or examining what an institution says and do not say in contrast with what is or not done.

Another qualitative method of psychoanalytic nature is *positionality*, as Parker states, “every claim to objective truth is also simultaneously the reflection of the historically-embedded subjective position of the researcher in what they are studying” (Parker, 2005b, 27). Donna Haraway states that feminist critical knowledge is always situated and embodied, and stands against “irresponsible knowledge,” which means that it is “unable to be called into account” (1988, p. 583). My research participates in that spirit, as much as in Haraway’s statement that “[s]ituated knowledges are about communities, not about isolated individuals” (p. 590). Yet, as Jesse Proudfoot

emphasizes, the importance of the researcher's positionality and the various identity marks she carries (race, nationality, sexuality, gender) in psychoanalytic geographic research goes beyond those consciously identifiable marks because the "split subject of the unconscious that is defined by its unknowability—by the persistence of an unsymbolizable 'kernel'" (2015, p.3), can neither be contained in identity nor render a full picture on reflexivity. My research looks beyond those identity claims and embraces the emergent *split* of the subject, a notion altogether different from the individual's ego (cf. 4.4.2) and hence I look for unconscious marks, particularly as embodied signifiers.

My conscious positionality refers to my being a cisgender woman and a non-white settler, located between the inside and the outside of the institution, as I am a trained Lacanian psychoanalyst, a PhD graduate student, and, at the time of the empirical fieldwork, also employed by VCH as therapist. But in my research, I also count myself as a subject of the unconscious through my research methods of participant observation and autoethnography because I also give consideration to that which exceeds conscious meaning or sense.

Four forms of reflexivity are discussed by Parker (2005b): confessions, positionality, theorizing, and crafting, and each can be observed in my research. Regarding confessions, my autoethnographic account with the AWP is presented in Chapter 6. My positionality is accounted above, but it is also a contributing factor in my analysis of various participants' positionalities regarding discourse (Chapter 4). Theorizing is present throughout my dissertation and is based on Freudian-Lacanian psychoanalysis. The final form of reflexivity, crafting, is best observed in Chapter 2, as per the way I curated the critical review of the literatures about trauma and healing. These various forms of positionality then account for my inherent bias: *I am not a neutral observer* because my bias is theoretically shaped by psychoanalysis and by my 14 years of experience at the institution of my study. My bias is also political, for I am interested in affecting mental health policy in as much as impacting the democratization of the processes that facilitate rigorous interdisciplinary and community-based mental health service design.

1.9.1. Focus group

The research modality of focus group was chosen because I wanted to listen to the interactions of various participants. Bosco and Herman indicate that focus groups constitute a “socially embedded form of research,” which offers a certain “transparency to the process of knowledge production” (2010, p. 3). According to Bosco and Herman, the focus group is also a hybrid research approach that allows the blurring of the rigid separation between data collectors and participants. Knowledge is being created in the conversations taking place in the focus group and then constitutes a form of “*doing* research and *being* in the research” (p. 4). The focus group produced a great deal of insights and conversations that were absent in the recent years of my institutional experience, and I observed that I was at ease while having important critical conversations with focus group participants.

1.9.2. Autoethnography

Ethnography in geography, according to Watson & Till, is “an intersubjective form of qualitative research through which the relationships of researcher and researched, insider and outsider, self and other, body and environment, and field and home are negotiated” (2015, p. 2). Autoethnography is a variation of the ethnographic method in which the subject counts themselves within the research process as part of the object of the study and, according to Dickson & Holland, it “emerged in the wake of the response from the social sciences and humanities to the inadequacies of the scientific method’s attempts to represent human subjectivity” (2017, p. 135). Although any psychoanalytic engagement could be considered autoethnographic in principle because the emergences of the unconscious —dreams, slips of the tongue, parapraxes— would nourish the research process, I had not specified it as a method at the beginning of the research project. Yet, in my research relations with the AWP community, autoethnography became the most suitable method. My interactions with this team, articulated in detail in Chapter 6, comprise some of the most significant results of this research, as they provided me with an opportunity for an understanding and an embodied articulation of the phenomenon of trauma as an effect of state-sanctioned violence (cf. 6. 6). Throughout this research, I worked within the institution along the path of least resistance, not opposing the system but “adapting” to it, responding in the most truthful way, letting my first reaction guide me to respond. I was traversed by the

experiences of this research, and I noted the effects in my thoughts and reflections. When needed, throughout my dissertation I will cite my research notes followed by the date of the entry to indicate any pertinent observation.

1.9.3. Lacanian Discourse Analysis

Lacanian Discourse Analysis (LDA) is based on the pioneering work of Ian Parker (2005) and David Pavon-Cuellar (2010), two critical psychologists of significant influence in the field of discursive analysis, who describe this method as:

[a] heterogeneous and transdisciplinary constellation of more-or-less explicit, systematised methodological conceptions, practical executions and theoretical suppositions, whose only common denominator is the analytical study of the discursive manifestations of language. (Parker & Pavon-Cuellar, 2014, p. 2)

LDA has gained solid status as a qualitative methodology in the field of discourse study in social sciences, psychology, psychoanalysis, political science, psychiatry, pedagogy, and philosophy. Parker and Pavon-Cuellar (2014) state that LDA is born from the epistemological perspectives of both Freudian psychoanalysis and continental structuralism, and that it shares insights found in other discourse analyses, in which Lacan had influence in one way or another, such as: a) Foucault's archeological analysis of historical discursive practices of power; b) Althusser's structural analysis of the materiality of ideology and the interpellation of subjects; c) the Marxist historical approach of Jameson's literary criticism; d) Derrida's deconstruction of differences and inconsistencies; e) discourse analysis by Laclau and Mouffe, which accounts for the discursive political and social construction of institutions; and f) critical discourse analysis by Fairclough, which looks at the reproduction of power relations (p. 3). The most significant difference between LDA and the above-mentioned discourse analysis methodologies is the effective focus on Lacanian theory and thus on the unconscious.

The LDA methodology does not have a formula; rather, it is based on Lacan's theory of language, and hence the analysis focuses on separating the symbolic from the imaginary, the subject of the enunciation from the subject of the statement (cf. 4.4.2) and retains the signifier instead of the signified content. The LDA method allows for the location of master signifiers, attending to the negative and non-sensical, but considers its own limits in three accounts: there is no metalanguage —so we can't explain language

outside language —; our own subjectivity is involved when allotting meaning; and renounces a totalizing knowledge, as “knowledge is neither finite nor permanent. In any field there has always been more to know” (Neil, 2013, p. 338).

One of the latest developments in relation to LDA is a volume edited by Parker and Pavon-Cuellar (2014) that ranges from the discourse analysis of films and literary works to politics in diverse regions of the world, and which concentrates on the concept of event—an emergence of language—to signal the unforeseen, unforeseeable, or inexplicable that appears as a veiled possibility in discourse (cf. 4.3.2 and 7.6). The purpose of LDA, Parker and Pavon-Cuellar claim, is not to integrate the event within the discursive structure. Instead of reducing the event to the structure by merely assigning a diagnostic value that could neutralize its potential, the authors propose that the event is something that occurs simultaneously in the very pronunciation of language (p. 7). The purpose of the LDA, as it happens in the clinic with an appropriate intervention, is to apprehend its singularity through the revalorization of various aspects such as truth, critique, act, or the symptom, as well as acquiring distinctive values.

The way I approach LDA in my research is by incorporating the elements of Lacan’s theory of discourse and organizing the elements in eight units of analysis. The theory of discourse is detailed in section 4.2 and: the *terms* or discursive spaces at play are S1 (master signifier), S2 (knowledge), \$ (subject of the unconscious) and object petit a (place of residue). The *positions* or discursive places in Lacanian theory correspond to the following: truth as cause, agent or semblance, the Other or place of jouissance, and production or surplus jouissance. Based on these eight units of analysis, I organize the questions of the semi-structured interviews, as well as categorize the answers as follows.

Core signification of trauma (S1 master signifier): Refers to the fundamental belief regarding what constitutes trauma and healing, which appears as apodictic—not requiring explanation—and is the condition for all further significations.

Knowledge (S2): Refers to the epistemological aspects that are deemed valuable in the ongoing practices of defining, speaking, listening, writing, and reading about trauma and recovery.

Otherness (the position of that to whom one addresses in a linguistic exchange): The suppositions that participants hold about the individuals they work with in the practice of attending to trauma and recovery.

Agency (\$): The empowered sense of self in the world. The factors conceived of as empowering the individual recovering from traumatic experiences.

Semblance: The position one is summoned to occupy within a particular linguistic exchange

Articulated Truth: The causal belief of trauma and healing and what is considered accurate, certain, and realistic in the recovery from trauma.

The traumatic object: That which is excluded from speech, that produces suffering and that appears as structuring everything else around.

Expected outcome: The particular production expected in a particular form of social bonding.

1.10. Outline of dissertation

This dissertation consists of seven chapters and a conclusion.

The first chapter serves as an introduction to the project, presenting objectives, questions, and methods that are engaged.

In Chapter 2, I present a review of the epistemic and critical notions that I employ in my research study. I am aware of what Sayigh (2013) states regarding the inherent bias in selecting discourses on suffering as a “a matter of the personal outlook and biases of scholars, editors and publishers within the genre.” (p. 52). While two vast fields are well-known in trauma studies: the clinical and the sociocultural, in my critical literature review I selected mainly discourses of the “psyche” because my objective is to articulate a critique of discourses that address trauma in the various sites of my research. First, I address the field of Freudian-Lacanian psychoanalysis in its conceptualization of trauma, followed by a discussion of the predominant discourses found within the sites of my research, such as biomedical psychiatry, the neurosciences, and cognitive behaviorism. I then proceed to discuss how psychoanalytic geographies,

which theoretically and methodologically inform my study, contribute to the study of trauma.

In Chapter 3, I present the institutional context in which the studied sites are situated. I first discuss the socioeconomic, political, and historical contexts of VCH, establishing a scalar analysis of Canada, the province of British Columbia, and the Lower Mainland which is the region where Vancouver is located. Secondly, I present some historical background of the mental health and addictions (MHA) services within VCH, followed by a thorough description of current MHA practices and treatments. To conclude, I explore the therapeutic landscapes and trauma-specific services (TSS) at the participant sites at VCH.

Chapter 4 proposes a conceptual model for understanding social bonding within the space of an institution by discussing the places assigned to individuals within discourse. I first explain Lacan's theory of discourse, which enables an analysis of the institutional linguistic exchanges. After presenting the main tenets of Lacan's theory, I review previous research conducted through Lacan's theory of discourse to contextualize the singular way I deploy this theory in the study of institutional discursive spaces. Second, using various empirical examples, I demonstrate how the structure of discourse is embodied in participants, that is to say, how participants come to occupy certain structural positions, such as knowledge, truth, or the place of residue, and how those positions are organized in two axes: one of representation and one of production. I claim that the master signifier "mental health evidence-based practices" (MHEBP), as it appears in institutional policies, manuals, and interviews, organizes the social links of mental health (MH) services at VCH. This master signifier corresponds to Lacan's university discourse, which I introduce here as a know-it-all discourse, which affects the socio-spatial exchanges among the various participants. But I also explore the relation of the discourse of the know-it-all to other discursive forms, such as the discourse of protest (Lacan's hysteric discourse) and the capitalist discourse.

In Chapter 5, I approach the institutional unconscious as both a linguistic structure and an abstract topological space of *extimate* nature. This space is an entwinement between the exterior and interior that combines the enjoying body of the subject and the body politic of society, both marked and created in language. I propose a journey that goes from the topology of the subject (Euler circles, torus, Moebius band) to

the topology of the institution (crosscap). I conclude this chapter by suggesting that the institutional unconscious at VCH, whose master signifier is mental health evidenced-base practices, works as a fetishistic protection, based on fantasy, that constitutes a defense against understanding the complexity of the psychical and intersubjective entwinement of this phenomenon, and also this hegemonic fetishism serves to reduce costs within the institution.

In Chapter 6, I articulate different forms and presentations of trauma by firstly differentiating the scales of social and individual trauma, the private and the public, as well as the subject's body of jouissance and the collective body politic. Secondly, I conceptualize three forms of trauma: accidental, developmental, and state-sanctioned trauma, and I do so by reflecting on my fieldwork; yet most of the empirical emphasis in this chapter is on three autoethnographic accounts of my research experience with the community of the Aboriginal Wellness Program (AWP). Through the accidental nature of trauma, I reflect on fantasy and anxiety, while developmental trauma allows me to examine the transmission of intergenerational trauma through body and memory. I then proceed to discuss and analyze my autoethnographic experience with VCH's Indigenous community, posing questions about the place of shame, community, and silence. Finally, I conclude the chapter by discussing how individual and social symptoms of trauma might be perpetuated through discursive exchanges of victimhood and perpetration. I exemplify the discourse of trauma or victimhood as a positional inversion of the know-it-all discourse (discussed in Chapter 4). The discourse of perpetration is instantiated with Lacan's master's discourse, via a discussion of white settler colonialism as the master signifier whose effects have impacted the Indigenous peoples of Canada.

In Chapter 7, I reflect on the empirical results regarding participant understandings of healing. I present three lines of inquiry that are of vital importance when dealing with the notion of healing trauma, organized around the ternary of human experience: the Real, Imaginary, and Symbolic. The Real register affords me reflections on aspects pertaining to the symptom, jouissance and surplus jouissance as well as the real structure that presents certain socioeconomic and temporal conditions; the Imaginary register frames the approach to the body, pleasure and reality principle and the socio-spatial aspects of service provision; and with the Symbolic I situate the conditions for the temporal emergence of the subject. I conclude by describing the major logical tasks required to reshape the spaces of trauma with the hope of bending its

various discursive formations: inscription and re-inscription, and present Lacan's analyst discourse as what might facilitate a clinic of the social bonding.

In Chapter 8, my final conclusions, I claim that the ubiquity of trauma is due to the accelerated historical events of the present: while recovering from the effects of the Covid-19 pandemic, we face various deleterious effects caused by anthropogenic global climate change, where the risk of mass extinction and the rise of far-right governments are intrinsically related to the global socio-economic and political neoliberal model. These and other socio-economic conditions damage subjectivities and produce social symptoms. I reflect on the importance of mental health interventions that promote subjective emergence, engaging various epistemologies, as well as substantiate the need for psychoanalysis in the mental health institution to encourage critical and democratic approaches, and to create protective social bonding for shaping the destiny we are rapidly approaching as a collectivity.

Chapter 2.

A critical literature review on trauma and healing

Neither speculative philosophy, nor descriptive psychology, nor what is called experimental psychology (which is closely allied to the physiology of the sense-organs), as they are taught in the Universities, are in a position to tell you anything serviceable of the relation between body and mind or to provide you with the key to an understanding of possible disturbances of the mental functions.

Freud, 1915/1973, p. 20-21.

2.1. Introduction

The word trauma comes from the field of medicine: trauma designates an inflicted wound that can be evident or hidden, as well as its physical, psychological and social consequences. Its etymology is Greek, a derivative of τραῦμα (*trauma*) as well as τιτροσχω (*titrosko*) which means to pierce, denoting a shock that punctures a barrier, a wound of sorts that causes an effraction (Laplanche, 1973, p. 414; Malabou, 2012, p. 6). Generally speaking, trauma refers to the impacts of stimuli –external and internal– that can compromise an individual and/or social group’s ability to cope, generating powerlessness and the feeling of profound distress. Trauma affects many individuals and communities throughout the world on a daily basis. The World Health Organization (2013) estimates that approximately 3.6% of those who have experienced trauma will develop a posttraumatic stress disorder.

Trauma varies considerably in terms of its geographical scales, settings, and distributions. It can emanate from public and widespread phenomena such as war, famine, land dispossession, political persecution, or environmental degradation, and can emanate from private and localized psychical events triggered by the specific experience of the individual in their context. The signification of what constitutes something as traumatic is always singular and usually involves some aspect of perceived violence, threat or destruction, and is unassimilable by symbolic means. For example, the mental health patients in this research study associated the word trauma with a wide range of experiences, from psychosis, hospitalization, homelessness, drug use, developmental or sexual abuse, to death and sexuality.

Traumatic experiences surpass the symbolic capacity of the individual to make sense of horrific experiences and affects all areas of a person's life: their body, cognition, behavior, sense of identity, dignity, relationship to others and ability to connect socially (Herman, 2015; Van der Kolk, 2014; Fassin & Rechtman, 2009). Trauma is present in virtually every aspect of human knowledge as it refers to the unsayable of human experience, and as such, a large body of research on trauma exists in almost every field of the sciences, humanities and the arts (Bistoën, 2016; Herman, 2015). As a ubiquitous signifier, trauma can be approached through very distinct epistemological perspectives, each engendering specific practices and each focusing on different causes and effects. The signifier trauma has profoundly marked our zeitgeist and has organized a breadth of theories and practices that sustain diverse discourses—that is to say, linguistic relations—that elucidate what constitutes trauma and the search to find ways to heal it. Such “trauma talk” (Wright, 2021, p. 236) abounds because trauma discourses are one of the dominant modes of representing our relationships with the past (Fassin & Rechtman, 2009, p.15), the ethical stands of our epoch (Bistoën, 2016, p. 7) and constitutes a social link, a screen to protect us from the Real (Soler, 2004, p.18). Every type of trauma discourse has its own unique ways of representing and producing relations of exchange among those who experience trauma and those who, to ameliorate suffering, respond to it. The concepts to understand trauma have evolved over time as a result of their particular context (Fassin & Rechtman, 2009; Bistoën, 2015). These transformations depend on the way concrete actors historically involved in traumatic experiences (soldiers, hysterics, workers, accident victims, survivors of domestic and sexual violence, etc.) interacted with a larger social milieu. Prevailing discursive relations about trauma, at any given time, not only shape therapeutic practices but also cause forms of social bonding and subjectivity (Bistoën, 2015; Fassin & Rechtman, 2009; Wright, 2021).

In this chapter, I present the epistemic and critical notions that sustain my research study. There are many perspectives in trauma studies, with two main fields that have been identified: the clinical and the sociocultural (Bistoën, 2016, p.vi). In this critical literature review, I engage mainly with discourses of the “psyche,” a term that originates from Greek ψυχή (*psykhē*) meaning 'soul' or 'butterfly,' which has been understood divergently throughout time and disciplines. First, I address the field of Freudian-Lacanian psychoanalysis in terms of its conceptualization of trauma, followed by a

discussion of the predominant discourses within the sites of this research, such as the fields of psychiatry, neurosciences and cognitive behaviorism. I then proceed to discuss how psychoanalytic geographies contribute to trauma discourses. Each of these approaches implicitly hold hermeneutic and heuristic articulations; on the one hand, there is an interpretation of causality and elemental suppositions of what constitutes trauma. On the other hand, there are pre-determined tactics to ameliorate human suffering caused by trauma. I will focus primarily on the Lacanian psychoanalytic approaches and biomedical and cognitive-behavioural approaches, in accordance with the research questions that this dissertation aims to respond to.

I conclude my critical literature review about trauma, with the following statement: Understanding the various ways in which the radical negativity of trauma has been studied at the individual and social scales, adumbrates the need to include various epistemological approaches that are currently absent in the regular functioning of VCH. This literature review seeks to actualize critical discussions among diverse disciplines and scales to organize ethical and effective interventions within the field of mental health institutions.

2.2. Trauma in psychoanalysis: structural and contingent traumas

The concept of trauma has been associated with psychoanalysis since its origins through the works of Jean-Martin Charcot, Pierre Janet and Sigmund Freud, who deployed the term trauma to explain the epidemic of hysteria at the end of the nineteenth century (Roudinesco, 2016, p. 64). The realm of hysteria, whose etymology is found in the Greek word *hystera*, or uterus, was a challenging condition that seemed prevalent in women who presented with diverse symptoms such as:

Neuralgias and anesthesia of very various kinds, many of which had persisted for years, contractures and paralyzes, hysterical attacks and epileptoid convulsions, which every observer regarded as true epilepsy, petit mal and disorders in the nature of tic, chronic vomiting and anorexia. (Freud, 1893a/1973, p. 4)

Charcot, a French psychiatrist who worked at the Salpêtrière and enjoyed a great deal of public attention, studied traumatic neurosis from the perspective of hysteria, which he called “the Great Neurosis” (Herman, 2015, p. 10-11). Alongside his pupils

Pierre Janet, William James and Sigmund Freud, Charcot contested the organically based etiology prevalent at that time and extended this diagnostic category to the male population suffering from posttraumatic stress, counterbalancing the hypothesis that people suffering from hysteria were malingerers. Charcot, however, was much more interested in establishing the diagnostic qualities of this disease and consolidating its study within the field proper to the neurological science, rather than focusing primarily on its psychic dimension (Herman, p. 11). It was Freud, in collaboration with Joseph Breuer, on one hand, and Pierre Janet, on the other, who introduced the psychic etiology of trauma. Janet, a known rival of Freud, introduced the idea that hysteria originates from psychic trauma in childhood and disputed Freud as the rightful creator of the method of using words to heal distress (Roudinesco, p. 66; Herman, p.12). Janet believed that a mechanical shock creates a psychic reaction that causes mental dissociation (Fassin & Rechtman, 2009, p. 31). Freud and Breuer, instead, were not concerned with finding an anatomical site for trauma but rather determined that sexuality lay at its core. In the words of Davoine and Gaudilleire (2004), the origin of psychoanalysis consisted of a shift of trauma etiology “from the lesion in the brain to the lesion in the Other” (p. 39).

Freud thought that psychic trauma was related to sexuality — to be understood here as the unsayable of the body — which is both a source of conflict and a source of repressive defence. Trauma for Freud is always defined in economic terms: “For the expression ‘traumatic’ has no other than an economic meaning,” (Freud, 1917/1973, p. 274-275), economic referring to the libidinal investment a subject of the psychical economy. The core of his first theory of trauma refers to the process in which an unusual amount of psychic excitation — either by accumulation of repeated events or by the occurrence of a single one — breaks the ability of the psychic apparatus to discharge the overwhelming excitations, leaving the person with a sense of helplessness. Freud explains the traumatic experience as one which “within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way, and this must result in permanent disturbances of the manner in which the energy operates” (Freud, 1917/1973, p. 275). In his earlier theories of trauma, Freud situates it within a system of consciousness-perception and a principle of constancy or homeostasis whose focus is the circulation of psychic and bodily energetic investments involved in tasks such as representation, affect and mnemonic traces. These fundamental notions of trauma will be discussed throughout this dissertation.

In his first topography of trauma, known as the conscious-preconscious-unconscious model, Freud establishes the notion of two events linked together: One event refers to an external stimulus (*Ereignis*) that sometimes is a cluster of events “instead of a single major trauma, we find a number of partial traumas forming a group of provoking causes” (Freud, 1893a/1973, p. 6). The external event is linked to another one constituted by the individual’s psychic experience (*Erlebnis*) (Laplanche & Pontalis, 1973, p. 414; Malabou, 2015, p.188; Žižek, 2009, p. 140). Freud initially believed that the external event (*Ereignis*) was always a form of seduction by an adult to which a child had to submit passively, and that psychic trauma occurred because of the individual’s inability to discharge through associative thought (words mainly) or a motor reaction (movement, physical shock, orgasm, etc.). Such overwhelming experience on the body and the psyche translates into an affective sense of powerlessness, or the Freudian *Hilflosigkeit* (Freud 1926/1973, p. 138). The term *Hilflosigkeit* refers to helplessness, an initial affect associated with absolute dependence of a baby on the caregiver, because of the so called “prematurity at birth,” which requires others to satisfy the baby’s basic needs to survive. The caregiver, a primordial Other, is often “incapable of carrying out the specific action necessary to put an end to internal tension” (Laplanche & Pontalis, p. 175), causing in the baby a state of utmost dependence and abandonment which, for Freud, is a paradigm of the traumatic situation (Freud, 1926/1973, p. 167; Soler, 2004, p. 50).

2.2.1. Debate on seduction theory and hysteria

In addition to the economic aspect of trauma, Freud’s first theory asserted the primordial role of sexuality in hysteria: “At the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood” (Freud, 1896/1973, p. 204). As alluded to above, Freud’s initial elaboration, also known as the “seduction theory,” was the first attempt to understand the process of repression (Laplanche & Pontalis, 1973, p. 350) and constitutes the main controversy at the heart of the relationship between psychoanalysis and trauma. A year later, riddled with doubts, Freud rejected this theory in a letter to Wilhelm Fliess, writing: “I no longer believe in my *neurotica*” (1897/1954, p. 215). Some claim that Freud might have rejected the seduction theory to cover the perverse bourgeois incestual milieu of his time, in a conformist cowardly denial of an endemic

nature of “perverted acts against children” in the Vienna of his time (Herman, 2015, p. 14; Mason, 1983, p. xxi). Freud gave Fliess the following reasons for his disavowal of sexual abuse as the underlying cause of hysteria: 1) the lack of treatment success after an apparent initial partial improvement; 2) in every case of hysteria, “blame was laid on perverse acts by the father” which would imply that perversion would be immeasurably more frequent than hysteria¹ (Freud, 1897/1954, p. 215); 3) the disclosure of the abuse, which is the underpinning of the early psychoanalytic method of abreaction, did not suffice for a sustained cure of the symptoms; 4) “it is impossible to distinguish between truth and emotionally-charged fiction” which evinced the question of sexual phantasy, and 5) “the unconscious never overcomes the resistance of the conscious” memory (Freud, 1897/1954, p. 216).

Feminist psychiatrist Judith Herman believes that the abandonment of the seduction theory led Freud “to develop a theory of human development in which the inferiority and mendacity of women are fundamental points of doctrine” (2015, p. 19). Herman’s argument relies on Dora’s case where Freud shifted the curious inquiry he used to approach his early discoveries on hysteria towards an over-imposing interpretation of Dora’s own sexual desire, which Herman sees as Freud’s disavowal of sexual oppression suffered by women and children. Dora’s case is a constellation of relations among Dora, her father, her mother and a couple, Herr K and Frau K. The 18-year-old woman was being seduced by the much older Herr K, the husband of Frau K who, on her part, was Dora’s father’s lover. Overwhelmed by Herr K’s attempts to seduce her, Dora developed a cough and aphonia symptoms and was taken by her father to consult Freud (Freud, 1905/1973, p. 7). Dora stayed in analysis for only 3 months and left unexpectedly after being confronted by Freud who suggested that she actually took pleasure in Herr K’s sexual advances. Freud’s error is considered by Lacan as Freud’s misrecognition of Dora’s identification with Herr K, a more pressing concern to locate the sense of the symptom, which occurred always in the absence of Herr K and

¹ This is perhaps the weakest of Freud’s arguments here and his question on the prevalence of perversion is of present relevance. Stephanie Swales states “Although perversion is not as common as neurosis, it is common enough that more clinical case reports should be made available for the purposes of better clinical diagnosis and treatment of perverts.” (Swales, 2012, p. 13) Meanwhile Danny Nobus questions the common place of the exceptionality of perverse clinical structures in consulting rooms, arguing that “that perversion is not one, but a multitude of structures, behaviours, fantasies, identities, and orientations—and perhaps an eternally shifting, yet none the less determined structural attempt at dislocating any type of sexual structuration.” (Nobus, 2006, p. 13)

which clarifies “who desires in Dora” since “the aphonia arises because Dora is left directly in the presence of Frau K” (Lacan, 1956/1993, p. 174). In my view, treating the case of Dora as a complicit cover up of sexual predators, as Herman argues, is a narrow critique. Freud’s error, consists, rather, in a theoretical bias of his freshly proposed theory of neurosis which he needed to prove empirically; such epistemological over-reliance prevented him from listening to Dora more carefully. On the other hand, Herman’s argument that Freud’s psychoanalytic theory, and not Freud himself, is inherently antifeminist is unsustainable. Freud, who was a medical researcher and not a grassroots activist, opened an unprecedented new space for listening to, and with, the truth expressed by the afflicted women of his time. Although his theory might contain some patriarchal perspectives about the conventional role or value of women, it is not antifeminist by structure. Rather, it provided a starting point of inquiry into feminine sexuality as pertaining to the hysteric symptom at a time when no previous discourses allowed it.

Roudinesco (2016) situates the drama of the theory of seduction within the conservative milieu of the Victorian era, which saw child’s masturbation and homosexuality as the greatest threat to societal values. She documents how the pediatricians of the epoch saw childhood masturbation as the cause of potential infectious diseases and, as a preventative method, they recommended “cauterization of the clitoris for girls, circumcision for boys” (p. 76), leading to a “great surgical *furia* that washed over Europe from 1850 to 1890” (p. 77). This horror at childhood sexuality and the consequent impulse to regiment it increased discursive sexual fantasy² and Freud’s project embraced the censored trauma of his time by attempting to understand it in a novel way.

The scandal behind Freud’s abandonment of the theory of seduction was primarily an American phenomenon that depicted Freud as the master mind of a “travesty of the truth” that renounces the actual occurrence of sexual abuse in children (Masson, 1983, p. xxii). Jeffrey Masson, a professor of languages, was entrusted with unpublished correspondence between Freud and Fliess by Anna Freud and Kurt Eissler who were the founders of The Sigmund Freud Archives. In 1984, Masson published a

² This approach to sexuality is close to Foucault’s (1979) interpretation of the repressive theory, which claimed that Freud’s epoch agitated sexuality rather than repressed it.

best seller entitled *The Assault on Truth* which ignited a revisionist fever. Roudinesco (2016) comments on Masson: “Imagining himself a prophet of a revised Freudianism, he began to believe that America had been perverted by an original Freudian lie” (p. 425), spreading rumours of Freud’s incestuous family “without offering the slightest proof” (Fassin & Rechtman, 2009, p. 82). Masson’s book deemed Freud’s abandonment of the seduction theory as his spineless lie disavowing the reality of sexual abuse against children. Masson believes that Freud denied his early experience in the French Morgue of Paris, when he studied under Charcot’s scholarship and read and listened to chilling forensic medical reports by physicians, such as Ambroise Tardieu or Paul Brouardel, whose scientific literature called attention to sadistic acts committed against children and which these physicians were to believe that “science preferred to take no notice” about such disturbing facts (Masson, 1983, p. 33). Masson largely quoted these forensic testimonies, leaving little doubt of the occurrence of horrific abuse of all sorts against children and young women in particular. Masson’s mistake, however, was not only to believe that the cornerstone of psychoanalysis is the seduction theory, but that Freud’s disavowal of such horrendous forensic testimonies in his psychoanalytic writings constitutes a deliberate act to “travesty truth” due to his lack of courage to speak out about such “threat to the existent social order” (Masson, p. xxii - xxiii). Masson’s inquiry nonetheless refers to the limits of the symbolic which I will elaborate on Chapter 4.

Masson’s negatively affected Freud’s reputation in the 1980’s in the US, an event that paralleled the decline of psychoanalytic practice in the field of global mental health that was already gaining momentum. Yet, Freud’s rejection of the seduction theory can’t be assessed on conspiracy premises; it may be more accurate to say he was a clinical researcher who was disinvested from the socio-political dimension of his time yet discovered something scandalous: that the psychic reality of human subjects, at its core, carries embedded sexual traumas, which involves the Other and leads the subject to employ fantasy to conceal such traumas.

Freud’s contemporaries also concerned themselves with trauma. Freud’s close associate Otto Rank claimed that human beings suffer actual trauma at the moment of birth. He posited that initial separation at birth was the source of every anguish, more so than the Oedipal complex, emphasizing the mother’s figure and diverging from Freud’s primary concern with the paternal conflict (Roudinesco, 2016, p. 288).

A few years later, Sandor Ferenczi (1949) disagreed with Freud regarding the sexual nature of trauma in “Confusion of Tongues.” In the article, Ferenczi returns to Freud’s rejected seduction theory, claiming that too much attention has been given to ‘disposition’ and ‘constitution’ and that sexual abuse in reality occurred “much more often than one had dared to suppose” (p. 225 - 227). He asserted that in the neurotic’s psychic apparatus there was an “alien implant” (Ferenczi in Jimenez Avello, 1998, p. 231) that constituted a confusion between the passionate tongue of the abusive adult and the tender tongue of the child. He believed that this conflict led the child to *identify with the aggressor*, a form of identification in which the child introjects the feelings of guilt and shame that should be carried by the abusive adult (Ferenczi, 1949, p. 228)³. Ferenczi’s technique has influenced the theory of trauma and it has impacted psychoanalytic technique in schools such as relational analysis and object-relations; he advocated for a counterbalance of the traditional analytic neutrality and proposed an “active technique” in which the analyst held a more empathic and less “hypocritical” professional stance.

Before abandoning his seduction theory, Freud had conceived the kernel of temporality of trauma via his key concept of retroactive effect, *Nachtraglichkeit*, articulated in the paradigmatic case of Emma Eckstein (Freud, 1895/1973) and which provides further consistency to the above discussion of the linkage of two events or scenes in trauma. Eckstein was a remarkable woman who made important contributions to the early period of psychoanalytic work and the first woman to become an analyst. Eckstein consulted Freud when she was 27 years old because of mood issues related to her menstrual cycle (Roudinesco, 2016, p. 58). She had also developed a phobic fear of entering stores by herself after experiencing a distressing event while shopping. To interpret her phobic symptom, Freud connected two scenes:

Scene 1: two employees (one of whom she found sexually attractive) laughed among themselves and she thought they were laughing at her dress.

³ Anna Freud (Laplanche & Pontalis, 1973, p. 191) pose the term “identification with the aggressor” earlier than Ferenczi but in a different sense, as an identification or physical or moral imitation with the aggressor that permits an outward direction of aggression in light of threat.

Scene 2: refers to Emma's memory as an 8-year-old girl when she went to a store alone and the owner (a pastry baker) squeezed her genitalia through her dress while laughing.

The linkage of these two scenes occurred through the affect of embarrassment and the signifiers "store, dress, laughter" (Freud, 1895/1973, p. 355; also see Blum & Secor, 2011, p. 103-104; Wright, 2021, p. 237). Through the employee's laughter, Emma remembered not only the baker's laugh and the squeeze through her dress, but also triggers Emma's shame, as she recalled as a child having gone to the same store a second time, after the assault had occurred. Freud states that through Scene 1 (employees) Emma connects the memory and affect of Scene 2 (the baker). Emma, however, is already an adolescent and not a child, so the memory awakens a potential sexual discharge. The possibility of discharge, the accomplishment of desire, anguishes her and such anxiety conforms the core of the phobic symptom through the words "dress", and "laughter". The sexual excitation (an attractive man could repeat the assault) and her being alone in the store psychically were threatening factors; the event with the employees is charged with fantasies bound up with the initial assault on her — pleased and ashamed—body, which then compels her fearful escape.

In this theory, the signification and resolution of the hysteric symptom was only possible through the establishment of a retroactive connection (and catharsis) with the first event (Freud, 1895, 401). Emma's case provides the paradigmatic model in psychoanalysis to consider the basic traumatic temporality of trauma: an effect of a specific shocking event that gets signified anew in a later occurrence. Yet Wright correctly points out that this understanding belongs to a "pre-psychoanalytic period" (Wright, 2021, p. 237) because Freud is not yet concerned with the unconscious mechanisms of the death drive, which are at the core of traumatic repetition and constitute a second layer of temporality.

2.2.2. Beyond the economy of pleasure

Traumatic neurosis was Freud's entry point to his second theory of trauma developed in *Beyond the Pleasure Principle* (1920), in which he coined the controversial term 'death drive,' one of the main "Freudian *skandalons*" (De Vos, 2016, p. 62). Through the phenomena of traumatic neurosis, children's play (*Fort-Da*), transference, and the neurosis of destiny, Freud expanded the notion of trauma and repetition, which

were instantiated by: a) the game his 18-month-old grandson played with a cotton reel, a canonical psychoanalytic trope called *Fort-Da* (meaning 'gone!'-'there!'), which appeared to mimic the mother's absence and reappearance, and this repetition produced pleasure in the toddler; b) disturbing memories of battle and nightmares in soldiers who suffered from traumatic neurosis after being in war; c) the mechanisms of transference in which analysands repeat affects and conflicts experienced with significant figures from their childhood that were now displaced to the figure of the analyst; and d) the fate of those who ended up in situations that keep oddly repeating a predetermination without the involvement of the subject's will or awareness (e.g. accidents, ending up being rejected in jobs, struggling with the same issues with every partner, etc.) Freud observed that stronger forces, more primitive than pleasure, opposed the principle of constancy – homeostasis – and the principle of pleasure. Freud believed that repetition demonstrated that there is no empire of pleasure but that stronger forces want to reproduce some prior condition. Furthermore, these forces of the death drive repeat despite well-known unpleasant consequences, paradoxically generating another kind of suffering from pleasure "that can't be experienced as such" (Freud, 1920/1973, p.11). This concept of compulsive repetition is later developed as part of a primordial masochism, when Freud states that pleasure in pain is the foundation of erotogenic masochism, as much as unconscious guilt (Freud, 1924/1973, p. 166).

Unlike some psychoanalysts of the first circle (Jung, Adler, Rank), Jacques Lacan embraces Freud's death drive and its compulsive repetition to fashion his own theory of trauma. Lacanian theory, which holds considerable global influence in the fields of clinical mental health, philosophy, social sciences and the arts, proposes three registers as fundamental underpinnings to determine the experiences of the human subject: the Imaginary, the Real, and the Symbolic, which roughly could be considered a parallel or rather a reestablishment of Freud's second topic, known as the ego, id and super-ego.

Turning to the concept of the Freudian death drive, Lacan develops the notion of trauma as an event belonging to the Real, which accounts for what is impossible to articulate in speech. The Real is the realm of the excesses (surplus) and deficits (lack) of the traumatic experience and produces *jouissance*, a term that denotes both punishment and enjoyment, a morbid or mortifying pleasure obtained through the sexual body of a

subject who speaks. I will develop further nuances of this concept throughout this dissertation.

Lacan sees trauma as the resultant hole effectuated by the Real, (the French word *trou* sounds like the word trauma, resulting in the neologism *troumatisme*) (Soler, 2004, p. 8) which perforates the symbolic and imaginary apparatus. Trauma is thus seen as a hole that creates havoc in the subject's capacity to incorporate overwhelming experiences that reach beyond representation and therefore remain within the unspeakable. Trauma is also seen by Lacan, as Hal Foster (1999) rightly captures, as the "return of the real."

The Lacanian theory of trauma draws from Freud's account of trauma as the insistence of repetition and, through the discussion of the Aristotelian concepts of *tuche* and *automaton*, proposes a temporality where two moments of trauma coincide –chance and automatism respectively– which Lacan illustrates through the canonical example of a tragic dream originally described by Freud. In this dream, after many hours at his child's funeral wake, a father becomes exhausted and takes a nap upon entrusting his son's vigil to an older man, who eventually also falls asleep. A candle falls and sets the coffin on fire. In the dream the child reproaches him, shouting: "Father can't you see that I'm burning?" a question that awakens the dreamer (Lacan, 1964/1998, p. 34).

This anguishing dream captures the paradigmatic temporality wherein Lacanian psychoanalysis locates the split of the subject in trauma: between transcendental trauma (in this case, the tragedy of the death of one's own child) and accidental trauma (the unlucky occurrence of the fire in the funeral home). The coexistence of a constitutive, ontological or structural trauma running parallel to a contingent or constituted trauma provides a fundamental underpinning of the Freudian-Lacanian understating of posttraumatic suffering (Verhaeghe, 2001, p. 55; Verhaeghe, 2008, p. 317; Žižek, 2009, p.141; Soler, 2004, p. 40; Malabou, 2015, p. 188).

2.2.3. Structural and contingent traumas

Experiences such as natural disasters, illness, war, dispossession, or any form of abuse represent potentially traumatic events that strike the subject by chance and, independently of any structure, impact the subject by the very nature of their violence.

Žižek puts it plainly: “A clarification: the impact is brutal, can’t be discounted on the premises of structure” (2009, p. 130). Traumatic events are unexpected occurrences for which the subject could not be prepared for nor stop from happening. The existence of these unfortunate events is contingent: they are not a necessity and preferably would never have occurred; but by unfortunate odds, they did. Unexpected traumatic events can happen to anyone, and the event is embodied by a subject previously inserted in a linguistic apparatus, already historically and socially shaped. As alluded to in the discussion of *Nachtraeglichkeit* above, the subject temporally connects a contingent experience with a previous disruption, linking two events by virtue of the economy of the drive. The previously inflicted trauma, also known as a transcendental or structural trauma, becomes constitutive and necessary to what makes us human: sex, death and alterity.

Toril Moi (2004), a third-wave feminist, cites McDougall in advancing important clarifications of constitutive traumas alluded to by Freud:

McDougall has provided an interesting definition of psychoanalysis. She considers psychoanalysis to be a form of thought that attempts to understand the psychic consequences of three universal traumas: the fact that there are others, the fact of sexual difference, and the fact of death. (p. 871)

Moi proposes to name these traumas differently. Instead of using the term castration –highly sexist in her view – she proposes the use of the term ‘finitudes,’ situating her categories of trauma in close proximity to those of McDougall, and renders them as follows: Spatial finitude (bodily separation from others), sexual finitude (people can only have one sex) and death. In my view, the traumas that McDougall and Moi list are constitutive, yet their analysis is limited by the biological premises of the feminist theory they rely on. The nature of structural traumas, in my opinion, roughly coincides with what Freud understood as the three sources responsible for our suffering: “Our body with its anguish and pain; the external world and its destructive forces; and the social burden of our relationship to others,” which Freud deemed as “perhaps more painful to us than any other” (1930/1973, p. 76). Consequently, my Freudian-Lacanian reading of structural trauma is always articulated in relation to a manifestation of the Real, which I render as follows: 1) the *sexual drive* in the body, 2) *finitude* as death and 3) *alterity* as the lack in language and the adversity of difference.

The first structural trauma corresponds to the Freudian concept of sexuality experienced by the subject through the body, an entity with an image (Imaginary), language (Symbolic) and a residual excess (Real) outside those registers. Sexuality as a site of affect loaded with unsolvable antagonisms can be approached through *Trieb* or the drive, a fundamental concept in psychoanalysis. Drive is the frontier between the somatic and the psychic, a border locus where vitality and destructiveness coincide. Notwithstanding the unrelatability of the experiences of the sexualized death drive, the subject cannot easily talk about them. The first embodied encounters of the drive are often experienced within the context of an early relation, and as such, the inherent traumatic excess of the drive has to do with some experiences of the body within the space of an Other.

The second structural trauma refers to death, the ultimate Master, which establishes our finite nature as organisms. Death refers to our own mortality, to the end of life of those we love, or the insistent repetition of the death drive within life. But death is also a finitude within the inexorable passage of time, which indicates the movement of life towards death, or as Freud states: “the ultimate object of life is its own extinction!” (Freud in Viereck, 1927, p. 3). This transcendental aspect of the speaking human is also known through Heidegger’s “being-towards-death (1927/1962, p. 296).

The third trauma relates, on the one hand, to alterity, which is the radical imbrication of every subject with an Other by means of language, which results in a constant co-production that forces us to be perpetually represented by a signifier to another signifier, and thus lacking being. On the other hand, alterity as a constitutive trauma, refers to the inextricable presence of personal narcissism and the need of dealing with difference in a social context. Difference among humans, the big and small narcissistic differences, at core pose the impossibility of answering the ontological question of our existence as *differentiated* sexual beings, in absence of a relation that would sustain such difference. Lacan expressed it this way: “We suppose that Freud might have had the idea of the sexual accord... But precisely what he explains to us is that he does not know...this is what made him discover the unconscious” (1972, p. 5).

So, both in Freud and Lacan we find at the core of the subject’s experience a constitutive trauma – a hole – connected to the fact that our subjectivity is entrapped in representation through language, unable to fully signify our sexual bodies and their

drives: the death of those we love, our own finitude, and our difference from others. Lacan might have summarized such a hole through his negative universal axiomatic statement regarding the lack of sexual rapport, or “there is no sexual relationship” (Lacan, 1973/1999, p. 79). It is in this terrain of ontological trauma that the occurrence of future traumas will find fertile soil to reproduce the continuum of symptoms we witness in traumatized individuals: from the extreme cases of horror, constant nightmares, flashbacks, dissociation, inability to concentrate or panic attacks (the overpowering invasion of psychic excitation), to the ongoing struggle of failing to make sense of tragedy.

Acknowledging the existence of “universal,” constitutive and structural traumas is crucial to the understanding and the treatment of any subject. Those affected by a contingent catastrophic event will activate constitutive traumas, contributing to the heightened complexity of the phenomenon of trauma. Catherine Malabou –a Derridean theorist who rejects Freud’s structural reading of trauma– and Lacanian theorist Slavoj Žižek, defending this reading, engage in a debate, which partially concerns the temporality of trauma. Malabou (2012), believes Freud is mistaken in claiming that his regimen of eventuality, (i.e., interpretation of traumatic events based on psychic realities) is always predetermined and sexual in nature. Malabou supports her argument by reflecting on patients with traumatic brain lesions (by accident or Alzheimer’s) whose typical presentation will involve the destruction of their previous personality, memory and sense of self and whose demeanor, in her view, is devoid of affect and meaning. These subjects, who she deems emotionally flat, suffer organic traumas that they are unaware of and thus unable to mourn or signify since they are disconnected from previous psychic content. With these cases, coined as “the new wounded,” she extrapolates “a legitimate model for understanding the structure of every type of psychic trauma” (Malabou, 2012, p. 10), including the socio-political realm. In Malabou’s view, this presentation is transformed when the subject obviates memory traces and history, a sort of politics of “annihilation of form” or “destructive metamorphosis” that lies between the Freudian death drive and the death of the drive (p. 20).

Žižek (2009) responds to Malabou’s claims by detailing the logical premises of the temporality of the psychoanalytic theory: “For Freud (and Lacan), every external trauma is ‘sublated,’ internalized, owing its impact to the way a pre-existing Real of ‘psychic reality’ is aroused through it” (p. 125). He also states that brain-damaged

subjects are still attached to the apparatus of *jouissance* (p. 129 & 136). Furthermore, what is most definitive, is Žižek's assertion that "past traumatic loss of substance... is constitutive of the very dimension of subjectivity" (p. 144). In other words, Žižek believes that Malabou's new wounded, as a paradigm that rejects the traumatic temporality assigned by psychoanalysis, is not sustainable because the apparatus of *jouissance* in the speaking being leaves a mark on the way one experiences trauma; this, indeed, constitutes the main contribution from psychoanalysis to discourses of trauma. Now, let us move on to how trauma has been approached by the neurosciences and psychology.

2.3. Neurosciences: bio-psychological supremacy

Before trauma was associated with psychoanalysis through the epidemic of hysteria in the late nineteenth century, traumatic stress was initially a part of psychiatric discussions. As a result of technological advances of a nascent European industrialization, numerous casualties with devastating psychic consequences occurred. Workplace accidents caused by manipulating industrial machinery were common as were train accidents, which in their early years, usually involved a significant number of collisions. As early as 1867, Eric Erichsen, a British surgeon attending to patients involved in railroad accidents described a traumatic syndrome he called the "railway spine" or "railway brain" (Fassin & Rechtman, 2009, p. 35; Kienzler, 2008, p. 219). This syndrome was presumably caused by the physical impact of the accident on the nervous system, causing a specific injury to the brain and vertebrae spine. Around 1889, the term "trauma neurosis" was coined by German psychiatrist Hermann Oppenheim, who described an organic base for the psychological manifestations of posttraumatic stress. (Fassin & Rechtman, 2009, p. 31).

Psychiatry, a medical field born in the dawn of the 1900's refers to the treatment of epidemic afflictions of the mind and operates under two main schools: the organicist and the psychosocial (Shorter, 1997, p. 69). Psychiatry's history influences the way trauma is conceptualized and traditionally it has provided the framework for the psychological therapy of those affected by posttraumatic sequelae. Forensic psychiatry, or the mental treatment of those involved with the judicial system, saw its initial involvement with trauma when laws around labour accidents came to exist (Fassin & Rechtman, 2009, p. 35). Workers in factories lost fingers or became paralysed while operating machines and they required treatment to deal with the aftereffects of the

stress. According to Fassin and Rechtman, most of the diagnoses of trauma neurosis were given to the victims of workplace accidents but they had a specific feature characterized by an adamant refusal to return to work unless there was a rightful financial compensation. The latter produced an alternative diagnosis to traumatic neurosis, called “sinistrosis” or “claimant disease,” introduced by psychiatrist Edouard Brissaud who refused to assess the victims of workplace accidents as malingering hysterics and advocated for economic compensation as the crucial step to help the affected individuals return to their everyday life and functionality (p. 38).

With the onset of World War I, military psychiatry flourished amidst the rise of patriotic spirit and idealizations of war. Those fighting on the front were confronted with death daily and had to constantly stay alert in case they came under attack. They witnessed the horrors of war and could not escape as desertion was punished with death. If they were injured, the doctors had to determine whether the injured were ready to return to combat. The pressure was on the doctors to determine whether the soldiers were genuinely hurt in combat or whether the injuries were self-inflicted so that the soldier would not have to go back to the front (Fassin & Rechtman, 2009, p. 63). The growing numbers of psychologically damaged by combat, “one seventh of the fighters were discharged for disability” (Davoine & Gaudilliere, 2004, p. 105) were looked upon with disdain, as malingering hysterics, “cowardly moral invalids” (Herman, 2015, p. 21), “pretenders” (Roudinesco, 2016, p. 188) or selfish individuals affected by an unpatriotic will (Fassin & Rechtman, 2009, p. 44).

The diagnosis of “shell shock” syndrome, which assumed that bomb explosions caused a physiological brain shock, reduced blame and saved honor for those suffering from posttraumatic psychological effects (Davoine & Gaudilliere, 2004, p. 107; Kienzler, 2008, p. 219). Yet, the suspicion that once was imposed on hysteria and traumatic neurosis escalated in rather brutal ways during the Great War. It is instantiated by “faradism” or “faradization,” actual torture deemed remedial that consisted in discharging brushed electroshocks along the soldier’s wet parts of the body. This practice was conducted at the discretion of the physician and was sometimes accompanied with psychological torture, harassing the traumatized soldiers with shouts and insults or explaining in detail the procedure they were about to experience: “It feels as though innumerable drills are driven right into the bones at furious speed” (Roudinesco, 2016, p. 188). This abhorrent practice was firstly contested in a legal case in 1920 against Dr.

Wagner von Jauregg, a director of the Vienna Neuropsychiatry Clinic, who was accused of using these inhumane treatments with the Austrian troops. Freud was a witness in this trial and defended his friend by arguing that the accused had acted incorrectly but out of ignorance about the principles underlying traumatic neuroses that psychoanalysis had elucidated by then. Some located this trial as the event that marked the introduction of psychoanalysis into the treatment of those who suffered psychological trauma during war, which paved the way to more humane treatments, while forced soldiers to engage in an intimate confession (Fassin & Rechtman, 2009, p. 51 & 63). Some psychoanalysts were enlisted as war psychiatrists, such as Sandor Ferenczi, Wilfred Bion, Karl Abraham, and Frieda Fromm-Reichmann, among others (Davoine & Gaudilliere, 2004, p. 102). Psychoanalysis thus had an important role in understanding and intervening in war trauma but not so much, as the young Lacan expressed back in 1947, to elucidate leadership, morale or identification among the troops (Lacan, 1947, p. 4). More importantly it was because procedures, such as the abreaction by linguistic means, curtailed brutal methods deemed “therapeutic” and spared soldiers from punishment as “deserters.” Psychoanalysis offered an alternative to conceptualizing what a traumatized soldier might be experiencing, opening the opportunities to work with war trauma as a disorder akin to madness (Davoine & Gaudilliere, 2004, p. 109). Inversely, war trauma also influenced paradigms in psychoanalysis, such as Freud writing *Beyond Pleasure Principle* (1920), not only as a response to the horrors experienced during and after World War I, but the trauma of war also expanded the concept of otherness, specifically “the disturbed relationship to another, human or nonhuman, expressed through a language game, verbal or nonverbal” (Sheppard in Davoine & Gaudilliere, 2004, p. 103).

The expertise gained in the psychological treatment of soldiers in World War I was key, albeit for the purpose of maintaining steady counts of bodies for combat. Thomas Salmon, a US psychiatrist, was sent to Europe in 1917 as a commissioner to learn from the psychological treatment of war neuroses that were practiced in England and France. Salmon produced a report known as “Forward Psychiatry” or “Salmon principles” which consisted in therapeutic guidelines to facilitate a better outcome of those suffering “shell shock.” These effective guidelines were classified as qualities of “proximity, immediacy, expectancy and simplicity” (Davoine & Gaudilliere, 2004, p. 116). Military psychiatry rejected the Salmon principles deemed “sentimental” (Sheppard in

Davoine & Gaudilliere, 2004, p. 107), as much as it also resisted psychoanalysis on the suspicion that potentially the discourse of the unconscious helped deserters.

The fact that for psychiatry and even for psychoanalysis the traumatized soldier's psyche, and not the event of war, was seen as the main problem is troublesome as Fassin and Rechtman demonstrated (2009, p. 60). The latter assumption is an example of how discursive constructions might veil the very site of trauma, an aspect I seek to nuance in detail in Chapter 4. Such suspiciousness around war trauma, however, began to fade in the aftermath of World War II, due to unspeakable horror experienced by Holocaust survivors, who left little doubt about their genuine claims of trauma. The survivor was the focus, but psychiatry was no longer the privileged discourse, as social memory required other means to deal with the collective aspect of the atrocities experienced (Mitscherlich, & Mitscherlich, 1975). Contributions by philosophy (Adorno, 1998), literature (Caruth, 1996) or psychoanalytic literature (Felman & Laub, 1992) work through the dark past constituted by the industrialization of death of millions of individuals in the extermination camps of the Nazi regime. Although the term of psychoanalytic inspiration, "survivor syndrome," created by Lifton (1980, p. 114) described the collective aspect of trauma and healing, it did not have a strong impact on therapeutic clinical practices for the affected survivors (Fassin & Rechtman, 2009, p. 73).

If Holocaust survivors contributed to raising awareness about the collectivity of trauma, in a different arena, Frantz Fanon brought an important contribution to discourses about mental illness and trauma in relation to larger aspects of the sociopolitical contexts. Working as a psychiatrist in the Algerian war of liberation against France in the late 1950's, and emerging from the intersection of psychoanalysis and psychiatry, Fanon proposed the causality of mental disorder to the sociopolitical conditions within which it had emerged. Fanon not only introjected the field of psychiatry with vital political consciousness in the context of colonial war, but he also decolonized psychiatry by contributing, in a novel way, to the psychological thought of oppression and anti-black racism (Fanon, 1961/2004, p. 181), implementing clinical innovations that will manifest two decades later in community psychiatry (Butts, 1979, p. 1016) and "liberation psychology" (Gaztambide, 2012).

War continued to bring an inquiry into trauma, as demonstrated by the Vietnam War, which positioned North American psychiatry as the leader in the conceptualization

of trauma, which coincided with the rising biologization of psychiatry and diagnostic technologies, reason for which Lacan advocated so adamantly for a return to Freud, as psychiatry and ego psychology had paralyzed the power of the Freudian discovery. Let us now turn to discussion of how trauma has been conceived by psychiatry.

2.3.1. Contextualizing biological psychiatry

To understand psychiatry in its privileging of biology, as opposed to the psychosocial understanding, we ought to listen to Edward Shorter, a historian of psychiatry who locates a drastic polarity between organicist psychiatry—which sees mental disturbances as caused by brain anatomy—and the vision of mental health symptoms caused by psychosocial conditions. Shorter deems psychoanalysis as a deviant hiatus in the history of psychiatry, grassroots movements as a political fashion in detriment of science, and the “new tendency for people to psychologize distress, rather than to medicalize it as a nervous disease” as a major problem for psychiatry (Shorter, 1997, p. 288). Shorter claimed that the organicist perspective was the predominant version at the birth of the discipline, except for some psychiatrists like Jean-Étienne Esquirol in France or Johann Christian Heinroth in Germany, whose perspective on the psychosocial causation of mental illness placed them within the so-called “romantic psychiatry” (p. 31).

During the nineteenth century and before the birth of psychoanalysis, mental illness was seen as either a degeneration of the brain or a matter of nerve malfunction. Mental illness was seen as a genetic transmission in which one generation passes the genetic information to another, worsening its presentation from one generation to another (Burstow, 2015, p. 39). This is exemplified by the psychiatrist who firstly defined sado-masochism, Krafft-Ebing, and who extended the term “degenerates” to all sorts of deviance, establishing the first seeds of social Darwinism, whose extreme consequences became evident when the idea of degeneration was adopted by the Nazi’s ideology. Otherwise, mental illness was seen as a matter of nerve disease, and thus treated with hydrotherapies and diverse “physical therapies” that were alternatives to the nascent psychotherapies. They consisted of insulin-induced coma therapy, sedatives such as morphine, or hypnotics such as Chloral Hydrate or phenobarbital, electroconvulsive therapy (ECT) and, in extreme cases, the use of brain surgery, known as lobotomy, which severed nerve connections in the prefrontal lobe.

Shorter situates the emergence of psychiatry as a medical discipline in late 18th century, which aimed to bypass the moral pursuits of the asylum,⁴ and intended to offer treatments, deemed of higher scientific status, to the public demand for mental health services. Pushing psychiatry's aspiration to be acknowledged as a science within the medical tradition required clinical-pathological methods that demonstrated the anatomic and chemical pathologies of the brain, a task which could only be achieved through the instruction provided within the university (Shorter, 1997, p. 70). The first biological psychiatry, "organized all across the Atlantic community" (p. 71) was consolidated by figures such as Emil Kraepelin, who was praised for his classificatory acumen, highly descriptive focus and clinically relevant nosology, whose influence in diagnostics prevailed until the 1950's (Young, 1996, p. 95).⁵

At the core of the psychiatric field there has always be a predominance of neuroscientific jargon that still relies on the biological, genetic and organic causes to explain mental illness; yet psychoanalysis dominated the field of psychiatry until the mid 1970's. Psychoanalysts shifted the focus from medications and anatomical diseases in psychosis to inquiry into unconscious aspects of neurosis instead. The dominance of psychoanalysis understood hysterical pathology as part of everyone's everyday life, "the mentally ill were everyone" (Burstow, 2015, p. 47). Analysts who sought refuge in the US, escaping the Nazi persecution of the Jewish population in the 1930's, contributed to the shift in focus of inquiry from biology to the unconscious with figures such as medical doctors Harry Stack Sullivan and Frieda Fromm-Reichmann (researching psychosis in institutions), non-physicians such as Erich Fromm, Erick Erickson, Herbert Marcuse, alongside of those who reconstructed psychoanalysis into a practice of ego psychology,

⁴ As proposed by Foucault's genealogy, the asylum emerged in the late eighteenth century as a relay of the medieval and early renaissance brutal punishments for the mentally ill, who were deemed wild beasts and placed among the criminals in sites such as the Bethlem Royal Hospital, known as the "Bedlam" in London. The era of the asylum, instead, was a philanthropic endeavour which seeks to provide the mad with the freedom from chains and a more humane treatment based on morality. Instances of such endeavors are a) the York Retreat in England, led by the Quaker William Tuke; b) a secular version in Bicêtre in France, led by Phillippe Pinel; or c) the Sonnenstein led by Ernst Pienitz in Germany. Foucault claimed that the humane replacement of disciplinary and therapeutic methods still remained within the master-slave dialectic, as the inmate was offered freedom on the condition to submit to the responsibility of controlling madness or else will be morally punished; in such a way, the asylum organized the inmate's consciousness of self through the exertion of guilt, moving from a "free terror of madness to the closed anguished responsibility." (Foucault, 1964/1986, p. 223).

⁵ For example, Kraepelin coined the diagnosis "dementia praecox" for what is now known as schizophrenia.

such as Ernst Kris, Rudolph Lowenstein and Heinz Hartmann (Shorter, 1997, p. 174). Psychoanalytic discourses held sway over most programs for the mentally ill for about four decades (1920-1970) in the North American context. The International Psychoanalytic Association (IPA) gained the upper hand over the American ego-focused psychoanalysis, influenced aspects of social and intellectual life, and offered training to non-psychiatrists.

Psychoanalysis, which privileged patient's words as meaningful, was dethroned by a resurgence of the Kraepelian classificatory impulse, which saw the language of the clinic—signs and symptoms—as mostly important for categorizing the speaking being's suffering. This Neo-Kraepelian wave of psychiatrists, allies of diagnostic manuals and psychopharmaceutical expansion (Young, 1996, p. 97), constituted the second biological revolution in psychiatry, marked by the positivistic assumption of the brain anatomic dysfunction (Shorter, 1997, p. 239), which has shaped the field of trauma within the global mental health institution. Community psychiatry thrived in the United Kingdom since around the mid 1930's, and extended to other countries, such as Canada, New Zealand, and the US through the idea of outpatient clinics, group therapies and therapeutic landscapes (Gesler, 2009, p. 230).

Regarding pharmacotherapies, nitrogen rich plant-based drugs known as alkaloids, opium or morphine have existed since ancient times, but the first forerunners of present psychopharmaceutic emporia are sedatives, such as Chloral (chloral hydrate), the first lab synthesized drug for the mentally ill by the leading pharmaceutical company Bayer. This was followed by barbiturates, such as phenobarbital found in the early 1900s (Shorter, 1997, p. 198). Yet the entry to the neuroleptic "cornucopia" was the antipsychotic Chlorpromazine, or "psychiatric penicillin" launched in 1953, (Shorter, p. 255) which gave free reign to the wave of cosmetic psychopharmacology, driven by drug industry rather than the academy (Shorter, p. 265). The most successful legal psychotropic drug ever created thus far, which is important to trauma treatment, is fluoxetine commonly known as Prozac, synthesized by the pharmaceutical company Eli Lilly in 1988. Prozac overthrew the previous successes of drugs such as Lithium (1950), the tricyclic antidepressants (Amitriptyline and Imipramine, also known as Tofranil, 1951), tranquilizers (such as meprobamate, known as Miltown and Equanil, 1955), and the highly effective but addictive tranquilizers for anxiety known as benzodiazepines, such as diazepam (Valium, 1960) or alprazolam (Xanax, 1971). Prozac, popularly

dubbed as 'mom's happy pill,' belongs to a new form of antidepressants known as Selective Serotonin Reuptake Inhibitors (SSRIs). Its popularity resides in the fact that people with depression felt their symptoms alleviated. Adding to its popularity was the drug's unintended side effect of causing weight loss, as well as being marketed as an aid to treat all kinds of mental distress that arise from the problems of everyday life (Shorter, p. 314).

The following is a list of medications used specifically for the treatment of posttraumatic symptoms:

- 1) Serotonin Reuptake Inhibitors (SSRI's) such as fluoxetine (Prozac), Sertraline (Zoloft) Venlafaxine (Effexor) or Paxil which supposedly "increases blood flow to areas responsible for higher levels of processing and critical thought" (Buhmann, 2014; Antunes-Alves & Comeau, 2014, p. 12) which "can make feelings less intense and life more manageable" (Van der Kolk, 2014, p. 225).
- 2) The controversial Propranolol, an anxiolytic that affects the sympathetic nervous system (Herman, 2015, p. 161; Van der Kolk, 2014, p. 225) which blocks the physical effects of adrenaline, reducing nightmares, insomnia and trauma triggering (Van der Kolk, p. 225). Its use has been contested by some bioethicists as it might alter "the memory storage process," inhibiting the storage of painful memories (Herman, p. 161).
- 3) Benzodiazepenes, such a Klonopin, Valium, Xanax, and Ativan, which are tranquilizers known for their risk to cause habituation or addiction (Van der Kolk, p. 225, Herman, p. 161).
- 4) Lithium or Valproate that are known as mood stabilizers and anticonvulsants, reducing arousal and irritability (Van der Kolk, p. 225, Herman, p. 161).
- 5) Second generation antipsychotic, specifically Risperdal and Seroquel, the largest-selling psychiatric drugs in the United States "1.5 billion in 2008" (Van der Kolk, p. 225).

Specifically with regards to the use of medication for PTSD, Bessel Van der Kolk, a Dutch psychiatrist based in Boston who has vast clinical and research experience in trauma claims that: "After conducting numerous studies of medications for PTSD, I have come to realize that psychiatric medications have a serious downside, as they may deflect attention from dealing with the underlying issues" (Van der Kolk, p. 37). He also

denounces how the number of people treated for depression in the US has tripled over the past two decades as the poor and racialized children have alarmingly been treated with antipsychotics through funded prescriptions known as “Medicaid” (Van der Kolk, p. 37).

The psychopharmaceutical business, bound by scientific research, university and health institutions, constitutes the seat of contemporary psychiatry and its development is linked to the emphasis on brain research (Burstow, 2015, p. 47; De Vos, 2016, p. 196). The pharmaceutical industry, allied to organicist psychiatric approaches, promoted what some deemed “the myth of the chemical imbalance” in the brain (Burstow, p. 59), which led to the overuse of medication and the displacement of psychotherapy, because the pharmacologic treatment focuses on the fast relief of apparent symptoms rather than on a therapeutic engagement. The current psychiatric biological pursuit has influenced our ethos, or what De Vos calls a discursive shift from “*having a brain to being a brain*” (p. 2 & p. 188). The pharmaceutical domination in the treatment of suffering, according to Burstow, was boosted by George H. W. Bush’s declaration of 1990 as the “Decade of the Brain” (p. 66). This declaration allowed for the proliferation of discourses that explained away violence, such as the school massacre at Columbine in 1999, as forms of ‘mental illness’ that can be treated with medications (Burstow, p. 67).

There have been counterbalancing positions regarding the exclusive use of psychiatric medications that come from pharma industries in mental health treatments. Diverse researchers have studied the effects of alternative drugs, such as MDMA (also known as ecstasy), LSD, psilocybin or ayahuasca in the treatment of PTSD or other mental health concerns (Pentney, 2001; Griffiths et. al., 2006; Begola & Schillerstrom, 2019; Jerome et. al., 2020; Dos Santos et. al, 2021). Some have proposed MDMA controlled protocols, similar to those conducted by the large pharmaceutical research, with a focus on the treatment of PTSD (Doblin 2002). These studies have demonstrated that guided therapeutic experiences under the effects of these drugs, can reduce severe PTSD symptoms with one or a few doses and also allow those using such medications within a therapeutic environment to access experiences of mystical nature that might “have substantial and sustained personal meaning and spiritual significance” (Griffiths, 2006, p. 268). Yet, funding for more controlled studies is reported as difficult to access due to the competition with big pharmaceutical companies that have huge vested

interests in keeping large populations under the influence of legal drugs (Jerome et al, 2020; Dos Santos et. al, 2021).

Biochemical correction driven by pharmaceutical capital, specifically for the poorest populations, has been widely researched and constitutes a displacement of the fate of people's mental health from their own hands and/or the communities they trust to the interests of the global pharmaceutical industry dominated by the brain disease model (see Mills, 2014; Burstow, 2015; Young, 1996; Van der Kolk, 2014; De Vos, 2016).

2.3.2. Debating the diagnostic value of PTSD

Diagnosis in the medical field, denotes a decision that an examiner makes after careful classification of signs —what is observable—, and symptoms —what is reported by an afflicted subject—, with the purpose of finding the causes of an illness they aim to cure. Diagnosis then is an interpretation or decoding of a signifier (embodied by the patient) that represents a signification of certain malaise afflicting their body or mind for another signifier (the doctor). The diagnosis affects treatment, research, service design and provision as well as access to financial compensation and formation of identities. In Chapter 7, I will address what sort of place diagnosis has in psychoanalysis, but for now, I will proceed to locate the discourse of diagnosis in the mental health institution, keeping in mind the following questions: How could a diagnosis contain enough information, on the one hand, to attend to the cause of suffering at the level of the individual seeking services in the mental health system? On the other hand, can an individualized diagnosis respond to collective trauma?

To explain the ubiquity of posttraumatic stress disorder, the diagnostic category that is used to define what constitutes trauma at present, we ought to contextualize briefly the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (2013) and which Young, a self-proclaimed “ethnographer of PTSD,” sees as the consolidation of “a new science of psychiatry, based on research technologies adopted from medicine (experimentation), epidemiology (biostatistics), and clinical psychology (psychometrics)” (1996, p. 7). The Neo-Krapaelians, interested in the systematic categorization of posttraumatic stress, emerged in the 80s and were inspired by previous classificatory attempts, such as Adam Kardiner's *The Traumatic Neuroses of War* (1941); anthropologist W. H. R. Rivers's

Instinct and the Unconscious: A Contribution to a Biological Theory of the Psycho-Neuroses (1922/2014); and *War Neuroses* (Grinker & Spiegel, 1945). Kardiner, a psychiatrist who was briefly analyzed by Freud and who embraced ego-focused psychoanalysis in the United States, had the strongest influence in the development of the first DSM edition. Working with veterans in the USA, Kardiner brought forward something that at that time was known as an “environmental” or “reactive” view of psychiatric disorders, which is to say, an emphasis on psychosocial factors was placed as opposed on physiological and anatomical causes, rendering pathology as a forced “adaptation” (Young, p. 90). The first version of the diagnostic manual, known as DSM I, was published in 1952 and aimed to provide an orderly vision of disease and therapeutic procedure, understanding trauma as a reaction to “environmental” biopsychosocial conditions that was organized within a continuum from mental health to mental illness (Young 1996, p. 98; Shorter, 1997, p. 299; Burstow, 2015, p. 74). The DSM II was launched in 1968 and its task force was led mainly by psychoanalysts, thus the terms “reactions” were replaced by “neurosis” (Shorter, p. 299; Burstow, p. 74; Young, p. 99). The first two models were marked by a theory of etiology, as opposed to the third edition of the DSM, published in 1980, which was developed under the supervision of a Neo-Krapelian psychiatrist Robert Spitzer. Spitzer was deeply interested in organicist psychiatry, and shifted interest from etiological focus to strictly relying on empirical observations and measurements, purging the manual of any language of the unconscious and consolidating the shift from “clinically-based psychosocial model to a research-based medical model” (Fassin & Rechtman, 2009, p. 86; Young, 1996, p. 100; Shorter, p. 106 & 300) which constitutes the present domination of the evidence based approach, to be detailed in Chapter 4.

Many criticisms against the DSMIII emerged at the time, with the most important being the lack of reliability and validity, which “implies lack of replicability and ambiguous observations” (Desmet, 2018, p. 13).

Or as Young (1996) explains:

Reliability and validity are closely connected. When the reliability of diagnostic criteria and technologies is low, the validity of the disorders that they identify is moot. That is, without reliable resources, researchers cannot establish, to the satisfaction of their public (mainstream American psychiatry), the homogeneity (shared identity) of the aggregated cases

(diagnosed patients) on which they are basing their statistical evidence.
(p.105)

Thus, without much consistency, other than the phantasmatic belief of those who use it, the DSM went still through two more revisions and now mental health clinicians follow the DSM V, which Burstow calls the “boss text,” as it fetishizes categorization, ignores etiology and demonstrates a totalizing aspiration to unity of diagnosis (2015, p. 43 & p. 73). Furthermore, the categorization constitutes ill-fated attempts to measure subjectivity within psychology. In my clinical experience, this diagnostic tool is often a source of confusion, as an analysand can obtain different diagnoses according to what they decide to disclose in the interview and which psychiatrist they see, even if all psychiatrists based their assessment on one and the same manual.

Posttraumatic stress disorder (PTSD) is the diagnosis most assigned to populations that suffer pervasive symptoms after experiencing a traumatic event. PTSD also has incorporated several previous concepts such as post-torture syndrome, concentration camp syndrome, rape trauma syndrome or “survivor syndrome” (Herman, 2015, p. 119; Bracken et al., 1995, p. 1073). The PTSD diagnosis, firstly coined in 1980 in the DSM III, consolidated the field of trauma studies and the US became its epicentre (Fassin & Rechtman, 2009, p. 77), thanks to the active militancy of diverse grassroots groups, such as war veterans, women working in rape relief, insurance companies and government agencies, who will determine from then on how trauma is approached in the mental health institution.

Activists such as the Vietnam Veterans Against the War (VVAW) were key to consolidating the importance of the diagnosis of PTSD. Men who returned traumatized after the Vietnam War presented all the symptoms of “shell shock” described at the beginning of the 20th century with the variant that they were seen as “self-traumatized perpetrators” (Young, 1996, p. 92) “baby killers” (Fassin & Rechtman, 2009, p. 94) capable of terrorizing acts.⁶ The veterans of the VVAW, back in their home towns, experienced the urgent need to confess the atrocities they had committed and so they

⁶ The returning Vietnam Veterans earned the term “baby killers” from an antiwar art poster, entitled *Q: And babies? A: And babies* (1970) which showed a picture by combat photographer Ronald L. Haeberle depicting bodies of civilians killed in the My Lai massacre on March 16, 1968, in which U.S. troops attacked unarmed South Vietnamese civilians and killed about 580 people, including babies. (Holsinger, 1999, p. 363)

organized “rap groups,” meetings among themselves to share the experience they had of the war, as well as providing public testimony of their involvement in war crimes (Herman, 2015, p. 26). At the same time, Vietnam Veterans also had similar symptoms to those who have been assaulted and who demanded compensation for the “atrocious-producing situations” (Lifton in Fassin & Rechtman, 2009, p. 92). The Vietnam veterans needed to find a diagnostic nomenclature to legitimize their disturbing reactions, characterized by the typical triad of posttraumatic symptoms, —reexperiencing, numbing/avoidance, and hyperarousal— (Curtois, 2004, p. 412) and such diagnosis, they thought, would aid their claim for the recognition of their suffering and resulting demand for financial compensation. Thus, one of the most significant ethical questions raised with the diagnostic of PTSD in the DSM III, was the admission of the fact that “acts committed with full awareness and even with enjoyment could give rise to PTSD” (Fassin & Rechtman, 2009, p. 93), bringing to light complexities that went unacknowledged in previous wars, such as the fraught and complicated relationship of individual and state responsibilities, something that is very important to my discussion throughout this dissertation.

Around the same time, during the 1960s and 70s, another “war” was brewing. Feminists were seeking recognition of ongoing sexual violence against women and children. Women activists such as Betty Friedan, the author of *The Feminine Mystique* (1963), criticized the newly achieved economic progress that left intact the oppressive social roles for women that kept them confined to domestic life as mothers and housewives. Through the momentum garnered by the critiques of Friedan and other feminists, the denunciation of sexual crimes against women and children emerged. Florence Rush, a social worker and activist of the women’s movement, presented a famous paper at the “Radical Feminist Rape Conference” in 1971, where she evidenced the commonality of sexual trauma in many of the girls she had treated and called out to counteract male domination by exposing sexual abuse (Fassin & Rechtman, 2009, p. 80). A few years later, in 1980, one of the most significant epidemiological surveys conducted by human right activist and sociologist Diana Russell, found in a randomly selected sample of over 900 women that one in four of the interviewed women had been raped and one in three had been sexually abused in childhood (Herman, 2015, p. 30). The private life of women soon reached the public sphere, and through “consciousness-raising” groups, women attested to the sexual violence endured, consolidating new

policies and treatment procedures for women who had been assaulted. Most recently, the denouncement of sexual violence against women gained significant discursive relevance in the #MeToo movement disseminated throughout social media platforms.

It is important to note that within this feminist struggle the role of psychoanalysis appeared “ambivalent” at best (Fassin & Rechtman, 2009, p. 81). While recognizing emancipatory impulses inherent in psychoanalysis, as well as the listening opportunities it had offered, the normativity of women’s role in some of Freud’s texts and the abandonment of the seduction theory were poorly received by activists who believed it to exacerbate the marginalization of women. Elizabeth Grosz (1990), following an extensive and rigorous account of feminism in relation to Lacanian theory, asserts a tactical position that enables “feminists to use his [Freud’s] work where it serves their interests without being committed to its more troublesome presumptions” (p.192). Yet, Juliet Mitchell’s Lacan-inspired critique of Freud in *Psychoanalysis and Feminism* (1974), is an example of how the value of psychoanalysis for its contribution to signify the larger social conflicts between the sexes may be rescued (Grosz, p.19).

While PTSD diagnoses afforded Vietnam veterans legitimacy as trauma victims, even despite being perpetrators of war crimes, the women’s movement gained some recognition of the gender violence they endured. The diagnosis of PTSD also undermined misogynous diagnoses, such as “masochistic personality disorder,” a label of psychoanalytic inspiration that refers mostly to battered women who remain in exploitative or abusive relationships despite opportunities to change the situation (Herman, 2015, p. 117) and which Paula Caplan (1993, p. 51) had previously challenged. Some, however, believe that this apparent beneficial shift in psychiatric labels is not as simple because other diagnoses also related to trauma history, such as borderline personality disorder (BPD) is given to “women at a rate of about seven to one over men” (Becker, 2000, p. 423). Borderline personality disorder is characterized by such a diversity of symptoms that many believed it to be the “hysteria of the present,” which involves interpersonal conflict easily apparent within transference, emotional dysregulation, and impulsivity, among a myriad of protean symptoms. Becker claims that BPD illustrates a “caste system of diagnosis and treatment” in psychiatry that involves moral assessment as BPD is mostly given to “the bad girl,” (who speaks and acts out) while PTSD with its non-blaming qualities is afforded to “the good girl” (who stays quiet) (p. 422).

Apart from the DSM V classification, the World Health Organization (WHO) has its own diagnostic system, mostly used in Europe, known as the International Statistical Classification of Diseases and Related Health Problems, currently in its 11th edition (ICD-11), which runs from 2019 to 2022. The ICD-11 includes two other diagnoses:

- 1) Complex posttraumatic stress disorder (C-PTSD) which expands understandings of trauma to repeated experiences of domestic violence, severe childhood abuse and trauma attachment occurring in the context of family and other intimate relationships, in a repeated and extensive way (Curtois, 2004, p. 412; Mahoney & Markel, 2016, p. 3).
- 2) Disorders of extreme stress not otherwise specified (DESNOS) which refers to “a posttraumatic adaptation to severe childhood abuse and attachment trauma” (Van der Kolk et. al., October 2005, p. 413).

Diagnoses of PTSD have changed substantially in each of the four DSM revisions between 1962 and 2013. As it stands now in the DSM V, the PTSD diagnosis falls under the category of trauma and stressor related disorders, instead of being organized under anxiety disorders as it was in all previous editions. This larger category of PTSD includes diagnoses such as acute stress disorder, adjustment disorder, reactive attachment disorder, dissociative identity disorder, dissociative amnesia, complex bereavement, or acute stress disorder, whose only symptomatic commonality consists in the exposure to a stressful event as a precondition (Pai, et. al., 2017, p. 2). According to the DSM V, the diagnosis of PTSD requires meeting a *sine qua non* criteria of direct exposure to actual or threatened death, serious injury, or sexual violence: “[W]ithout this trauma exposure, psychiatric symptoms reported by an individual would not qualify as PTSD symptoms (Pai et. al., p. 3). The exposure should be directly experienced and witnessed in person, (if the direct experience occurs through digital media it qualifies as PTSD only if the exposure is work related), or through indirect exposure (formerly known as vicarious traumatization). Compared with previous editions, the DSM V now excludes, for example stressful events such as divorce, heart attack or terminal cancer, but accepts as trauma specificities such as “waking up in surgery or seeing a life-threatening hemorrhage in one’s child” (Pai et. al., p. 2). Thus, while “PTSD diagnosis may rival in scope the epidemic of hysteria and neurasthenia during the last half of the nineteenth century” (Becker, 2000, p. 425), its diagnostic considerations are arbitrary and render

trauma as necessary but not sufficient to grant the diagnosis of PTSD, affecting access to compensation or services.

The symptoms of PTSD can be divided into four types: intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity, which manifest in recurrent, involuntary, and distressing memories, dreams, dissociative reactions (e.g., flashbacks) or persistent avoidance of stimuli. To be diagnosed with PTSD, these symptoms must be temporal or contextually conditioned to the event deemed traumatic and should either emerge within the first six months after its occurrence or worsen the symptoms pre-existent to traumatic exposure (American Psychiatric Association, 2013, p. 271–272; Mahoney and Markel, 2016, p. 3; Pai et. al., 2017, p. 5). Pai et. al. suggest that one of the main advancements of DSM V regarding PTSD is the separation of the subjective response to trauma from the objective definition of trauma: “[T]he new criteria for trauma and exposure to it further limit the types of events that qualify as trauma for consideration of this disorder and more carefully define qualifying exposures to trauma” (2017, p. 5). The latter statement, which renders auspicious the objective definition of trauma exposure over the subjective response, instantiates clearly the absence of subjectivity in the PTSD diagnostic practices. One of the most inventive critics of the DSM V, Sam Kriss, describes the manual as a “book of lamentations,” a dictionary of madness, but mostly a dystopian novel, containing “everything that can possibly be wrong with a human being... Our narrator seems to believe that by compiling an exhaustive list of everything that might go askew in the human mind, this wrong state might somehow be overcome or averted” (2013, np).

The criticisms of PTSD diagnoses are vast and diverse in their focus. Derek Summerfield, a British specialist in humanitarian psychiatry and psycho-traumatology who worked all over the globe, launched an important debate in 2001, questioning the wide use of PTSD diagnostic, which he claimed was a Western invention. Summerfield’s intervention was broadcasted on BBC and incited more than fifty scholarly responses, creating a loud protest among both psychiatrists and people diagnosed with PTSD. Summerfield condemned the use and abuse of PTSD diagnosis, denouncing it as a North American influence that extends its domination through the medicalization of suffering. Summerfield was followed later by Patrick Bracken, Celia Petty, and Hannah Kienzler who stated that “PTSD is an example of how society and politics have helped to create rather than discover mental illness” (2008, p. 222). Although Summerfield’s claim

is one on behalf precisely of the victims of violence, the debate, according to Fassin & Rechtman (2009), revealed a paradigmatic shift:

Summerfield's arguments were unacceptable to the victims because he claimed to defend their cause while at the same time condemning the trauma model as inherently Western. In doing so, he unwittingly revived doubts as to the authenticity of their suffering, restoring a link to the attitude of skepticism toward victims that had prevailed for over a century. (p. 28)

Bistoën identifies a few problems regarding the diagnosis of PTSD, such as the impetus towards finding common traumatic responses; the Western emphasis on individual psychotherapies, inadequate to addressing collective trauma, which becomes a "*depoliticizing* instrument in service of the status quo;" (2016, p. 13) and the universalization of vulnerability as means of preventing the risk of traumatization. Bistoën claims:

The assertion that PTSD reflects a universal human response to distress suggests that it is possible to predict the impact of war, violence and disaster on Western and non-Western people alike. Moreover, it supports the idea that there exist universally applicable medical technologies to address this form of suffering. (p.16)

Bringing the collective aspect of trauma into discussion is important, as PTSD is not only used within the consulting room of mental health teams, but as a widely used diagnostic tool that determines mental health treatments for social trauma. Cultural and social trauma refer to events that cause significant disruption and wounds to the collective experience, such as slavery, war, the Holocaust, genocide, terrorism, displacement or natural disasters. Collective trauma leaves painful memories for individuals and groups of people and involves individual aspects as much as cultural and sociopolitical variables. I will discuss the connection between social aspects of trauma and the intrapsychic experience in Chapter 6, but in the context of PTSD discussion, it is worth noticing how agencies such as the United Nations Organization (UNO), the World Health Organization (WHO), and their affiliated global non-for-profit agencies, address the psychological and emotional needs of the traumatized population by deploying PTSD diagnosis to Non-western populations in ravaged zones. The latter assumes vulnerability, need of therapy and the implementation of tools used in the Western world, which largely ignore cultural specificity and prevent diverse Indigenous modalities from gaining legitimacy (Summerfield, 1999; Bracken et. al. 1995; Kienzler, 2008; Perera, 2010).

PTSD as a diagnosis, in my view, constitutes a futile attempt to determine the validity of a subject's claim of suffering. The exposure to the Real, a phantasmatic occurrence which can't be located in the sensible world and yet has tangible effects on the body and mind, can't be measured, tracked or predicted. The above controversy brings to the forefront some of the aspects that my research highlights, such as medicalization of suffering, trauma conceptualization as a false dichotomy between individual or collective approaches, and the paradoxical value of the victim's label, all central elements considered in Chapter 6.

2.3.3. Debates on neurosciences, somatic approaches and epigenetics

Thus far I have reviewed how trauma has been conceptualized throughout time by psychoanalysis and also by psychiatry in its diagnostic and medicalizing ways; yet a global “neuroturn,” (De Vos, 2016, p. 129) towards the neurosciences and the brain, as the privileged site of study, has emerged in the past couple of decades which explains trauma in its biological aspect, not so much to locate a permanent lesion like in the early years of psychiatry, but rather focuses on the way trauma alters the nervous system to highlight the ability of the human subject to regulate and achieve plasticity. There is strong interest among mental health practitioners around trauma-specific practices that combine neuroscientific understandings —the neurobiology of stress extrapolated to trauma— and theories of attachment, represented by figures such as Bessel Van der Kolk, Stephen Porge, Paul Levine and Pat Ogden.

Overall, the mind-brain-body unit of analysis focuses on understanding the physiology of the brain in the occurrence of posttraumatic symptoms. Symptoms such as flashbacks, easy startle, hyper alertness, nightmares, panic attacks or feelings of shame, anger or self-loathing, according to this paradigm, occur as a repetition of a persistent neurological reaction fixated on aroused neuropaths, which prevents the nervous system from normal functioning. The overall function of the nervous system consists of processing information from both the environment and the interior organs to initiate appropriate responses; traditionally the brain is divided in three parts: the *central nervous system* (brain and spinal cord), the *peripheral nervous system* (nerves) and the *autonomic nervous system* (sympathetic and parasympathetic involved in activation and homeostasis respectively). The brain is divided longitudinally in two hemispheres, right

and left, and each is split into strongly connected lobes with particular functions: occipital (e.g., link to perception of vision); temporal (e.g., memory); parietal (e.g., perception of touch and speech); and frontal (e.g., thought, movement, personality and behaviour) (Pocket Anatomica, 2004, p. 189-191). There is a system, internal to the *central nervous system*, of utmost importance for trauma stress called the “limbic system” —for its resemblance to a ring— which is associated to survival behaviours, such as “expression of emotion, feeding, drinking, defense, and reproduction, as well as the formation of memory” (Pocket Anatomica, p. 192). The limbic system includes diverse structures such as the hippocampus, amygdala, septal area and hippocampus. The *autonomic nervous system*, concerned with “the operation of body functions and mechanisms outside our voluntary control” (Pocket Anatomica, p. 242) regulates responses emerging within the limbic system when we are under duress, anxious or scared, preparing the body to raise defenses, such as those commonly known as “flight, fight or freeze.” The autonomic system is divided into the sympathetic autonomic nervous system —in charge of activating the body’s defense responses, such as increasing blood pressure, accelerating heartbeat and breathing, enlarging pupils or activating sweat glands—; and the parasympathetic autonomic nervous system —in charge of restoring the body to normal functioning, such as allowing salivation, digestion, elimination, and relaxation to replenish and restore internal body functioning to normal state (Pocket Anatomica, p. 244). As Magistretti and Ansermet (2016) argue, alongside the automatic nervous system, the interoceptive and exteroceptive systems are key to embodiment and contribute to the maintenance of bodily homeostasis:

Exteroceptive sensory systems such as vision, hearing, olfaction and touch detect stimuli that originate from the external world. In contrast, the interoceptive system provides the means to detect the general state of the body... This system informs the brain about the state of viscera, glands and smooth muscles. (p. 141)

“After trauma, the world is experienced with a different nervous system,” claims Van der Kolk (2014, p. 53), one of the most influential voices within the neurosomatic perspective of trauma. Van der Kolk is credited with contributing to the first neuroimaging studies of PTSD, expanding the reach of PTSD to include developmental trauma disorder (pertaining to developmental age in which trauma emerges and indicating attachment causality). In addition, he opposed the overuse of medication and advocated for alternative treatments such as yoga, Eye Movement Desensitization and

Reprocessing (EMDR) and neurofeedback. In his book *The Body Keeps the Score*, Van der Kolk (2014) synthesized the principles of this modality as follows:

1) Our capacity to destroy one another is matched by our capacity to heal one another. Restoring relationships and communities is central to restoring well-being; 2) language gives us the power to change ourselves and others by communicating our experiences, helping us to define what we know, and finding a common sense of meaning; 3) we have the ability to regulate our own physiology, including some of the so-called involuntary functions of the body and brain, through such basic activities as breathing, moving, and touching; and 4) we can change social conditions to create environments in which children and adults can feel safe and where they can thrive. (p. 38)

Van der Kolk argues that posttraumatic stress involves a fixation on a survival response, organized by the so called “Triune Brain” (MacLean in Van der Kolk, 2014, p. 59 & 64) that consists of three parts for which animal metaphors are used. These metaphors are used for the purpose of psychoeducation and are based on the presumed evolution of each of the following systems: a) the “reptilian brain” is the most primitive part of the brain, phylogenetically and ontogenetically, which consists of the brainstem and basal ganglia in charge of arousal, sleep, chemical balance, breathing, etc.; b) the “mammal or emotional brain,” which categorizes perception and warns of danger through emotion via the limbic system; and c) the prefrontal lobe, also called the “rational or human brain,” which is in charge of planning, anticipating, coordinating action and empathically understanding (Van der Kolk, p. 59). Due to the violent traumatic experience, the brain’s capacity to work normally is affected and the critical balance between diverse structures is disrupted. The logic that underlines the cerebral process in trauma is described as two neuropaths, the “high road” (reptilian to rational brain) and the “low road” (reptilian to emotional brain) (Le Dox in van der Kolk, p. 60) which operates as follows: the “low road” is activated by the thalamus (just above the brainstem) grasping sensorial and proprioceptive stimuli (movement and position) which sends an alarm signal to the amygdala —“the smoke detector” of the nervous system— in the shortest time, activating the limbic system and ordering the hypothalamus to release stress hormones (norepinephrine for the short time effort and cortisol for a longer endurance of stress). The “high road” runs from the thalamus, via the hippocampus, to the prefrontal cortex, the so-called “rational brain,” with the purpose of sorting out information, as well as to plan, anticipate and discern appropriate actions. When the reaction from the “reptilian brain” is of unusually great intensity, such as startling

responses in posttraumatic traumatic sequelae, the sympathetic nervous system — arousal based— overloads and activates the defensive response, while the prefrontal lobe is disengaged and partially unable to perform its usual tasks. This mechanism repeats in posttraumatic stress, resulting in a life organized by permanent stress, as if the scene of trauma becomes omnipresent.

The so called “neurocircuits” are to be understood in relationship to two terms: attachment and attunement. Attachment theory was developed in 1957 by psychiatrist John Bowlby, a psychoanalyst who renounced Melanie Klein’s orthodoxy, and Mary Salter Ainsworth, a Canadian developmental psychologist working in Uganda (Bretherton, 1992, p. 760). They came up with a theory based on observations of the mother’s and the infant’s behavior and explores the conditions that create safety, security and protection within the dyad mother —or early care provider— and child (Benoit, 2004, p. 541). The child develops some behaviours, such as smiling, crying, clinging, following, and sucking (Ainsworth et. al. 2015, p. xvii), which are meant to seek proximity or contact to gain a sense of safety and to allow a secure environmental exploration. Attachment relationships in this theory are categorized as secure or insecure, the latter with three modalities, known as avoidant, resistant or ambivalent, and disorganized or chaotic (Benoit, p. 542). In other words, if the child does not feel sufficiently safe with a parent or caregiver at the time when the infant, in its ontogenetic prematurity, requires attention and reassurance to interact with the world, the baby will learn how to respond by trusting, avoiding, resisting, or disorganizing in relation to others. These forms of early attachment are affected by emotional “attunement”, a term that means “being attuned to” and refers to ways in which people tune to physical signs and subtle facial expressions to calm each other when distressed and that regulate the early responses to fear and danger (Van der Kolk, p. 112). The neurological base for these phenomena is found in mirroring mechanisms, mimetic functions, imitation or simulation coordinated by the MNS (Mirror Neuron System) discovered by Fonagy in 1997 (Weigel, 2016, p. 47) and which Lacan and Winnicott had already discussed from a psychoanalytic perspective through the concepts of the “mirror stage” or Winnicott’s “good enough mother,” (Lacan, 1949/2006, p. 75; Winnicott, 1958/2001, p. 237).

The understanding of trauma based on its neurological causes has also been discussed by Stephen Porges, who expands the “arousal theory,” as he believes that it neglects larger questions of how the nervous system, which he understands in its

evolutionary aspect, relates to social aspects, the environment and its interaction with other systems, such as the immune system (2001, p. 123). Porges gave birth to the polyvagal theory in 1994 to locate posttraumatic stress effects within the tenth cranial nerve, known as the “vagus,” the longest and most complex of 12 pairs of nerves that go from the brain branch off to every major organ in the body, that is, the eyes, nose, mouth, heart, lungs, stomach, intestines, and so on. Porges calls it a “poly” vagal nerve to designate the many nerves that branch out off from the main vagus nerve to the other organs of the body. This theory engages phylogenetic explanations of the sociality of the autonomic nervous system, which controls arousal and relaxation processes and proposes the basis of physiological responses in social behavior by establishing a connection to visceral reactions triggered by this nerve in response to gestures, facial expressions or voice tones perceived as stressful. In other words, this theory refers to the “gut feelings” present in affective human responses to others while in social engagement, which Porges claims “is intimately related to stress reactivity” (p. 185). Depending on how the different branches of this large nerve are activated, divergent reactions ensue, such as mobilization, communication or immobilization. For example, when a healthy baby is stressed and needs comfort or support, it firstly engages socially by calling for the caregiver’s attention, such as crying. If such a strategy persistently fails or if the infant encounters more stress because of the caregiver’s reaction, the baby will recourse to more primitive ways of soothing such as flight or fight. And if the more primitive way also fails, the last mechanism available to the infant is an even more primitive reaction such as preserving stasis by freezing movement or collapsing. In posttraumatic suffering, the traumatized individual maintains ongoing reactions of stress that negatively impact the immune system and affect the “health, growth and restoration” of diverse organs, essential to overall health (Porges & Dana, 2018, p. 51).

Another author interested in neurosciences with a focus on trauma is Peter Levine, a biophysicist and psychologist who trademarked the therapy called “Somatic Experience” (SE). Levine focuses in understanding the cycles of under- and over-activation that occurs in traumatic sequelae, recognizing an orientation to the external environment (exteroception) and increasing interoceptive awareness (Levine et. al., 2018, p. 622). Levine’s follows a model found in animals under stress in their natural environments, such as: startle-alert, defensive and exploratory orientations, and self-protective responses. The aim of SE therapy works “with the body narrative, attending to

somatic cues before developing an interpretation of the verbal narrative, and this may differ from psychoanalytic approaches that prioritize associative memory and unconscious fantasies” (Levine, 1997, p. 623). Levine uses neurological lingo in more simplistic ways compared to others as it mostly relies on evolutionary and ethological vitalist comparisons of humans with other animals for the purpose of explaining trauma. In Levine’s book *Walking the Tiger: Healing Trauma* (1997), the human subject’s reactions to traumatic events are compared to impalas, tigers, or trees (p.15 & p. 33). I take issue with this approach as it might contribute to an underlying social Darwinism, or an uncritical discussion of the larger socio-political and historical aspects involved in trauma.

An integrative approach that focuses on trauma is the Sensorimotor psychotherapy developed by Pat Ogden et. al., (2006) which is based on Ron Kurtz’s body-oriented psychotherapy known as the Hakomi method. Sensorimotor psychotherapy integrates therapeutic perspectives such as psychodynamic, cognitive behavioral, neuroscientific, and theories of attachment and dissociation with somatic based approaches that focus on body sensations and movement. The Sensorimotor psychotherapy engages with client’s narratives and focuses on cognitions and affect, as well as on a “bottom-up” approach that addresses “unbidden *physical* sensations, movement inhibitions, and somatosensory intrusions characterized of unresolved trauma” (Ogden et. al, p. 29).

There is also a nascent field of trauma research, known as neuropsychoanalysis, the surprising blend of neuroscience and psychoanalysis, whose engagement ranges from cultural studies (Weigel, 2016), philosophy (Johnston, 2013; Malabou, 2015) to interdisciplinarian approaches (Magisttreti & Ansermet, 2016; Johnston, 2013). The neuropsychoanalytic efforts to account for trauma within the body and the mind follow a parallelistic philosophy rather than a monolithic separation of objects (De Vos, 2016, p. 35). Neuropsychoanalysis highlights an interdisciplinary intention that bridges brain studies and an inquiry about the unconscious, specifically with respect to affect, embodiment, memory, dreams, infant’s early relationships and, prominently, the drive. As articulated by Wiegel and Scharbert who edited a book on neuropsychoanalysis, bridging psychoanalysis and bio-neurology in the 2000s is a “reverse mirror” of hostility and skepticism from the side of psychoanalysts, as compared to the 1900s when neurologists were more reticent to engage in thinking psychoanalysis (Wiegel, 2016,

p.1). This hybrid field attempts to reconceptualize Freudian metapsychology “within a totally different episteme and a terminology based on anatomical mappings of brain areas (and its lesions), of somatic markers, neurological functions [and] the role of neurotransmitters” (Wiegel, 2016, p. 3). For the latter’s purpose, neuro-psychoanalysts incorporate humanities scholarship engaged with historical and scientific perspectives of the psychical apparatus and inquiry its epistemology.

Among researchers and clinicians of neuropsychanalysis, there are divergencies particularly with regards to Freud’s concept of the drive, which constitutes one of the first structural trauma (alongside death and otherness): “The idea of drive consequently determines the amount of engagement with physiology or biology that is demanded by psychoanalysis” (Wiegel, 2016, p. 8). Magistretti and Ansermet (2016), a Lacanian psychoanalyst and a neurologist, respectively, work on the concept of the drive conceived as within the nervous system yet absent of biological determinacy. Their work highlights a plastic principle —flexibility within the rigidity of the anatomy— that regulate body homeostasis and follow principles quite different in the human than in animals: “In humans the homeostatic regulation mediated by the interoceptive system goes beyond the reflex level at the spinal cord, brainstem and hypothalamic levels” (p. 143). By means of language and its representative qualities, and beyond a generalizing neuroanatomical reflex, these authors explain the anatomical seat of representation of somatic markers and symbolic re-representations as “equivalent to the Freudian *Vorstellungsrepräsentanz*” (p. 144), the representative or ambassador of the drive. Magistretti and Ansermet locate the seat of the drive in the insular cortex, part of the cerebral cortex where sensory signals generated in the body are terminated. Still concerned with neuroanatomy, they overpass the simplistic mainstream neuro explanations about how the body and mind interact, to trace the mechanisms involved in mentation (mental representation) of the proprioceptive information (internal to the organism) and the exteroceptive stimuli (the environment) that culminate in motor actions (discharge), which will be discussed in detail when I review the specifics of the body within trauma in Chapters 6 and 7.

Adrian Johnston, a Lacanian philosopher, following the trailblazing work by Antonio Damasio, sees an opportunity in Lacanian neuropsychanalysis to think brains as a *cerveau morcelé* “a detotalized, not-thoroughly-systematic/systematized system,” (2013, p. 55) which can allow us to think somatic phenomena through the Lacanian

Real, as Johnston claims that “there is something in the organic more than the organic itself” (p. 49). Johnston engages with the concept of *transcendental materialism* to propose:

an account of the genesis of denaturalized subjects out of embodied libidinal economies, itself situated within the framework of a nonreductive, quasi-naturalist materialism synthesizing resources drawn from psychoanalysis, neurobiology, and philosophy. (p. 48)

To Johnston, the neurosciences confirm the incompleteness proposed by Lacanian psychoanalysis as he claims that the brain as living system is “non-Whole/not-One” (p. 50) and constitutes itself a “barred corpo-Real in excess of the barred (and barring) big Other” (p. 53).

Ed Pluth, supportive of Johnston’s rigorous dialogic endeavour with the natural sciences, questions primordially the divergent nature of the objects of study in light of the dialectical nature of the psychoanalytic inquiry between theory and its object; he points out the risk of a reductionistic belief that sustain that being and structure derive from a neurobiological base theory (2013, p. 88). De Vos, in his book “*The Metamorphoses of the Brain – Neurologisation and its Discontents*” (2016) engages extensively with the neuroturn in its educational, philosophical, cultural, sexual, spectacular and political aspects, arguing that this brain fever “signals a fundamental and structural break qua subjectivity and sociality” (p. 5). Quite opposed to the obscenities of the “brain fest” (p. 188), de Vos sees this neuroturn as a superego’s imperative, as an ideological movement to erase the question of the subject since the neuro discourse has successfully moved the inquiry of the subject’s being from “having a brain to being a brain” (p. 3). This rich debate will be further discussed in my dissertation.

To conclude the natural sciences discursivity of trauma, I want to mention epigenetics, a field about two decades old within the discipline of genetics that studies the molecular level of events that cannot be explained by genetic knowledge, and which contribute to think of trauma in its biological aspect. Epigenetics literally means “above genetics,” and according to Lehrner and Yehuda, refers to environmental influences that affect the expression or suppression of genes by “directing transcriptional activity” (2018, p. 1763). The field of epigenetics describes the complex and dynamic interface of environment-biology in the intergenerational transmission of traumatic effects, through highly selective procedures of biochemical semiotics at the molecular level (DNA

methylation, the most common procedure). The process of methylation is the biochemical process that attaches methyl groups to other groups within a cell, impacting gene transcription by activating some and suppressing others (Lehrner & Yehuda, 2018, p. 1768). Methylation does not change the DNA sequence but affects the manifestation or silencing of certain genetic functioning, and thus the phenotype, that is, the individual's observable traits. Although these changes are stable — at least more so than the above-described hyperarousal reactions of the nervous system— these changes are reversible (Nugent, et. al., 2015; Lehrner & Yehuda, 2018). Epigenetic studies about intergenerational transmission of trauma have observed how DNA transcription of certain parts of the code influence the way cells react and thus it modifies larger phenomena; for example, Nugent, et. al. (2015) reviewed several studies of children and adolescents who have suffered trauma and whose immune system has partially been affected, thus presenting chronic medical issues (p. 58). Yet, exposure to the traumatic event is not necessary for trauma to leave its mark in a lineage. A few studies on victims of famine shows that the starvation effects in pregnancy affects the adiposity developed in offspring up to the third generation, providing support that “environmental stimuli or deprivation during pregnancy may have effects on health outcomes over two generations” (Painter et. al. in Lehrner et. al., p. 1170). These findings were similar when studying epigenetic marks in paternal semen, which showed that “adult offspring of fathers exposed to famine had higher body mass index and obesity rates” (Veenendaal et al., 2013 in Lehrner & Yehuda, p. 1770). Thus, the epigenetic mechanisms that activate or silence certain genes required not immediate exposure to modify the cellular response. However, Lehrner and Yehuda demonstrate something important for my Lacanian approach on language:

The experience and transmission of trauma effects are embedded within a larger cultural context that includes narratives, beliefs, and practices. The effects of trauma are also felt and transmitted within a sociostructural context that includes access to resources, relative safety of the neighborhood, and the larger political environment. (p. 1769)

I will discuss in depth the transgenerational transmission of trauma in Chapter 6 but for now is sufficient to highlight how epigenetics research might provide a possible connection between the memory that has been conserved at a molecular level, and which shapes the expression of the genome, language, and the material effects of what psychoanalysis calls the negativity of the Real. I now explore how trauma is seen within

the field of psychology, the dominating psychotherapeutic model in the mental health institution.

2.4. Cognitive behaviorism: The hegemonic model of therapy

Psychology, the discipline that studies the mind, is older than psychiatry and emerged in antiquity through the exploration of vast phenomena, such as cognition, senso-perception, emotion, behaviour or interpersonal relationships. Psychology is currently a field of study that ranges from clinical, to educational, experimental, human, social or critical focus with vantage points combined with other sciences, such as neurosciences, social sciences, psychoanalysis or the humanities. In the treatment of trauma in the mental health institution, as can be seen in Chapter 3, psychoeducation, a model intrinsic to the Cognitive Behavioral model, is the predominant therapeutic approach not only within the research sites of my study, but in the global scene. The roots of cognitive behavioral therapy are found in behaviorism and cognitivism, and in this section, I review the underlying tenets of this perspective.

The philosophy of science supporting behaviourism is grounded in the tradition of materialistic monism, associationism and logical or positivistic empiricism (Ford & Urban, 1998, p. 328) whose tenets are that: “Scientific observation is objective, that controlled laboratory research is necessary to prove theories, and that laws about basic processes are deterministic, allowing them to be extrapolated and applied with a little loss of predictive power” (Barone, et. al, 1997, p. 9). This modality has its antecedents in the work of Ivan Petrovich Pavlov, the first Russian Nobel prize winner of Medicine in 1904, who was interested in learning theories through the study of biomarkers in basic research with animals. Pavlov developed a theory known as classical conditioning, which described the acquisition of conditioned responses in animals, the extinction of such behaviour, and the induction of experimental neurosis (Wampold, 2015, p.19). Pavlov was the first well-known researcher that proposed a conditional and contiguous relationship between stimuli (environment) and response (organism); later these notions were developed by John Watson, from the Columbia University, who in 1921 conditioned a phobia to white rats in “Little Albert,” a 9-month-old boy, by pairing the presentation of the animal with a loud noise. And yet, Watson never bothered to treat the boy’s conditioned phobia.

B.F. Skinner, a known radical behaviorist from Harvard University, in the late 40s expanded behaviorism by asserting that the stimulus-response causality is subjected to the laws of contingency and reinforcement. For the association to occur, the environmental event must be contingent to the response elicited, while the reward or punishment must reinforce or extinct such associations. The basis of these theories follows a three-term contingent relation that exists between antecedent stimuli, the behavior, and its consequence, known as A-B-C. Behavior in this model can be strengthened through positive reinforcement by providing a desired reward (physical or social), and it can also be strengthened through negative reinforcement, by removing something aversive. A few models of reduction or strengthening of behaviour emerged, for example: operant extinction withholds presenting consequences to maintain a given behavior; negative punishment reduces the frequency of behavior by removing a consequence after the performance of a behavior; and positive punishment weakens behavior by presenting aversive stimuli contingent to the undesired behavior. These theories were expanded by Canadian theorist Albert Bandura, from Stanford University, who proposed a social learning theory that incorporated the hybrid work of Dollard and Miller's on imitation, which was psychodynamic and behaviorist in spirit, and proposed that humans learned through others who serve as a model to the behaviours (Ford & Urban, 1998, p. 331).

This behaviorist approach, quite popular for its ability to be measured, excluded subjective introspection, and thus cognitive approaches emerged to address mentalization or exploration of mind processes and states. In the 1980s, behavioural programmes proliferated and started to include cognitive components to treatment. Opposing the trends of the time, psychoanalysis and behaviorism, Aaron Beck, a psychiatrist based at the University of Pennsylvania, created Cognitive Behavioral Therapy (CBT) originally for the treatment of depression, and nowadays is extended to treatments of anxiety, anger and posttraumatic stress. Beck trained within a "psychodynamic" tradition, a term that diluted Freudian dogma into clinical practices that engage conceptions from diverse traditions (Jung, Adler, Erickson, Kohut, etc.) and focused on the concept of the autonomous ego and its strengthening, However, Beck moved to cognitivism as he discovered that conscious thoughts were hurdling the process of change, and thus "there was no need to go deeper; a model based on his

patients' internal representations of themselves, their experiences, and their future could account for both their dreams and their symptoms" (Hollon, 2010, p. 68).

CBT's theoretical underpinnings owed its philosophical origins to the Stoics, particularly Epictetus, whose focus on affect refers not so much to *what* happens to people but *how* it is perceived. Other philosophies influenced the later CBT's umbrella of treatments (mindfulness) such as Buddhism and Taoism with regards to the impermanence of self and the assumption that "all phenomena are empty of inherent existence" (Murguia & Diaz, 2015, p. 39 & p. 45). CBT assumes that human suffering is caused by an underlying biased information processing that produces automatic thoughts accessible to conscious inquiry. These thoughts are considered "inaccurate" beliefs about the self, the world and the future that cause negative emotions and maladaptive behaviors (Hollon, 2010, p. 65; Gaudiano, 2008, p. 2). To remediate such suffering, Beck devised through randomized clinical trials "basic strategies for teaching patients how to explore the accuracy of their own beliefs and how to protect themselves from the biasing effects of schema-driven processing" (Hollon, p. 65). CBT is action oriented, focused on symptom reduction and the therapist's role consists in facilitating emotional learning of the processes assumed to be the cause of the suffering. The therapeutic core of CBT explains the underlying faulty mental processes —clusters of beliefs, patterns of information engagement, etc.— and develops skills to remediate the unhelpful thoughts, which *structurally* inhibit critical thought and ethical agency, as the theory is concerned with the modification of perception rather than with social and environmental contexts.

CBT was extended by Albert Ellis, creator of Rational Emotive Behavioral Therapy (REBT) (1956) and by David Burns (1980), famous for his bestseller "Feeling Good." Ellis follows another "ABC" model (activating event— belief system— cognitive disturbance) to determine dysfunctional thoughts, which in a nutshell relates to three main categories of grandiosity that are framed as *must* statements: "I must be successful, others must treat me well, conditions under which I live must be agreeable to me" (Murguia & Diaz, 2015, p. 38). After considerably well-funded research, this model reached the conclusion that gently reprogramming the individual's language from "must" to "I would prefer" could do the trick of improving people's lives (Murguia & Diaz, p. 39). In contrast, Burns (1984) identified a few cognitive distortions to help individuals to recognize the faulty cognitive distortions. Among the *automatic thoughts*, Burns listed:

“all or nothing thinking, overgeneralization, disqualifying the positive, jumping to conclusions, catastrophizing, minimization of the positive, or ‘should’ statements” (p. 75). The role of the therapist is to invite the client to come up with statements that counteract such irrational responses.

Nowadays, CBT is an umbrella term that includes many cognitive therapies, often focused on a particular trait or pathology, such as problem-solving therapy, dialectical behavior therapy, rational-emotive behavior therapy, cognitive processing therapy, mindfulness-based cognitive therapy, compassionate-based therapy and, of course, trauma-focused therapy. Among the therapies used in the researched sites we find Dialectical Behavioral Therapy (DBT), a modified approach from the traditional cognitive treatment, created by Martha Linehan, an adjunct professor of psychiatry and behavioral sciences at University of Washington in Seattle. The DBT modality is considered part of CBT’s “third wave” as it reincorporates behavioral aspects that were in vogue in the 1950s (Gaudiano, 2008, p. 2). The DBT is used to treat personality disorders, prominently borderline personality disorder (BPD), asserting that cognitions are necessary but not sufficient for improvement, and proposing instead skill training modules, such as: Core mindfulness, emotional regulation, distress tolerance, interpersonal effectiveness, and relationships (Linehan, 1993, p. 10). Another counselling modality used in the sites I researched is Motivational Interviewing, which is used primarily in addictions services as a therapeutic technique to overcome repeated and unwanted behaviors. Motivational Interviewing proposes six stages towards behavioral change: precontemplation, contemplation, preparation, action, maintenance and lapse. The clients considering behavioral change discuss their stage of change with their counsellors, and through evocative questions, the therapist encourages thought reframing by highlighting the disadvantages of the status quo and by engaging intention and optimism regarding change (Miller & Rollnick, 2002, p. 24). All of the above-mentioned therapies are based on psychoeducation and follow a manual that specifies behaviors that need to be either increased or decreased, details cognitive-behavioural techniques, and provides homework exercises so people practice the techniques outside of sessions.

The cognitive behavioural approach to trauma, marked by a focus on thinking, emotion and behaviour, has dominated the treatment of trauma sequelae within the global mental health institutions in spite of the fact that there is a large body of evidence

supporting *alternative modalities*, such as a) somatic approaches to treating trauma that blend the neurophysiology of the body with analysis of social and relational attachments (Van der Kolk, 2014; Porges, 2001; Levine, 2018; Ogden, 2006; Fisher, 2019); b) co-adjutant mind-body interventions such as yoga or meditation in places that intentionally create the conditions to gain a mindful relaxation (Stevens & McLeod, 2019; Ong et. al., 2019; Cramer et. al., 2018; Kelly et. al, 2018; Gallegos, 2017); c) psychodynamic-based approaches to explore unconscious attachments, interpersonal complexities and ethical inquiry regarding compulsive repetition (Van Nieuwenhove et. al., 2018; Van Nieuwenhove et.al., 2019; Schottenbauer, 2008; Bistoën, 2016; Leichsenring et. al, 2015; Leichsenring, 2014, Desmet, 2018); d) therapies that empower identities through socially aware narratives (White, 2004; Beaudoin, 2005; Combs & Freedman, 2012); e) expressive art therapies, like art, music or movement, which afford ways of processing psychological aspects outside speech, grounding the individual in culture (Schouten, 2015; Hass-Cohen, 2014); f) there is evidence on the importance of therapeutic companionship, key to any program, led and designed by peers (Repper & Carter, 2011; Mahlke et. al., 2014; MacNeil & Mead, 2005; Lowery & Stockes, 2005); g) social justice inquiry to target inequality for vulnerable populations, structural stigma or settler racism (Piat, 2012; Hatzenbuehler & Link, 2013 & 2014; Dupuis-Rossi & Reynolds, 2019; Timothy, 2012; Linklater, 2014); h) humanistic models grounded in social healing practice in dialogue with social theories (Wampold, 2015; Kienzler, 2008; Davoine & Gaudilliere, 2004); i) complementary and alternative medicine (CAM) like acupuncture or massage therapies (Singer & Adams, 2014; Shay et.al., 2019); j) access to culture, in supportive ways, to regain anti-oppressive social connections through intersectional lenses (Gone, 2013; Liu et. al., 2014; French et. al, 2020; Reeves & Stewart, 2015; Hartmann et. al., 2019); and k) combination of somatic and cognitive treatments, such as Eye Movement Desensitization and Reprograming (EMDR) that uses bilateral stimulation —eye movements or alternating tapping— arguably to reintegrate traumatic memory by activation of emotions, images and sensations that emerge in free association (Korn, 2009; Shapiro & Brown, 2019; Thompson et. al., 2018).

Notwithstanding the above evidence, the model dominating the treatment of adult trauma in the global mental health settings is CBT through the implementation of psychoeducation, cognitive restructuring, and exposure therapy (Fernandez, et. al., 2018, p. 81) and by incorporating variants known as Prolonged Exposure (PE),

Cognitive Processing Therapy or Trauma Focused CBT (TF-CBT). The organizing principle of these trauma treatments are aligned with the DSM V whose two main criteria to identify trauma read as follows: the “presence of recurrent, involuntary, and distressing memories, dreams, dissociative reactions (e.g., flashbacks) and persistent avoidance of stimuli associated with the traumatic event” (American Psychiatric Association, 2013, p. 271). Thus, the CBT treatments assumed that trauma memory is stored hierarchically (from low arousing level to high arousing level). The emphasis of CBT’s trauma therapy is on managing anxiety avoidance as it relates to the traumatic memory, by organizing diverse levels of stimuli to find what memories are being triggered and then gradually expose the individual to them (from low to high). When certain stimuli trigger memories that eventually become consciously intrusive thoughts, the subject experiences heightened anxiety. If memories keep repeating, they generate symptoms of hypervigilance, startle responses, and most importantly avoidance, which manifests itself as destructive behaviours. Yet the CBT therapeutic model is based on an individual’s “narrow focus on their own memories, thoughts and beliefs” (Bracken, 2002, p. 210), and thus constitutes an epitome of the theoretical bankruptcy of the CBT modality. The CBT model constitutes an exercise of governance of the experience, as has been seen in research that traumatic memory is a “man-made disease of memory,” created by the clinical discourses that demand memories to fit the Dx of PTSD (Young, 1996; Summerfield, 1999). The CBT model also demands from the analysand to produce what the manual says should be produced, hence constituting a validation of the therapist and the system more so than the analysand.

Dany Lacombe, a Foucauldian scholar, gives a well nuanced example of what is at stake with the CBT’s reductionistic approach. Lacombe engaged in an ethnographic research project in 2000 in a prison treatment program for sex offenders in British Columbia, Canada. She observed that the treatment resembled school teaching, was grounded in risk management and the techniques of introspection, reflection and self-discipline. But the program was mainly organized around the offender’s ability to internalize their crime cycle to prevent relapse into criminal behavior by a stated expectation that the offender voiced their sexual fantasies. If the sexual fantasies—an equivalent of the traumatic memory in CBT’s trauma model— were absent, offenders were thus considered at risk of relapse (Lacombe, 2007, p. 56). This treatment,

Lacombe concludes, “governs the self of the sex offender, by providing a fixed identity” that “once a sex offender, always a sex offender” (p. 59).

At its core, CBT’s focus on the symptom produces a similar demand to analysts in diverse mental health clinics, such as those struggling with suicide, eating disorders, anxiety, anger, etc. Each symptom has a predetermined definition, a psychoeducational process and a clinical strategy that needs to be followed within the manual. In doing so, CBT’s therapeutic processes reinforce the same symptomatic identities it aims to treat.

Yet, those who suffer from complex PTSD (as above described a notion of incremental and repeated exposure to great emotional stress or abuse) receive another kind of treatment, which combines psychoeducation with other treatments that allow certain narrativization through multimodal, phase-based interventions or any other hybrid modality that starts with CBT and increases in depth as the treatment advances (Mahoney & Markel, 2016; Kaminer & Gillian, 2017; Edwards, 2013). For example, the Narrative-Emotion Process model (NEP), under the CBT umbrella, states that “the empathically attuned, responsive therapist can help clients develop a 'storytelling function' for a more emotionally integrated, coherent understanding of the self and relationships” (Macaulay & Angus, 2019, p. 42). Even when there is a significant awareness of the complexity of trauma and the need to incorporate multilevel intervention, even including psychodynamic jargon such as transference or attachment coded in the unconscious, the model is mechanistic as the awareness of complexity turns into a short-term, manualized approach that is effective in “as few as 12 sessions, following a model of (a) skills and safety, (b) hierarchy development, and exposure, and (3) psychodynamic elements” (Mahoney & Markel, p. 5). Reading this body of research feels as if reading a cooking recipe:

Now that the individual has had the opportunity to incorporate multiple skill sets as well as functionally process the traumatic content using a hybrid of cognitive and behavioral aspects, he or she is ready to begin to explore the deeper content of the psychopathology (e.g., characterological aspects). (Mahoney & Markel, p.15)

Sprinkled with some joyful statements and the person is good to go.

2.4.1. Debates on Western and reductionist approaches to the complexity of trauma

While psychiatry dominated the field of diagnosis and the neurological discourses of mental suffering, behaviorism and cognitivism have provided the basis of a reductionistic approach to “pragmatically” respond to suffering, premised on a learning economy of reinforcements and a response-based paradigm with an emphasis on measuring effectiveness. The cognitive behavioural model of domination of the global mental health, mixed with simplified popularizations of neuroscientific lingo, constitute a form of ideology, as Sampson (1981) articulates:

The cognitivist emphasis that marks much of contemporary psychology participates in presenting a portrait of humanity in which mental events, mental activities, mental operations, mental organization, and mental transformations are of greater importance than events, activities, operations, organization, or transformation of the external world. Furthermore, not only are these mental operations cut off from their objective roots in social and historical practice, but also, in being located within the mind of the individual, they cut off people from effective action to change their circumstances rather than their subjective understanding of these circumstances. (p. 733)

The use of CBT treatments outside of the clinic, such as areas ravaged by war or natural disasters, have elicited important debates among scholars that study humanitarian mental aid (Summerfield, 1999; Bracken, 1995; Bistoën, 2016; Fassin & Rechtman, 2009). For example, “[w]ar zones increasingly attract projects under the umbrella term ‘psychosocial’” (Summerfield, 1999, p. 1492) which are vital for social assistance and community reorganization, but the needed aid has increasingly turned into an epistemic domination that aims to elicit certain responses or else default to pathologization, all the while basing subjectivities on psychological models that are manufactured in Western universities.

This *a priori* has been criticized by the very discipline of psychology through a large study that sparked an important debate with abundant responses. Henrich et. al.'s *The Weirdest People in the World?* (2010), engages evolutionary thinking in psychology and behavioural sciences to claim that psychological studies, “expect humans from all societies to share, and probably share substantially, basic aspects of cognition, motivation, and behavior” (p. 62). Yet, Heinrich et al., argue that most of the population behind the universalizing claims hold a disproportionate reliance on what they call “WEIRD

subjects” (p. 63) where WEIRD stands for Western, Educated, Industrialized, Rich, and Democratic:

A recent analysis of the top journals in six subdisciplines of psychology from 2003 to 2007 revealed that 68% of subjects came from the United States, and a full 96% of subjects were from Western industrialized countries, specifically those in North America and Europe, as well as Australia and Israel (Arnett 2008). The make-up of these samples appears to largely reflect the country of residence of the authors, as 73% of first authors were at American universities, and 99% were at universities in Western countries. This means that 96% of psychological samples come from countries with only 12% of the world’s population. (p. 63)

Despite the critiques and the increased frustration among therapists and analysands alike, CBT has positioned itself as a “small revolution” (Wampold, et. al., 2015; Gaudiano, 2008) and constitutes a staple for research funding and publication in the field of psychotherapies (Wampold, et. al., p. 26). This ample support is due in part to CBT’s ability to be massively reproduced via treatment manualization, as compared to humanistic or psychodynamic treatments, thus, fitting “more neatly into the clinical trial paradigm” (Wampold, et.al., p. 27). I will articulate in Chapter 4 how CBT’s success, and by extension much of the so-called “evidence-based research” in the mental health institution, is a phantasmatic mechanism that provides a fragile protection against the complexity and challenge of trauma and mental health issues.

Thus far, I have reviewed various approaches to trauma, from psychoanalysis, to psychiatry and psychology. As my research is informed by the methods and conceptualizations of the discipline of geography, I now turn to review how trauma is approached in psychoanalytic geographies.

2.5. Spatializing trauma in psychoanalytic geographies

The subfield of psychoanalytic geographies (Callard, 2003; Nast, 2000; Kingsbury & Pile, 2014) has contributed to situating trauma within a dynamic “topological constellation” (Blum & Secor, 2014, p. 115) wherein the causes and effects of trauma are not simply located ‘inside’ an individual’s mind but are rather materially externalized in lived socio-spatial relations and practices (Kingsbury, 2007; Pile, 2014). Such an approach challenges traditional, rigid and static topographic understandings of trauma,

and enhances our understanding of how spatial-based experiences of trauma are embedded in wider social, cultural, and political contexts.

2.5.1. Extimacy and scale

Space in geography has been studied from perspectives that range from the mathematical study of two- or three-dimensional variables of quantitative physical space, to notions of place, landscape, territory, site, property, proximity, distance, embodiment and position (Massey, 1994; Derek, 1994; Crang & Thrift, 2000; Davidson, 2009). To think the complexity of unconscious space, psychogeography relies on Lacanian topologies, such as *extimacy*, a concept that refers to an “intimate exteriority” (Lacan, 1959/1992, p. 139) at the core of human subjectivity and that interconnects the loci of subject and Other, entwined in a Moebius band-like topology. Lacan characterizes the unconscious as a discovery and defines it topologically as radically *extimate*: “That which is inside the subject, but which can be realized only outside, that is to say, in that locus of the Other” (Lacan, 1964/1998, p.147). Lacan utilizes the Moebius band as a model of the unconscious where “its outside continues its inside” (Lacan, 1964/1998, p. 156), a continuous boundary that has no back and front or external/internal distinctions. The Moebius band is important because it provides a way to access the unconscious, as “it is in the surface that depth is being seen” (Lacan, 2006, p. 503). For Kingsbury Lacan’s concept of *extimacy* is a crucial point to problematize topologically “a profusion of binary distinctions between, for example, outside-inside, truth-fiction, man-woman, departure-arrival, signifier-signified, container-contained, subject-object, being-appearance and past-future” (Kingsbury, 2007, p. 246).

Another way to think trauma from a psychogeographical perspective is through the concept of scale, a common reference in geography to situate objects in spatiotemporal measurement, level, relation or size, and whose significations range from being an “epistemological tool” to being considered a “material attribute of the world” (Sayre & Di Vittorio, 2009, p. 19) (cf. 1.3.2). To situate the object of trauma in the divergent spaces of the individual subject and the society she inhabits, I guide my inquiry with the notion of scale as proposed by Kingsbury and Pohl, who, following Žižek, describe scale as a post-foundational concept. That is to say, instead of seeing the notion of scale as something that provides ontological universal attributes, scale is instead rendered as an epistemological category of spatial imaginaries that emphasizes

the role of fantasy, the disproportion of size, and the changing relations of inside/outside (Pohl & Kingsbury, 2021, p. 207). For example, the scale of trauma could not provide a consistent ontological base because it cannot measure the specific effects of the variation or impact of trauma either within an individual or a population. Rather the scale of trauma is a discontinuum that signals more complex interactions; for example, the magnitude of traumatic events and their relational effects are primarily determined by the role that fantasy plays and which refers to “the coordination of desire, organization of enjoyment, and the covering up of a certain threatening lack” (Pohl and Kingsbury, 2020, p. 208). The scales of trauma will be further discussed in this dissertation, when I formalize the spatial aspects of trauma that interconnect the subject and the institution (cf. Chapter 5 & section 6.2).

2.5.2. Trauma rendition in psychogeography

Psychoanalytic geographers have rendered trauma in a variety of forms and in this section, I review a few examples. In *The Body and the City*, Steven Pile (1996) provides spatial reflections on the nature of psychic space. Pile analyzes the psychic, political and spatial relation between the city and the subject by taking Freud’s metaphor of the city of Rome as an example of psychic space. Freud wonders if memory-traces in the mind could function as an ancient city with its ruins hidden under the newly built constructions. Freud refutes such analogy, stating that: “The same space cannot have two different contents” (Freud quoted by Pile 1996, p. 241; and in Blum & Secor 2014, p.115). Pile believes that Freud’s response “marks a rejection of the static, passive and undialectical notion of space (which is encapsulated and exemplified in his notion of the unconscious as a space without time)” (1996, p. 243). Thus, Pile locates the dialectic spaces of identification, incorporation, idealization, introjection, etc. as relations of proximity that are embedded within power and resistance, both at the level of the family (e.g., children’s tantrums) or society at large.

Another example of topologies of trauma is found in the work of Virginia Blum and Anna Secor (2014) who approach material and psychic spaces of trauma by discussing Freud’s early studies on hysteria; they compared Freud’s map of Emma Eckstein’s symptoms, above discussed, to maps drawn by children who witnessed a shooting attack in their elementary school, reported by Pynoos and Nader (1989). Blum and Secor provide insights to think clinical and socio-spatial aspects, as they elucidate

how “the intersection of psychic and material space is the (always already) condition for the origin of trauma” (p. 111). They spatialize the way in which trauma —a psychic condition— fixates and extends in material space by locating trauma in a topological relation of psychical and material correlations. For instance, they discuss Freud’s case of Elizabeth, a woman who had leg pain related to the very site where her ill father had rested his leg when she changed his bandage; the hysterical symptom is mapped in the material space of the body —leg pain— as a corresponding folding of psychic associations related to her incestual fantasy towards the father. In addition, Blum and Secor claim that trauma “topologically transform domestic and everyday spaces,” (p. 107) as in Freud’s case of Anna O, whose room provided the material space in which trauma repeats itself. In these paradigmatic examples, Blum and Secor engaged with similar concerns expressed by Pile, and they agree that “it is materially impossible for previous structures to co-exist on the same site” (p.115). Blum and Secor’s main contribution to psychogeography reside in rendering topologic space as:

Not defined by the distances between points, but rather by the characteristics that it maintains in the process of distortion and transformation (bending, stretching, squeezing but not breaking) (p. 105)

In this way, they demonstrate that certain mechanisms, such as fantasizing a safe space or the perception of psychic proximities render trauma as a “topological constellation, a set of unconscious coordinates that upends the passage of time” (p. 115) Particularly useful is their rendering of network topologies, where nodes remain connected in the same way until a cut or an addition is made, which has relevant therapeutic value, and which I will discuss in Chapter 7.

Jesse Proudfoot’s (2019) rendition of traumatic landscapes is another example of grappling with the spatialization of trauma, where Proudfoot theorizes the relationship among addiction, place and trauma. This contrasts with Gesler’s therapeutic landscapes, which explores places designated for the pursuit of wellness and health, (as discussed in Chapter 3). Proudfoot proposes two different ways of reading *addiction-in-place*, deploying detailed case stories. One reading, developed through case “C,” is the *addictogenic landscape*, a place of high environmental stress from which addiction emerges as self-medication, facilitating adaptation to the repetitive unbearable conditions of life, such as crime, unemployment, family loss, violence or physical danger (p. 196). The second one is a *landscape of trauma*, which refers to addiction as a

psychoanalytic symptom, which following Freud constitutes “a *repetition* that occurs in place of the remembering of a traumatic event or prior relationship” (p. 198). These two landscapes are relevant to both the clinical and the social intervention as a guide for therapeutic strategies. The two landscapes roughly coincide with the spatialization of trauma that I propose below. The *addictogenic landscape* can be better approached as a protruding void, that is to say, trauma repeats itself in socio-spatial conditions of reality and thus requires an answer by political means (p. 199) whereas the *landscape of trauma* requires interventions that attend to the psychogenic causes of addiction, and by extension the subjective rupture in the structure.

By using racialized geographies in the U.S., Heidi Nast (2000) maps and discerns a psychic explanation of racism via a “racist-oedipalization,” in which the figure of the black person occupies the place of incestuous, and heterosexist Oedipal configurations where the constitutive triad mother-son-father is interiorized as ‘whiteness’ whereas incestuous is resolved as “blackness.” Following Jameson, Fanon, Butler, Deleuze and Guattari and some geographers, Nast explores the psychic reflection of unresolved conflict of otherness, internalized as an imaginary and symbolic space present in remnant social struggles of the past and the present; through sexual codifications for men and women, white and black during the times of slavery, she contrasts it with current urban racist socio-spatial segregation. Nast concludes that “in the context of modern colonizations —past and present— psychical interiorization is an embodied spatial effect tied to racist and familiarized political geographic struggle (p. 222). Although such aspects of historical context are crucial to understanding systemic inequalities and racist violence, Nast’s rendition of Oedipus serves to illustrate a myth in a socially constructivist mode of social codifications, but as Callard (2003) has relevantly critiqued, constructionism is an inadequate conception to render the unconscious.

Robert Wilton (1998) deals with spaces of difference relevant to trauma in a study that follows the process of prospect consultation in a neighborhood in California, to build a group home to house patients with AIDS. The project raised hostile reactions among residents of the community despite their self-identification as progressive, considering such a home as not belonging within their space. Wilton explores concepts of abjection and the ominous (*unheimlich*) to account for spaces and psyche landscapes of exclusion. The way Wilton articulates the alienation of body image in the other is relevant:

We attach meaning to our bodily experiences through the psychical production of 'body images.' Moreover, these body images are not confined to our bodies, but extend beyond them to encompass elements of the object world and the body image of others. (p. 176)

The way Wilton connects alienation of the body and exclusion to a certain reaction of uncanniness and abjection is of social and clinical relevance since the space of imaginary otherness is crucial in the embodiment of tension or conflict and is always at the core of the negotiations of trauma. Wilton's study locates exclusion in spatial proximity, which "weakens the social distance between self and other and challenges the integrity of individual identity" (p. 178). In Chapter 7 (cf. 7.4.1), I develop some ways in which our subjective experience of trauma requires other materiality to extend the body.

2.5.3. Taming the unconscious in geography?

One of the most relevant debates within psychogeography was initiated by Felicity Callard (2003), who criticized the "psychoanalytic turn" that has impacted the discipline of geography since the 1990s. Callard argues that geography has been marked by certain interdisciplinarity that is subjected to "cannibalization and expulsion" of each discipline and consequently results in a "tamed" version of psychoanalysis (p. 296). Geography's impetus, Callard claims, addresses social and cultural imperatives such as political action and resistance, which might divert the attention from the most relevant contributions of psychoanalytic thought. In this process, Callard argues, psychoanalysis has been transformed into a version of social constructionism itself (p. 298), weakening the powerful insights of Freud's theory by downplaying "its more politically unpalatable aspects" (p. 295), such as impotence or lack of agency. Although Callard does not specifically deal with trauma, her inquiry about the unconscious within the field of theory and politics in geography is of great importance to my research, as Callard demands a more rigorous engagement with psychoanalytic thought instead of suturing it to "a radical politics of resignification" (p. 305). This debate rightly situates unconscious as opaque and hurdling (Lacan, 1964/1998, p. 21), and thus, demands from geography the incorporation of concepts such as the death drive and trauma to showcase psychoanalysis in its full force.

Kingsbury (2007) mostly agrees with Callard, unfolding his answer via Copjec's claim that "psychoanalysis is the mother tongue of our modernity" (p. 236). Here,

Kingsbury alerts us to another, perhaps more fundamental taming in geography insofar as it tends to reduce concepts such as the drive, desire or the very unconscious to “the effects of discourse, the social, history, culture and biology” (p. 236). Yet, Kingsbury affirms that the psychoanalytic concepts Callard advocates to revive, such as repetition, compulsion, the death drive and traumatic neuroses “are no less susceptible to becoming psychologically dolled-up than the Freudian unconscious” (p. 238). Kingsbury calls for a geographical examination of subjectivity and social spaces through spatial models obtained particularly from Lacan, such as *extimacy*. This debate informs my approach in this dissertation, especially in terms of my treatment of the emergence of the unconscious and its partial veiling by what Lacan (1969/2007) calls the university discourse, which I rename as “know-it-all” in Chapter 4 (cf. 4.3.2). The “know-it-all” form of discourse structures social bonding in the mental health provision at VCH, as much as on the larger scale of the global MH (Mills, 2014).

2.5.4. Two topologies: structural rupture and the protruding void

The spatialization of trauma, from a Lacanian perspective, accounts for the way in which trauma as a spectral positivity emerging from the Real creates impasses in the Imaginary and the Symbolic registers. This nothing as something (The Real), which one may or may not be consciously aware of, cannot be named and yet profoundly convulses the sensual experience of a subject or a social group. Spatializing trauma can be thought of as the Lacanian *nospace* (Lacan, 1972b, p.3; Friedman & Tomsic, 2016, p. 110) ex-sisting in the space of negativity, characterized by what exceeds any symbolization which refers to *Das Ding* and object petit a, but also by condensations, displacements, dreams or parapraxes, proper to the unconscious, which manifest in symptoms such as nightmares, flashbacks, or intense affect in posttraumatic suffering.

Conceptually, I propose two complementary topologies of trauma that refer to the entwinement of two different spaces related to specific forms of temporality that Lacan develops in Seminar 11: the Aristotelian categories of repetition, *automaton* and *tuche*, respectively, which will be detailed in Chapter 6 (cf. 6.3. and 6.5.). In this chapter, I only introduce these topologies: One is the *structural protruding void* whose form is given by the systematic collision of the symbolic against negative space, and whose immediate effect ensues bending of the structure to preserve its form. I instantiate this topology in Chapter 5 (cf. 5.6) and 6 (cf. 6.5.1) through the crosscap, depicted in Figure 1. I use this

topology to support my proposed spatialization of trauma in the institution via empiric results, which I articulate as the back and forth of language (enunciation and statement) that is already an effect of a self-intersection of discourse (cf. 5.6), maintaining the void at bay. Finally, I insatiate this trauma space when I describe the “accursed share” (Bataille, 1967/1988, p. 59) that humans passed through others in intergenerational trauma.

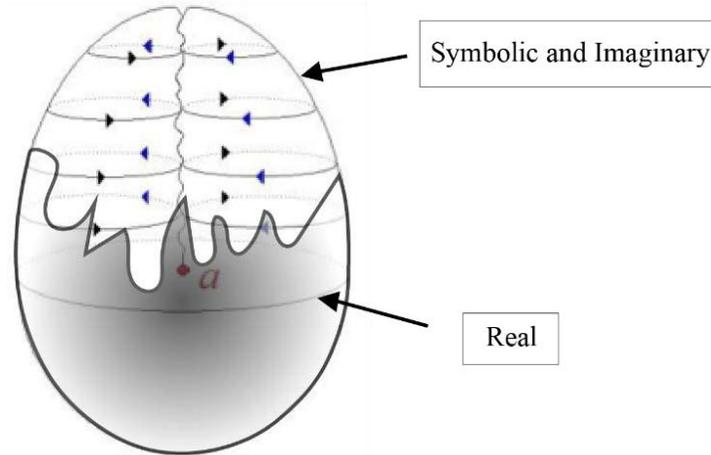


Figure 2.1. The topology of the protruding void, demonstrated by the crosscap, shows that collective and intergenerational spaces of trauma overstretching the Real —indicated by the shaded surface— beyond the place preassigned to it by discourse.

As a *protruding void*, trauma is the Real which the Symbolic and Imaginary registers must accommodate, as depicted in Figure 2.1. However, this void of the Real is also originally created by a discursive form. The question now is how to reconcile such a paradox. Žižek (2017) names this spatial logic as the “universality of antagonism, the Real of a stumbling block, of the impossibility around which a society is structured” (p. 273). Drawing from Lacan’s later work on topology and the advances of quantum physics regarding matter’s response, Žižek explains trauma as the necessary bend of the symbolic apparatus to the immobility of the Real, by virtue of which the Real gets constituted. To unpack such a statement, we first need to locate three moments of a quasi-dialectic that occurs between the Symbolic and the Real. There is a pre-symbolic Real, the one that must be sublated by the subject and whose remainder is object *a*, which is a testimony of the impossibility of capturing all what the Real is.

Žižek (2017) explains it like this:

'Something' stands for the brute Real, and 'nothing' for negativity at the core of the subject, the negativity proper to the symbolic order (as Lacan repeats again and again, negativity is introduced into the Real only through the rise of the symbolic order)...Here we encounter the first paradox: while subject arises through the symbolization of the Real (subject is by definition subject of the signifier), it is strictly correlative to the failure of symbolization: subject's objectal counterpart is a remainder of the Real that resists symbolization. In other words, complete symbolization would have realized a structure without subject, a structure that would no longer be symbolic. (p. 17)

This is to say, the *protruding void* is not only the Real, which disrupts and makes holes to the symbolic order, —as in the topology I explain below— but is rather a double movement of a) the Symbolic apparatus shaping to the curvature of the pre-symbolic Real, and b) through the latter process the Symbolic shapes the Real, which sets the mechanism of repetition in motion. This alternative spatiality allows us to approach trauma with a focus on discourse, which is the larger socio-spatial relationship within which a speaking subject ex-sists. This reading also locates repetition as *automaton* as what draws the impasses of representation at the level of the socio-spatial scale. I claim that automaton “designates the sustained repetition of the signifying chain, as ... the necessary repetition of signifiers, and in principle the repetition of the phallus as support of speech” (Fernandez-Alvarez, forthcoming).

Another trauma topology I propose is the *structural rupture* whose form could be thought of as a letter that cuts, tears up or over stretches linguistic space to the point of rupture, and whose immediate effect is anguish and an urgency to repair the damaged tissue by producing excessive symbolic material to cover the wound. This topology of trauma it is based on Lacan's definition of trauma as a *trou*, a hole perforating the symbolic and imaginary spaces (Skriabine, p. 79; Soler, 2004, p. 8). In the topology of structural rupture, an event of the Real void, often experienced as violence, a brutal injury of sorts, punctures the linguistic surface of the subject or society forming a rupture that renders impotent any attempt to represent the trauma in symbolic ways. I insatiate this topology in Chapter 5 when I describe the institutional unconscious as a perpetual coproduction of the subject and the social (cf.5.7).

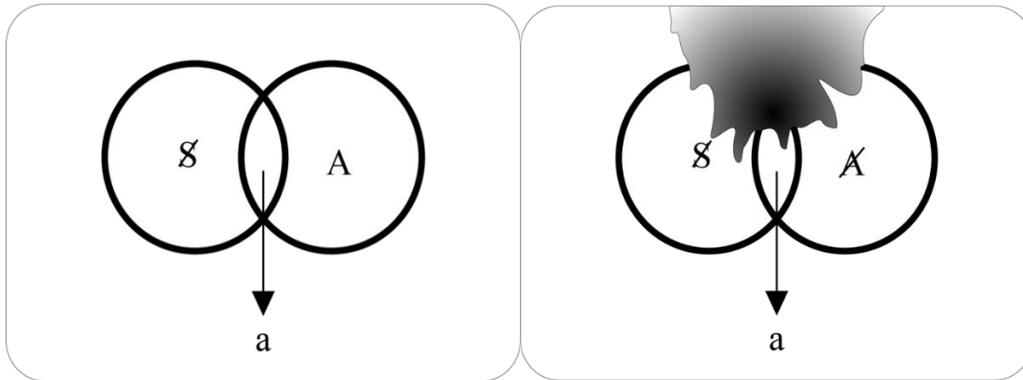


Figure 2.2. The topology of the structural rupture depicts the impact of trauma in the subject. On the left, the structure of the subject only with the constitutive trauma (object *a*) and on the right side, the rupture caused by constituted trauma, indicated by the shaded surface, which renders both subject and the Other in lack.

This rupture of the structure, even in its surprising and incalculable nature, brings forth a form of repetition that reorganizes the symbolic space and consolidates further (over)significations. Such repetition is the one that Lacan defines as *tuche*, the odd event that upsets libidinal economy, sometimes in a haphazard way, but in which trauma appears always as an unlucky occurrence. One could even play with the homophony of *tuche* and *touché*, the surprising hit of the contingent. *Tuche* is considered repetition by chance, the ever-failed encounter or (mis)encounter of the Real as trauma, as "unassimilable" (Lacan, 1964/1998, p. 55). This hollowing of the structure will result in divergent vicissitudes depending on how such perforation and the resultant lack is approached in the specific clinical presentation, a discussion to be developed further in the next two chapters (cf. 6.3 and 7.3.).

The misfortune experienced by *tuche's* repetition, is nothing else but an insistence of the letter, hollowing the symbolic structure to claim an inscription through a signifier. I argue that Lacan designates the letter as the "material support" of social discourse (Lacan, 2006, p. 413) and, as I claim elsewhere, "it is different from the signifier because the letter has no access to meaning, it mainly stands there in its hollowness, waiting to be rescued by a subject who will take agency of it. The signifier, instead, does have meaning in that it represents the subject for another signifier within a signifying chain" (Fernandez-Alvarez, 2020). Thus, the traumatic hole in the structure, equivalent only to the act, is potentially one of the most powerful opportunities for change. However, as Bistoën (2016) has signaled, the paradoxical potential of trauma is

that its very nature shatters subjectivities and thus freezes action. It is the conceptual notion of the repetition —*tuche* – of a letter that ruptures which informs my proposed politics of inscription detailed in Chapter 7.

These two modes of conceiving the non-space of trauma are complementary and refer to both the Freudian return of the repressed and the Lacanian return of the Real, a notion that explains the symptom, detailed in Chapter 6. The traumatic in both cases emerges as a structural impasse that causes suffering because we experience a “missed encounter” with the very structure of the Real. Trauma is a *misencounter* of the Real because in the occurrence of a traumatic event a subject was short to fall and disappear in the open rupture caused by the brutal event, but did not. Trauma is also a *misencounter* of the Real because we stumble over something absent, a void that yields important effects. Although both forms of *misencountering* are *extimate* and affect equally the subject and society, the main difference resides that in the first topology of the protruding void there is not a single event but the sustained repetition of social conditions. That is to say, the protruding void corresponds to the Real conditions we are trapped in and whose repetition demonstrates the inherent structural resistance to transform. In comparison, the structural rupture shows a locatable event somehow available to conscious awareness, but the subject is lost, as the rupture shatters subjectivity. In summary, while the subject is aware but absent in the event of trauma in the topology of structural rupture, in the topology of the protruding void, the subject is unaware of its cause, it is opaque, yet it appears in discourse.

2.6. Conclusion

In this chapter I have presented various theories that provide different discourses on trauma and the subject who undergoes it. These various discursive trends constitute my theoretical corpus; each involves antagonisms and generates questions that I will engage throughout the upcoming chapters. It is my intention to elaborate on the kind of subjectivities that are implied in each discourse and on the sort of response each produces regarding trauma within the mental health institution. I will also use the above-mentioned debates to discuss relevant aspects that pertain to *jouissance*, sexuality, the materiality of the body, the place of psychoeducation and the unconscious entwinement of subject and others in practice. In this conclusion, however, I want to position myself with regards to the debates indicated above.

2.6.1. Trauma is a negative universal

Several authors have criticized the so-called universality of trauma as established through the diagnosis of PTSD (Summerfield, 1999; Young, 1996; Bracken, 1995). Fassin and Rechtman (2009) consider that universalizing trauma through a humanistic approach such as the one that Cathy Caruth's (1996/2016) proposes—trauma as a relational way to connect cultures based on our unknown past traumas—amounts to trivialization. Furthermore, they argue that the Lacanian approach that grounds trauma in the emergent repetition of the void of the Real promotes a transhistorical structure of trauma that blurs the various scales of violence and might erase their history (p. 19). For his part, Bistoën (2016) rightly states that “[t]rauma psychiatry presupposes the existence of some kind of inborn *universal human subject* that is affected by distressing experiences in more or less the same way across different times and places” (p. 17, original emphasis).

I agree that understanding trauma as a universal category applicable to every culture and person who experiences a catastrophic event, as DSM V defines it, impoverishes the conceptualization of the phenomena of trauma. Elsewhere, I have argued that any universalism is problematic when captured by a predefinition of a particular master signifier, deemed prescribed ontology for its positive quality (Fernandez-Alvarez, 2020). I reject the universalization of diagnostic categories that pursue an overgeneralization of trauma and a treatment design *en masse* and I assert that trauma, —a notion that goes beyond a PTSD diagnosis and encompasses the unspeakable— is a negative universal.

Trauma with its intangible causes and overwhelming effects, within a continuum of severity, affects each of us, within variable scales of violence and historical contexts. As Žižek (2017) puts it, “*actual universality ‘appears’ (actualizes itself) as the experience of negativity, of the inadequacy-to-itself, of a particular identity*” (p. 274, original emphasis). Trauma, understood as universal phenomena of the negative, prevents any easy assimilation into relationality, historization and identity, hence the imperative of approaching it in relation to larger social phenomena. Soler indicates that the effects of trauma are a matter of resources available to a subject, “resources” to be understood not in the sense of an individual psychology and methods they follow, but resources as a social bonding, a link to a stronger or weaker collectivity that allow the subject to create

“a protective screen” (Soler, 2004, p. 72) against the protruding void of the Real⁷. The particular experience of a subject, one that Lacan would prefer to call “singular,” is not however a-historical or transhistorical as the above-mentioned critiques argue, since I will demonstrate how discourse and its effects, albeit not fully traceable, are locatable in socio- psychic space and conditioned to a temporality.

2.6.2. Sexuality as jouissance is always involved in trauma

The main controversy that psychoanalysis generates in contemporary trauma studies is precisely its claim that the psychic apparatus contains an *a priori* condition that hosts the contingent misfortunate event. The psychoanalytic version of trauma is considered essentialist for Foucauldians such as Fassin and Rechtman, as it assumes the existence of a “psychic given inscribed in the unconscious” (2009, p. 7). On their part Derrideans, such as Malabou, also claim that psychoanalysis’s account of trauma does not give “chance a chance” (2015, p. 187). I oppose these critiques and will demonstrate that trauma, paradigmatically, involves the concept of sexual jouissance, the core against through which subjectivity is produced. Traumatic suffering requires conceptual analysis of jouissance to understand how the strength of the life force is commandeered by death through an insistent repetition that traps the body. I will show how in trauma the object *a*, as a residual element of the unspeakable, emerges in different linguistic positions to cover up the inherent impotence and impossibilities of discourse.

2.6.3. Materiality of the body in trauma requires proper listening

The conceptualization of traumatic stress interrogates the place of the materiality of the body, as it involves —de facto— jouissance. This is the resultant production of psychic energy manifested in tension and discomfort, somatization and affect dysregulation. Such experiences insist on asking the eternal Cartesian question of the entwinement of body and mind, how do we explain their interaction?

My position regarding the materiality of the body runs parallel to a psychoanalytic dualism, supported by the notion of the drive, which links the body with the mind. Such hybridity includes somatic anatomy and function —the diverse systems connected

⁷ Clearly, there better and worse forms of such collectivity, for example, communist versus fascism, socialism versus capitalism, etc.

through the various parts of the brain— immanently linked to a linguistic apparatus. The concept of the drive is crucial to advance discourses on trauma, as people experiencing traumatic suffering hardly find ways to manage the overwhelming charge of psychic nature on the organism that captures the insistence of the unsayable Real in their bodies. Although I believe that some anatomic and physiological aspects of our bodies constitute a form of the Lacanian Real, I will engage in a discussion on the status of such somatic materiality and the modes of the Lacanian Real that might be at stake. I will be following Miller's (2016) developments on the "speaking body" to argue for a materiality of the body (Real) that can be heard, in a specific way, through the signifier (Symbolic); but also, will discuss the crucial role of the Imaginary in creating the notion of a body.

2.6.4. The reductionistic dominant approach constitutes a hegemonic fetish fantasy to deny complexity and reduce costs

Trauma treatment in VCH, as I will demonstrate, is concerned with psychoeducational, skill-building and manualized therapies that are built on CBT. These modalities of limited benefit impede the rise of ethical and subjective agencies, and in lieu, foster efficient adaptation to the oppressive conditions of the world we live in; as Woolfolks indicates "the communitarian critique of psychotherapy identifies the ideology of psychotherapy with liberal individualism and moral relativism" (2015, p. 143). As I understand it, CBT leaves untouched the difficult questions posed within the clinic of trauma with regards to therapeutic relation, compulsive repetition and ethical agency, all which are crucial to elucidate a treatment that builds stronger and less oppressive social bonding. The dominant reductionism in mental health treatment functions as a fetish fantasy that helps the mental system to protect itself from the extreme challenge posed by trauma in the context of diminishing investment in mental health care as a result of neo-liberalism. On the other hand, psychoeducation constitutes a form of psychologization of malaise that exerts a subtle but powerful governance over self and others.

2.6.5. Unconscious requires a social practice intrinsic to a subject

The unconscious of a subject appears in glitches and brief instances within everyday life. The unconscious of an institution hides in plain sight in the void created by

repeated linguistic exchanges. To understand trauma, we must include a methodology to think a conceptual analysis of the entwinement of the individual and social levels. If we think of the quality of individual and collective traumas –physical or emotional trauma, sexual abuse, war, genocides, natural disasters, massacres, colonialism (the content of any news program), we find discreet yet inherently related aspects of subjective and societal trauma. Every individual trauma involves and affects the social; thus, its understanding needs to nuance the individual aspect as much as those of the societal level. To grasp the emergence of trauma within institutions, the subject of the unconscious must become identifiable and must intrinsically problematize the connection to a social milieu. Or as Kienzler writes: “To explain social suffering, one must embed individual biography in the larger matrix of culture, history, and political economy” (2008, p. 225).

In the next chapter I will situate the research institution in its socioeconomic, political and historical context of praxis to advance an understanding of the challenges involved in trauma specific services (TSS) at VCH.

Chapter 3.

Situating Vancouver Coastal Health: socioeconomic, political and historical contexts of its praxis

The empirical work of this research was conducted in five of VCH's community mental health sites that serve adult populations. In this chapter, I present the institutional context in which the studied sites are situated. I first discuss the socioeconomic, political and historical contexts of the MH system in the scales of Canada, BC and the Lower Mainland. Secondly, I present some historical background of the mental health and addictions (MHA) services within VCH, followed by a thorough description of current MHA practices and treatments. Next, I explore the research sites as therapeutic landscapes before turning to discuss the practices of trauma specific services (TSS) at VCH as part of my overall attempt to critically situate its institutional contexts.

3.1. The mental health system in Canada

...the funding is excellent in Canada. I used to live in group homes for six years. We only had \$95 a month to spend, but I've been living independently for the last four years, and I'm given, I believe, around \$600 spending money for food or clothing or what have you, so the funding is excellent. The medications are very good. I went through a period where I didn't eat; I think it was 10 days; I just had coffee and cigarettes. I got sent to the hospital again, and they suggested I go on a drug called clozapine, and they called it the gold-standard of psychiatric drugs, and it's been very good for me. Since I've been on those, it's been about six years since I last used crack. (A12)

This assertive voice is from Bob (pseudonym from fieldwork interviews), a Caucasian male in his 30s, who has been diagnosed with schizophrenia and has been receiving diverse services for about 10 years in one mental health team (MHT) of VCH. Bob's story might suggest a successful treatment. In many ways it is. Thanks to psychosocial interventions, such as case management and supportive therapy at the MHT, Bob connected to the Income Assistance Office of the Ministry of Social Development where he was helped in getting financial aid on a regular basis to cover his long-term disability needs. Bob also got some prescribed drugs that, as per his statement, helped him to manage his concurrent symptoms; he got connected to Coast

Mental Health, an agency that provides community-based support services that offer “a wide range of social, health and well-being, and employment and education opportunities” (Coast Mental Health, 2020), affording Bob access to opportunities for social connection. Bob states, “You get to socialize with people there on disability ... because I’m not very social, so I find that the social work is working, but I’m still very set in my ways” (A12).

Bob was also helped by the MHT to access independent housing, that is, a single occupancy suite in a building with 51 other tenants where he has lived for four years now. Bob states, “That’s been tremendous for my social growth. We’re like part of a family sometimes... and I feel it’s the case. I’m happy; I’ve been there four years now.” How do such highly praised services work in Canada at large, and within the province of British Columbia? A report on the Canadian Mental Health system states that 1 in 5 Canadians will experience a mental health or addiction challenge in their lifetime, and that 38% of those issues will start before the age of 15 (CIHI, 2019 p. 6). Does Bob’s positive assessment reflect the challenges faced by the federal and provincial MHA systems? These are some of the questions I address below.

The Canadian Health System has provided universal extended health care since 1974 as part of the introduction of the Canada Health Act (Barnet & Barnett, 2009, p. 59), which ensured the provision of health services for all Canadians. Seventy percent of the total cost of health care in Canada is paid by public funds, and approximately 65% of those funds are derived from the provincial and territorial governments, with another 5% coming from other parts of the public sector. The remaining 30% is paid by the private sector through out-of-pocket spending (14%), private health insurance (12%) and non-consumption (3%) (CIHI, 2019b). Canada spends less on mental health (7% total of health care) compared with most Organization for Economic Co-operation and Development (OECD) countries, which ranged from 8 to 15% (CIHI, 2019a, p. 13).

Federal spending in total health expenditure represents about 12% of Canada’s gross domestic product (GDP) and was expected to reach \$264 billion in 2019, or \$7,068 per Canadian (CIHI, 2019b). Most of the money is spent on hospitals (27%), drugs (15%) and physician services (15%) with hospitals accounting for the largest expenditure in the total health public sector disbursement (CIHI, 2019b). As a result, we

have seen an increase in the provision of hospital-based ambulatory and community care (CIHI, 2019a, p.15).

Between 2015 and 2017, Canada spent about \$15.8 billion, or \$125 dollars per Canadian, on mental health and addictions services (CIHI, 2019a, p.15), and this expenditure is trending upwards to an estimated increase of 9% in 2022. Canada's 4% annual increase in mental health expenditure is disproportionately higher than the country's overall annual increase in health expenditure. The last federal budget of 2017 confirmed an investment of \$11 billion over ten years to the provinces and territories with the following stated priorities: improving MHA services, improving access to home and community care, enhancing performance measurement, Indigenous health, and ongoing collaboration, innovation and accountability (CIHI, Priorities, 2020).

In all Canadian provinces and territories, mental health and substance use services are delivered primarily through local health authorities and are heavily focused on children and families. In BC, the Ministry of Health works with other provincial offices to produce mental health policy, such as the Ministry of Mental Health and Addictions and the Ministry of Children and Family Development. Additional providers include agencies that are funded by the Ministry of Social Development & Poverty Reduction, Municipal Affairs & Housing, and other government departments that coordinate housing and employment services, as well as services provided through the criminal justice system (CIHI, 2018). A *Special Rapporteur*, a report generated by a United Nations commission on behalf of the Human Rights Council, on a recent visit to Canada noted that the Canadian mental health system focused on the sustainable development of services across the country, broadly ranging from promotion and prevention of mental health conditions to treatment and rehabilitation services (United Nations, 2019).

As mentioned, hospitals account for the largest portion of total health spending by the public sector, estimated at 34% for 2019. Needless to say, this has an impact on how MHA programs and services are funded; the increases in Canadian MHA expenditures (a budget increase of 56% or \$1.9 million) are typically channelled to community programs rather than residential and ambulatory services, and this is, at least in part, due to the deinstitutionalization movement described below.

Bob tells us that he has been receiving services since about 2009, and so his treatment occurred within the context of the systemic changes that resulted from the federal government's creation of the Mental Health Commission of Canada in 2007. The Harper government created this commission in response to recommendations made by the Standing Senate Committee on Social Affairs, Science and Technology's 2006 report, "Out of the Shadows at Last" (MHCC, 2006), and its purpose was to provide a national framework for mental health. The national mental health strategy for Canada was developed from 2007 through 2017 and was extended to 2022. One key element of this strategy consists of a recovery-oriented mental health system, which became public in the Spring of 2012 (MHCC, 2015). "Recovery-oriented initiatives" is a term that emerged from advocacy by those with MH lived experience and their guidelines are as follows:

First, they recognize that each person is a unique individual with the right to determine his or her own path towards mental health and well-being. Second, they also understand that we all live our lives in complex societies where many intersecting factors (biological, psychological, social, economic, cultural and spiritual) have an impact on mental health and well-being. (MHCC, 2015, p.4)

The entire Canadian mental health system has undergone significant change over the past 50 years when provinces and territories shifted care out of psychiatric hospitals into an evolving community-based services model. The rise of the human rights movement paved the way to the deinstitutionalization of psychiatric patients all around the world and the shift responded to a number of factors, among which are the negative effects of prolonged hospitalizations, developments in psychopharmacology, the emergence of new psychosocial models of rehabilitation, and cost-containment concerns (Morrow, 2007, p. 76; Carpenter 2000 in Curtis, 2010, p.192).

3.1.1. Challenges in British Columbia: From Riverview Hospital to the Greater Vancouver Mental Health Service Society

British Columbia constitutes the third province, after Northwest Territories and Newfoundland and Labrador, that on average spends the most per capita on community MHA care (2017–2018) incurring an expenditure of \$146 per Canadian (CIHI 2019a, p. 18). This is a result of the particular challenges faced by the province: According to the Canadian Mental Health Association (CMHA) almost one million British Columbians (one

in five) will experience a mental health or substance use issue “of varying severity and types every year” (Darcy, 2019, p. 4). According to the Ministry of Mental Health and Addictions created in 2017, BC has:

the country’s highest rate of hospitalization due to mental illness and substance use. Suicide has become the ninth leading cause of death in Canada. The overdose crisis continues to ravage our communities, with 1510 deaths in 2018. And the effects of substance use (including alcohol and tobacco) are taking a major toll on both physical and mental health (Darcy, 2019, p. 5).

Consequently, as a response, BC has a 35% increase per capita in MHA versus a 24% of total public-sector health expenditure, spending about \$6,548 per person and forecasting a 3.4% increase in the next two years (CIHI, 2019a, p.15). With Mental health services now a provincial priority, the Ministry released a report in June 2019 titled *A Pathway to Hope*, outlining an ambitious 10-year plan to transform the mental health and substance use care system based on four pillars: wellness promotion and prevention, seamless and integrated care, equitable access to culturally safe and effective care, and Indigenous health and wellness. The strategy aimed to shift the approach from a crisis-response system to one that is focused on wellness promotion, prevention and early intervention (Darcy, 2019).

The importance of mental health and substance use services in this province continued to grow since the early 2000’s, which led to the 2010 launch of the project called *Healthy Minds, Healthy People* (HMHP): A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (Ministry of Health Services, 2010). The action plan called for a “holistic, evidence-based approach to deal with complex, multifaceted issues of mental health” (Rheaume, 2016). This plan is implemented through the British Columbia Ministry of Health, which delivers health services in seven publicly funded healthcare authorities, comprised of 5 regional authorities: Fraser Health, Interior Health, Vancouver Island Health, Northern Health and Vancouver Coastal Health, as well as 2 provincial authorities: Provincial Health Services, First Nations Health (Government of BC, 2020b).

Mental health in British Columbia can be dated back to the era of institutionalization when the main modality of treatment for the mentally ill was the psychiatric hospital. With a gradual beginning in the 1960s, the deinstitutionalization

transition in BC reached its highest point when the Riverview Hospital started closing its doors in the late 1990s (Chamber, 1993). The Riverview Hospital was built in 1909 on 1,000 acres purchased by the provincial government to house a temporal “Hospital of the Mind” in a rural area in Coquitlam, near Vancouver. The hospital opened in 1913 and became a permanent provincial hospital of tertiary nature and by 1951 it housed 4,630 patients (Read, 2009, p. 25). Adjacent to the hospital were botanical gardens, a nursery and the colony farmlands, which having both therapeutic and commercial interest, produced crops and milk using mostly patient labour. These horticulture and occupational therapeutic forms changed over time and all of them closed by 1983, and in 1984 the provincial government sold 57 hectares (141 acres) of Riverview lands to build market housing units, known now as Riverview Heights (Chamber, 1993; Ombudsman, 1994; Ministry Health Branch, 1970).

Since the late sixties and after the publication of the Mental Health Act in 1964, there was a declared intention to reduce the population of Riverview Hospital to move towards community care centres. The hospital started to receive patients from private practitioners and the focus of Riverview’s management shifted from psychiatry to administrative issues. In 1987, a report was produced titled *A Draft Plan to Replace Riverview Hospital* (Government of BC, 2020a), which expressed the following challenges in the process of deinstitutionalization:

A significant portion of the \$53 million in funding was required to address pressures caused by inflation and demographic increases, leaving \$36 million for the development of new services in the areas of housing, emergency response, rehabilitation, clinical services, consumer/family services, child and youth services and alcohol and drug services for aboriginal people. While this augmentation provided a critical boost to the community mental health system and permitted the expansion of a broad range of services, it did not address the still inadequate supply of services relative to the needs of the most disabled individuals.

In 1992 another report was issued, *Listening: A Review of Riverview Report*, by the BC Ombudsman, to address complaints from patients and their families and “to articulate the means to achieve fairness for people being served by a public agency who may not be in a position, due to illness or treatment, to hold the authority to account for maladministration” (Ombudsman, 1992, p. i). The main concern of this report was the lack of detailed mechanisms to respond comprehensively and justly to patient collective

advocacy, for which they recommended, among other things, a properly funded advocacy body run by the patients (Ombudsman, 1992, p. ii).

The Riverview Redevelopment Project, under the BC Ministry of Health, relocated about 600 residents who had chronic mental illnesses and transition them into other inpatient facilities for later send back into their communities; this Redevelopment project finalized in 2012 with the closure of Riverview Hospital. At present, only a few facilities remain open as tertiary mental health facilities (such as Connolly Lodge, Cottonwood Lodge and Cypress Lodge) which can hold up to 64 patients (Chamber, 1993; Fraser Health Authority, 2013). Additionally, there are cottages used as transitional housing for patients with diverse mental health conditions. Since 2017 the provincial government funded a \$101 million mental health and addiction treatment facility on the Riverview grounds, which was expected to open its doors in 2021, and indeed did. The Red Fish Health Centre now houses 105 patients in a facility that incorporate therapeutic landscapes to provide specialized care for adults with severe and complex mental health and addiction challenges.

The Riverview development plan “pledged increases of annualized funding for mental health services including supported independent living beds, residential care resources, and increases to staffing and training for community-based services” (Morrow et. al. 2006, p. 5), and yet many insisted that the closure of BC’s largest psychiatric care facility has had an unintended impact on other areas of public health, as it had not contemplated sufficient funding or issues such as diverse health inequity variables (Morrow, 2007, p.76). Freeman points to an uneven distribution of the money that was saved by closing Riverview Hospital:

From 1962 to 1977, the population of the provincial psychiatric hospitals fell by 78 percent. Unfortunately, the savings thus realized were not reinvested in the system by developing community support initiatives. (Freeman, 1994, p. 19)

Other experts continued to highlight the inadequate budget that had already been identified and the significant risks that resulted, claiming that “[d]ue to a deficiency in mental health resources, this population is at risk for homelessness, drug abuse, incarceration in jail, and suicide” (Read, p. 25) and it was suggested that an increase in investment in both long-term care facilities and in supportive housing for individuals with chronic mental health was necessary due to the fact that about 30-36% percent of

homeless people suffer from a mental illness. The inadequate funding of community-based services and housing is not exclusive to Canada; this is a tendency previously noted in other nations of the West (Boyd & Kerr, 2016, p. 424).

Notwithstanding those financial criticisms, studies from the early period of deinstitutionalization appeared optimistic when comparing Canada's mental health service systems to those of the United States. One study observed better results in Vancouver when compared to Portland, Oregon, USA, suggesting that when successfully implemented, deinstitutionalization increases social satisfaction (Cutler, et. al. 1992, p.127). Also, others observed that the Greater Vancouver Mental Health Service, the agency leading community MHA services in the Lower Mainland, was producing better client outcomes for people with serious mental illness than those in care under the mental health services in the USA (Sladen-Dew et. al., 1993).

In the early 1970s, during the early phases of deinstitutionalization, the Greater Vancouver Mental Health Service Society (GVMHSS) was established to offer community-based mental health services to persons with schizophrenia and other major mental disorders. This society was part of "The Vancouver Plan," the only regional mental health service in British Columbia administered as a non-profit society with the approval of the provincial government (Sladen-Dew et. al. 1993, p. 309). At that time, Canada did not yet have a National Mental Health Policy like the USA, UK, Australia, and New Zealand (Lurie, 2005, p. 97), and the regionalization was a response to manage the fiscal constraints. GVMHS was deemed by some as a "a rare example of what is possible when the political will exists to make a long term, adequately funded commitment to the mentally ill in the community" (Sladen-Dew et. al. 1993, p. 308). The claim success relied on the decentralization of the model, a relatively non-hierarchical organizational structure, and a "committed and skilled multidisciplinary team, which allowed the integration of services into communities through sustained partnerships among professionals, patients, families and community agencies" (Sladen-Dew et.al., p. 309).

The philosophy of GVMHSS was described as de-emphasising office-based psychotherapeutic strategies "in favour of practical assistance and support to the patients and their families where it is needed – their homes, out on the streets, in hotels, schools and long-term care facilities" (Sladen-Dew et. al., p.309).

GVMHSS used to serve those who struggle with serious mental illness, but also helped in connecting people in transitory crisis with services. In the 1980s, increasing case loads, associated with patients being discharged from Riverview Hospital, posed a challenge in terms of capacity and the system's ability to respond to the needs of those considered seriously mentally ill. The solution envisioned by GVMHSS was the development of several programs to target specific needs—programs that modelled the current mental health services. The shift from not-for profit management towards a regionalized mental health system came with the creation of VCH, which can be traced to Canada's federalist health care system reform that occurred between the 1980s and the early 2000s. Specifically, "most provinces undertook structural changes over the 1990s in response to a rising tide of austerity politics that led health ministries to embrace a neoliberal ideology as a way out of the fiscal crisis within the health care sector" (Masuda & Chan, 2016, p. 6-7). Thus, from its birth, VCH has been dealing with a financial limp with regards to health in general but most particularly regarding MHA expenditure constraints.

3.1.2. The mental health system in Vancouver Coastal Health

VCH, one of Canada's largest health care providers that serves a highly diverse population in regard to culture and economic status, has a geographic catchment of urban, rural, and remote areas including Vancouver, the North Shore, Coastal Garibaldi, and Richmond. VCH provides services that range from acute (urgent care) primary (education and prevention at home, the clinic or the hospital) and secondary and tertiary (specialized services) care, and is the main centre for clinical services, research and teaching in B.C, serving over 1.25 million people—nearly 25% of the province's population.

VCH has over 14,000 employees, spread across 86 disciplines, and 112 locations working to achieve "one collective healthcare team that's coming together to deliver an exceptional care experience for all" (VCH, 2018). Like any public health system, VCH is tasked with developing leadership, expanding funding, enhancing health promotion and prevention, improving access to services, collecting data and conducting research. Regarding the latter, VCH's Research Institute, the primary funder of my research, is one of Canada's top-funded health research institutes bringing together multiple health care disciplines in the largest academic and teaching health sciences

centres, such as Vancouver General Hospital, UBC Hospital and GF Strong Rehabilitation Centre, to advance clinical, health system, technological and innovative research (VCHRI, 2020).

VCH plans to expand access to community-based mental health and substance use (MH SU) for children and youth (age 10-25), recognizing effective early interventions to treat mild to moderate mental health, development and behavioural problems through models of community mental health care that are culturally appropriate and integrated with primary health services. They aim to expand availability of integrated community-based MH and SU services for people with complex health needs (Darcy, 2019). The Federal government has committed to providing the provinces and territories with \$5 billion over ten years, having assigned \$100 million in 2017 and 2018 (CIHI, 2020).

According to VCH financial statements from The Auditor General of British Columbia (2014 -2019) and from Independent Auditor, BDO Canada LLP (2020 – 2021), the budget allocation for mental health and substance use services has remained constant over the past eight years at approximately 9% of the total budget. The overall budget for the health authority has gradually increased over the same period. With that, there has been an 11% increase in overall expenditures for mental health and substance use:

Table 3.1. VCH’s budget allocation for mental health and substance use services (VCH, 2014-2021 p. 6-7)

Year	Budget Allocation
2014	\$ 288, 843
2015	\$ 287, 562
2016	\$ 277, 052
2017	\$ 283, 702
2018	\$ 317, 466
2019	\$ 319, 764
2020	\$ 336, 195
2021	\$ 352, 905

Travis Lupick notes that in 2015, provincial contributions to VCH were reduced by 1 percent from the previous year. Yet, “Since 2010, the change in ministry funding for VCH has averaged plus-two percent per year, barely keeping up with inflation, let alone

costs associated with new technologies and aging baby boomers” (Lupick, May 2016). It’s worth noting that the substantial increase in expenditures from 2017 to 2018 coincided with a change in government, from the Liberals to the NDP, a change that saw the birth of the BC Ministry of Mental Health and Addictions. The financial statements of the health authority reflect its response to the global pandemic COVID-19 , declared in March 11, 2020.

There are scholarly critiques around the way mental health care is being designed and delivered and how the resources have been used in the province, which will be addressed in this chapter’s conclusion. Before I turn to this literature, I first situate the diverse socio-spatial practices that occur within VCH.

3.2. Current mental health and substance use practices at the researched sites

Throughout my dissertation’s research, five Vancouver Coastal Health sites participated in a series of interviews to better understand trauma-specific services within the health authority. The analysts and clinicians interviewed were connected to multi-disciplinary teams ranging in services and specializations from the Mental Health and Substance Use Outpatient Services (MHSU OS), South Mental Health and Substance Use Team (South MH), Kitsilano Mental Health and Substance Use Services (Kitsilano MH), Three Bridges Substance Use (3BSU), and the Aboriginal Wellness Program (AWP). In the following section, I explore current MHA services and ongoing practices, most of which evolved from the initial plan deployed by GVMHSS between 1970 and 2000.

3.2.1. Mapping practices and mental health services at Vancouver Coastal Health

Acute Services: As discussed above, most of the expenditure in the federal health budget has been allocated to hospitals. Consequentially, the system invests in services that prevent the economic drain caused by hospitalization through a community health approach that implements more ambulatory and community services than inpatient activity, such as emergency units to conduct psychiatry assessments and promote stabilization. The Access and Assessment Centre (AAC) is a centralized

service for mental health and substance use services. AAC provides short-term assessment, stabilization and treatment services for individuals experiencing a psychiatric or mental health crisis. Their services are available between 7:30 a.m. to 11 p.m., 7 days a week, by phone or in person in their offices located at the Vancouver General Hospital campus at the Joseph & Rosalie Segal & Family Health Centre (VCH, Acute Short Term). This model evolved from the community response units developed at GVMHSS (Sladen-Dew et.al., 1993, p. 310). The AAC incorporates another service that the GVMHSS had created to respond to mental health emergencies, formerly known as Mental Health Emergency Services (MHES) and developed in partnership with the Vancouver Police Department. It consisted of a small team and a mobile unit (Car 87) staffed by a community nurse with a plain clothes police officer, providing afterhours emergency service (Sladen-Dew et.al., 1993, p. 311). Such services can now be accessed through the AAC. Worth noting is that there are important controversies about the participation of the police in shaping public discourses about mental illness, addiction and stigmatization, which has impacted policy and resources (Lupick, 2014; Boyd & Kerr, 2016).

The sites involved in my research facilitate the stabilization of acute crises through some of the following services: The Acute Home-Based Treatment, which offers short-term mental health treatment in home settings to manage increasing symptoms or distress related to mental illness or substance use. Venture, a twenty-bed community facility started by GVMHSS, is located on Main Street at 13th Avenue in Vancouver and provides supervised, short-term crisis interventions to facilitate stabilization outside the hospital (Sladen-Dew et.al., 1993, p. 312). Inpatient units, commonly known as psych wards, also provide acute treatment, and at the same time are a source of referrals for the participant sites. The population from the studied sites have access to the largest hospitals in the province —Vancouver General Hospital (VGH) and Saint Paul’s Hospital (SPH). Both hospitals provide psychiatric beds, along with group and individual treatments in specialized units that treat specific conditions, such as psychosis, mood disorders or concurrent disorders. SPH is administered by the Providence Health Care Society, a not-for-profit organization that was created by the “Sisters of Providence” in 1890, and that continues to serve the entire province from its sites within the Vancouver Coastal Health region. It is worth noting that PHCS is governed by its own independent

Board of Directors, unlike VGH whose board is appointed for two-year terms by the provincial government.

Rehabilitation services: The rehabilitation services available for the population of my research are provided by occupational and recreational therapists on site which facilitate case management and client's access to a variety of services. The analysands can access the Gastown Vocational Services to explore and pursue educational and employment opportunities. There is also the STEPS Mental Health Rehabilitation Program which provides skill development in diverse areas such as home management, life skills, interpersonal relationships, education, and work or recreation. These rehabilitation services evolved from those implemented by GVMHSS, and at the core continue the same mandate, which aim to help service users with "housing, transportation, money management and meaningful daily activity" (Sladen-Dew et.al., 1993, p. 311). STEPS also works in partnership with organizations such as Coast Foundation, the Mental Patients Association (now called Motivation, Power and Assertiveness) and the Canadian Mental Health Association. These partnerships that started with GVMHSS are still in place today. However, many other agencies that were funded by VCH throughout the years have recently lost significant funding as a consequence of budgetary constraints. Included among the agencies that have lost VCH funding is the Art Studios, one of the few options available for clients who identify creativity as a means to wellness. The Art Studios was funded and operated by VCH for 21 years, and in 2013 lost its entire annual funding of \$357,000 a year. (Yong, 2013; Lupick, 2016)

Not long after the funding was cut, the Art Studios was rescued by a private donor (McLean, July 12, 2013). In March 2020, the Lookout Emergency Aid Society and the Mood Disorders Association assumed the management of the Art Studios, and it is expected that this will allow the continuity of this important program (VCH, 16 January 2020). Another agency that has lost VCH funding is Gallery Gachet, a collective space for artists struggling with MHA issues that provides opportunities for individuals to connect and publicly present their art. Gallery Gachet lost \$130,000 in annual funding from VCH in 2015. Also impacted by funding cuts was ARA Mental Health, an advocacy group for people with disabilities, which lost approximately \$230,000 a year from VCH. In addition, a reduction of \$634,000 a year from VCH funding (Lupick, 2016) impacted the DURC (Drug Users Resource Centre), which is a drop-in facility in the Downtown East

Side (DTES) that serves people with addiction issues. Finally, the West Coast Mental Health Network, a non-profit, registered charity and peer-run organization founded in 1991 that serves “those who have experienced the mental health system and for those who seek help and support in recovery,” (Westcoast Network, 2020) lost all its funding in December 2013.

However, since 1997 VCH has provided more than four million dollars each year in health promotional grants across the whole region and of that funding 90% “is currently committed to providing stable, long-term core operational funding to approximately 70 programs hosted by registered not-for-profit partners” (VCH, Health Grants, 2020). VCH also ensures access to support projects led by people with lived experience of mental health issues or addiction through the Consumer Fund Initiative, which apart from funding diverse initiatives such as self-expression, artistic or spiritual activities, also includes Crisis Grants (up to \$85 to Vancouver adult mental health consumers who are experiencing significant financial strain due to unexpected circumstances) and the Education Leisure Fund that provides funding of up to \$400 for education and leisure courses or activities (Spotlight on Mental Health, 2020).

Housing Services: A foundational aspect of any successful mental health community treatment is stable and affordable housing. Safe and stable housing is necessary to facilitate social integration for individuals who struggle with serious mental illness and is a particular challenge to the population of Vancouver given the lack of affordability in this city. In 1978, GVMHS founded Mental Health Residential Services to provide affordable stable housing that matched service users in terms of their individual needs. Currently, by way of the Mental Health Supported Housing, Housing First Placement, and Community Transition teams, Mental Health and Substance Use Supported Housing Services continues to provide housing support to service users who are experiencing chronic mental health and substance use issues, are homeless or difficult to find housing for, and are accessing housing to maintain their recovery (VCH, Housing, 2020).

Multicultural Services: Vancouver is the third largest city in Canada and one of the most ethnically diverse as nearly 50% of the Lower Mainland population are first generation immigrants “that speak over 150 languages and dialects in addition to English and French” (Sladen-Dew et.al., 1993, p. 312; Boyd & Kerr, 2016, p. 419;

Ganesan & Janze, 2005, p. 312). UBC's Cross-Cultural clinic serves various hospitals and provides support to all of the sites involved in my research. The Cross-Cultural clinic's outpatient services operated as a program until 2017 and has been incorporated to one of the researched sites (MHSUOS), to provide psychiatric assessment and medication recommendations to the Chinese, Punjabi, Hindi, Spanish and Vietnamese communities.

3.2.2. Practices at the Mental Health and Substance Use Service programs

In this section, I present the mandates of each of the researched sites and the services they offer. Substance Use and Mental Health services remained in two separate treatment designs and practices, one for Mental health and another for Substance Use. Those who struggle with the co-occurrence of mental health concerns with drug or alcohol problems, used to be served by GVMHSS through the Dual Diagnosis Project and currently these services occur in an integrated way in most of the MH and SU teams.

Mental Health & Substance Use Outpatient Services — Vancouver (MHSU OS) is mandated to serve 19 years and older residents of Vancouver with a goal of supporting individuals who live with conditions diagnosed as personality disorders, depression, anxiety or substance use issues. Services are focused on transitioning service users to accessing primary care resources in the community and include:

- 1) Psychiatric consultation which aims at diagnosing, prescription and monitoring of psychiatric medications and treatment suggestions.
- 2) Group therapy
 - a. UPT: Unified Protocol for Transdiagnostic Treatment of Emotional Disorders which targets depression and anxiety and follows a psychoeducational cognitive program.
 - b. Life after Trauma: Psychoeducational and skills program for people who have a history of developmental trauma; this is Stage 1 of trauma specific services.

- c. Interpersonal Psychotherapy: Process-based group that deals with depression as a result of interpersonal losses, role conflict and life transitions.
- d. Dialectical Behavioural Therapy (DBT): a manualized counselling program for people with the diagnosis of borderline personality disorder.
- e. Psychoeducational groups and a process group for people bereaved by suicide.

3) Online email therapy (Kelty's Key Program) provides cognitive behavioural therapy (CBT) and self-help resources for issues such as depression, generalized anxiety, panic, family support, or insomnia.

4) Short term individual psychotherapy for people with suicidal ideation, bereaved by suicide, or concerned about others who are suicidal, through SAFER (Suicide Attempt, Follow-Up, Educational and Research) (VCH, MHSU OS, 2020).

Kitsilano - Fairview Mental Health and Substance Use Team (Kitsilano MH)

is mandated to serve residents of Vancouver for adults 19 years and older, diagnosed with a major mental illness and experiencing significant problems that interfere with their functioning in the community. Primary diagnoses include schizophrenia (and other psychotic disorders), and mood disorders (i.e., bipolar and major depressive disorders), in addition to services provided to people who have co-occurring disorders such as personality disorders, substance abuse/misuse, mental challenges, etc. The main services provided are the following:

- 1) Case management (mental health and rehabilitation support).
- 2) Group therapies, such as component courses of Dialectical Behavioural Therapy (DBT); Wellness Recovery Action Plan (WRAP), a manualized psychoeducational tool to self-designed prevention and goals processes; and other groups to enhance social and brain functioning (Smart Brains) (VCH, Kitsilano - Fairview, 2020).

South Mental Health & Substance Use Services (South MH) is mandated to serve residents of Vancouver for adults 19 years and older, experiencing emotional,

psychological or psychiatric concerns; living with severe and persistent mental health issues; or struggling with substance use and addiction. Services provided include:

- 1) Case management (mental health and rehabilitation support).
- 2) Addiction medicine.
- 3) Short-term (6-8 sessions) counselling in substance use, opiate replacement therapy, harm reduction and acupuncture.
- 4) Group Therapy.
 - a. Sisters Together Active in Recovery (START) a 12-week program for women having problems with the use of drugs or alcohol, LGBT+, including process group and a variety of modalities, such as acupuncture and art therapy.
 - b. Self-Management and Recovery Training (SMART) a CBT psychoeducational group (VCH, South, 2020).

Three Bridges Substance Use Services (3BSU) is mandated to serve residents of Vancouver struggling with substance use. Services include:

- 1) Short-term individual counselling for adults (6 to 8 sessions).
- 2) Longer-term counselling for Youth (24 years-old and under).
- 3) Group therapy.
 - a. Ongoing meditation & mindfulness groups.
 - b. Acupuncture for addictions.
 - c. SMART meetings.
 - d. Vancouver Addictions Matrix Program (VAMP) is a 16-week abstinence-based intensive day treatment program based on skills training on recovery and relapse prevention. There are diverse

streams, so people are welcome to choose the stream that best matches their LGBT+ identity. (VCH, 3BSU, 2020)

Substance use services are provided from a harm-reduction perspective and include needle exchange, which provides supplies for safer drug injection and smoking, as well as information and referrals to health and substance use services. There is also a drug check service and medication programs to treat opioid addiction, one of the most challenging forms of substance use disorder which include addiction to heroin, fentanyl and oxycodone. The medication program provides opioid agonist treatment.

It is a well-known fact that Vancouver is currently in the midst of an opiates overdose crisis. Illicit drug overdose deaths identified by the BC Coroners Service started to increase in 2013 after fentanyl, an opioid that is up to 50 times more toxic than heroin, was first detected in the illegal drug supply. According to journalistic research:

In B.C., the percentage of illicit-drug overdose deaths involving fentanyl has increased from four percent in 2012 to 15 percent in 2013, 25 percent in 2014, 29 percent in 2015, 67 percent in 2016, 82 percent in 2017, and 87 percent in 2018, according to the province's coroner service. (Lupick, June 14th, 2019)

In data gathered over three years, the OD presented an increase in percentage in drug related deaths reaching 439 deaths by December of 2018 (VCH, *Response to Opioid Crisis*, 2018, p. 6). The most affected are men between the ages of 30 and 59; based on housing patterns “people at risk of an overdose death in VCH live with greater socioeconomic disadvantage than those in other parts of BC” (VCH, *Response to Opioid Crisis*, p. 15). It is also worth mentioning that during the emergence of the pandemic, the deaths from increased 93% in April 2020 (Takeuchi, June 12th, 2020). Furthermore, 1,720 apparent opioid toxicity deaths occurred between April and June 2021 (approximately 19 deaths per day), similar to the period between January to March 2021 (1,792 deaths) but representing a 2% increase compared to April to June 2020 (1,680 deaths) and a 66% increase compared to April to June 2019 (1,038 deaths) (Public Health, 2021).

A number of factors have likely contributed to a worsening of the overdose crisis over the course of the pandemic, including the increasingly toxic drug supply, increased

feelings of isolation, stress and anxiety and limited availability or accessibility of services for people who use drugs.

3.2.3. Aboriginal Wellness Program (AWP)

In 1999, the Mental Health Evaluation and Community Consultation Unit, an Adult Mental Health Division of the Ministry of Health Services had the first of many meetings of the Aboriginal Mental Health Committee at the Longhouse at the University of British Columbia (UBC) in response to concerns about barriers in mental health service delivery for Indigenous peoples. From these meetings a discussion paper was drafted with regards to the 'Best Practices' for Aboriginal Mental Health (Smye & Musell, 2001). Some of the concerns expressed in the report were the following: the lack of a core Aboriginal Mental Health program federally or provincially; the jurisdictional and inter-ministerial barriers faced by individuals; the inequalities in accessing services between reserve and urban services; poor housing options as one of the most pressing social issue affecting mental health, the lack of a specific program to address the mental and emotional effects of residential schooling system and the lack of community rehabilitation programs. The consultation unit was also concerned about the lack of understanding and respect to the traditions, values and health belief systems of First Nations and other Aboriginal people. The National Native Alcohol and Drug Abuse Program (NNADAP), which has operated since the 1970s, was one of the first federal health programs to be devolved to Aboriginal administrative authority (Smye & Musell, 2001, p. 3).

A ten-year trilateral agreement, the BC Tripartite First Nation Health Plan (First Nations Health Authority, 2020), was signed in 2007 by the BC First Nations Health Council, the BC provincial government, and the Canadian federal government. In 2008, VCH asked Tanya Gomes, an Indigenous female facilitator from Guyana South America living and working with the urban Aboriginal community, to form the Aboriginal Health Practice Council for the Region:

Aboriginal Health Services wanted to establish a process for addressing Aboriginal peoples' clinical services; and although VCH saw the initial task of the practice council as developing clinical guidelines for health care service delivery to urban Aboriginal community members, Tanya

articulated the need to have Aboriginal leadership guide the work. This required the building of right relationships with the local land based and urban Aboriginal peoples. (Gomes et. al., p. 567)

All three parties committed to four priority areas that include governance; relationships and accountability; health promotion and disease; and injury prevention. This agreement created the framework for First Nations and Aboriginal leadership at VCH that since has been committed to “decolonize imposed health structures and support and respect the resurgence of Indigenous knowledges” (Gomes et. al., p. 567). Initially, it is explained, Aboriginal Health VCH, urban Aboriginal community members and Elders from the local nations created a health practice council, identified challenges, and drafted protocols and principles to respect and recognize their cultural health practices and “to develop clinical practice guidelines for health services to urban Aboriginal people” (Gomes et. al., p. 568). In 2008, in direct response to the Tripartite Health Plan priorities, Aboriginal Health Services in the Vancouver region was formed and also the Aboriginal Wellness Program (AWP).

From VCH’s Aboriginal report of 2017-2018, we learn that they provide services to Aboriginal Health Team (Primary), Aboriginal Patient Navigator, and the Aboriginal Wellness Program. Together with Elders in Residence, primary health care network lead a pilot project called Indigenous Cultural Safety, which aim to educate STAFF on Indigenous cultural competence: “Over 1500 VCH staff have taken the newly developed in-person Indigenous Cultural Safety (ICS) foundational training, including the Senior Executive team” (VCH, 2018, p. 2).

The AWP is mandated to develop and deliver culturally safe mental wellness and addiction programs for First Nations and Aboriginal people residing within the Lower Mainland. Services include adult counselling, support groups and cultural support & teachings. AWP takes a holistic approach that is client-centered, building upon the strengths of the person. Elders and Traditional Practitioners are brought in for specific purposes that are centered around the person’s needs, cultural and spiritual beliefs (VCH, AWP, 2020). The AWP highlights of the year include the successful response from Client Care Survey, which showed high levels of client satisfaction in “diverse activities such as Hosted a Grief & Loss Group, Intergenerational Healing Workshop Supported the Indigenous Mental Health forum with 85 people May 2018” (VCH, 2018, p. 3)

3.3. Therapeutic landscapes in Vancouver Coastal Health

I have reviewed the various practices conducted at the researched sites. In this section, I discuss the spatial arrangements that influence the way people experience places and shape the practices held in those sites. The term “therapeutic landscapes” comes from health and medical geographies and is used to define the impact of environmental aesthetics in places that pursue wellness and health maintenance (Gesler, 1992; Evans et. al., 2009) Carefully planned healing landscapes are found in every culture since ancient times. For example, sites with thermal, mineral or medicinal waters, healing gardens, retreat centres within nature, etc. Environmental variables, such as the size and arrangement of space, lighting, colour, nature and art display are aesthetic factors that require consideration when designing spaces that promote health and healing.

Critiques of mental health institutions have a long history in geography, especially as they pertain to the work of philosopher Michel Foucault who studied, under his own method of “archeology,” the evolution of the mental health asylum, linked to regimes of power, in which relations of control and discipline are established in institutional settings. According to Evans et al., (2009) aesthetic considerations in hospital design bring to the forefront non-verbal aspects pertaining to “power relations, cultural difference and psychic apprehension of place.” (p. 718)

The researched sites in my study could be seen as “geographies of *power* as much as they are geographies of *care*.” (Curtis, 2010, 193) but the studied sites, however, are not located in hospitals apart from the MHSU OS program, which is on the Vancouver General Hospital campus in the Segal building. This building embraces the importance of the environment and its influence on mental health. The Segal building is an aesthetically pleasing work of geothermal architecture that combines efficiency and beauty. Laura Case, the Vice President of Vancouver-Richmond Community Services and Dr. Soma Ganesan, the Head of Vancouver’s Mental Health, stated in an interview that the environment had been amply considered, including the “amount of light in each room, quiet places for reading or meditating, fresh air, greenery and artwork to activate the senses” (VCH, 2016, np). The hospital has beautiful views of the mountains, rooms with private washrooms, and a gym. It has sunny places, pleasant colors and noise reduction. The wards, however, remain locked and require an authorized digital device

to access and exit. This bright, clean and ordered space is in stark contrast to the old Psychiatric Assessment Unit at VGH, which appeared crowded, dark, and somewhat untidy. During my research, I interviewed a woman 55 years of age, diagnosed with bipolar disorder, who stated that part of her trauma concerned hospital treatment. Yet she also added that her experience in the Segal building “helped me avoid a traumatic emergency experience. The staff at the Segal Centre were very kind, hospital has improved significantly” (A13).

Located on the second floor of the Segal building there is MHSU OS, whose practices are separated into the “front house” and the “back house.” The reception area is located in the front house and the waiting room is well lit with a goldfish aquarium at the centre. The “back house” offers an open layout with various workstations separated by sound-proof barriers. Meeting rooms for groups are located in the back of house and they are large and well lit, with spatial flexibility to expand, reduce or rearrange the rooms by way of sound-proof wall partitions and tables. The therapy rooms are functional and ordered, equipped with brand new computers, comfortable furniture and dimmable white light. They each have a different piece of original art displayed, as do the walls in the hallways (Figure 3.1). The back of the house has secured access to staff and ushered clients and is separated from the front house by digitally locked doors, activated with a device or the staff’s identification.

This spatial model emerged in the early 2010s and has influenced recently built sites, such as 3BSU and AWP, each with their own singular designs. These new workplaces moved from an older model of personalized “cellular offices” towards a new design of desk rotation and open-plan generic offices; this global tendency for “dynamic” environments is less concerned with notions of personalized workspace, place or time and relate to shifts in organizational development that involved reducing economic costs and increasing the casualization of work (van der Voordt, 2004).

Although the three sites (MHSU OS, 3BSU and AWP) shared this spatial design, there were nonetheless some important differences. For example, consulting rooms are called “interview rooms” at MHSUOS, while 3BSU called them “therapy rooms” (Research notes, February 28, 2019). The site 3BSU, located in downtown Vancouver, shares the back of house with another mental health team (not included in my research), and one of its distinctive features is individualized bathrooms for a safe environment for

LGBT2S+ populations. Much like MHSU OS, 3BSU has original art displayed along the corridors, in the waiting area and in the consulting rooms (Figure 3.5). The waiting room in 3BSU displays a screen with various art and nature images, and messages for analysands.

The site AWP, located in East Vancouver in the “Gold Corp Centre for Mental Health” building, uses the back and front house model, yet includes personalized offices and the backhouse is not locked. AWP’s consulting rooms are decorated according to the therapist’s style and include Indigenous imagery and motifs. AWP also provides a larger room for holding talking circles and meetings, decorated with a colorful mural by artists Paul Windsor (Heiltsuk) and Jerry Whitehead (Cree) (Figure 3.2) that have representations of diverse nations. The entrance has a pillar titled “A Healing Welcome,” painted by Windsor, with depictions of symbolic relevance, such as the sun, eagles, raven, salmon and a yellow cedar tree. The waiting room is well lit with natural light, has water and coffee, and binders and pamphlets with information about programs. The back of house, not locked and with less staff, maintains a certain warmth and relationality, compared with the other two sites hosted in these new buildings. In the focus group, one clinician from AWP expressed it like this: “Almost everyone that comes [to AWP] in their own words will say that it is like a piece of a poem because of the space itself. It is a very intentional space” (FG Cl6).

Thus far, I have reviewed three landscapes located in newer buildings. The offices for the other two teams (Kits MH and South MH) are located in older buildings, not designed specifically for VCH, and represent the prevalent model before the beginning of the 2010s. This older design maintains the front and back house concept and the spaces are also separated by a lock, although at the Kitsilano site the lock is not automated. Both sites have furniture that is in relatively good shape, but not uniformed and clinicians who shared the space decorate it according to their taste, creating shared yet personalized consulting rooms. The consulting rooms are spaces where staff work either with analysands or on their paperwork and conduct case management calls. The lighting is diverse; some use white lamps while others combine warm light lamps and natural light (Figure 3.3). At both of these sites, the art displayed appears not as commercial and the decoration is more personal than corporate. The waiting area at South has access to coffee and water, some plants and a big screen, similar to the one in 3BSU that presents depictions of nature and information of interest to analysands. At

the Kitsilano site, the reception area is long and has some plants, and there is one receptionist whose desk has some decorations on it (Figure 3.4). Close to the door and separated by plexiglass, there is a community board with calendars of events. During a few of the interviews at Kitsilano MH, noise was an issue, as I could hear loud activity in the halls. Clinicians working in these two places highlighted the importance of environmental awareness: “All of this low lighting, you know; [to create] just a cozy environment” (CI4); “the STAR room, is a low stimulation environment... we have kind of a secondary waiting area over here that women can wait here so it is not as busy or noisy” (CI5).

Are these researched sites therapeutic landscapes? Although such a question is not the focus of my research, I want to spatially situate the places where the empirical part of my research was conducted. These sites correspond to what is known within health geographies as “post-asylum” therapeutic spaces (Curtis, 2010, p. 185; Bondi, 2005, p. 435), a term that refers to contemporary community service settings that constitute both material environments as well as symbolic and imaginary constructions associated to them. A community mental health place is a “transitional space,” meaning that in principle it should constitute:

an alternative social environment which, in contrast with wider society, does not stigmatise and marginalise people with mental illnesses and offers them stable spaces of attachment and structure to help them establish reassuring patterns of organisation in their daily lives (Curtis, 2010, p. 210)

References to spatial elements appeared in the interviews I conducted, with one participant of the focus group mentioning an absence of “intentional spaces” at VCH (FG CI1). Similarly, other participants agreed, one of them stating the importance of “working in facilities that reflect the people who are accessing services and having safety and low barriers” (FG CI1). Intentionality refers to the awareness of meaningful purpose of the space by those who inhabit it and relates to “geographical knowledge production” (McCormack, 2009, p.101). The sensorial experience of the spaces manifests not only an epistemological framework within the researched sites—a type of privileged knowledge— but it also aids our understanding about whether or not these spaces create a sense of belonging, which in human geography refers to the “multisensory modes of attachment, inhabitation, and involvement through which places became meaningful” (McCormack, 2009, p. 103).

Mental health settings are not intrinsically therapeutic as “they are experienced in very different ways by different people at different stages in the life cycle and reflect both shared interpretations of place and personal constructions of self-in-place” (Moon, 2009, p. 44). The researched sites, as therapeutic landscapes, provide abundant points of engagement but I will only approach general differences between the aesthetics observed in new and old buildings to highlight a few aspects of how the space is institutionally organized through the described visual elements, spatial arrangements and kinesthetic activity occurring there. Both aesthetics meet, unevenly, in what Curtis explains as desirable features in mental health settings, a “comfortable, protective and homely environment” (2010, p. 195). The new buildings bring comfort, safety, efficiency, functionality and beauty, but with the exception of AWP, they remain quite medicalized, as demonstrated by the aseptic uniformity of the consulting rooms, the various locks and the lack of singularized spaces, which prevent creating a warm atmosphere and intentionality. These new spaces appear to denote a medical place rather than a site to belong to, identify with or attach to —qualities that therapeutic landscapes should have. A participant made a comment regarding the automatic front doors at MHSU OS: “I’m telling you. They have got to go... they just open right at you in your face. It’s going to get somebody killed” (A15).

Additionally, the work conducted with MHA populations is intense in nature and the spaces in which it occurs affect both the users and providers and services. Spaces need to be designed, as Curtis indicates, to encourage positive and supportive social interactions (2010, p. 197) and specific to counselling practices, the place needs to create a sense of safety, confidentiality and relationality, “in which to explore sensitive and private issues” (Curtis, 2010, p. 209). Based on my experience, shared by many of my colleagues, the transition from old to new buildings required a long and difficult consultation and adaptation process that included surveying the nature of procedures and practices that will be conducted, up to consideration of the colors and materials preferred by staff. Notwithstanding, the shift to open space working areas without privacy and the lack of individualized spaces were the most resisted aspects of this work-space transition. The creation of these new spaces has had a negative impact on therapeutic practices by deemphasizing the value and importance of community and of singularized space. One could argue with Veitch (2011) that the spatial shift has increased social density and thus provided more opportunities for social interactions, but this spatial shift

has also changed some aspects of the territoriality of personal space, particularly regarding privacy, and we know that the research in this area of study “consistently reports a strong desire for privacy among employees” (p 39).

Older buildings provide a sense of safety and support by creating a homey environment that, based on my own experiences with people with whom I have worked for more than a decade, heightens a sense of belonging and inclusivity. However, old buildings often have noise or other issues that can prevent the space from being adequately private and calm, such as in Kitsilano MH. However, the lack of efficient and flexible spaces —such as the group rooms in new buildings— seems to have been somewhat compensated for with creativity, as exemplified by a gender-based alternative waiting area at South MHT.

AWP is perhaps the best therapeutic landscape that I found in the researched sites at VCH. AWP balances both the modern, efficient design of the new buildings with the active creation of a place to belong and heal, which allows for more relationality and identification by means of maintaining the personalization of singular spaces that allows the analysand to feel represented. The aesthetic at AWP avoids a medicalized environment and thus provides opportunities for serving the person within an environment of care that includes physical, emotional, mental and spiritual aspects of well-being. As reflected in the AWP 2018 Report, a distinct trend among Indigenous health provision sites is to promote health in one place, which has:

received high praise from the clients they serve in a Patient Experience of Care survey completed in the spring. The survey highlighted the exemplary services the AWP therapists provide and showed high levels of client satisfaction in all areas. (VCH Aboriginal Health, p.9).

This aesthetic, in addition, contributes “to explor[ing] shared interpretations of place and personal constructions of self-in-place” (Moon, 2009, p. 44).

To effectively provide services for people who suffer from trauma effects, it is important that both the users and the providers feel comfortable sharing space in which such delicate work happens. It is important to create spaces that nurture relationality, intentionality and inclusivity. I will now situate the trauma specific practices that occur in the researched sites.

3.4. Trauma related practices

Joe (pseudonym) is a 54-year-old Caucasian male who receives support around his substance use and related psychosis. In the interview Joe states that his trauma stems from early sexual abuse, of which he does not have conscious memory. He also believes that his experiences of psychosis and his involvement with the criminal justice system have contributed to his trauma. Joe's drug of choice is crystal meth and when I asked him in what way his trauma connects to his substance use, he answered:

So deeply. Very deeply. When I use, if I use, I go into what I would consider to be a trauma mode, and by that, I mean I create both real and perceived issues of trauma... I'm still having the trauma because I am in that period of psychosis, and so if I feel, for instance, this is a for instance, that my place is being wiretapped and there are hidden cameras everywhere. So, if I wasn't using in that moment, I wouldn't think that, but because I'm using, I'm still experiencing my body, my soul, my very being is still feeling all of the trauma that I would be feeling if that actually were the case... I'm still going through the same trauma. It's real, although it's not. The trauma is real, the facts are not. (A17)

Joe has been receiving services for four years at 3BSU Team in downtown Vancouver. He has a medical diagnosis of HIV and consequently he also receives services at the Infectious Disease Centre, where his main psychotherapy occurs, along with diverse treatments at the Peter Centre. His description of trauma represents the complexity of a traumatic experience in the context of substance use and psychosis. So, how do trauma-specific services at the studied sites respond to circumstances such as Joe's?

3.4.1. Trauma informed care

Since May 2013, across the Coastal Health region, services have been following the "Trauma-informed Practice Guide" (TIP, 2013), which indicates that about 76% of Canadian adults "report some form of trauma exposure in their lifetime" and 9.2% meet the criteria of posttraumatic stress disorder (PTSD); this percentage increases to 90% for women with mental health and substance use concerns (TIP Project Team, 2013, p. 9). This prevalence of trauma among MHA populations defines the researched sites, de facto, as trauma-specific, and requires those programs to "address the impact of trauma and support overall recovery" (p. 71). Universal assessment and implementation of TIP in health systems has gathered momentum since the integrative work of Harris and

Fallot (2001), which aims to prevent re-traumatizing people in the context of service provision.

Trauma-informed care (TIC) practices have been conceptualized as a “universal precautions philosophy” (Zingaro, 2012, p. 35) which, based on practice evidence, “should be implemented universally” (Reeves, 2015, p. 706). Comparable to the shift from abstinence-oriented substance use treatments to a harm-reduction approach, trauma informed care is a model that moves away from a PTSD diagnosis-based approach towards an increased consumer engagement and recovery philosophy (Poole & Greaves, 2012). There are studies that advocate for this practical approach at different points of the lifespan (McKenzie-Mohr et. al., 2012; Harber, 2012); with specific populations (Palucka & Lunksy, 2012; Agic, 2012); in diverse settings (Perivolaris & Pottinger, 2012; Abbot, 2012); for both substance use and mental health needs (Haarmas, 2012; Poole & Lyon, 2012; Covington, 2012; Mills, 2015); with a gendered perspective (Dell, 2012; Toner & Akman, 2012; Akman & Rolin-Gilman, 2012; Umaña, 2012; Fallot & Bebout, 2012) within family systems (Baker, 2012) and specific for Aboriginal populations (Menzies, 2012).

Within VCH, there is an ongoing impetus to educate on TIP culture through the Trauma Informed Care Educational Series, which reaches all clinical levels of health (primary, secondary and tertiary) and focuses on increasing staff understanding of trauma in the context of service provision. The Regional Trauma Informed Practice Steering Committee works on an ongoing strategy to promote new guidelines and education across VCH. However, there is not yet a component within the institution to supervise and evaluate the actualization of TIP. When I attended a couple of these meetings, several members of the committee —employees working on this project on voluntarily basis— expressed how difficult it is to do this work while attending the demands of their regular workload.

My research reveals that there is a general awareness of trauma-informed care among service providers at every level within the participant sites, yet such awareness is not always successfully actualized, as I will discuss in depth in Chapter 4, mainly because the hegemonic discourses are dominated by the illusory effectiveness of mental health evidence-based treatments.

3.4.2. Trauma specific services

Trauma Specific Services (TSS) are counselling and other clinical interventions designed to treat the actual sequelae of trauma and to facilitate recovery (Jennings, 2004; Kirst et. al., 2017). Numerous protocols of so called “best TSS practices” exist for both group and individual services and include peer support and self-help for adults, children, families, parents and caregivers (Jennings, 2004). Most of these models are psychoeducational, skill-building, manualized therapies that are built on cognitive-behavioural therapy (CBT). There is empirical evidence on diverse epistemologies, that could diversify relevant services for people with posttraumatic suffering, but CBT is the hegemonic practice at present. One of the participant clinicians in my research study stated that the Outpatient Psychiatric Services, between the years 1999-2000, provided an extensive program for TSS —a PTSD clinic that lasted only a year after the limited external funding dried up. This program included both supportive and psychodynamic groups and allowed for each of the person’s preferences:

Any kind of trauma-informed group would be by interest of that person, and again it would have a dynamic flavor to it, and it might be very specific based on that person’s interest at the time. Then we went through a phase where we had actually quite a large population of clinicians and psychiatrists, various disciplines, who were interested in trauma, and so there was a time where we actually put together a proposal to start a PTSD clinic, and it started off as just a group, and then we were trialing our own protocol and studying it. (CI2)

The clinician added that this clinic involved the community and included diverse trauma modalities. It was a three-stage program that was flexible and involved individual and/or group therapy:

So, you would do the assessment and decide how would we like to do stage one, and then the patient, in consultation with the staff, would decide do they want to do stage two and then we had variability on how to do stage two, so again, you could do stage two in individual or you could do it in our group, and then for stage three we also had a group. Actually, we had two parts to stage three, so we had a support group and then we had a long-term support group that was indefinite, as long as you needed. (CI2)

Regrettably, the therapeutic reality at present is far from that. Trauma-specific services identifies three main stages for the treatment of trauma: 1) creating safety by grounding therapeutic relationships and developing strategies to cope with emotions; 2) processing

grief, memories and meaning, as well as articulating the unspeakable that was endured; and 3) a reconnection to social life (Mahoney & Markel, 2016; Herman, 2015; Haskell, 2012; Korn, 2009). My research reveals that there is a generalized awareness of trauma-informed care among service providers at every level within the participant sites. There are some programs that provide second stage TSS, but the vast majority of MHSU services at VCH focus on the first stage, providing therapeutic modalities predominantly through sequential and psychoeducational skill-based groups. The majority of TSS at VCH are either psychiatry-based (medication, case management) or therapies of relatively short duration that address strategies to cope with the affect rather than processing histories, identities or meaning (Fernandez-Alvarez, 2020c, p. 294). Therapy is often provided in artificial groups where bonding outside of the actual group time is discouraged, and participants are closely monitored in terms of the content of their disclosures, on the premise that it's in the client's "best interest," to safely prevent re-traumatization or to maintain the integrity of the protocols (i.e., DBT) (for a detailed discussion cf. 7.4.4.5). The trauma therapies provided at VCH are not integrating a true psycho-socio-spiritual approach and are instead increasingly focused on a rigid manualization of interventions rather than addressing a person's actual needs. For example, a clinician participant stated: "You're teaching someone, here's the method," and continued, "so the protocol is very specific and cognition based, and so you're taking them [clients] through a manual." (CI2).

This predominant psychiatric and psychoeducational model is chosen partially due to the temporo-spatial demands posed by the increasing need, high complexity and acute presentation of the population served (cf. 7.2.1). However, my study shows that the exclusive use of psychiatric pharmacotherapy and manualized skill-building training does not suffice to treat the complexity of trauma because it hinders the possibility for service users to be heard and to establish relations in a more meaningful way. About 30% to 60% of people accessing services for complex trauma sequelae do not react well to CBT approaches according to empirical observations (Sciarrino, 2017; Schouten et. al., 2019). Moreover, relying almost exclusively on psychoeducational approaches provided within a classroom instead of a therapeutic space produces subjective emptiness within the institution, a concept that I develop in Chapter 7. As I mentioned elsewhere: "[T]he traditional idea of therapy as a form of inquiring subjectivity appears to be disappearing in mental health institutions" (Fernandez-Alvarez, 2020c. p. 294)

Easing psychosocial suffering and therapeutically expanding an individual's emancipatory agency starts with an adequate conceptualization of subjectivity and trauma, as well as employing methodologies that nuance complexity and facilitate listening to a person's subjective truth. If a program fails to address the subjective aspects of an individual, we face the so called "revolving door" approach to treatment as patients repeatedly return to request further treatment because the root issue has not been addressed. As a leadership participant stated: "What I have seen is, addressing [trauma] fully to the degree that each individual is capable of and ... there is not typically a return, if they have done trauma processing" (Ld1).

The complexity of traumatic experiences and the ineffability of posttraumatic suffering requires an engagement with various orders of human knowledge. My research calls for a more comprehensive approach to TSS that emphasizes a relational model of service delivery and the provision of a broader spectrum of therapeutic choices, consistent with what we know is the highest available standard of care (Triliva et. al., 2020). I will further discuss the mechanisms that have determined VCH's choice to treat MHA analysands with this therapeutic modality (cf. 4.3). I will also provide a nuanced elaboration of why the solution is not only a matter of *adding* new therapeutic forms (7.3.2), but rather incorporating structural mechanisms that preserve an ongoing critical integration for program design and delivery while at the same time promoting critical pedagogies (Pillen et. al., 2019) and self-reflective practices on the clinician's positionality regarding knowledge and power. I believe that only then will VCH's MHA programming truly align with the provincial government's vision to "build a holistic, person-centred and person-directed system" (Darcy, 2019).

3.5. Conclusions

In this chapter, I have situated VCH by reviewing its scalar complexity, its historical development of practices and its current programs. I conclude situating the institution critically, as follows: The biomedical model that sustains the therapeutic spaces and practices of mental health and addictions services at VCH is influenced by the neoliberal condition that more generally afflicts global mental health, ignores upstream causality, and diminishes the role of critical, flexible and diverse individual and community therapeutic initiatives.

Can VCH's mental health system be seen as effective based on Bob's experience? Although his story is one of compelling success, Bob's situation cannot be extended to most of population at VCH, as he is a voluntary participant, satisfied with the services received. Unlike many VCH clients, he does not present with marked health determinants of inequity as he is white, male, and comes from a relatively stable, upper socioeconomic, and educated family background, factors that might have contributed to the success of his treatment. Moreover, situating the complexity of a public mental health system requires not just a consideration of individual cases but rather, as Barnett and Barnett (2009, p. 127) claim, engagement "with entire target populations and entire service systems for extended periods of time," to which individual stories of lived experience provide valuable additional information. A mental health system must develop strategies to meet requirements of prevention, screening, interventions, health and safety legislation, policy, and the provision and regulation of services. Given the demand to meet all of those requirements within the limitations of time and human resources, the system has opted to rely on a hegemonic biomedical model to attend to the human suffering of its users, justifying it through economic reason. As various participants of the focus group voiced it, "Decisions on mandates are made around economics" (FG CI3 & CI4). By choosing such a model, MHA treatment relies on the discipline of psychiatry for leadership, which traditionally, as Morrow rightfully argues, "has not responded in any significant way to the substantive evidence that mental distress is intimately tied to social inequalities like poverty, homelessness, racism, homophobia and sexism" (Morrow, 2007, p. 73).

Barnett and Barnett explain how public health sector organizations all around the world are in a constant state of restructuring in their attempts to regulate organizational relationships of economy, policy and society "as a way of responding to capitalist crises" (2009, p.58). The MHA crisis faced by the province falls heavily on the VCH region, and consequently it has to attend to demands imposed by the multifactorial combination of the opiate crisis, housing crisis, and an increasingly complex and acute mental health demand. The latter has led VCH to address the population's needs by utilizing a managerial form of health system restructuring that is "heavily influenced by the new public management [model], focusing upon accountability and performance contracts to improve overall sector efficiency" (Barnet & Barnett, 2009, p. 63) at the expense of

attention to communities of care, sense of place, and democratic and critical practices. Morrow asserts that, with regards to the care and support of people with mental illness,

the province has lost sight of active recovery models and is letting a preoccupation with cost containment guide decision-making, rather than the values reflected in 'best practices' for the care and support of people with mental illness. (Morrow, 2007, p. 7)

Masuda and Chan are concerned about the change of values in mental health care economics, managed through a "rationalistic model of health system access" rather than one that incorporates community-based initiatives. They argue that this could be seen as a paradigmatic shift that occurs with regionalization which "was the mantra of neoliberal health reforms" (2016, p. 590). The diminishing importance of community in the mental health care strategy in BC has also been largely noted in journalistic research, in five parts, conducted by Lupick (2016) as well as in various studies conducted around the world (Bracken, et. al., 2012; Triliva et. al., 2020).

Based on the discussions in this chapter, I claim that VCH's system programming follows a global tendency that serves populations affected with MHA issues within a predominantly biomedical model, which is reflected in their spaces and practices. The *Special Rapporteur* states that, notwithstanding provincial advancements made with regards to law and policies in the Canadian mental health system,

mental health care seems to be still dominated by a biomedical model, the overuse of psychotropic medications and an overall conception that mental health conditions result from chemical brain imbalances or other neurobiological and genetically determined mechanisms. (Rapporteur, 2019)

The biomedical model has been responsible for many crucial scientific discoveries and its importance in society should never be dismissed, given the unquestionable role in fighting illnesses and promoting health around the world. However, with regards to mental illness and addictions, and specifically regarding the provision of trauma-specific services, this hegemonic system is highly problematic, and I will briefly list some of my concerns.

When a system relies on a biomedical model to address mental health suffering, it "focuses on bodily malfunction and body repair" (Moon, 2009, p. 35), which, in the context of the MHA system, is interpreted as needing to repair the brain, rendering

mental illness, and associated traumatic experiences, as a matter of individual experience inside the person's head and devoid of subjective history and context. As various clinicians expressed during my research, VCH's primarily biomedical model proposes a unique approach to all MHA needs: "one size fits all is a significant barrier" (Ld2); "one size fits all is disempowering" (Cl5). According to Mills (2014), the one-only solution to all mental health and substance use represents a phenomenon of the "McDonaldization" of people's health through an exercise of a "pharmaceutical reason;" it also colonizes ontologies, and imposes exclusive forms of knowledge and experience, constituting "epistemicides" that accommodate imperialistic agendas that serve the demands of psychopharmacological markets (p. 42). The biomedical model has also been criticized as a "regime of ruling" founding all its apparatus on diagnoses based on a "boss text" (DSMV) (Burstow, 2015, p. 70-73) and preferred treatments are linked to the burgeoning of the psycho pharmacological business (Morrow, 2007, p. 72). The biomedical model has also been criticized for ignoring "the unique cultural identities, histories and sociopolitical contexts of the everyday lives of Aboriginal peoples, putting them at risk of not having their health care needs recognized and met" (Smye & Mussell, 2001, p.9). Finally, I agree with Masuda and Chan when it comes to VCH's reliance on a biomedical model that:

perpetuates a long pattern of health sector neoliberalization in Canada, reflected in an ideology of individualization, austerity, corporate governance, and a reassertion of a technorationalist biomedical model of health over a relational socio-ecological model of well-being. (2016, p. 590)

If mental health issues and trauma in particular are always at the core of any MHA concern, there is a need to effectively understand causalities, and that requires clinical inquiry further upstream, rather than continuing to consider MHA as a presumed illness of an organ. Although the practices that I have reviewed in this chapter aim to deliver services within a "bio-psycho-social continuum" (Bradley, 2015, p. 25), the actualization of services often ignores the larger context of a person. As I claimed elsewhere: "The point is not to exclude psychiatric practices or psychotropic medications but rather to prevent the reductive fetishization of the 'brain' and its disorders and the dominance of certain treatments that produce alienated subjectivities" (Fernandez-Alvarez, 2020c, p.294).

To address the complexities of trauma involved in MHA at VCH, adequate policy is needed, one that incorporates intersectionality, which is to say, the socio-spatial location within the institutional structure of diverse dimensions of an individual's identity, such as race, class, gender, age, and ability. Such an approach would allow “to proactively promote equity and human rights through policy making” (Cook et. al. 2017, p.244). Furthermore, Morrow & Weisser rightfully critique the system as not being able to attend the complexities of people's lives and so they advocate for a social justice framework in mental health “that makes use of the social determinants of health and/or the social model of disability” (2012, p. 34). If such demand is crucial and relevant to the MHA system at large, with regards to TSS, an equally vital demand should involve the incorporation of critical therapies that empower subjective emancipation and wellbeing.

To adequately comprehend how individual clients, like Bob or Joe, are entwined with the socio-spatial practices at VCH, and to discuss in what ways the predominant biomedical and cognitive-behavioural modalities prevail, it is necessary to approach the discursive spaces in which service users and providers collide within the mental health system, which I will discuss in the following chapter.



Figure 3.1. MHSUOS: Consulting room with synthetic plants and original art



Figure 3.2. Aboriginal Wellness Team. Talking Circle Room.



Figure 3.3. South MHT: Consulting room with plants and non-commercial art



Figure 3.4. Kitsilano MH: Display at the entrance to consulting rooms, passing the waiting area

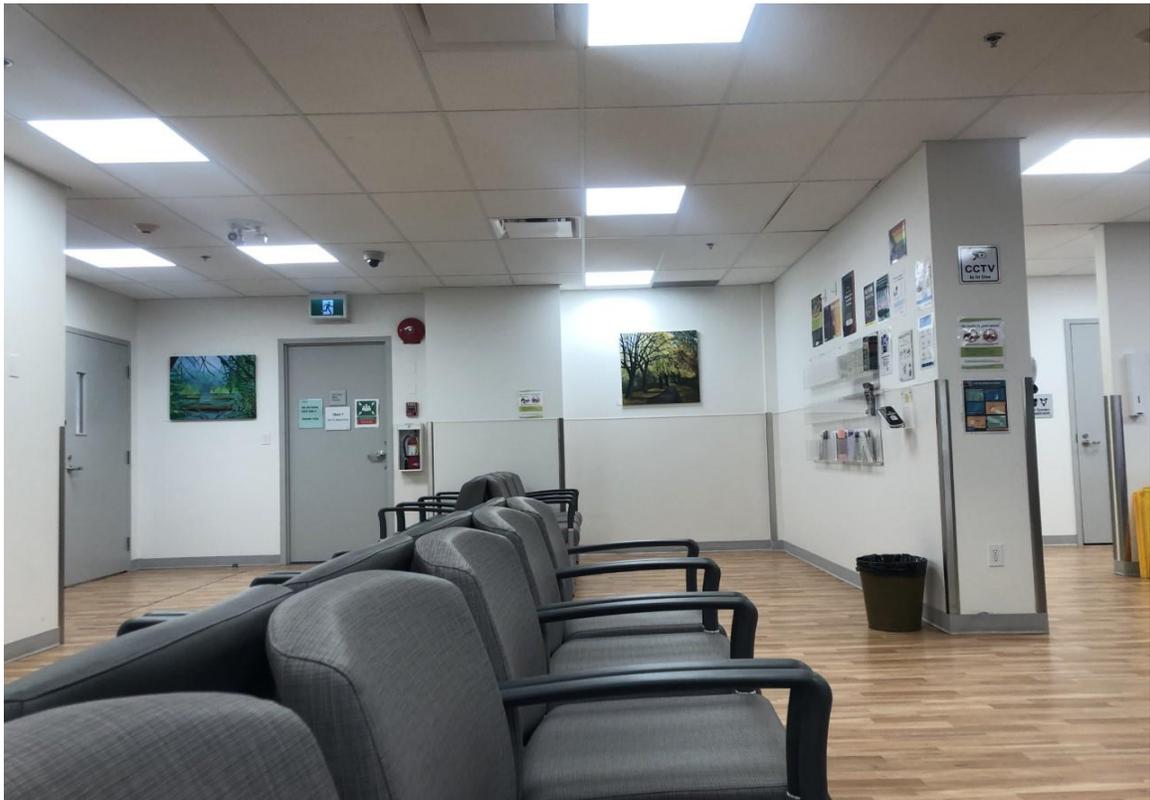


Figure 3.5. 3BSU: reception with art on the walls and individualized washrooms on the right.

Chapter 4.

Placing discursive spaces

In the discourse, I do not have to obey its rule, but find its cause.

Lacan 13.11.1968.

4.1. Introduction

In this chapter I propose a conceptual model to understand social bonding within the space of an institution, which I render as both a structure that connects subjects through language and an abstract space that maps the unconscious. I will first explain Lacan's theory of discourse, which enables an analysis of how linguistic exchanges are embodied within the institutional space. After presenting the main tenets of Lacan's theory, I will review previous research conducted through Lacan's theory of discourse to contextualize the singular way I deploy this theory in the study of discursive spaces of Vancouver Coastal Health's participant sites. I will focus on two cases (Case A and Case B) obtained from two of the 20 semi-structured interviews I conducted to demonstrate how the structure of discourse is situated and embodied. I explore how participants come to occupy certain structural positions, such as knowledge, truth, jouissance or residue, and how those positions are organized in two axes, one of representation and the other of production. I claim that the master signifier *mental health evidence-based practices* (MHEBP), as it appears in the interviewees' speech, as much as in institutional policies and manuals, organizes the mental health (MH) social link, corresponding to what Lacan proposed as the 'university discourse,' which I render here as a 'know-it-all' discourse. I further explore the relation of the know-it-all discourse to other discursive forms, such as the discourse of protest (Lacan's hysteric discourse) and the capitalist discourse, the fifth discourse developed by Lacan in 1972, which I instantiated with Case C and Case D, obtained from my literature review. After discussing various linguistic arrangements, I conclude this chapter by analyzing how the know-it-all discourse exerts hegemonic power within the institution by forcing consensus through the master signifier; yet the limited power of signifiers and the failure of knowledge create possibilities of resistance.

4.2. Lacanian theory of discourse

Lacan's theory of discourse, which informs and guides my research, consists of four quaternary formulas that indicate the way in which individual intrapsychic conditions interact in intersubjective relations to account for sociocultural and political productions (Bracher, 1994; Parker & Pavon-Cuellar, 2014; Schroeder, 2008; Vanheule, 2016). With these algebraic formulas, Lacan attempts to bring the whole of his theoretical apparatus to a minimalistic expression to understand structures that host overdetermined embodied practices, shedding light onto the functioning of society by mapping the various individual possibilities of desiring and enjoying.

Discursive space refers to the *positions* that speakers and their interlocutors occupy in language and the *terms* that are exchanged in the social relations they sustain. Lacan defines the structure of discourse as "a group of elements, forming a co-variant set" (Lacan, 1972a, p. 8). By discourse, Lacan understands "fundamental...stable relations... of one signifier to another" that subsist in language without the need for speech (Lacan, 1969/2007, p. 13). Such relations "are discourses without speech, which subsequently comes and lodges itself within them" (Lacan 1964/1998, p. 166). Thus, discourse is a mode of social bonding within a particular structural arrangement. Lacan classifies four of them: *master*, *university*, *hysteric* and *psychoanalytic* and these fundamental relations can help understand four phenomena respectively: governing/commanding, educating/indoctrinating, desiring/protesting, and analyzing/transforming/revolutionizing" (Bracher, 1994, p. 108). They are, also, an attempt to problematize and think more carefully about what Freud named as the impossible professions of governing, educating and analyzing, which "one can be sure beforehand of achieving unsatisfying results" (Freud, 1937/1973, p. 248).

According to Braunstein, the discourses were born out of an attempt to extrapolate the understandings achieved in the clinical onto the political within the context of the events of 1968 (2012, p. 132). May 1968 is known as a liberating movement that challenged institutions both in France and in other parts of the world; it started with student protesting the bureaucratic and authoritarian academicism in various universities in France and culminated in a massive strike joined by about six to seven million workers from factories, administrative positions and professionals who called for new government elections (Fernandez-Alvarez, 2020c, p.284). Within this *Zeitgeist* of

radical critique against government institutions, Lacan's theory of discourse proposes, rather than a protest, a method to ascertain the logic that repeats structural conditions rather than ultimately breaking with them.

To contextualize Lacan's theory of discourse, we ought to remember that for Lacan "language is the condition of the unconscious" (Lacan, 1969/2007, p. 21). The theoretical consequences of this statement are twofold:

- 1) The subject of the unconscious is conceptualized by Lacan as what a signifier represents for another signifier, contra the Aristotelian *hipokeimenon*, which literally means an "underlying substratum" that would assign an essential substance or quality to the individual. Instead, the Lacanian approach understands that any idea or abstraction (a signifier) can influence the subject in the way they embody the effects of those signifiers. Lacan's theory of the subject considers that a person, as a subject of the unconscious, is historically and unconsciously alienated through the discourse they grew up within and which they know nothing consciously about, epitomized in Freud's statement "the dreamer does know what his dream means: only that he does not know that he knows it" (Freud, 1915/1973, p.101). Such alienation is in principle transcendental or structural, yet always submitted to a historical context, as I will demonstrate when discussing the social bonding clinic.
- 2) The unconscious can become apparent through the analysis of the relations that are sustained by language. This means that even if there is no explicit speech to acknowledge events, norms or procedures, language nonetheless still sustains linguistic exchanges. Such exchanges occur through words, silences, acts and disruptions, which support the structure of a practice.

The subject of the unconscious, structured through language, is always connected to a discourse that serves as a conduit of superegoic imperatives. Referring to discourses without words, Lacan asks "what would we make of what appears in the guise of the superego?" (Lacan, 1969/2007, p. 13). This question is crucial to advance the analysis of discourses, as in every institution (motherhood, friendship, workplace, etc.) there are actions and expectations, both implicit and explicit that are implemented through superegoic injunction. These compulsory repetitions sustain the way in which an

institution works, yet often are unavailable for elucidation, despite these veiled conditions being crucial to maintain the *status quo* of particular social relations.

Discourses beyond utterances, then, are inscribed and sustained by the superego, and they form the structure in which an institution works its repetitive practice. To make the repetition legible we need to find its letter within the matheme given by Lacan in his discursive formulas. A letter is a minimal structure that repeats the *existence* of something of the Real, as Joan Copjec rephrased Lacan, “structures are real” (1994, p. 11) in that the positional arrangements of linguistic places account for the etiology of an empirical phenomenon even if the cause of such structure does not *appear* except by its effects (1994, p.13). These notional devices inscribe themselves within the logic of the singularity of the unconscious as it is manifested in the analytic practice; as such, although the Real structure is stable, it must be considered case by case (Braunstein, 2012, p. 132; Verhaeghe, 2001, p. 33) as various discursive shifts occur indeed within the same social space of an institution, as I demonstrate with the switch of Case A from the university discourse to the hysteric discourse (4.3.7).

Prior to explaining the logical arrangement of discourse, I consider of importance to locate the minimal speech act between subjects. In his rendition of the graph of desire (Lacan, 1958–59, p. 6), Lacan shows how the subject of desire functions linguistically by situating the places of subject (\$) and the big Other (A, in the French original as *Autre*). The detailed rendition of this graph exceeds the scope of my dissertation yet suffice it to say that at the first level of the graph, as seen in Figure 4.1, the subject requires at least two signifiers when the subject speaks. A saying, marked in the graph by a line that goes from the signifier to the voice, is retroactively signified by the subject according to what the big Other (A) has coded via the master signifier (or signifier number 1, S1), organizing further significations of speech. S1 constitutes the frame in which the signification of the Other, s(A), will bring about content or meaningful knowledge for the subject (or signifier number 2, S2). This minimal speech act extends substantially because S2 slides towards another signifier within the signifying chain, offering endless possibilities of saying the same thing with multiple words. The voice tends to exponentiation by the fact that there is always another signifier (Sn) until a halting point in speech is reached, wherein signification occurs retroactively, always involving

the Imaginary circuits of the ego, the ideal ego and ego ideal⁸. Clarifying this mechanism is important not only for further understanding of how psychoanalytic intervention occurs (cf. to 6.5), but also to situate the linguistic space of discourse.

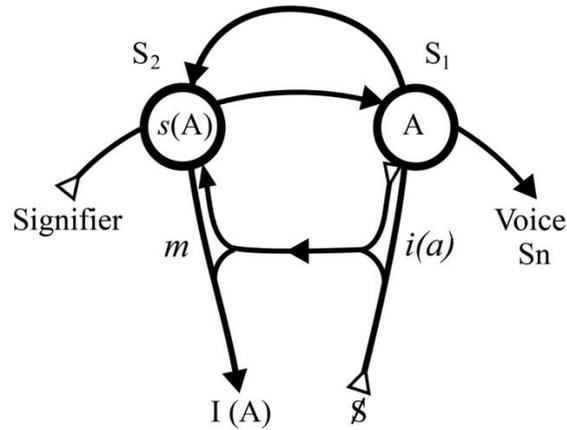


Figure 4.1. First level of the Graph of Desire (Lacan, 1958-59), shows the minimal act of speech and the way the master signifier (S1) conditions retroactively any further meaningful signification (S2) within discourses.

Lacan's formulas are a representation of a subject among others and each structure holds four different *positions* that Lacan originally named in Seminar XVII (1969/2007) and then renamed them in the Milan Discourse (1972a) as: 1) agent or semblance; 2) other or jouissance; 3) production or surplus jouissance; and 4) truth. The four positions or loci are fixedly established in a type of algebraic fraction and the general formula for the discourse is depicted in Figure 4.2.

⁸ Elsewhere, I have rendered the various forms of the ego in relation to the gaze: the ego as how I see myself, the ideal ego as how I would like to be seen, and the ego ideal as how I imagine others see me (Fernandez, 2016, p. 73).

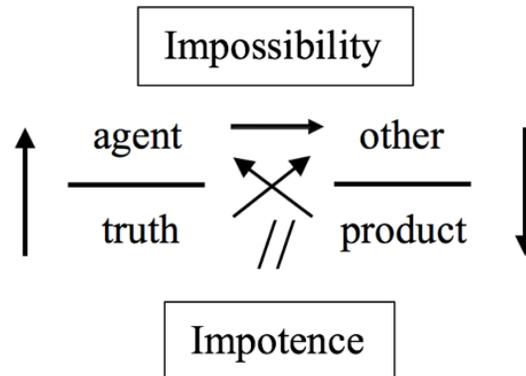


Figure 4.2. Lacan's fixed positions in discourse, locating impossibility and impotence (Modified from Lacan, 1969-70/2007, p. 169).

Verhaeghe provides an amusing metaphor to read the four discourses as bags with each having four compartments where one can put things in: "The compartments are called positions, the things are the terms" (2001, p. 21). The positions connect through vectors at the two levels characterized by two types of relation: the upper one is impossibility and the lower one corresponds to impotence (Verhaeghe calls it 'inability,' p. 23). As depicted in Figure 4.2, the upper line presents a relation that is always impossible: "The impossibility is due to...what it is that stands in the way of grasping, of seizing the only thing that could perhaps ultimately introduce a mutation, namely, the naked real, without truth" (Lacan, 1969/2007, p. 174). In other words, the impossibility corresponds to the insufficiency of any truth to account for and to fully transform the Real. Such impossibility attains differentiated effects in each discourse and those effects unite "a group of subjects through a particular impossibility of a particular desire" (Verhaeghe, 2001 p. 24). Thus, the way we bond with others is an effect of the way a group accounts for the impossibility of saying something about the field of the Real. This is related to the famous Lacanian aphorism of "*Il n'y a pas de rapport sexuel*" or "There's no such thing as a sexual relation" (Lacan, 1972/1999, p. 12), which indicates the impossibility to fully account for the sexual non-relation or non-rapport. Not being able to signify or even write the sexual relationship is of relevance because it is the central impossibility in every speaking being (*parletre*) and as such it cannot be formalized in their rules and laws of what constitutes the difference is sexuation between a man and a woman, and neither can provide a norm for how sexuality should be experienced or expressed. This impossibility of the speaking being in language is activated every time that something of the unconscious knowledge confronts the subject.

In contrast, the lower relation of discourse presents a “block,” a permanent lack of communication between truth and its discursive production, which constitutes an impotence of connecting the agent’s truth and the receiver’s production. Such a scenario occurs because the agent cannot know the truth that inhabits her/him (is concealed to consciousness) and therefore what she/he asks within discursive exchanges will result in a production by another that is alien to the core of her/his demand. Lacan adds that discursive impotence is a way of protecting the conscious recognition of the impossibility.

The *terms* or loci of embodiment are what circulates in the fixed positions and are: S1, master signifier; S2, knowledge, \$ divided subject and object *a*, which will be detailed below through the analysis of key empirical findings.

4.2.1. Research with Lacanian Discourse Analysis

There are several studies that have relied on Lacan’s theory of discourse to understand and interpret social bonding. Van Roy, et. al. (2016) conducted a qualitative study with five groups of physicians in general practice who were engaged in clinical supervision through Balint Groups, a group modality that originated in the Tavistock Clinic in London around 1950s and aimed to elucidate emotions, thoughts and subjective reactions among general practitioners with regards to specific clinical cases. This study demonstrated that most discussions in the participant Balint groups presented a form of “puzzlement,” which was read as an indication of structural impossibility (Van Roy, et. al., 2016, p. 12). They noticed that most of the groups presented the “hysteric discourse” as the dominant modality and the central focus of the Balint Group process, yet they recognized that the analyst’s discourse was crucial to exploring aspects of subjectivity within the group.

Jeanne Schroeder, a feminist lawyer, engages with Lacan’s theory of discourse to account for the circulation of these discourses with regards to the implementation of law and to explore the involvement of jurists and lawyers in the four different discourses. Schroeder locates quite pertinently the discourses of power, Lacan’s master and university discourse, as masculine positions on the side of the governor whereas the analyst and the hysteric discourses are feminine, *supplementary* positions on the side of the governed: “The masculine does not merely fail to hear, it affirmatively refuses to

acknowledge the feminine” (Schroeder, 2008, p. 2). She recognizes the cyclical aspect of discourse: “Although the two critical discourses critique the discourses of power, they will necessarily also regenerate new discourses of power” (Schroeder, 2008, p. 3). While Schroeder concludes that social order requires both the masculine and feminine positions and thus all four discourses are useful, she advocates for the hysteric ethics to counteract the ethics of law.

Michael Gunder utilizes the four discourses to discuss a vast literature review on the shaping of urban planning in the postmodern Western city with ideals such as difference, diversity and multiculturalism. Gunder observes that normative beliefs of the university discourse guide consensus through ideological mechanisms and that “urban policy narratives and discourses are initially taken to heart by the policy planner and then prescribed for the ‘planned’ public” (2005, p. 85). The said ideals seek to provide an illusion of certainty, wholeness or social harmony, which is the field of ideology proper manifested through fantasy and desire; these mechanisms indeed work to obscure “the agonistic reality of difference and lack that constitutes the human condition” (Gunder, 2005, p. 85).

In the following section, I render my own approach to Lacan’s theory of discourse to explore the discursive spaces among service users and providers within VCH. As stated in section 1.3.4, the institutional space is composed of libidinal phenomena, objects, events, pacts, history and meanings, and so I assume the institution as a psychosocial space of an individual among others that create social bonding via linguistic formations that follow a superegoic semblance to sustain the master signifier. Rather than explaining the psychodynamics of shared functions such as identifications, pacts and ideals (Kaës, 1989; Roussillon, 1989), my analysis is framed in the discursive spaces and thus looks for different ways of establishing socio-spatial bonding and traces the embodied mechanisms that occur through their exchanges.

Space is a geographical term *par excellence* and has multiple theories, being theory itself “geographically, historically and institutionally located” (Crang & Thrift, a form of space (. The study of space ranges from the materiality of physical and regional geographical space, to the textual and writing spaces in literary studies, to socially produced anthropologic and sociologic spaces of interaction (Elden, 2009; Kitchin, 2009). In my dissertation, I approach space as a process and as movement rather than

as a container, and more specifically as a theory about how the subject embodies places and non-places via language. Place is a term phenomenologically more laden than space, which refers to meaning, a sense of belonging or a practice (Cresswell, 2009, p. 173). Michel de Certeau (1984) further supports how I approach the difference between place and space, when he establishes a distinction in the following way:

A place (*lieu*) is the order (of whatever kind) in accord with which elements are distributed in relationships of coexistence. It thus excludes the possibility of two things being in the same location (place) ... A place is thus an instantaneous configuration of positions. (p. 117)

In contrast, space:

exists when one takes into consideration vectors of direction, velocities, and time variables. Thus, space is composed of intersections of mobile elements. It is in a sense actuated by the ensemble of movements deployed within it. (p.117)

Therefore, I define *discursive spaces* as the dynamic process of social bonding occurring by an individual putting their body of *jouissance* in a linguistic place determined by the social structure in which they participate. Those discursive spaces then are places (the master signifier, knowledge, desire) but also non-places (object *a*, *jouissance*) revealed by the unconscious as that which does not operate as expected because it shows the residual production, as I will demonstrate in this chapter. Before proceeding to the analysis of the discursive spaces at VCH, I will explain next what exactly I mean by embodiment.

4.2.2. Embodiment

People working in an institution embody places in language that sustain a form of social bonding. Embodiment refers to the study of the body among other bodies, and in geography has been researched through emotions, rhythms —e.g., speed or slowness—, the everyday life or performativity in human practices (Cadman, 2009, p. 460). The study of the exchanges between the human body and other beings and other objects explores various forms of knowledge on how a subject obtains information via their bodies. Embodiment research goes beyond the representational and has been highly influenced by philosophical currents, such as phenomenology (Heidegger, Merleau-Ponty, Wittgenstein), structuralism (Foucault, Baudrillard, Lyotard, Derrida) and

neovitalism (Spinoza, Nietzsche, Bergson, Deleuze and Guattari). This field has been described by Cadman as “sensuous and expressive; historical and invested; and capacious and affective” (Cadman, 2009, p. 460), which summarizes some interests of embodiment research on how one becomes a self through performativity or the expression of affective capacities. Embodiment in psychoanalytic geographies find a good example in the collection by Nast and Pile (1998) who compiled perspectives on bodily relations and practices, such as filtering, confining or excessing the body, studied in a continuum that goes from large scale geopolitics (Nast, 1998, p. 69) to the city (Wilson, 1998, p. 99), to the spaces of home, family and memory (Bordo et. al., 1998, p. 54), to the sexed body (Grosz, 1998, p. 31). In my dissertation, however, when I use the word embodiment, I allude to the subject’s *body of jouissance*, indeed a sensual body — created by the experience of the senses— that carries emotions and rhythms, as much as agitations and calmness, connected to the body *qua* organism commanded by the drive. I understand embodiment as what the subject does to account for the silent effects of language in their experience of bodily jouissance. Unable to be fully articulated through knowledge, the truth of the body is a *nonsensical sensed* experience and is non-representational. Access to the subject’s body jouissance comes to them via the sensuality of the image and offers access to *rational elucidation* mainly by language. The body is divergent in its scalar analysis as the individual’s body of jouissance in trauma is privatized and presents with significant suffering, for which any psychoanalytic strategy requires to promote a know-how to do with the non-representational historical unsayable of the subject’s body. In contrast, the body politic is not private, as it is constituted by the flesh that supports collective performativity of discursive spaces, and thus psychoanalytic strategy to liberate collective suffering resides on finding the cause of the positions in which speaking subjects are caught in social exchanges, In both scales, embodiment however requires finding ways to deal with the residual surplus.

In the analysis that follows, I detail the way in which analysands, clinicians and people in leadership occupy positions in discourse to account for an impossible-to-track entwinement between intersubjective and intrapsychic structures. Although it is impossible to track the individual singularities that participate in discourse, the Lacanian mathemes bring the individual and the social together and allow us to interpret how certain linguistic exchanges stabilize compulsive repetition, which in my dissertation refers to institutional responses to trauma. Lacan’s theory of discourse refers to

exchanges among signifiers that represent the subject for another signifier. Even though a “subject” in theory of discourses can mean anything that carries the weight of signifiers, and therefore can refer to mere representatives not necessarily embodied by anyone, in my dissertation, unless otherwise specified, “subject” most often refers to an embodied individual person who is represented by the spoken signifiers and occupies a position in a discursive structure. The sensuous embodiment of a given linguistic signification within discourse is what I sought to demonstrate in this chapter. Most of my analysis maps how individuals occupy the linguistic space of a determined loci, such as the positions of truth, master signifier, knowledge or subject of the unconscious. In Case A, obtained from one of the 20 semi-structured interviews I conducted, I analyse the linguistic exchanges occurring at VCH in their own temporospatial context, which are embodied through emotions, rhythms and speech. My analysis of discursive embodied exchanges, however, is *not focusing* on specific individuals, on their intentions or motivations, but rather maps the interactions of the players that support the dominant structure of the social link that sustains the trauma-service provision at VCH.

Lacan’s algebraic formulas of discourse, useful to understand structures that host overdetermined embodied practices, shy away from heavy interpretation and “a thirst for meaning” (Lacan, 1969/2007, p. 15) to avoid being captured by language within the same discursive constellation. Lacan tried to subvert the innate human fascination to explain phenomena within the imaginary realm (meaning, narrative content, etc.) which, a result of mirror experiences and spherical thinking, always leads to repetition of sameness. Having said that, my discussion below involves a certain narrativization, *inherent* to any interpretation, with the purpose of tracking the linguistic spaces that the participants present as sensible and experienced. My analysis participates strategically within the Imaginary and Symbolic narrativization and has been chosen purposely to name and make legible the embodied positions that respond to the cause of discourse, which Lacan indicated as a vital task of psychoanalysis: “In the discourse, I do not have to obey its rule, but find its cause” (Lacan, 1968, session 13.11.1968).

4.3. Case A: the psychiatrist, the counsellor, the supervisor and the client.

... in mental health settings, people can be really pathologized, and I’m um...(H) I’m getting a bit emotional... I had a situation that I’m thinking

about right now which I think is what's making me tearful; it was really unfortunate, and I had a young woman who was really, I think significantly misunderstood and pathologized, and I felt, like, in a lot of ways she was actually oppressed and some harm, I believe, some emotional harm was done to her. Not intentionally by the psychiatrist, but it was just *a byproduct of having this medical model* and this sort of lens that was not trauma informed in my opinion, and the client really suffered because of it... (Case A as reported by Cl4. *My emphasis*)

A complex but not uncommon situation is described in this case, which was presented in a semi-structured interview with a participant who works as a clinician in a mental health team that serves populations with psychosis and substance use (concurrent disorders). How do we understand the interactions above described by a clinician who faced a conflict involving a client, a colleague and a supervisor? How can this example elucidate the unconscious mechanisms occurring at VCH? To advance the analysis of how discursive spaces have been embodied in this case, we need to remember that each example constitutes a snapshot of a social bond, and as such it does not explain personal motivations or individual intentions but rather positions occupied by diverse actors. The discursive formulas cannot capture the social totality and should be read rather as “moments” in which the master signifier commands certain domination and produces particular subjectivities. We also have to consider the parallax presentation of the subjective and the discursive, which I explain as follows.

4.3.1. Reading the parallax of representation and production

Within the quaternary structure proposed by Lacan, we find two possible readings of the discursive relations, depending on what position each involved actor occupies when speaking within a particular social link. These possible readings are known as a “parallax” within discursive relations (Žižek, 2006; Tomsič, 2015; cf. 1.3.2) and it is a way of locating how a phenomenon appears differently in two alternating lines of sight. Parallax is a term used to calculate measurements in astronomy to focus optical perception, and to create aesthetics of movement and depth in films and digital productions. Parallax is useful to think about social linkage because it clarifies how the social and the individual appear in alternation, as depicted in Figure 4.3: when in movement one can focus on one side (the clouds) only by blurring the other (the mountains).

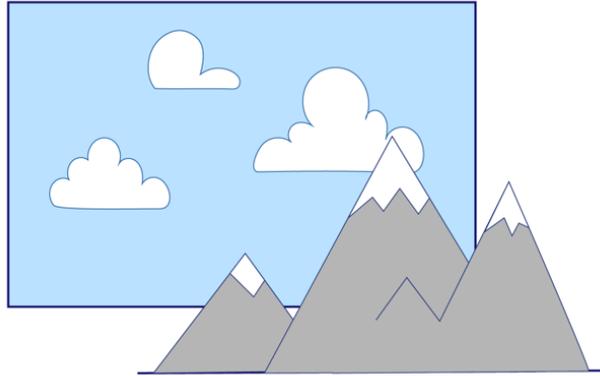


Figure 4.3. Parallax effect shows the alternation of focus.

This structural disparity, or “short circuit” (Žižek, 2006, p. ix) creates two possible interpretative axes within the formula of social bonding: One is the *axis of representation*, (Figure 4.4) which focuses on the sliding of signifiers, while the *axis of production* (Figure 4.5) illuminates the cause of the obtained material production within discourse. The *axis of representation* allows us to concentrate on the socio spatial and relational structure from the place of signification and corresponds to the axis of the signifier and desire. The *axis of production*, in contrast, refers to the subjectivity engendered within this social link and relates to jouissance and surplus jouissance. I will explain how the *axis of representation* and the *axis of production* are traceable in this exchange.

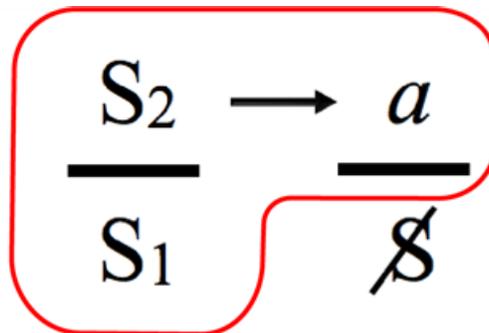


Figure 4.4. Axis of representation

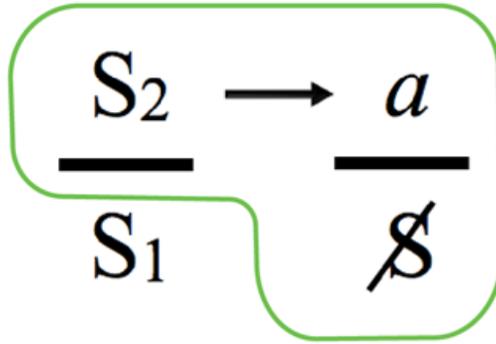


Figure 4.5. Axis of production

4.3.2. University discourse: know-it all.

I now proceed to explain how Case A shows a particular form of social bonding within the mental health institution that illustrates Lacan’s university discourse, which Žižek refers to as scientific and technological discourses that define “the hegemonic discourse of modernity” (Žižek, 2006b, np). I prefer to call this discursive form “know-it-all” because it captures the totalizing aspirations of knowledge at its core, which is related to the concept of the One, the spherical form of thought (cf. 4.6.1), and the exclusion of the negative or unknowable, topologically detailed below.

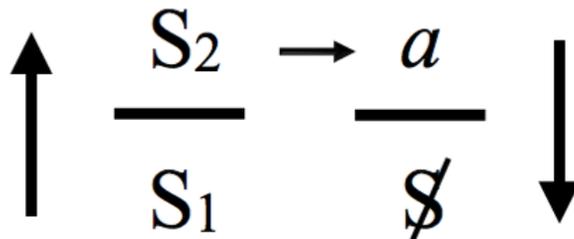


Figure 4.6. Lacan’s university discourse (know-it-all).

The Lacanian discourse formula represented in Figure 4.6 is read from the bottom left position (place of truth as cause) towards the top left (place of agent of semblance), then headed to the upper right position (receiver, other of jouissance) and ending at the right bottom position (production of surplus jouissance). The left-hand side represents positions emerging from speaking subjects who send a message, and the right-hand side corresponds to positions that the receivers are “summoned to assume” (Bracher, 1994, p. 109).

In Case A, we find a relational form that involves four actors within a mental health team that is based on the biomedical model. As I discussed in Chapter 3, the *raison d'être* of the biomedical model, a philosophy that impacts the global mental health scene, is to find a disorder to fix (cf. 3.5). In this case, a psychiatrist interviewed a young woman with a “concurrent disorder,” the confluence of a substance use concern alongside a mental health issue. The clinician says:

I thought that the session was really inappropriate the way that it was carried out, and that the assessment was oppressive, and I felt that the psychiatrist was being very, very harsh and really blowing things out of proportion, and not understanding the client had a preconceived idea of what was going on for the client, based on a diagnostic category of the medical model (C14).

A first reading of this discursive constellation, the position of truth as cause is occupied by the master's signifier, S1, which I will explain below why it corresponds to mental health evidence-based practices (MHEBP), supported by the person in leadership. Such master signifier causes an agent of semblance to act by occupying a form of knowledge (S2), placed in the psychiatrist, as demonstrated by the following account from the participant clinician:

because of the stress of the interaction that she [client] had with the psychiatrist, she started to show more, I think, symptoms that the psychiatrist felt was, like, *bipolar* or like a decompensation, and I was trying to say ... I don't think it's their diagnosis that's showing up here; I really think it's them asserting themselves and feeling emotionally charged. (C4 *my emphasis*)

The psychiatrist addresses something difficult to understand, such as the client's disarrangement, her being “emotionally charged,” which the psychiatrist read as symptoms of mental decompensation “symptoms that the psychiatrist felt was, like, *bipolar* or like a decompensation,” and by doing so the patient is put in the place of the unknowable object *a*, place of *jouissance* in this discourse. The structural relation represented in Figure 4.7 produces a specific subjectivity ($\$$ surplus *jouissance*, occupied here by the clinician in this interview). Let's detail these exchanges in what follows.

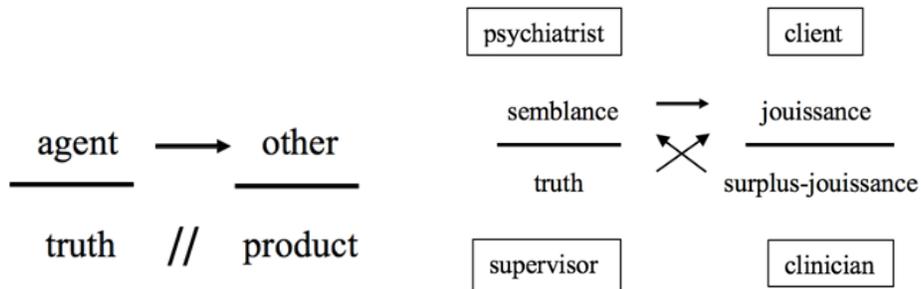


Figure 4.7. Discursive spaces placed in position as elicited in Case A

The clinician in the above example advocated for the client by challenging the authority of the psychiatrist, and the issue was taken to the supervisor, resulting in a twofold effect: first, the client was suspected of demonstrating diagnostics traits of decompensation that forced her to provide proof of sanity or else will face serious ontological threats:

... [the client] had to do so many things to prove that she was well, unfortunately. There were threats of her child being taken away; she had to do multiple random urine drug screens to prove that she's sober, and she was. You know, blood tests to show that she's taking her medication, which she had been. All of these things and like... you know, a threat of taking her license away, etc. just kind of went on and on and snowballed. (C14).

And second, the clinician was blamed for inappropriate self-involvement in their advocacy on behalf of the client, as Clinician No. 4 reported that the psychiatrist and supervisor were:

even questioning me, like do I have some sort of special relationship with this client; why am I having such a strong reaction, you know, am I treating this client like it's a personal friend or something like that, which wasn't the case. (C14)

I will detail each of these discursive spaces in the following analysis.

4.3.3. Master signifier (S1): mental health evidence-based practice.

The master signifier, or S1, refers to the “signifier function” (Lacan, 1969/2007, p. 21) brought about by the signifier of the Other (e.g., parents, culture, institutional ideals). Elsewhere (Fernandez-Alvarez, 2020, p. 149-150) I have worked on the master signifier as an “apodictic necessity” that builds social reality and sustains a form of repetition that

corresponds to the Lacanian logic of that which “does not cease to be written.”⁹ The master signifier conforms the subject’s primary identity (unary trait, or minimal mark to enter the symbolic) and guides any symbolic connection to a particular social bond.

In Case A, the master signifier corresponds to the implicit authority that organizes all the significations within the institutional practice. I argue that S1 is the signifier mental health evidence-based practice (MHEBP) which, in the specific context of VCH, supports a supremacy of the biomedical model and sanctions the psychoeducational literacy of the mentally ill as the essential psychotherapeutic strategy. This is to say that the subject requires certain semblance—an appearance—of supporting MHEBP to enter symbolic exchanges in the institution or else they will be excluded. This signification always acts retroactively in the sense that the master signifier MHEBP is the justification to any therapeutic action within the institution. As Parker explains, master signifiers:

function as anchors of representation in a text [speech included] through such rhetorical tropes as the insistence that ‘this is the way things are’, that is not subjected to challenge or dissent. A speaker adopting the position of S1 here makes a claim to authority that is maintained by repetition of the claim rather than reasoned argument. (2005, p. 170)

The word “evidence-based,” not present in Clinician’s No. 4 account, however, holds the institutional ideal that shapes superegoic expectations of service providers at VCH. If they want to participate in the social link, such predetermined ideal reinforces performative identities for those who engage in a professional exchange. The master signifier MHEBP is the true support of the relation in Case A rather than the curiosity to elicit the analysand’s knowledge about their own struggles with substance abuse, their

⁹ I have articulated the master signifier as follows: “We lean on masters to gain a sense of identity, orientation, consensus, love and recognition, and we relate to them, as Freud signaled, with ‘the same sanctity, rigidity and intolerance, the same prohibition of thought – for its own defence’ (Freud, 1927b/1973, p. 27). The master signifier is at the core of our identity because, on the one hand, it is what gives us the trait to identify with, and on the other, provides a function of securing signification. In Lacanian theory, the master signifier refers to the ‘signifier function’ brought about by the signifier of the Other (parents, culture, institutional ideals) that has contoured the subject’s primary identity by introducing a ‘unary trait,’ or a single element or minimal mark that allows the subject to enter the Symbolic field and thus name oneself. The master signifier (S1) represents the subject for all other signifiers (S2) and is akin to the Lacanian concepts of the ‘name of the Father’ and the ‘phallus.’ The master signifier voices, at the social level, the core of the superegoic demand to ‘belong’ to a group or ideology. The superego is commanded by the Master signifier, whose symbolic identification originated in an idealized father whose castration the subject aims to conceal with the purpose of safeguarding her own lack and the subjective split from emerging.” (Fernandez-Alvarez, 2020, p. 149-150)

mental illness and their desire to keep and raise a child. As the worshipped master signifier, MHEBP, causes and structures the signification of what mental illness or trauma means to the professionals providing services, who relay in apodictic statements—assumed *de facto*, which need no reasoned exposition— of what helps an analysand and what does not. But what is indeed understood by evidence-based practices in mental health? Why do I believe this to be the S1?

The word evidence comes from the Latin “*evidentia*” meaning “appearance from which inferences may be drawn” (Online etymology dictionary, 2020). Generally speaking, evidence-based practices are defined as a “conscientious, explicit, and judicious use of best available scientific evidence in professional decision making,” which “involves assessment, intervention, and evaluation procedures, as well as practitioner’s critical thinking” (Roberts and Yeager, 2004, p. 4-5). MHEBP constitutes a conundrum that involves universities, ethics review offices, hospitals, clinics, professionals from diverse disciplines and analysands who bond through this form of know-it-all relation. Even though research in every discipline has some “evidence” to validate their theoretical premises and justify their relevance for the treatment of trauma, the notion of ‘evidence-based’ within the global mental health institution refers mostly to evidence that supports the hegemonic system in place: the biomedical model with its diagnostic categories and pharmacological reason, as well as cognitive-behavioral psychoeducation as core interventions (cf. 3.4). The totalizing aspirations of the “know-it-all” discourse rejects certain kind of scepticism or disinterest at the core of the scientific method, as Cindy Zeiher (2017) states: “science is controlled by the disinterested scientist even if its outcomes are not” (p.3).

Although each field has its own justification for their professional value (psychiatry, nursing, social work, counselling, etc.), the research evidence that is privileged within VCH follows guidelines from the disciplines of psychiatry and psychology (American Psychiatric Association, 2010; American Psychological Association, 2017, respectively) which are based on a positivistic perspective of science that searches for certain *quantitative* evidence through the implementation of randomized clinical trials (RCT) via Cochrane paradigm. Cochrane is a British international organization formed in 1993 that organizes research findings to determine the best evidence-based medical interventions based on systematic reviews that impact therapeutic and economic decisions to implement health treatments. Cochrane model is

used in medicine as the “gold standard” of research and its systematic method is crucial to building reviews that inform how best the human organism can be treated. This paradigm helps determining, for example, what vaccinations under rigorous research provide the best evidence to assure that a population will receive the best treatment available given the scientific context at the time. For example, the vaccinations for Covid 19 were granted emergency approval, which has not been the ideal solution but arguably the best possible option according to the scientific knowledge of the time.

Evidence-based research in medicine determines the most efficacious and most effective interventions based on randomized controlled trials (RCT)¹⁰. For example, efficacy refers to how well a vaccine prevents illness under the *experimental* conditions of research. Moreover, evidence-based research also measures treatment effectiveness—how well a vaccine works *outside of the experiment*, which is usually conducted through observational case-control studies. These paradigms are essential to producing knowledge on the biochemical, molecular and systemic aspects of the human body. Yet when we implement RCT and Cochrane standards to think human subjectivities at large, the same conditions cannot apply. Posttraumatic suffering, despite sharing similar signs—nightmares, flashbacks, etc.—affects the subject’s body and mind singularly for they signs have an unconscious that cannot be predicted, categorized or treated as if it were an illness of the brain, and alleviated exclusively by pharmacotherapy and manualized psycho-educational therapies, as it is recommended by the dominant discourse. Trauma’s complexity cannot be fully based on the current privileged evidence about how to best treat it or else the treatment becomes conservative and misinformed. McGorry explains that:

Cochrane is Cochrane, a fact that is understood by academic researchers. However, in the wider society and the media, these inevitably conservative findings that fail to draw on the complete body of evidence may be misconstrued. (2012, p. 223)

If we count subjectivity, as Zeiher does, we must admit that the acceptance of scientific knowledge “is determined not only by peer review but also by its being subject to influence from economic or political conditions and demands” (2017, p.2). Apart from

¹⁰ RCT is a type of scientific experiment that “randomly” selects participants to two or more groups with the purpose of measuring the effectiveness of new treatments by comparing the responses between the experimental group that received the intervention and the control group which receives either a placebo, an alternative treatment, or no intervention.

diverse concerns discussed in Chapter 2, a number of critiques against MHEBP have emerged, such as: 1) MHEBP is criticized for its lack of effectiveness as research with RCT is often untranslatable to service level and hardly responds to cracks in the system, accessibility, or more complex understandings of quality of care (McGorry, 2012, p. 222); 2) for not acknowledging bias or power inherent to their methodology and for lacking self-reflectivity (Parker, 2004; Wampold, Imel & Miller, 2009; Wampold & Imel, 2015); 3) for other methodological concerns, such as external and internal invalidity in psychological experiments (Truijens et. al., June 2021), as well as replicability issues regarding nomothetic measurement (meaning that the psyche of a subject is unable to produce general measured scientific laws) (Desmet 2018; Wampold & Imel, 2015); 4) for the lack of contextual intersectionality lenses (Cook, Morrow & Battersby, 2017); 5) for the potential disempowering effects resulting from neglecting collective historical and cultural perspectives (Mills, 2014; Perera, 2010); and 6) for predefining subjectivities (Hacking, 1986) that preordain “healthy” identities, also called “sanism,” as moral pursuit to be achieved in treatment (Lacombe, 2008; Morrow & Weiser, 2012). Even though the American Psychological Association published some concerns about the rigidity of the current standards and proposed a three-level assessment of best literature evidence, clinician expertise, and the analysand’s own values, expectations, and preferences, the “jury is still out,” so no significant changes have been implemented (Brown & Curtois, 2019, p. 135).

Within the researched sites at VCH, the signifier “evidence-based,” an adjective that is used as a noun, appears as both an imperative to abide by and as a site of critique. A participant from leadership stated that:

Alternative forms of healing would be something that would be outside of anything that would be empirically evidence-based. I would not embed them in the health care system as it stands now. We all need to learn a lot more about the neuroscience of the brain. (Ld3)

A similar take was recorded by a mental health and substance use counsellor who explained the importance of differentiating therapeutic interventions to preserve research protocols: “I think within each protocol, you can have treatment fidelities while still naming other things [from other forms of therapy] ... so, I can act as translator basically, but I’ll still be in this protocol *because I am*, and it keeps it, evidence based” (Cl2, *my emphasis*).

The latter slip / *am*... evidence-based, demonstrates the participant's focus on the technique rather than on the client, and the former statement by leadership assumes a categorical exclusion of what is not MHEBP. Other professionals, however, consider "evidence-based" to be a problematic concept; for example, a participant occupying a leadership role at a substance use team, commented on VCH not supporting body and somatic aspects of trauma work due to a fixed selectiveness on evidence:

I think that VCH is very interested in being best practice and evidence based. And I think probably... I actually don't know if anyone has looked at what kind of evidence and best practice is out there, so it may be that no one has done that work. Because I think the assumption is that it's not evidence based [yoga or somatic work]. I don't know if that's true actually; there might be research but *no one's looking to find it*. For many people, the gold standard is randomized clinical trials, and I do not think that is the only way that treatment can be evidence-based. (Ld5)

Others expressed the following regarding treatment: "There is always having to be evidence-based but because most of evidence-based is medically oriented, because that [is] where the focus is, that governs how mandates are formed... and why do we do that?" (FG Cl1). "You know with the MHSU redesign the idea is to use best practices that are evidence-based but what are those? DBT and CBT. The mind is not within the brain, the mind is more expansive than that" (FG Cl2). Also:

With these evidence-based models and the economics base of these models everything is so westernized. So, I almost find it funny sometimes that we talk about cultural safety and cultural competency especially within the realms of indigeneity and marginalization and oppression, but I think it just goes back to the people who are making those decisions are not those people and that is so frustrating. (FG Cl3)

Such statements show antagonisms that nourish differentiation within the institution, yet despite the diversity of voices among the professional service providers (clinicians and leadership), the MH practices stick to the hegemonic view that supports the signifier EB. However, for analysands, the signifier "evidence" resonates in very different ways, as shown in the following statements: "I have a lot more *evidence* of trauma in my life than I have memory of trauma" (Al5); or speaking about her recovery, an analysand said: "To me that is *evidence* enough that God is out there" (Al6). To service users, as per these quotations, the concept of evidence-based practices does not appear to be of particular interest; they are more concerned about the very appearance of trauma in one case, or spiritual reassurances in the other case. But for

the service providers MHEBP is a veiled master signifier yet exposed in all its power as it organizes the social link around the treatment of trauma at VCH.

In Case A, the MHEBP as master signifier, distant from the time and space of the analysand's history, structures both the psychiatrist performance of the interview and the supervisor's support of the psychiatrist, all to preserve a know-it-all discourse in the institution. Acting as an "expert" agent, the psychiatrist assumes the *moral imperative to know* what the analysand might be experiencing, instead of engaging the *ethical imperative to listen* to the person, so the analysand can understand themselves on their own terms. Backed up by the supervisor, the psychiatrist imposes his professional knowledge to sustain the illusion of knowing-it-all about what the patient is going through "it even went as far as my supervisor and the psychiatrist believing that the client was so good at manipulating me because she has this borderline personality disorder. 'Oh, she manipulated you so well', you know, 'she's done such a good job of splitting'" (C14).

In Case A, instead of supporting the very voice of the analysand or engaging in critical, dialogical or collectively articulated discussion of what indeed constitutes "client's best interest," which has become a rhetorical phrase commonly used to justify certain clinical actions, the signifier evidence-based acquiesces to blind authority within the institution to claim higher quality and legitimacy of treatments, even if no evidence is probed critically.

Specific subjectivities result from this structured exchange and those who do not comply are threatened with exclusion, as demonstrated by the suspicious attitude towards the analysand and the clinician's involvement. This example shows that the master signifier is embodied by the supervisor, who entered the conflict last but who is key in preserving the discourse, by backing up the psychiatrist instead of supporting the advocating clinician. Had the supervisor approached the conflict differently, the social bonding would have moved into another discursivity, perhaps protest, as explained below (cf. 4.3.7).

4.3.4. Discourse starts at the loci of truth

The term 'evidence-based' (EB) as a master signifier occupies the place of truth in the researched institutional social bonds and constitutes its cause.¹¹ Master signifiers are concerned with sense and not with meaning. Meaning refers to a given subjective signification by means of the subject's statement of a signifier whereas sense is a desired direction towards where the subject's speech aims at their own being, their own existence (Lacan, 1969/2007, p.57).

The signifier 'evidence-based,' as S1, shows a sense of truth that cannot carry, to paraphrase Lacan, the client's existence because on this account the client was "significantly misunderstood and pathologized" (Cl4), resulting in what Lacan calls a myth, a nonsensical (*pas-de-sense*) reflection of a person's situation epitomized by the diagnostic label given to the analysand.

Truth as cause can be interrogated as follows: what kind of truth leads the mental health system to not properly listen to people, to overwork clinicians or to provide services devoid of subjectivity? Lacan differentiates truth from objective facts or propositional logic, which refers to the validity of a true or false statement. Instead, he proposes the notion of truth as material cause, which Ed Pluth (2019) connect to signifiers, the building blocks of language: "the material cause in psychoanalysis plays a role that would be different from how efficient, final and formal causes might play a role in it." (p. 300). Thus, truth as cause in psychoanalysis refers to an inevitable unconscious relation that the subject has with the signifiers that build the language that speak them, or as Lacan put it, "[t]ruth...is certainly inseparable from the effects of language taken as such" (Lacan 1969/2007, p. 62). Yet, by its structure truth cannot be *all* said.

To think of discursive truth as cause, one must accept the necessary split between truth and knowledge. Structurally, truth is characterized as only being able to be half said because the other half corresponds to the knowledge of jouissance that

¹¹ Aristotle proposed four forms of the cause: formal, material, efficient, and final. It is the conjunction of the four that constitutes a thing. (Stein 2012, p. 700). For Heidegger and through the example of a silver chalice, he renders the four causes as more than mere explanations and rather these causes are: "four ways of being responsible [to] bring something into appearance. They let it come forth into presencing" (1954/1977, p. 9).

cannot be stated but rather felt as the *nonsensical sensed* (Lacan, 1975/2005, p. 31). Truth as cause carries strong affect, as a result of repression and as such, has the power of grabbing the subject “by the stomach” (Lacan, 1969/2007, p. 56-57). This affective aspect was present through the tears of Clinician No. 4 which constitutes a production of certain *jouissance*, itself split between inarticulable knowledge (what the Clinician No. 4 experiences in her body) and a causal truth (the signifier EB) which remains veiled because the cause of discourse always escapes us. In the representation axis, the S1 ‘evidence-based’ appears veiled and it remains impotent to say or track the consequences of the significations it engenders, while in the axis of production EB remains external to discourse as it cannot generate a relation among the various actors that could trace the material effects.

Once again, psychoanalytic theory of discourse rejects notions of individualization or intention. For example, the same supervisor, whom I identified as embodying the master signifier, was a participant who also criticizes the biomedical model by stating “how bureaucracy can be very re-traumatizing,” adding that “one size fits all is a significant barrier.” He also stated that:

every person has intrinsic value and deserves to have their trauma acknowledged and validated and access to care, whether that is client or clinician. I am a huge believer in the human condition rather than people who are sick and people that are healthy. (Ld7)

Despite her compelling eloquence, when it comes to preserving the integrity of S1, the supervisor chooses to default to an implicit hierarchy wherein a psychiatrist holds superior power, as defined by the fact that his opinion matters the most when deciding treatment course, over any other clinician, due to their proximity to the biological determinism in which EB is grounded. That is what discourse does, forces positions despite people’s intentions.

4.3.5. Knowledge S2 as semblance: the psychiatrist

The signifier S2 is knowledge that Lacan defines as “something that links, in a reasoned relation, one signifier, S1, to another signifier, S2” (1969/1991, p. 32) and as something that constitutes the signifying chain supporting discourse. Lacan (1969/2007, p. 21) makes the distinction between knowledge as *connaissance* and knowledge as *savoir faire*. Both depend on a signifying articulation, but *connaissance* relates to

representation, accumulative information and theory whereas *savoir faire* refers to an embodied know-how and practice, which Lacan relates to *episteme* or “transmissible knowledge” (p. 22). Knowledge as *savoir faire* is the form of knowledge operative in psychoanalysis, which refers to the ability of the subject to confront the Other’s jouissance within themselves, which might allow the subject to elucidate a know-how to deal with the painful enjoyment that lacks lexicon. The place of knowledge in Lacan’s university discourse always involves *connaissance*, which is impotent as it renders the speaking subject as an object to the Other’s enjoyment, source of profound anxiety. It is only through desire that the subject can afford a partial separation from the anxious inquiry of what one is for the Other. Following this logic, we can say that in Case A, as reported by Clinician No. 4, each of the four speaking beings involved in this case (clinician, supervisor, analysand and psychiatrist) aspire to know how the Other desires and enjoys, and in doing so, they enter a dialectic, themselves as an object for the other that inquires “what am I for the Other?” Imagining what I am for others, is a sure way to enter discourse as we want to be socially recognized as valuable. In Case A, S1 has all the powers in the know-it-all discourse, establishing the cause of the social link within VCH and structuring the psychiatrist into a semblance of knowledge, who addresses the client with a “very harsh” “preconceived idea of what was going on for the client” (CI 4). Semblance refers to an appearance, a resemblance of the master signifier itself that represents the speaking subject for another signifier (for something else or someone else). Like Clinician No. 2, whose slip of the tongue says, “because *I am*... evidence-based,” demonstrates that EB represents her as a person for the institution. Regarding semblance, Grigg indicates that “the subject both believes and doesn’t believe in semblants but in any case, opts for them over the real thing because paradoxically they are a source of satisfaction” (2007, np). Semblance satisfies the requirement of social link because it creates a consensual automatic etiquette according to the dominant discourse that protects a subject from conflict or chaos and preserves discursive *appearance*, which Lacan says it is often related “to be a success, or to be light, or to be chic” (Lacan, 13.01.1971).

The interaction with the psychiatrist is described by Clinician No. 4, by imaginarily addressing him in this way:

The questions you were asking and the way you were talking to them and the fact that you weren’t hearing what they were saying, and you

were judging, and you were being very critical and making assumptions and things like that. (C14)

From this statement, we presume that the psychiatrist is unable to grapple with whatever disarrangement the analysand presents. Such failure is read by the psychiatrist as a potential risk, possibly related to substance abuse, the well-being of the analysand's child or concerns about driving motor vehicles: "Threats of her child being taken away; she had to do multiple random urine drug screens to prove that she's sober, and she was... a threat of taking her license away" (C14). The physician then makes semblance of EB by diagnosing the analysand and imparts an encompassing knowledge that precludes any further inquiry into what constitutes the person's suffering, their agitation or conflict, which the physician ultimately does not want or cannot understand. The diagnostic category, grounded in the arbitrariness of mental disease classification, is the impotent core of the biomedical model, and is opposed to the subject's experience of her own suffering, which remains incomprehensible to any external actor.

The inability to understand something that only the analysand knows, even if the person does not know that she knows it, triggers a spatial need to place the lack somewhere. The psychiatrist places the lack in the client, then in Clinician No. 4, instead of assuming his ignorance about the client's suffering. The totalizing knowledge that dominates this social bonding structures the psychiatrist's response to the unknowable—the analysand's *jouissance*—by covering such lack with the master signifier.

4.3.6. Object *a* in the place of *jouissance*: the analysand

The place of the other of *jouissance* is embodied by the analysand positioned here as the Lacanian object *a*. Object *a* is the product of what exceeds the effects of the signifying chain in the divided subject and is a structural lack that elicits diverse responses that organize the discourse around it. Object *a* "designates precisely what of the effects of discourse presents itself as the most opaque...and yet essential" (Lacan, 1969/2007, p. 42) and therefore reveals the traumatic proper — the discordance, the unspeakable— because it lacks signification. The Object *a* is an unavoidable and unassimilated residue, a disarrangement, causing desire and surplus of *jouissance*, that is to say, causing both lack and excess. The other of *jouissance* constitutes, as per Vanheule's paraphrase of Lacan, a "disturbing dimension in the experience of the body,

which renders the subject unable to experience itself as a self-sufficient enjoying entity” (2016, p. 4).

Object *a* is precisely the hole within know-it-all discourse; the location of the lack of knowledge and the impossibility of absolute or totalizing knowledge). Certain knowledge is necessary for the mental health worker to provide care for a person, such as self-awareness, critical thinking, knowledge about the psyche and, yes, of illnesses of the human body and brain. Mental health service provision relies on professionals who *know* the best possible way to conduct a person’s inquiry about their own suffering. However, the rigid understandings of what constitutes knowledge in the mental health system excludes another kind of knowledge that is of higher importance in the psychological field: the practical knowledge of the analysand, the possibility of their ability to access their *unconscious savoir faire* about their own psychic suffering.

Instead of placing the lack of knowledge in the right place, either through the psychiatrist, the clinician or the supervisor, the “know-it-all” discourse places the lack in the analysand because she is the one who displays *jouissance*. Consequently, she the client brings forward an enigma with their behavior and emotional reactions. In the reality of mental health service provision, one often knows nothing of the person’s *jouissance*, regardless of how exhaustive an anamnesis is. The key to recognizing and naming *jouissance* is ciphered in the analysand’s unconscious knowledge, elicited only through free association and by the renunciation of providing a pre-determined interpretation for the individual, and its strategy consists in knowing how to listen. (cf. 7.5.1).

4.3.7. Produced subjectivity: the counsellor

The divided subject, or \$, refers to the speaking being, unconsciously represented by a signifier *for* another signifier, the reason for which a subject can appear only after a signifier chain has been established. The divided subject can be an individual but also an idea or abstraction and in social bonding it is always subservient to the master signifier. Braunstein (2012) states that this subject of discourse encompasses the linguistic and grammatical subject, as well as:

[T]he connection with the political subject (subject citizen of democracies) and the psychological subject (understood as the innermost emotional

interiority of the live organism) represented to himself and to others by the pronoun 'I'. (p. 36)

The subject of the unconscious is split, best understood with Lacan's aphorism "[t]hat one says as fact remains forgotten behind what is said in what is heard" (1972a, p. 7). Lacan's words allude to the split between what one says consciously in speech, (understood as the subject of the *énoncé*, the manifest statement) and what speaks in one's own speech which the subject is oblivious about (understood as the subject of the *énonciation*, the latent content). The divided subject has other manifestations: it is divided between what he/she wants and his/her actions; it is divided between his morality and his true enjoyment.

The production of the university discourse—all spherical thinking, semblance of all knowledge—is a surplus, an excess of the signifier which demands a specific form of subjectivity that props up the narcissistic ideal of the master signifier, or else subjectivity will be excluded. As discussed above, social bonding positions the receiver to summon the effects of discourse's excess and thus produces surplus *jouissance*. In Case A, the excess is produced once the lack has been located and placed in the analysand, about which the Clinician No. 4 protests; yet, as depicted in Figure 4.7, the subjectivity that is produced in this exchange is one that reinforces the submission to what the signifier MHEBP mandates, via the psychiatrist, or *else* the subject is excluded from the social bond. The latter position was disrupted by the clinician's resistance which will be further discussed spatially (cf. 5.6.1).

This social bond in the mental health team produces a form of subjectivity that must absorb the effects of language even when the master signifier escapes the subject, producing "*plus de jouir*" (surplus *jouissance*) (Lacan, 1972a, p. 12). We observe in Case A this demand of the master signifier that requires submission to an ideal of scientific objectivity—the diagnosis, the higher opinion of the psychiatrist—has de-subjectifying effects of both the analysand and the advocating clinician. Surplus *jouissance* is an economic concept that concerns the accumulation of excess and expenditure of loss in the psychic apparatus and constitutes a discursive effect that will be discussed in section 7.2.3. For the purpose of this discussion, however, surplus *jouissance* is occupied by the excluded or the rejected, where the logically negative actualizes, as this position of residual production of the master signifier is a position of loss—the Clinician No. 4 could not save the analysand from experiencing distress and did not accomplish much in their

advocacy for the analysand— yet, this space in every social bonding structure is relevant precisely because the way it is occupied can rebalance power, as the residue, *qua surplus jouissance*, can transform such loss into a new discourse. Lacan stated that “the effect of truth is only a collapse of knowledge. It is this collapse that creates a production, soon to be taken up again” (Lacan, 1969/2007, p. 186). In other words, the clinician in Case A, precisely as a result of their advocacy for service user, relay this position of loss through a resistant protest, as I will discuss next.

4.3.8. Relay by the discourse of protest

Discourses are continually shifting at the site of production, whenever they encounter the traumatic *residue* of object *a* —unable to be understood, hence the cause of anxiety— which gives rise to other forms of discursivity. Each discourse attempts to answer a lack or the impossibility of an encounter in the previous discourse. The vignette described in Case A depicts a discursive relation that attempts to answer the question posed by the client’s symptom (object *a*) and her potential risk (impossibility) and demonstrates how S1, as cause of this discourse, disavows the fact that the master signifier ‘evidence-based’ constitutes an impotent response to the question posed by the analysand’s situation. This example also shows that the conflict relies on hierarchy and a totalizing knowledge, leaving no space for listening to the analysand or acknowledging the clinician who advocated for her.

Braunstein states that “the four discourses can’t be excluding; as each one of them supposes the presence and mobilization of the other three” (2012, p. 134). In the above example, the know-it-all discourse is partially bracketed, put in suspense or relay by the engagement of Clinician No. 4 in a discourse of resistant protest (Lacan’s hysteric discourse). The discursive form of protest is subversive because it unveils the lack that the know-it-all discourse pretends to cover, precisely, with knowledge. I call this the “discourse of protest” because it conveys the function (protesting against S1 and unveiling the constitutive incompleteness of S1) but also because “hysteric” can be misconstrued as involving only a subject with certain diagnosis, which Lacan was far

from signifying, as he was referring to the “beautiful soul” that Hegel proposes in his *Phenomenology of the Spirit*.¹²

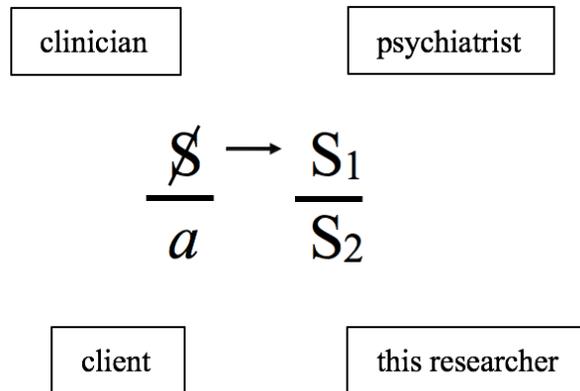


Figure 4.8. Lacan’s hysteric discourse (protest or resistance)

A relay, as used in telegraphy, picks up a signal from one circuit to transmit it afresh in another circuit, and in theory of discourse a relay is a logical operation that carries over the linguistic exchange to start a new form of social bonding. As described in Figure 4.8, and within the same time and same space of the know-it-all discourse, in the very same mental health team, another discourse starts, another way of relating and communicating. The discourse of protest starts with the analysand’s disarrangement, misunderstood and medicalized, for which the clinician advocates on behalf of the analysand. In this new kind of bonding and relation, the analysand as object *a* causes the subject (Clinician No. 4) to assume the place of semblance of protest to address *S*₁ (EB occupied by the psychiatrist). From this social bonding of protest, the present research occupies the place of production due to the fact that it conveys something of the knowledge elicited by this discursive modality. As expressed by the participant in the following way:

I’m just sort of reflecting on my tears, and I think one of the reasons perhaps I’m feeling really emotionally touched is that.. I was really looking forward to this conversation, and I was just really, um... I think... I was really... moved that you were doing this research because I think it’s really important... taking these important things into account in VCH.
(C14)

¹² The beautiful soul of the hysteric lives off the disorder it denounces, which can lead to misrecognition of its own involvement in what she/he denounces, as the hysteric gets “caught in the trap offered by the mirage of consciousness to the I infatuated with its own feeling, which Hegel turns into the law of the heart.” (Lacan, 2006, p. 345)

By extension, this research attempts to leave such unconscious emergence opened for revalorization, through unveiling the statements from the participant clinician. In this social bonding the protestor resists the dominant discourse by interrogating the master signifier of biomedicalization and forces it to recognize lack therein. From this interpellation knowledge is consequently produced, which is reflected in my research, and demonstrates the shortcomings of S1. The protestor shares her complaint and shows the master signifier's limits, or in psychoanalytic terms, the agent protestor shows the master signifier's castration. Hysterical identification is the support of this discourse instantiated by the identification of the Clinician No. 4 with the analysand, whose protest was silenced, as well as by my own identification with the participant clinician and the analysand, because their voices represent the painful effects I want to highlight in my research. The suffering caused by the excess and the lack of the master signifier EB within VCH is ubiquitous in the field of global mental health, as I will demonstrate below with cases C and D, but this modality also extends to other institutions, such as the school and workplaces at large, who implement guidelines on how to support people within the MH field.

The hysteric mechanism of identification at the core of protest brings forward great complexities in the socio-political sphere, as the protest discourse can lead to mere enjoyment in the act of protest for the sake of castrating the master as opposed to seeking radical transformations. This can be observed in social phenomena such as the one that carries identity politics to the point of "cancel culture" by imposing another master signifier that appears superior or possessing higher moral ground. In those instances, the hysteric's protest veils their own form of enjoyment, and if not recognized, it only establishes dominance of a new master signifier without allowing circulation towards other discourses, such as the possibility of democratically and critically generating a new master signifier. In Case A, the protest does not seem to be overridden by a fixation on the superiority of another master signifier because the clinician and the analysand did not manage to upset much of the power of S1. My own research, however, as production of knowledge of this social bonding is not engaged in erecting another S1, for successful change of the dominant know-it-all discourse requires to first acknowledge differences within the institution. Kaës articulates clearly the highly threatening nature of institutional change because "to reform is to refound; therefore, it is to destroy the phantasy of the institutional community" (1989, p. 50).

4.4. Case B or the threat of words: The example of Reiki

I would like to discuss four other examples to instantiate how this same discursive constellation (Lacan’s university discourse) occurs in other cases and in diverse scales. Case B presents a short paragraph of an interview with a young woman at the mental health team, and she denies having experienced any difficulty with anyone from her team: “No. If there is, I just can’t remember it” (A11). But when I asked if there is anything else that she would like to say about her trauma healing journey that the system should know, she responded:

A¹³: Well, I am really into energy work like Reiki and stuff like that but that is not very scientific, so I do not think it is used a lot in mental health. I found it particularly effective. So, there’s that.

H: Do you talk about Reiki with your therapists here?

A: I don’t really talk about it with them.

H: Oh, why is that?

A: I fear they won’t accept it or understand it.

H: Because it is considered, as you said, non-scientific? Do you have fears of feeling rejected, or?

A: Just looked down upon. (A11)

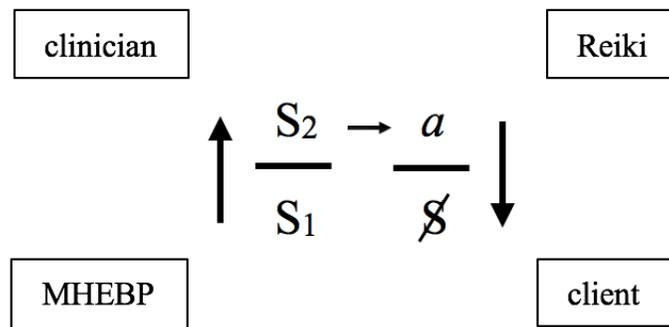


Figure 4.9. Case B: the same structure of the know-it-all discourse with different content.

In this example the same formula of Lacan’s University discourse appears again, as described in Figure 4.9: the embodiment of S2 is occupied by the clinician who could be a case manager or a therapist, of whom we do not know anything from this interview (and who could well be enthused about Reiki for all we know). Yet, independent of the clinician’s particular preferences or style, to the analysand the clinician appears as an agent who prescribes her a particular governance over what is allowed to be said, which

¹³ As explained in Chapter 1, when quoting dialogue from my interviews, I use H for Hilda and A for analysand.

constitutes an exclusion and is the site of object *a*, embodied by whomever this analysand sees for her Reiki practice. In a different discursive modality, the analysand could speak eloquently about her somatic insights through Reiki, furthering her body's agency through the particular know-how she obtains from such practice. The analysand explained that the Reiki facilitator names aspects of her body, "they might say something afterwards like 'I felt this in your solar plexus' or whatever" (A11). Such exchanges have the potential for the somatic creation and recreation of indispensable elements in trauma. Yet what is *de facto* excluded in the know-it-all discourse is not only possible treatments but also *mere discussions* of other modalities, resulting in the production of a docile subject, (the subject who speaks in this example) and who chooses to be quiet about what is important to them for risk of being "looked down upon" as a result of the exigencies of S1. A signifier of science (MHEBP) regulates what the analysand can and cannot say. To protect MHEBP, some people in leadership positions at VCH, as quoted above, consider that "alternative forms of healing would be something that would be outside of anything that would be empirically evidence-based", even when there is research evidence of significant benefit to people with posttraumatic suffering. Alternative modalities, such as yoga, contemplative practices, acupuncture, traditional medicines, energy therapies or expressive and movement therapies that can help people to deal with posttraumatic suffering are seen as taboo and even their discussion appears to be forbidden.

Curiously enough, the word Reiki turned out to be a taboo within the context of my research. Being a recipient of a generous Team Grant awarded by the VCHRI, I submitted a final grant report on my research and before submission, two well intended and highly esteemed advisors of mine, asked me to reconsider adding the word "Reiki" in the final report as funding readers might feel "put off" if I mentioned treatments completely out of biomedical evidence and also not provided at VCH (Research notes, December 13, 2019)¹⁴. A seemingly innocent word such as Reiki turned out to be a powerful example of how language could be seen as threatening when outside of the limits of the master signifier.

¹⁴ One of them also advised me, rightfully so, to omit my critique of the MHEBP because the length of the final report did not allow an in-depth explanation of what I am here articulating. More interestingly, they worried that such critique could affect my potential eligibility for future research projects.

Other “bad words” I encountered in my research referred mainly to alternative treatments, such as yoga, as demonstrated by one participant who disliked Van der Kolk’s “tangential or circuitous” perspective: “He was talking about yoga, and I was like ‘yoga?’ (laugh) I mean, I do yoga, but I wasn’t thinking about if this (hesitation)... and sure enough the research is interesting on that (laugh)” (Cl2). As I discussed in Chapter 2, Van der Kolk has been a pioneer in supporting EMDR and yoga by articulating the neurobiological effects of stress on the body of the traumatized individual and how this also affects their ability to establish attachments. Although his work has received a great deal of recognition, those modalities have not been implemented at VCH because they are not seen to meet the demands of the rigid parameters of MHEBP.

4.5. Cases C and D: The know-it-all discourse meets capitalism.

Now I want to shift my focus from VCH to a larger scale by analyzing two examples within the global context of mental health service provision to subjects affected by trauma. The following examples were found in my literature review, and they instantiate how Lacan’s university discourse is relayed by the socioeconomic model we live in: Case C reports on cultural issues ignored by the biomedicalization of trauma in Cambodia and Rwanda (Summerfield, 1999); and Case D refers to a wave of suicides among farmers in India (Mills, 2014). With these examples I argue both, that Lacan’s university discourse is not a regional affliction but rather a global scale phenomenon; and that the know-it-all discourse can be relayed not only by protest and resistance (hysteric’s discourse), but indeed by the capitalist discourse via the neoliberal markets of mental health industries.

4.5.1. “Cultures of silence”

Dereck Summerfield (1999), a psychiatrist with vast experience in humanitarian aid, articulates seven assumptions about psychological trauma extended to large populations in war-affected areas, which constitute the interpretative framework of Western psychology and psychiatry. The seven assumptions held by global Mental Health system are based on the hegemonic EBP, which universalizes suffering and renders human response to stressful situations as “traumatization,” based on PTSD diagnostics and biomedical supremacy. Under this discourse, Summerfield indicates that

war is deemed as “always” a mental health emergency that requires professional intervention outside local workers who are deemed as burned out. Summerfield gives the example of Cambodia, which “has reportedly been inundated by researchers with PTSD checklists” (p. 1452) who believe that a “culture of silence” existed because of locals’ refusal to talk to MH workers about their painful memories of traumatic experiences during the Pol Pot’s regime in the 1970s. Another example given by Summerfield involves UNICEF’s work done by Western clinicians in Rwanda who, using two psychological questionnaires, evaluated the mental state of over 3000 children between the ages of 8-19 who had survived the massacre of their families and friends during the 1994 genocide. Summerfield believes the researchers were influenced by their prior assumptions and used the results of the checklists to support their biases. For example, with regards to the psychoeducational service provision on site, they encounter that the word “stress” did not exist in the Kinyarwanda language and “family members” was a term difficult to translate, yet the European organization in charge of the MH provision in the aftermath of the 1994 genocide continued conducting “baseline knowledge” assessment of children and adults through Western lenses.

4.5.2. “Harvesting despair”

“Harvesting despair” is the title of one of the chapters in China Mills’s book *Decolonizing Global Mental Health* (2014). Mills discusses the case of a wave of suicides among farmers in Vidarbha in the region of Eastern Maharashtra, India. The affected population of farmers cultivated cotton and soybean, which are products subjected to market fluctuations that require private financing credits granted before the farmers are allowed to sow. Mills writes, “[T]his reliance on credit puts farmers in a precarious position, as they become particularly vulnerable to crop failure or to price fluctuation of crops in the world market” (p. 36). According to Mills, about 4000 farmers died by suicide in 2007 which made the region to be known as the “suicide district” (p. 36). Many farmers poisoned themselves with pesticides and many wrote letters to the government about the unbearable indebtedness, leading various research teams to believe that about 87% of the suicides were linked to debt. The government responded by providing platforms of individual intervention, deploying psychiatric teams whose focus was on “psychological healing sessions” (p. 37).

Mills skillfully demonstrates how this suicide epidemic is a systemic issue related to the agrarian crisis, a complex socio-political and economic issue, connected to the emergence of neoliberal policies about the hybridity of seeds, the aggressive increase of pesticides in farming and the privatization of subsidies. Yet, the distress suffered by these men in serious financial duress was conceived by global mental health as a matter of psychiatric provision that included “effectiveness of reduction of access to pesticides; improvement of medical care for pesticide poisoning in low-income or middle-income countries; improvement of treatment for depression; and access to anti-depressants” (Mills, 2014, citing Patel et. al. 2005, p. 39). The latter shows the legitimization and massification of a type of psychiatry that ignores socioeconomic and political aspects, which Mills dubbed as “McDonaldization” of mental health services and psychopharmaceutical imperialism (p. 41-42).

In both Summerfield’s and Mills’s discussions, the Westernized global MH discourse, based on EB premises, is relayed by the capitalist discourse. Know-it-all discursivity persists in the above instances —as psychologists and doctors who practice those interventions are still organized by the master signifier MHEBP; however, capitalism dominates in these examples through the profits of psychopharmaceutical industry in Mills’s case and the health dollar allocation for global MH emergency relief funds in Summerfield’s example. Capital dominates in the above instances rather than knowledge or the sociopolitical protesting of the conditions they are invested in.¹⁵ In the capitalist discourse, subjectivity is erased, and the terms are no longer connected because monetary profit has become more relevant.

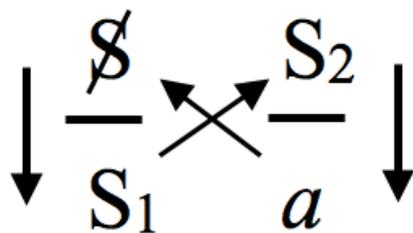


Figure 4.10. Lacan’s capitalist discourse shows a change of direction of exchanges, blocking social link.

¹⁵ For an excellent account of the possible politics of trauma at the level of humanitarian psychiatry, check Fassin & Rechtman (2009) who propose reparation, testimony and proof.

In a talk given at the University of Milan in Italy, known as the *Discourse of Milan* (1972a), Lacan proposed the capitalist discourse as an overt substitution of the master discourse of governance. In the new discursivity, we find a shift in the direction of the arrows, shown in Figure 4.10, and the function of social bonding is no longer possible because the subject is replaced by money and the market interests.¹⁶ This discourse is different from the four other discourses (master, university, hysteric, and the analyst) in that the capitalist discourse forecloses impossibility, meaning that castration and the sexual non-relation are bypassed, creating a short circuit that hurdles the social link (Braunstein, 2012; Vanheule, 2016; Tomsič, 2015). Thus, in this discourse there is no social relation because monetary gain, rather than linguistic exchanges among people, circulates in a figure eight of infinity. Alenka Zupančič refers to this discourse as “the logic that governs the field of goods as commodities, and their association with the Good in the moral sense of the term” (2019, p. 95). Conceived as such, under the apparent interest of bringing mental wellbeing, a moral good, to communities facing duress, the global MH know-it-all discourse utilizes this engagement to position the capital of health and psychopharmaceutical industries as subjects in this discursive modality, rather than the embodied subjects at stake in those examples: the local therapists who could perhaps guide the humanitarian aid within *their own cultural practices* in Summerfield’s case, or the very farmers in Mills’s example, who instead of only being medicated with drugs and psychoeducation, could be aided to politicize their cause. The capitalist discursive modality runs fast and it “consumes itself,” as Lacan said, as if “on casters” (Lacan, 1972a, p. 7). The capitalistic discourse accelerates, as if on wheels, creating profound inequal effects. The capitalist discursive structure poses difficulty to read because even when it is sustained in language, the exchanges happening (notice the arrows in Figure 4.10) do not permit an interaction among the participants in the circulating discourse. This discourse can’t find its cause or define its historicity either. The place of truth *qua* cause no longer affects semblance (the agent) forbidding the possibility of social bonding. Zupančič (2019) clarifies the antagonisms established by the capitalist discourse:

The opposition here is not simply between capital and people, but rather between people and ‘something in people more than people’ (our ‘value’

¹⁶ This theory has also been extended by Jacques Alain Miller, Braunstein and others to add new modalities of social bonding emerging under circumstances of late capitalism or neoliberalism. (See Fernandez, Dec 2016)

as labor power), with the latter being situated outside ourselves, on the side of capital, its accumulation and global circulation, and hence subjected to its radical abstraction. (p. 102)

For the capitalist discourse instantiated by cases C and D, this means that capital, human and financial respectively, necessitates of people's *jouissance*, a production of psychic labor. From *jouissance* —what is “in me more than me”— (Lacan, 1964/1998, p. 267), capital abstracts its value to circulate psychopharmaceutical or therapeutic merchandise, by literally abstracting financial value from those in crisis (cf. Fassin & Rechtman, 2009, p. 157).

4.6 Conclusions: Hegemonic power of the know-it-all discourse

Thus far, through the discussion of the above cases A and B, I described the theory of Lacan's university discourse, which is based on a totalizing epistemology and creates a specific social bond at VCH. Here, more important than the analyst's own knowledge, what is key is to protect the ignorance about it with a semblance that props a master signifier that pretends to know-it-all by the tautological fact of being called evidence-based. The last two cases C and D showed how the know-it-all discourse affects not only Canadian institutions but rather affects the global mental health system because it ignores socio-political causality and preserves surplus value for the global elite. I conclude that the know-it-all discourse found at VCH exerts hegemonic power over the population they serve.

Hegemony comes from the Greek word *hegémōi*, to lead or to guide, and according to Antonio Gramsci, who took the term over from Lenin, hegemony determines the sense of direction of a practice. While hegemony was originally envisioned by Gramsci as leadership, the direction of a constituency often is achieved by forced consent (Houssay-Holzschuch, 2020, p. 358). I demonstrated how the institution forces consent in a social situation by the implicit pressure to maintain fidelity to the master discourse, akin to what Kaës coins as the narcissistic contract, which preserves a place for any member of the institution, as long as it is willing to sustain what is believed to be the original heroic foundation of the institution (1989, p. 47). The master signifier congeals hierarchy and offers signifying supremacy whenever people offer fidelity to it, but if they criticize the master signifier, exclusion results.

Power can be read in multiple ways and the contemporary locus classicus is the work of Michel Foucault, a historian of power. Foucault locates power right at the core of subjectivity, which results from a social construction, and believes that the source of power could not be located in the sovereignty of the state and the discourse of rights but rather in the very mechanism of the relations among subjects, within the very biopower that makes omnipresent the dyad of power and knowledge (Foucault, 1975/2003, p. 280). With the Lacanian perspective one can partially agree with the fact that knowledge within social bonding is submitted to the master signifier and its oppression is seen by its effects—as I am demonstrating in my research—yet power in psychoanalysis is never only a matter of knowledge (signifiers and ideology) but of what exceeds the symbolic apparatus; therefore, it involves the power of *the lack of knowledge* that produces the specific ways in which a subject and a society fantasize, enjoy and suffer (*jouissance*), and thus, as Tomsic states, the reproduction of the relations of domination is achieved “by means of the production of enjoyment” (2020, p. 15).

Therefore, my conception of the power of the institutional know-it-all discourse is threefold: 1) on the one hand, discursivity works within a forced consensus, and if people resist or protest, they are excluded. 2) in a Foucauldian way, power is subjected to a construction of discourse via the subject—which I read with Lacan as within the axis of representation—; and 3) the power of the Real—axis of production— resides in nonrepresentational and spectral aspects of fantasy, enjoyment and desire, and it is also in these unconscious formations where contingent possibilities of emancipation appear.

In the next chapter, I present a theoretical discussion of a topological nature to illuminate how the psychosocial space in which discourse occurs is entwined as an *extimate* space that inheres on both the individual and the social scales. The topologies I will explore next engage psychoanalytical geography and clinical psychoanalysis to demonstrate both scalar parallax and the two bodies at stake in the abstract (unimaginable) space of the institution, which will provide yet another articulation of how the know-it-all discourse functions in space.

Chapter 5.

Topological entwinement of the subject and the social: the institutional unconscious

[t]hat one says as fact remains forgotten behind what is said in what is heard

Lacan, 1972a, p. 7.

In this chapter, I focus on the Real structure of the institutional unconscious, which I render as an *extimate* space (cf. 2.5.1) or an entwinement between exterior and interior that combines the enjoying body of the subject and the body politic of society. To further explicate the *extimate* space that is inherent at both the individual and the social levels, I develop a theoretical model based on Lacanian topology to clarify how subjective space stretches in discourse and creates psychosocial spaces that go back and forth from the subject to the social, forming the institutional unconscious. I am proposing that the Real, the Symbolic, and the Imaginary registers, which Lacan spoke of as “three dimensions of space” (Lacan 1968/69, p. 6) or a knot of equivalencies, shape the spatial surface of the structure we live in. Made of language and flesh, such materiality of hyperbolic geometry is an abstract space that connects the subject’s body and the body politic. To explain the interweaving of the two scales —the subject and the institution— and the two bodies —jouissance and politic— I draw a trajectory that goes from the topological structure of the subject to the institutional one and then back again. I connect various topologies, starting with those pertaining to the subject: departing from a letter-point that gives rise to a Euler diagram, I describe its transformation into a torus, then to a double tori, then a Moeibus band that presents the topology of an interior eight. I instantiate these topologies with brief considerations of the clinical work with trauma, which will be further discussed in the coming chapters. Only after describing the topological space of the subject, I turn to discuss the topology that pertains to the intersubjective entwinement of subject and institution detailed through the crosscap surface, with which I instantiate the institutional space. The crosscap allows us to locate the linguistic arrangements that affect the materiality of the subject’s enjoying body and the body politic. I conclude that the institutional unconscious at VCH works as a hegemonic fetish, based on fantasy, which constitutes a defense against understanding

the complexity of the psychical and intersubjective entwinement of the phenomenon of trauma, and that such fetishistic fantasy also serves to reduce costs within the institution.

5.1. Spherical thinking

The university or know-it-all discourse is a result of spherical thinking, which involves totalizing and identitarian thought. This form of thinking is based on Ptolemaic and Platonic philosophies that followed Pythagorean mathematics, in which the notion of identity $A=A$ invariably results in sameness. In comparison, topological thinking allows for reasoning in a non-Euclidean way, where the same body or space can host points of deformation without losing its integrity. Spherical thinking finds subjective support in the mirror stage, which appears between the ages of six to eighteen months where the little human finds the logic that provides a constitutive gestalt of a complete unfragmented body by means of reflection in a form that “*appears to him as the contour of his stature that freezes it and in a symmetry that reverses it*” (Lacan, 2006, p. 76, my emphasis). The mirror that forms our cohesive body, necessary for life, is also the precursing element to our spherical thinking of totality, which is also the One intuitively apprehended in the field of sexuality, as described by Lacan through the “deriding” myth of Aristophanes in Plato’s *Symposium*. In this myth, a love character is presented as a being cut into two “like hard-boiled eggs sometimes ...so flattened out that they seem to be but half of a complete being” (Lacan, 1960/2015, p. 87). The myth of “sharing the sexual enjoyment” (p. 86) as *One*, supports the idea of the impossible sexual relationship (the idea that 1 plus 1 will make One —the sexual union—, instead of 2). Thinking in a spherical way preserves the zesty idea of a center and the neat separation of the interior and the exterior regarding the cosmos, the environment, and our bodies. Lacan highlights that the sphere as a “whole form” (p.89) is deemed perfect and thus produces the pleasure of the organized whole (*Gestalt*).

Following Lacan’s topology, the sphere as a form of thought is further related to the Kantian transcendental aesthetics that posits that a totality can be reduced to one point in space and time, and that when such notion is brought into signification it generates tautology (Lacan, session 07.03.62). Such spherical thought is totalizing and tautological not only because it disavows negativity, by which I mean things that are intangible, unknowable, or disarranged, but also because all that is apparent is seen as identical to itself. Thinking spherically renders a phantasmatic all-encompassing social

space in which any potential failure could be well calculated and all that surrounds us, the little crevices unexplored, can eventually be known thanks to scientific and technological advances. The consequences of this form of thought involve, in my research, the idea that to cure mental and emotional suffering we are only required to apply well known techniques or wait for the advancements in neuroscience to overcome the inherent catastrophe that subjectivity entails. The Real space where the institutional discourses unfold, however, is quite different from a sphere and thus I now turn to my topological discussion.

Topology is a field of mathematics that studies bodies, its holes and bending from a non-Euclidean perspective, which means it approaches spatial transformations beyond the geometry of three dimensions —height, width, depth— that hold determined points and lines. Topology is known as analytic geometry or “rubber sheet” math, as per its ability to deforming, twisting, stretching and cutting, but not breaking the body of any given object of study, which can be deformed without losing its integrity (Ragland & Milovanovic, 2004, p. xx; Blum & Secor, 2011, p. 1034). Kingsbury defines topology quite succinctly:

Briefly, topology is derived from the Greek *topos*, place and *logos*, study and once dubbed by Gottfried Leibniz as ‘analysis situs’ (an analysis of place). Topology is a non-Euclidean qualitative branch of ‘qualitative’ mathematics that replaces all references to distance, size, area, angle, scale and dimensionality with concepts of ‘proximity’ and ‘neighborhood’... Topology examines how things can change shape or become distorted yet still retain properties of continuity, contiguity and delimitation. (2007, p. 245)

Topology,¹⁷ the “flower of mathematics” (Lacan, 1972b, p. 8) was developed within psychoanalysis to think the Real structures, for Lacan assumes “the strict equivalence between topology and structure” (Lacan, 1972/1999, p. 9). Lacan’s models and schemas have been widely studied and discussed, such as the optical model of the Mirror-scheme, where Lacan deconstructs the imaginary mechanisms that support the ego; the Schema L that locates the imaginary and symbolic underpinnings of the speaking subject of the unconscious; or the graph of desire where Lacan brings the whole of his theory into a dynamic visual map. The Lacanian topological models, proper,

¹⁷ There are few rich edited collections of psychoanalytic topologies, for example: Ragland & Milovanovic (2004); Friedman & Tomsič (2016) and specific to psychogeography, Kingsbury & Secor (2021).

range from surfaces —the torus, Moeibus band, crosscap or Klein bottle—, to Borromean knots, which build a mathematical formalization, even if “[t]he real can only be inscribed on the basis of an impasse of formalization” (Lacan, 1972/1999, p. 93). Such impasses of the Real is what moves any psychoanalytic theorist to conduct a form of Lacanian “topologerie” (Nassio, 2004, p.102; Greenshields, 2017, p. 38) which is a practice (Wegener, 2016, p. 48) that shows and writes a structure (Ragland & Milovanovic, 2004, p. xix; Lafont, 2004, p. 3) of the subject and their environment, even if, and precisely because of its impossible formalization, for the subject of the unconscious leaves always a “non-writable remainder” (Friedman & Tomsič, 2016, p. 23), which I have been coining as the traumatic residue from discourse.

All said psychoanalytic topological surfaces can be produced in multiple ways, due to the inherent bending properties, and thus the way one topologizes space depends on the singularity of the reader and the writer of such models. This aspect of the singularity of topological production is similar to what constitutes the style of the analyst, which I render as an effect of the analyst’s desire and their “know-how.” An analyst’s style requires for them to have encountered castration in a dialectic manner in their own analysis and to be able to articulate something of such encounter at the end of analysis. The latter allows to focus on the analysand’s speech, to puncture the texture of the analysand’s speech to reveal the insistent letter that might torment the analysand. The *savoir faire* or “know-how” of the analyst consists in an awareness of *lalangue*, the active core of the real ways in which an analyst intervenes, which brackets the analyst’s *jouissance* out of the therapeutic process (Fernandez-Alvarez, 2019, p. 861). Similarly, albeit exclusively in the theoretical landscape, topology renders a subject —an analyst— that “provides an intuitive understanding of transformations” (Ragland & Milovanovic, 2004, p. xx) in space, even if the Real topology resists because of its inherent exclusion from specularization and tangible materiality.

The topology I am writing about here refers to the unimaginable, impossible space that connects subject and others, the individual and a community, constituted by the volume of lived experience within an institution. This impossible *nospace* (Lacan, 1972b, p. 3) is shaped by discourse and organized around a protruding void, or “the unlocalizable principle that makes all localization possible” (Kingsbury and Secor, 2021,

p. 11), also akin to Adorno's "non-identity" (1973, p. 5), that sustains the reproduction of everyday life within the institution.¹⁸

The institutional examples discussed in the previous chapter show how the socio-spatial relations are modulated by forms of desire (circulation of symbolic and imaginary aspects) and jouissance (the simultaneous affect related to somatic sensations of pain and pleasure) that an individual experiences with others. Jouissance involves the subject's speaking body that suffers, enjoys and speaks and who is radically mediated by an Other *who does not exist* but who is imagined as omnipresent despite not having any ontological substance, consistency or flesh. As a condition of language, this Other firstly embodied by the caring Other, is entwined with the speaking being and has profound effects on the subject as the Other sublates anxiety, desire and jouissance. Even though the Other lacks a real existence, it is imagined in the clinic through superegoic figures, often in a masculine form but in feminine form too, such as a hunter, a dictator, a foreman, a witch, a family member, or a fascist. A participant expressed the superego in this way: "I hear voices and they really bring me down and put me in really bad place because I feel helpless. They have power over me" (A11) The big Other, then, is located in the space of the Imaginary and the Symbolic, within thoughts, yet speaking beings find often an embodied version of it by projecting their superego and fantasies onto others. As Lacan explains:

I have no guarantee of any kind that this Other, through what there is in his system, can give me if I may express myself in this way, what I gave him: his being and his essence as truth. There is no, I have told you, Other of the Other. (Lacan, 1958, p. 16).

The figure of the big Other lacks any guarantee and to detail such quality in the abstract shared space of subject and the Other within the institution, we need to embark on a topological journey that starts in the letter.

¹⁸ Blum and Secor (2011) elucidated the isomorphism of material and psychic spaces in Freud's case known as the Ratman. The authors find, for example, the spatial equivalence between the journey of the Ratman —the material space— and its convoluted symptom —the psychic space—, which indicated the impasse between the topographic and the topological (p. 1045).

5.2. Letter as the point of departure for any subject

The letter is the mark of a voided knowledge, a hollowed point where the journey of every speaking body starts. Working on Lacan's Seminar XVIII, I claim elsewhere (Fernandez-Alvarez, 2020b) that the letter is different from a signifier in which the letter has no meaning but it shows itself. This could be instantiated by what analysts in mental health services express as hopelessness about change, for their awareness of an insistence of fate or tradition is compulsively repeated in their lives, and such repetition appears as a forced way to enjoy and suffer, much like the others in their lineage did despite the subject's efforts to undo such repetitions. The letter is that lineage branding and although partaking of the Symbolic and the Imaginary, the letter is located in the Real and constitutes a littoral that indicates the distinction between two non-reciprocal and heterogeneous domains (that which is known, that which can't). The letter straddles between the seashore of truth and knowledge, on one side, and the sea of jouissance in the other. Elsewhere, I argued that:

On one side of this landscape, a foundational, symbolic stroke linguistically structures our jouissance in all its meaninglessness. The letter, emerging as littoral, makes a bord on the ocean of jouissance, edging the hole of knowledge. On this domain, the letter signals and animates the subject to enter a trajectory of branded corporal routes, marked by the word of the Other, to increase and release psychical tensions.

On the other side, there is a seashore of knowledge and of incomplete truth. The letter presents, here, its meagre ability to inscribe jouissance, yet it marks a limit of the symbolic. On this side of the littoral, the letter breaks down semblance, the term Lacan uses to designate discursive identifications, and when that occurs, a bit of knowledge of the subject's being becomes legible, partially inscribed. Somewhere else, I render the process of inscription as a partial symbolic assimilation, or legibility, of which does not stop not being written (the impossible), and the process of re-inscription, as a new way of writing that does not stop being written (the necessary). (Fernandez-Alvarez, 2020b)

From the insisting letter and the Other's branding of jouissance on the individual's flesh, we move to a logical set of the subject, exemplified by the minimalistic Euler circles.

5.3. Euler diagram and the perpetual coproduction of subject and society

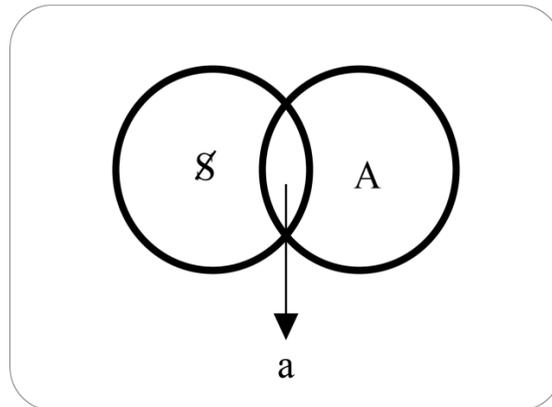


Figure 5.1. Euler circles as the set of the subject of the unconscious ($\$$ stands for the subject, A for the Autre, —Other— and a designates object petit a).

The logical set presented in Figure 5.1 shows two interrelated elements. The left side is the locus of the subject of the unconscious, structured and split by language. On the other side is the social, showing the locus of the Other (*Autre*),¹⁹ the source of language and desire. Lacan (1962) says that it is around these circles that two relations can be articulated: intersection and unions (session 11.04.1962), which will shape the logical mechanisms that pose the subject with the heuristic tasks of alienation or separation, being or meaning, detailed in Seminar XI (Lacan, 1964/1998, p. 211). The intersection $\$ \cap A$ shows that the relevant relatedness of this set-subject is occupied by object *a*, which stands for a void or *nospace* (Lacan, 1972b, p. 3) that corresponds to the topological space of the negative, the *Undinge* of the Kantian transcendental aesthetics, the “nothing” or the “nothing as something” (Friedman & Tomsic, 2016, p. 96-97). This is the basic split to which the mental health therapist is confronted with when listening to the analysand: Who speaks in what the patient says? Is a full speech coming from the subject of desire? (Lacan, 2006, p. 206) or is their speech empty, coming from the superegoic Other of culture and tradition? What of the trauma —the unsymbolized— insists in what the analysand *does not* or cannot say? These ongoing questions underly the psychoanalytic inquiry in the clinic and its relevance to mental health services reside in whether the clinician can interrogate the analysand’s speech about the oppression

¹⁹ For reading Lacanian topological models I maintain the original French word *Autre* instead of its translation Other for its common use in most Lacanian scholarship.

and suffering from the place where it ultimately resides, since the Other —often experienced as the abuser— has been internalized.

The subject perpetually co-produces psychic reality between desire and enjoyments imposed on them by others, culture and society, and by the efforts of separating from such alienation. These antagonisms create logical impasses, that present the subject with a forced choice, Lacan says, because the subject has to emerge as being *qua* lack of being in *separation*; or the subject remain hidden and obtains sense by the Other's meaning, which excludes their subjectivation and persists in *alienation* (Lacan, 1964/1998, p. 210). It is important to remark that the subject's set shows, once again, an aporetic parallax between alienation/separation that has profound clinical relevance: one is symbolic in nature and refers to the fact that a subject, represented by a signifier for another signifier, cannot represent itself and thus identity, desire and enjoyment are necessarily co-produced through the collective Other. The other impasse is the Real and refers to the constitutive lack within the set that involves what is excluded because "in the Universe of discourse there is nothing that contains everything" (Lacan, session 16.11.1966). Such impasse of the Real is what in set theory is known as Russell's paradox (or Russell's image, as Lacan calls it) which alludes to "the catalogue of all the catalogues which do not contain themselves" (Lacan, 16.11.1966). This paradox means that for the subject to include itself in a set that includes/excludes an inexistent Other, as well as an object *a* absent and lost, the subject is established as "minus one," as forecluded (*Verworfen*) (Lacan, session 07.03.1962). The latter forces the subject to count itself not as the *One of totality* but as the *countable One* (Lacan, 16.11.1966), for which the subject requires a first mark or unary trait, *ein einziger Zug*, that allows the subject to enter language. Thanks to this original mark, the subject uses the Other's signifiers to relate but not to fully disappear in the Other (Lacan, 1964/1998, p. 256). These mechanisms of logical nature are again central to the work in the mental health field, as it requires from the therapists to inquire from what position an analysand speaks: Are they caught in the Imaginary register —ideal image of self or others— and can't find strength in their lack of being? What are possible ways of accessing the Symbolic register to support subjectivities via their speech, desire, the act, or creativity? In what way the analysand's body might be imprisoned in the alienating meaning of the Other? Is the analysand willing to let go of their position as object for the Other? Are they too isolated —*separated*— from society for fear of being an object? Can

the analysand count themselves as one of value renouncing the spherical ideal of the One? How their destiny can be written through their sayings via language's polyphony? These are some questions that concern subjectivity about how to elicit the subject's appearance so they can name themselves, amidst all the difficulties of the dialectics of alienation and separation. I address these questions at length in Chapter 7.

5.4. Two tori intersected as the dyad of lived experience

The Eulerian diagram in Figure 5.1 shows the set $\{\text{subject} \cup \text{Other} \cap \text{object } a\}$ and if we inflate the diagram with lived sensuous experience, it becomes a torus. A torus is an orientable, genus one surface constituted by a tube empty on the inside. The torus demonstrates the mechanisms of desire and demand occurring within the subject in her/his experience of an internalized Other. Lacan renders the torus by collapsing the Euler circles onto one another, on condition of making a cut or a turn of one of the circles to make the interior eight (Figure 5.2) that turns the circles into a ring or torus (Lacan, session 11.04.1962). This surface ring, as depicted in Figure 5.2b, is the structure of neurosis and desire (Lacan, 1972b, p. 16) because it exhibits the entwinement of subject and "the dimension of the Other between desire and demand" (Lacan, 14.03.1962). The subject is linked to the Other through "two irreducible circles," that is to say, circles that could not shrink down to a point of disappearance, and thus they are unable to be filled in, constituting a fundamental lack, an eternal void (Lacan, 1962-63/2014, p. 133). As shown in Figure 5.2b, one circle runs around the length of the 'donut' and is known as toroidal axis, which relates to desire. The other circle is in the poloidal axis and is demonstrated by a circle that repeats in spiral corresponding to the repetition of demand, namely of what constitutes the drive (Lacan, session 28.03.1962).

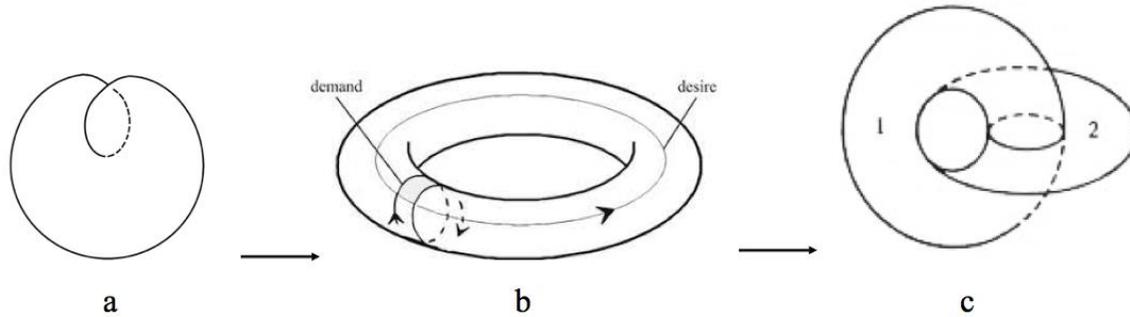


Figure 5.2. The entwined space of subject and Other stretching from a) figure eight to b) circles of demand and desire, to c) the entwinement of these circles in lived experience (two tori intersected). Modified from Greenshields (2017, p. 66)

These two circles are superimposed and if we cut the torus, let's say with the rotating knife of language, we will obtain two interlaced pieces that link two tori, which is a surface similar to a ring with a handle.²⁰ This surface shows the two empty circles of desire (1) and demand (2) as presented in Figure 2c, which form a buckle or knot of subject/Other in which the neurotic subject is trapped.

These models mean for the mental health practitioner that the analysand's demand within service provision constitutes an opportunity to facilitate subjective emergences, if the analysand's demand is listened to with radical ethics of desire instead of the know-it-all structure of the mental health industry that tries to satisfy the analysand's demand by responding with a fast solution, bypassing complexity. The double tori show how an analysand might actualize their early attachment to an Other via the transference. In the psychoanalytic sense, demand is omnipresent when we speak, as the speaking subject aims to be recognized as worthy and lovable. The demand of the Other is an assumption made by the speaking subject of what the Other wants²¹, so the subject can be loved. In this way, the subject confuses her own desire with what she imagines the Other wants, or as Lacan puts it "there is imaginarily incarnated the relationship of inversion" (21.03.1962), which gives ground to the dialectic

²⁰ The cut in Lacanian topology is crucial as it denotes a subjective production through language, or as Lacan puts it: "In our *aspheres*, the cut, closed cut, is the said. It makes subject: whatever it circles..." (Lacan, 1972b, p. 3, my italics).

²¹ The Lacanian "*Che vuoi?*", 'What do you want?', is the question that best leads the subject to the path of his own desire" (Lacan, 2006, p. 690).

of frustration, key to dissatisfaction, but also, if well punctuated, to possibilities of assertive desire (Lacan 14.03.1962).

5.5. Moeibus band qua subject of the unconscious

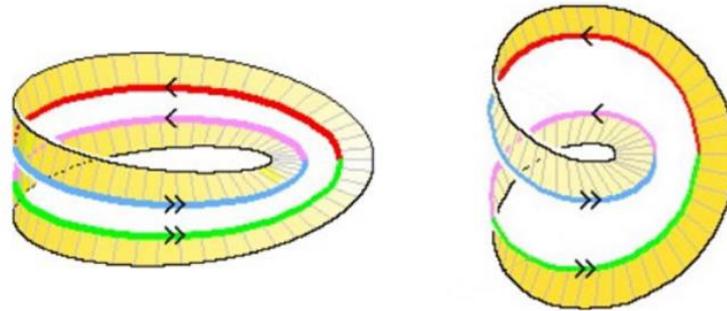


Figure 5.3. Moeibus strip and interior eight. Modified from Greenshields, 2017, p. 52

When the entwined torus of the Other and the subject is cut through the early experience of separation, we obtain a Moeibus strip. The double tori collapsed onto itself, flattened and cut, gives rise to the subject in the social through the non-orientable, one sided, one-edge Moeibus band, in which the subject and the Other are already intertwined and a torsion shows its alternate parallax emergence. This is what I referred to in Chapter 2 as *extimacy*, or a space wherein the interior is excluded and the exterior is included, or in Lacan's words, that "which is inside the subject, but which can be realized only outside, that is to say, in that locus of the Other" (Lacan, 1964/1998, p. 147).

The Moeibus band is a rectangular strip that has one or any other odd number of twists and whose extremes are linked, which provides its shape with the property of continuity as there is no possibility to differentiate the back/front, Other/subject, conscious/unconscious, jouissance/language. The *extimate* properties of non-orientability and unspecularity make the Moeibus surface central to Lacan's understanding of the subject's structure. As illustrated in Figure 5.3, folding the Moeibus loop within itself results in the Lacanian interior eight, which is vital to the processes of repetition and counting oneself through retroactive signification (*Nachtraglich*) (Nassio, 2004, p. 105). The repetition within the Moeibus loop is key to understanding trauma because to articulate the unsayable of trauma, via language, is to loop the cycle of repetition various times within the Moeibus band. If we place the Moeibusian surface

flattened between our two hands fully open, there will always be a part of the strip that we cannot touch. This untouchable, the twist of the Moeibus band, shows the difficulty to fully perceiving and grasping our own subjectivity. Also, being non-orientable, this surface if turned inside out or up and down, its shape remains, resulting in “*not having a specular image*” (Lacan, 1962/2014, p. 96). The latter means that the speaking being has to compensate for the disorientation of being, the lack of a consistent image, with the recourses of the ego. When the Moeibus band is cut from the entwined tori, the subject “of the signifier and its object momentarily appear” (Ragland & Milovanovic, 2004, p. xxvi) constituting the subject of the unconscious. A *separation*—a partition from the inside, from *das Ding*, the first imprint of the outside and also of the good,—(Lacan, 1959-60/1992, p. 54) occurs to separate the subject from the object of desire (Lacan, 1962/2014, p. 237). This process of cutting from the inside initially occurs when an infant is forced to let go of the nipple, and from then on, the scybalum, the gaze, the voice or the phallus and its further losses. The loss of object *a*, separated from the body, will be marked with a trait, the unary trait, connected to a form of primary identification that, as mentioned above, allows the subject to count itself and enter the Symbolic, the only register where lack could be represented.²²

The topology of the subject of the unconscious as a Moeibus band is relevant to think mental health provision, because it poses the psychic complexity of a subject in its inherently immixing condition with the social. The question remains of how a service provider can ethically approach this opacity called subjectivity, the only recourse to displace oneself from the place of object for the Other and object for others. How an intervention can hear the social link in what the subject speaks and intervene ethically, the only way to transform destructive *jouissance* into pleasure and desire. How could a therapeutic intervention within the mental health field bypass a mere saturation of the client’s ego—which reinforces the symptom *ad infinitum*—and instead allow the truth of the subject to be occupied? What can one do with the radical causality of object *a*—the nothingness under our speech—? These questions are addressed in Chapter 7.

²² The Real does not lack a lack. The Imaginary denies it by the activation of the specular image—semblance or fantasy. Only the symbolized can be counted as lack, for only what has been symbolically registered—a dream, a loved one, a book, a self-image— can become a loss.

5.6. Crosscap: back and front of language in the social space of the institution

The Moeibus band, inflated by the lived experience of the subject in the social space generates a self-intersected projective plane, best exemplified through the non-orientable crosscap surface. The above-mentioned topological journey serves to explicate how the cut of the subject by the Other of language produces the Moeiban subject of the unconscious which is a structural element of the crosscap. My reading of the Lacanian crosscap exemplifies the intersection of subject and discourse in the institution.

As René Rousillon proposes (1989, p. 188), the entwinement of the lived experience of psyche and the social institution is always sublated and unable to be grasped by mentalization, representation or symbolization. The crosscap shows such impossible space and it is constituted by a projective plane made of a disc or hemisphere whose boundary is divided into two halves by means of a Moeibus band (Stillwell, 1980, p. 64). Lacan used the crosscap to indicate the separation of the subject from object *a*, via the phallus, emerging from “the necessary crossing of the Moebius strip through the disc” (Lacan, 1972b, p. 3).

The crosscap surface in psychoanalysis has been obtained from the R schema (Lafont, 2004, p. 23), which “demonstrates Lacan's quadripartite structure of the subject” (Blum & Secor, 2011, p. 1039). This quadrilateral schema shows the *extimate* nature of reality in relation to both the symbolic triangulation located on the site of the Other (Ideal, Mother and Father), as well as the imaginary triangulation on the side of the subject (formed by Image, Ego and the Phallus). These rich approaches account topologically for the subject's structure, but not for the specific connection among embodied others through discourse.

My proposal is that the crosscap's closed surface shows topological connections that demonstrate socio-spatial exchanges within the institution that other topologies, above described, could not represent, and that yet inhere its shaping, as I discuss in detail below. The impossible space of the crosscap, which Lacan also refers to as a wolf trap, a bonnet or a bishop's mitre, could well be conceived as a tridimensional interior-eight space of an immense, mother of pearl, conical pyramid seashell. That, or a non-

orientable giant pumpkin (VCH), whose interior-eight space (sites) hosts thousands of ants (speaking beings) that follow a linguistic journey to self-intersect the personal and the social without awareness.

The link between the subject's body and the body politic in this intersectional one-sided space is impossible, because to be possible it will require that all "arbitrary point sets" (Stillwell, 1980, p. 3) be mathematically described or enumerated. That is to say, the counting and tracing of every intersection of one subject (one point set) to another subject (another point set) is necessarily elusive; as in Case A, for example, it is impossible to follow exactly the embodied linguistic exchanges occurring at the time of the interaction. Yet, trying to topologize this space facilitates placing the location of exchanges within the know-it-all discourse.

5.6.1. Deconstructing the self-intersection of the crosscap

To better understand this institutional topology, we need to deconstruct the crosscap by taking first the disk, which holds various points, as depicted in Figure 5.4, which stands for an individual subject branded with their own singular letters from a collectivity to which they belong —lineage, tradition—, and which will determine their identities, fantasies and symptoms.

The disk has four sections that host multiple, antipodal and diametrically opposite points that correspond to lettered subjects. Each point-lettered subject intersects over the diametrically opposed point sets of other subjects branded with their own letters. When closed with a torsion, this structure may resemble a sphere, or what Lacan calls *asphere* (Lacan, 1972b, p. 13) and is glued or stitched with a twist by means of a linguistic operation, joining the four parts of the edge, (S1, S2, \$ and an empty placeholder of object *a*) as depicted in Figures 5.4b and 5.4c. The Moeibus surface is produced in this intersection and stands for the subject as an effect of discourse. Yet this intersection of the subject with other subjects is impossible to track or show within the totality of the structure, and thus their various effects can be traced either *one by one* by individual accounts or also by the dynamics of the group, such as the various pacts, myths, official history, ideologies or residues (Kaës, 1989, p. 53; Roussillon, 1989, p. 189).

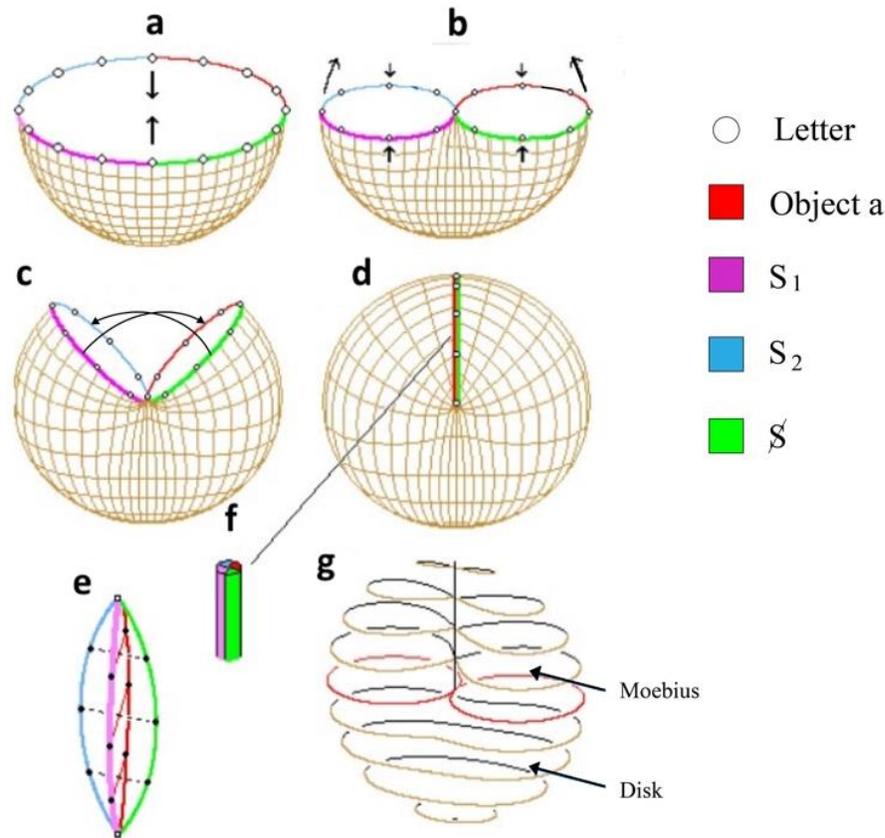


Figure 5.4. The crosscap stitched by discourse. (Image modified from *Hyperbolic Non-Euclidean World and Figure-8 Knot*, 2021. Retrieved from http://web1.kcn.jp/hp28ah77/us27g_cros.htm on June 30, 2022.

Each subject is born into language and positioned in discourse by means of their embodied relation to various signifiers. In Case A, a particular institutional social bonding is actualized and every participant as a speaking being must abide by what the discourse dictates; regardless of the subject's singularities and the involuntary veiling of their own historical letters (which, of course, in my research is impossible to know), the participants are linked to discourse by *the specific historical contexts of a shared language*, as Lafont eloquently states because "[l]anguage is a space where anybody can enter, and nobody can leave" (2004, p. 12). This means that the dominant know-it-all discourse at VCH holds a systemic grappling by the very fact that speaking subjects are convoked by language around what we do not know (the void of object *a*) and what is imposed by the master signifier as the condition to enter the social link. I discussed that one strategy to disrupt the structural grasp is the resistant protest (cf. 4.3.7), but there are other forms as well, such as the linguistic and affective reshaping of the

institutional structure, which stands for transformation, to be discussed in Chapter 7 (cf. 7.6).

If we cut horizontally the look-alike Chinese fortune cookie (Figure 5.4d), the Moebian subject appears as inhabiting the upper part of the structure, as depicted in Figure 5.4g where the *extimate* alternation of conscious/unconscious, interior/exterior, private/public occurs. Meanwhile object *a*, the place of the void, is the disc or hemisphere on the bottom part of the structure. As depicted in Figures 5.4e and 5.4f, the self-intersection occurs between truth as cause (in pink); semblance/agent of knowledge (blue), other of jouissance (red) and surplus production (green); the colors of the model stand for each of the four elements of discourses folded in an internal infinite self-intersecting loop.²³ The phallus and its castrating function is what allows the self-intersecting operation, as the phallus is the “privileged point” of the structure that “allows a point trespassing from one side of the surface to the other” (Lacan, 23.05.1962). Object *a*, instead, is both a constitutive void, depicted as the crosscap’s hemisphere or disk in figure 5.4g, as much as a placeholder and a residue of the void, as represented in figure 5.4b. This is to say that discursive entwinements cut out object *a* but safeguard a place for it, which in the example discussed, object *a* was occupied by the analysand’s symptoms. This excision of the unknowable, — the negative or the impossible Real, object *petit a* — appears distinctly in each modality: by surplus production in the master’s discourse; by a governed other in the know-it-all university discourse; as causal force in the protesting hysteric discourse; and as mere semblance in the analyst’s discourse, and each creates very different conditions for how the specific body of a subject appears within discourse. From this discursive operation —all places taken— there is always a residual place. In Case A, discussed in the previous chapter (cf. 4.3), the residual place —place of excessive production— is locatable in the position of the counsellor who was suspected of having a “special relationship” with the analysand, as reported: “Why am I having such a strong reaction, you know, am I treating this client like it’s a personal friend or something like that, which wasn’t the case” (C14). This is a well-known phenomenon within every institution when its dynamics have been affected

²³ The crosscap has a folded loop, made by discourse, which closes the structure. Jos Leys (2016) offers an animation to visualize the self-intersection on YouTube.

by what Kaës coins as the “pact of negation,” which has the purpose to silence differences and is rendered as a

generic intermediate formation that all bonding, being a couple, a group, a family or an institution, condemns to the fate of repression, negation or disavowal to maintain it as the unrepresented and the imperceptible. (1989, p.51)

The excluded space of negation hides in the crosscap’s line of self-intersection, which contains a folding loop with the four terms of discourse. The non-orientable topological structures that include a Moebius band are constituted by a “double circuit topology of the hole” (Skriabane, 2004, p. 79), hence the crosscap surface self-intersects twice, constituting “the necessary crossing of the Moebius strip through the disc” (Lacan, 1972b, p. 3). In other words, the Moebius band —with no edge— shows a speaking subject going twice around the same loop —a hole that has an edge— to get back to its starting point of speech. This is exemplified in the clinic by the many ways and abundant words and narratives with which an analysand might account for their traumatic experiences, always returning, perhaps imperceptibly, to the same point of impasse.

Similar to the Moebius band (subject), the crosscap surface (collectivity) includes a hole (a surface with an edge) that must also be navigated twice between the back or the inside, and the front or the outside of the surface. At VCH, the crosscap presents an isomorphic —same form— at least linguistically, to what is known as “back and front of house” in the real spaces of the institution (cf. 3.3) and which characterized many social service institutional spaces. It is precisely in the self-intersecting crosscap surface of the institution that we locate Case A, where the four actors participating in the social link and rooted in the mental health practice, maintained the closed surface by the investment into semblance, which secures the circulation of the privileged master signifier and “restores this surface, to the spherical mode” (Lacan, 1972b, p. 13). Up to a point the structure gets spherical, because as instantiated in Case A, the closed structure was broken when the counsellor refused semblance and, as she reported, called out the psychiatrist as follows:

I really think it’s them [analysand] asserting themselves and feeling emotionally charged because of the way that you were interviewing them and the questions you were asking and the way you were talking

to them and the fact that you weren't hearing what they were saying.
(CI4)

By taking the responsibility for advocating on behalf of the analysand against the master signifier of biomedical and diagnostic supremacy, the clinician instantiated a subjective appearance rather than choosing to remain in a residual place. Once the discursive cause was revealed by the counsellor, the structure was disrupted and opened briefly only to be closed again when the supervisor backed up the master signifier and its hierarchical arrangement and the clinician's protest was questioned, demonstrating a value of truth regarding what matters most, in this case the power of the psychiatrist rather than the analysand's situation or the advocacy by the counsellor.

5.6.2. Back and front of language in the crosscap

To finalize my conceptualization of the topology of the institution, I'll show the location of the latent (enunciation) and manifest (statement) contents within the topology of collectivity. For Freud, the manifest content refers to what is conscious or preconscious in any given phenomena. For example, the "text" or speech one presents when describing a symptom or a dream is a product of a disguising labor that requires, as Freud says, theorizing on the part of the analyst. The latent content, on the other hand, refers to the unconscious thoughts or signifiers, residues of the day, body memories present in dreams, symptoms or parapraxes, and the latent content is elucidated by the labor of interpretation conducted by the analysand aided by the analyst's technique (Freud, 1933/1973, p. 9-10).

The projective flows of the crosscap space, as it is depicted in Figure 5.4, circulate through both manifest and latent contents, "whereby its front face is everywhere stitched to its back face" (Lacan, 1972b, p. 13). That is to say, discourse circulates among speaking subjects, constantly traversing from the individual to the social in a self-intersection constituted by a folded line of infinity. In this intersection, a linguistic content —of an individual subject— is relayed by others in a multiple and unpredictable linguistic combinatory. This process of signifying space occurs under the vigilance of semblance, that tends to a spherization —a totalization of meaning— as an imaginary recourse to maintain a consistent master signifier.

This entwinement of the back and the front surface is clarified with the Lacanian temporal aphorism that reads as follows: “That one says, as fact, remains forgotten behind what is said in what is heard” (Lacan, 1972a, p. 6). This means that the effects of language within the institution are always hidden both spatially (as we cannot track all the sayings and immediate effects) and temporally (we can only hear after we have spoken) or as Lafont writes, “If a subject is ever present in spoken words, these words are spoken in topology, in a set not entirely present in the moment of enunciation” (2004, p. 6).

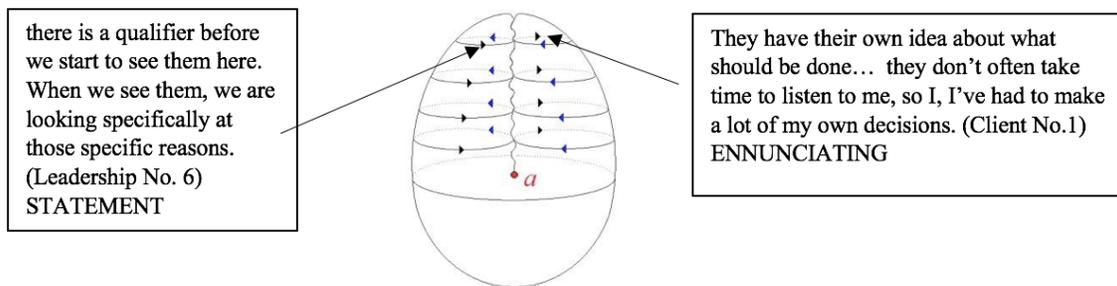


Figure 5.5. Crosscap structure showing the back and forth of language in the institution. Modified from *Eccole Lacanienne du Psychanalyse*, 2020. Retrieved from <https://ecole-lacanienne.net/> on June 20, 2019.

Regarding the crosscap, Lacan commented that “the inside face is merged with the outside face for each one of its points and its properties” (16.05.1962). In Figure 5.5, we contrast two verbal expressions, obtained in two separated individual interviews, one of leadership and another of an analysand, linked by means of their signifying effects. The subject of the statement²⁴ in the front, verbalized by a participant from leadership, finds the resulting effects as the enunciation subject (the analysand) in the back, connected regardless of its distant spatiotemporal dimension. The participant from leadership, after the statement shown in figure 5.5, added that “trauma work actually, I think, is a different therapy, it is not always supported with *what it is we are treating*... long-term therapy would be a luxury in the system” (Ld6). This statement, justified by the rationale of finite nature of institutional resources, meets the very effects of the

²⁴ As stated in Chapter 1, “the symbolic dimension of speech splits between the *statement (énoncé)* – the grammatical “I” that shows the signifier that represents the subject, and the *enunciation (énonciation)* which is the unconscious “I” that produces a subject who emerges as a consequence of the speech act (Lacan, 2006, p. 677 & 730; Lacan 1964/1998, p. 139) (cf. 1.3.1). Also, this version “The statement” refers to “what is said” while the enunciation “is the act of speaking; it is the dimension that announces the one who speaks.” (Negro, 2014, p. 102).

statement that specifies that qualifiers are “*what it is we are treating,*” in a chronic long-term analysis and who feels unheard and alone in their decisions.

Lacan envisions the signifier as the very cut in the surface of discourse, as what is said allows a “synchronic possibility which constitutes the signifying difference” (Lacan, 16.05.1962). The cut of topology made here is voiced by leadership supporting, once again, the master signifier veiled in the word *qualifier* determined by those manuals that claim to be mental health evidence-based practices (MHEBP), which determines both the direction and the effects in the back of surface. This frontal statement determines the institutional fantasy, which will be discussed in Chapter 7 (7.5.2).

5.7. Trauma and the institutional unconscious

In this chapter, I have approached the institutional space through a topology that formalizes the intractable exchanges between the dominant signifiers within a discourse and its subjective effects. To conclude, I will clarify what is meant by “the unconscious” when referring to a bonded collectivity.

The unconscious as a puzzling disruption —parapraxes, symptoms, dreams— holds an ethical rather than an ontic or ontological status: “Its status of being, which is so elusive, so unsubstantial, is given to the unconscious by the procedure of its discoverer” (Lacan, 1964/1998, p. 133). That is to say, there is no unconscious proper until a subject, in his “thirst for truth” interrogates it and the above noted manifestations are irrelevant if not recuperated by a subject. This ethical status of the unconscious is similar to the logic of the letter, which is transformed into signifier exclusively by a subject’s ability to grasp it. Who will be the subject —not the ego— that will ethically become the occupant of the unconscious? What kind of subject would take responsibility for the unconscious in the consulting room and in the social field? These are questions that the institutional unconscious puts forward and relate to how the unconscious can become socially legible, a process that is akin to the event. An event refers to that which leaves place for “the unforeseen and the unforeseeable, or for the eventually subversive and the disruptive” (Parker & Pavon-Cuellar, 2014, p. 6) by means of a “polifaceted revalorization of values,” such as revalorization of the real, truth, critique, act and change; or the revalorization through distinction of repetition, the subject or the very discourse (p. 9).

The ethical status of the unconscious in both scales —the subjective and the discursive— demonstrates its closed topology. When approached from the *subject's perspective*, the Freudian unconscious opens in glitches, slips, errors, in dreams and fantasies. The unconscious is coded in the materiality of the signifier, what is said (subject of the statement) rather than what it means (subject of enunciation). And the unconscious is also coded through the musicality of *lalangue* —the somatic echoes of the said (Lacan, session 18.11.1975) —the repeated rhythms learned in our mother's tongue. The subject's unconscious reaches truth only after semblance is broken and a form of mythical knowledge is produced; it is mythical because the ultimate *truth of the truth* is an impossible knowledge to represent and convey because of the limits of language.

When approached from the *perspective of discourse*, the unconscious in the social emerges not *only* through slips of the tongue, errors or fantasies, but also through the analysis of linguistic relations circulating within the Real structure that inheres in the reproduction of practical life. That is to say, at the surface of an institution, the unconscious is coded through the master signifier and appears through enunciation and statement speech acts, being semblance —the superegoic guardian of the master signifier— that keeps the structure sealed.

Semblance closes the structure, makes of it a sphere with the purpose of suturing the residual object *a*, which in Kaës's analysis (1989) corresponds to a psychodynamic process, present in every institution, to conceal the negative to preserve the narcissistic pact of a hegemonic ideal. The unconscious within an institution is open when semblance is broken and the traumatic element, as placeholder of the void, is identified; in this way, the status of truth in the social is defined by both the revelation of the cause of discourse and allotting a value to such revelation²⁵.

The effects of the unconscious in discourse require a heuristic strategy to deal with the impossibility of the symbolization of the residual, which I will elaborate in the

²⁵ Two cultural and political examples are 1) the young Swedish social and environmental activist Greta Thunberg, who consistently breaks semblance of social discourses when speaking in the public, manifesting the traumatic kernel at the core of social and environmental suffering. 2) Diametrically opposed, but within the same structural movement, Donald Trump also breaks semblance bypassing political correctness in public speaking, and showing openly bigotry and racism, which also reveals the traumatic kernel, yet with a different truth value. I will detail the breaking of semblance, when discussing traversing the fantasy in Chapter 6 (cf. 6.5.2).

final conclusions of this dissertation. Yet, to place some possible points of articulation to decode the repressed and the residual of the institutional unconscious, I want to conclude this chapter with a discussion on the significance of giving prominence to the exclusive treatments deemed as “evidence-based.”

The institutional unconscious at VCH can be traced through the socio-spatial exchanges that raise semblance, or a sanctioned etiquette, to preserve the power of the master signifier; the institutional unconscious is opened only when the semblance has been broken and someone takes the ethical responsibility for the unveiled effects of the dominant discourse. I reviewed how the master signifier is constituted by an empty signifier of great potency, understood in the discussed cases to be the signifier *mental health evidence-based practices* (MHEBP). The attachment to this master signifier MHEBP within the researched community of care functions as a fetishistic mechanism based on fantasy that works against accepting the complexity of traumatic suffering and that simultaneously covers the anxiety caused by a lack of know-how to deal with the roots of such difficulty. By relying only on the easiest interpretation of what constitutes MHEBP, the institution reduces costs in their response to the overwhelming demand for mental health services even when there is an acknowledgement of the challenge “how do we divide up our resources to be able to match the demand and the need in Vancouver?” (Ld6).

The empirical results of my research indicate the following: to varying degrees, 6 out of 7 research participants felt that they had been helped at VCH. They valued the professional help from the clinicians, such as the medical, group and individual services received, the facilitated access to services outside the institution, and some recognized the improvement of hospital care. But the know-it-all discourse sustains a fantasy of sufficiency and competency, as if it were able to respond to all symptoms that analysands bring into the clinic. Fantasy, in the Lacanian sense refers not so much to the well-known wishful thinking, but to that which covers a traumatic kernel. Žižek defines fantasy as “a basic scenario filling out the empty space of a fundamental impossibility, a screen masking a void” (2009b, p. 126).

There are strong values within the institution, such as being aware of safety and being person-centered: “The intention is around providing high quality service that is client centered and directed by clients” (Cl6); yet, such intention is backed up with

predigested solutions that result in the following themes: *Not feeling heard* (5 of 7 client participants) and the *lack of access to a form of healing they find helpful* (5 out of 7), such as alternative forms of healing, one-to-one counselling, group therapy specific to their interest and outside of the psychoeducational approaches, or receiving enough time to process their concerns. As one participant clinician from a mental health team stated:

So I teach many clients grounding, both physical and mental grounding, soothing, and practice these with the client... Clients often ask for counseling or trauma-specific counseling and we are often not able to provide those resources (C11)

Even though psychoeducational teachings, such as emotional regulation, mindfulness, etc. can be very important to a person, those teachings are often devoid of the incorporation of the analysand's own knowledge about themselves in their healing process and there is no access to other epistemic traditions of trauma healing, such as expressive, body or community practices.

The institutional unconscious shows a crosscap topology, whose constitutive entwinement cannot be understood if the Moeibus topology of the subject is not considered as both instituted and institutive (Castoriadis, 1997, p. 8). The self-intersection between the *back*, the subjective, personal, and of individual experience and the *front*, the public social discourse social, are linked linguistically by means of their signifying effects. The intersection of such linguistic exchanges is disavowed by semblance, which operates within a spherical space of sameness that mirrors the master signifier, which represents the sanctioned institutional bonding. As René Kaës stated,

most of the social representations of the institution—mythical, scientific, or militant—make the economy of thought of the subject's relationship to the institution. Their role is *to heal* the narcissistic wound, to avoid the anguish of chaos, to justify and maintain the costs of identification, to sustain the function of ideals and idols. (Kaës et. al., 1989, p.18 original emphasis, my trans.)

These mechanisms show a fetishistic protection, based on fantasy, that constitutes a defense against understanding the complexity of the psychical and intersubjective entwinement of this phenomenon, and also serves to reduce costs within the institution.

Fantasy is to a know-it-all discourse what the fetish is to MHEBP. For Freud, a fetish is a form of disavowal in which an individual experiences an ego split that allows them to deal with ambivalent feelings about the acknowledgement of a traumatic component. For example, a fetishistic subject is aware of the mother's lack of a penis or feminine castration, which announces castration to all; through the fetish, however, the subject disavows the reality of castration and displaces it onto another object (feet, smell, etc.) (Freud, 1927/1973, p.152-57). For Lacan, the fetish concerns the castration complex, which furthers the Freudian version by situating castration beyond anatomically based sexual difference and in the signifier phallus²⁶ that no one indeed possesses or embodies because it is only a signifier of lack. The Lacanian fetish constitutes a denial of castration, that is to say, a denial of the lack of phallus in the Other (Lacan, session 28.03.1962). For example, a fetishistic attachment to language, culture, law or an institution is used to grant consistency to an Other, bypassing any form of negation (privation, frustration, or castration). For Marx, fetish refers to the concept of commodity fetishism, which consists in assigning intrinsic value to goods that are perceived as being produced and exchanged among things, instead of among social relations of people (Marx, 1867/2013, p. 47 For example, the latest iPhone is a commodity, an object reified, whose value is assigned as a result of mere exchanges among things (i.e., seller brand and money paid for the good) instead of its intrinsic value made out of human labor and relations of people behind the means of production. Knowledge pertaining to a commodity's inherent social relations is avoided because it might involve traumatic content, such as becoming aware of the human exploitation or pollution involved behind the production of this commodity. Yet for Marx commodity fetishism is not the result of a decision but rather is a *socially necessary* illusion, that is, built into the reified nature of capitalist relations of production. There is indeed a parallel here with structural linguistics exchanges.

The master signifier MHEBP works as a hegemonic fetish because it is a signifier, devoid of signification, of epistemic domination imposed by consenting coercion (Houssay-Holzschuch, 2020, p. 358) that holds a mystifying value for the purpose of covering an impossible situation. In my research, the signifier MHEBP constitutes a hegemonic fetish because institutional discourse has to hide the castration anxiety,

²⁶ The phallus is a signifier of lack, a logical necessity that the speaking subject believes to have (masculine form) or be (feminine form).

which refers to the limits of service capacity, as demonstrated by the following statements by a participant:

We do not work necessarily that well together team by team and I think that is probably something that we would kind of need ... we need to be listening to the people who are most affected... I think people need space and time. We do not do that well here. (Ld7)

While people within the institution know very well the challenges of service provision, the disavowal of the discursive relations persists despite the very challenging nature of serving people with highly acute and chronic mental health issues, who often have a form of posttraumatic suffering. Alongside the disavowing mechanism of knowing/not-wanting-to-know the reality of trauma's difficulty, there is a displacement into a practical solution (meds and CBT for all) that is necessary but insufficient. Also, MHEBP becomes a fetish when people are more concerned with measuring effectiveness or filling mandated checklists instead of listening more carefully to people's concerns, replicating relations to techniques and tools, rather than relations to people. A critical psychiatrist illustrates this well when he says: "No longer matters who has symptoms, it only matters what the symptoms are" (Reidbord, 2012, n.p.).

With the above discussions on the function of fantasy and fetish in the know-it-all discourse, we are now able to identify the way trauma functions in the institution, which will be discussed in the next chapter.

Chapter 6.

Scalar analysis of various forms of trauma.

Raven shaped us; we are built for transformation. Our stories prepare us for it. Find freedom in the context you inherit—every context is different: discover consequences and change from within, that is the challenge.

Lee Maracle, 2017.

6.1. Introduction

In May 2021, Canada and many parts of the world were shaken by the ominous discovery of 215 unmarked graves near the Kamloops Indian Residential School in British Columbia. In the following months, these findings extended to other provinces within Canada, counting more than 1,100 unmarked grave sites by August 2021 (Cardoso, 2021; Canada: More unmarked graves, 2021). According to the former chair of Canada's Truth and Reconciliation Commission, Murray Sinclair, an estimated 6,000 children died out of the 150,000 Indigenous children that "were removed and separated from their families and communities to attend residential schools" (TRC 2015b).

These findings are relevant to the place in which this research has been conducted, as the city of Vancouver is located on the unceded lands of the Musqueam, Squamish, and Tsleil-Waututh peoples. The findings provide a glimpse of the recent horrific history of Canada regarding the colonization practices imposed on the Indigenous populations that inhabited this land, long before settlers from diverse regions arrived. The unearthing of these human remains constitutes *de facto* a return of the repressed, a symptomatic residue of state-sanctioned violence that allowed a certain discursive structure to leave traumatic sequelae in communities, despite the immense resiliency and spirit of the Indigenous Peoples whose lands are now known as Canada.

In this chapter, I articulate different forms and presentations of trauma, firstly by differentiating the scales of social and individual traumatic presentations. The former scale refers to the discursive arrangements that sustain the socio-spatial practices of a public and collective body politic; the second refers to the private scale of the individual whose flesh is embodied by language and thus carries a body of *jouissance* in the

constant struggle of becoming a subject. As I have demonstrated with the concept of *extimacy* (cf. 4.4.2), the social scale is always present in the subject through discursive formations based on language, and thus a rigorous analysis of the scalar entwinement is required to understand how a subject is affected by a traumatic event, according to the discourse in which this event emerges. In the same fashion, it is crucial to understand how a collectivity is affected and in what way the individual person contributes to its signification. Therefore, in this chapter, I alternate the scalar focus in each discussion.

Secondly, I conceptualize three forms of trauma: the contingent, the developmental, and the state-sanctioned trauma by reflecting on my fieldwork, obtained from interviews conducted at the participating VCH sites. Most of the empirical emphasis in this chapter, however, is on three autoethnographic accounts of my research experience with the community of the Aboriginal Wellness Program (AWP). Through the contingent nature of trauma, I reflect on fantasy and anxiety, while developmental trauma allows me to examine the transmission of intergenerational trauma through the body and memory. I then proceed to discuss and analyse my autoethnographic experience with VCH's Indigenous community, posing questions about the psychical and social geographies of shame, community, and silence.

Finally, I conclude by discussing how individual and social symptoms of trauma might be reproduced through discursive exchanges of victimhood and perpetration. I show the discourse of trauma or victimhood as a positional inversion of the know-it-all discourse that dominates global mental health. The discourse of perpetration is instantiated with Lacan's master discourse, via a discussion of white settler colonialism as the master signifier whose effects have impacted the Indigenous peoples of Canada.

6.2. Two scales: social and individual trauma

The field of trauma studies bifurcates in communities that either study it from medical, psychological, or clinical perspectives, or through the historical, sociocultural, or moral perspective (cf. Chapter 2). Out of these perspectives, only psychoanalysis can account for the subject of the unconscious, and therefore is the only approach that can provide a lynchpin to understand the link between the subject who suffers those traumatic experiences and the socio-spatial aspect where it emerges.

The parallaxic presentation of the private-individual and the public-social trauma, poses different challenges and demands as well as divergent scalar strategies. As Jenny Edkins states, “The subject and the social order in which the subject finds a place are both in a continual process of becoming” (2003, p. 13). If that is the case, to conceptualize the spatial differentiation of scales and to think through a heuristic strategy based on the unconscious, one must track the cause and the traumatic element at the core of discourse.

Trauma’s complexity might prompt some to look for a form of measurement, and there are indeed some screening forms that evaluate stressful life events with the purpose of supporting research and treatment planning. For example, the SLESQ (the stressful life events screening questionnaire) is a 13-item self-report measure that assesses lifetime exposure to traumatic events, for the purpose of assessing trauma magnitude. Even though this tool measures exposure, the questionnaire can’t measure the effects of suffering because there is no such a thing as a “sufferometer,” for trauma affects people differently according to sensibilities, phantasmatic grips, and the socio-spatial and cultural contexts in which it occurs. Thus, the dimension of traumatic suffering, although relevant to the collectivization of restitutive justice, cannot be sized in the individual subject; as a service user phrased it accurately: “I also know that the word [trauma] doesn’t have an associated gradient or level. If it’s just trauma, it could be small, medium, or huge; you have no way of accessing that with just that word” (A16).

My proposed topologies to spatially approach trauma: the *rupture in the structure* and the *protruding void*, are linked to subjective and social repetition, respectively. In the first approach, the transcendental traumas of the subject are constitutive by the evental (Badiou, 2010, p.9) but unfathomable experiences of the Real (sex, death, and alterity). These structuring events of trauma, negative universals indeed, apply to every subject. But for those who suffer from traumatic sequelae, on top of the constitutive traumas, there is a surplus event of a contingent nature that disturbed their bodies and psyche. To place the effects of this spatial accident—a rupture in the structure—it is necessary to account for the individual’s intrapsychic experience, by which I mean the place of fantasy and their position in the social discourse.

From the perspective of the protruding void, social trauma occurs as an event or series of events that stretch the void of the Real for a collectivity. Social trauma is

defined by Giesen as “a response to a sudden breakdown of legitimate social expectations and the rapid decay of social institutions and social structure” (2001, p. 14473) which engenders a “ruminating memory of a past that suddenly confronts a community with the abyss of incomprehensibility” (p. 14474). Thus, while fantasy and position in discourse inhere in the understanding of individual trauma, memory and community are integral to understanding the collective aspects of trauma.

Individual trauma is often deemed as an unfortunate occurrence, single or repeated, of bad luck, whose troubling and painful effects require *private* responses. Trauma at the individual level requires confidentiality and privacy so the meaning and truth of the duress endured can be expressed. That is why individual trauma is primarily listened to in private spaces where a confidential engagement is granted, such as in religious confession, close friendships, family, or in psychotherapeutic spaces. Social trauma, instead, *appears* only when multiple casualties are collectivized and thus it is *public* by necessity, not only for the important aspects of memory preservation, but also for forming an effective political will to demand justice. To collectivize trauma, people create social bonding and build solidarity in communities that share various aesthetics, ideologies, and accessibility such as in social activism or spiritual practices; these conditions however do not constitute a necessity, as war or natural disaster can bring together people who otherwise have nothing in common.

Regardless of the private or public dealings of trauma, the inherent non-knowledge of trauma remains inaccessible, constituting various taboos in society or points of departure for creative acts. Bistoën states that

[s]ocial or cultural trauma is considered to derive from forms of radical social change” and that “these major upheavals share the defining potential to perform a rupture within the pre-existent social order. (2016, p. 116)

The latter is important because, regardless of its impenetrability, trauma is profoundly linked to *potential resignifications and restructuring for both individuals and societies*.

I have mentioned above that there is no “sufferometer,” yet the recognition of social trauma requires that its effects are quantified and measured because it is only by collectivizing—counting one plus one plus one—that social trauma is made visible and becomes apparent. This has been the case in different time periods and historical

contexts: for example, people affected by industrial accidents, rail and work-related injuries, hysteria, or war; those affected by Transatlantic slavery trade or colonial dispossession, as experienced by Indigenous people in Canada; or most recently the collective denunciation of gender violence in the #MeToo movement. When social trauma reaches collective acknowledgement, it shows how a devastating event impacts a community and serves the purpose of delineating responsibilities as much as creating the conditions for witnessing, the recording of collective memories, proof of legit claims, restitutive justice, or ceremony (Benjamin, 1968; Adorno, 1973/1998; Fassin & Rechtman, 2009).

Davoine and Gaudilliere (2004), two psychoanalysts who draw on anthropological approaches, regard social trauma as that which produces madness and is constituted by a linguistic disarrangement that leads to delusions, accidents, etc. Madness is a desperate attempt to find a way of connecting social history to personal story and tries to inscribe “the pieces of suppressed —not repressed—history, at the crossroads of the most particular and the most general” (Gaudilliere, 2009, p. 6). Thus, as Bistoien summarizes, the study of social trauma:

investigates the ways the damaged ‘tissues of social life’ can be restored, rather than taking the individual psyche as the locus of intervention. It accomplishes this by acknowledging the survivors as political agents and thinking interventions on the level of the Other (the field of the symbolic), for example in the focus on forms of remembrance and commemoration (2016, p. 116).

After I have established a broad differentiation of social and individual trauma, I will proceed to further discuss trauma based on my research results.

6.3. The contingent trauma: anxiety and fantasy

One of the studied sites in this research, Mental Health Substance Use Outpatient Services (MHSU OS), serves populations which have experienced the loss of a loved one to suicide, an event deemed as traumatic. During the 14 years I worked at that site, I heard countless reflections of a “what if” nature, for trauma is often signified as preventable or as a misfortune that could have been avoided if only certain conditions had existed. In the interviews conducted for my research, two analysands define trauma as: “any sort of adverse event that impacts you [and] affects your daily functioning” (A16)

or “when something has impacted something else, like a car accident” (A15). In this section, I discuss the contingency of trauma, revisiting one of the topologies proposed in Chapter 2, to show the spatial entwinement of both scales.

The topology of the *structural rupture*, as illustrated in Figure 6.1., demonstrates a Euler or Venn diagram wherein the subject is depicted as a logical set composed of two elements: the speaking subject (\$) and the Other (A), standing for language and culture (cf. 4.4.2). Trauma impacts both, the subject and their social context, for this perforation creates a shared *nospace* (Lacan, 1972b, p.3), caused by a hollowing event coming from the Real corresponding to the Lacanian *letter*, that cuts, tears up, or overstretches linguistic space to the point of rupture. I explained before what I mean by the letter: an insistence of the Real, partially available to symbolic means only if inscribed by a subject via a signifier.

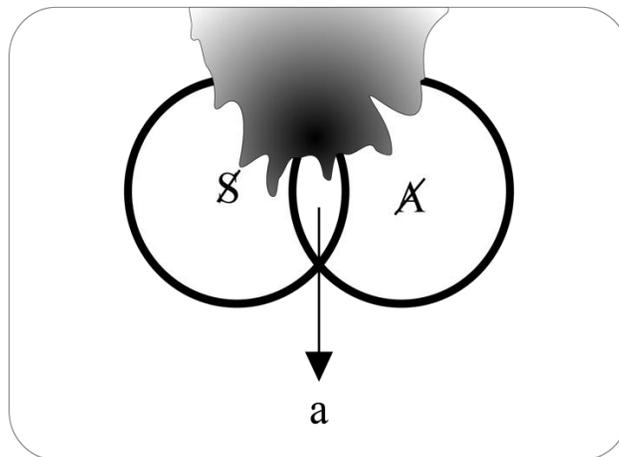


Figure 6.1. The topology of the structural rupture depicts the impact of trauma in the subject, indicated by the shaded surface, where both subject and the Other are in lack.

The traumatic impact of a letter opens the space of intersection ($\$ \cap A$) that was occupied before by the spectral presence of object *a* and the effects of this rupture show the Other’s lack. In other words, in trauma the Other lacks and is castrated, therefore cannot give consistency to the symbolic order, neither provides protection against the Real. This rupture, outside of knowledge, urges the subject to find a way to repair or close the gap, so the compulsive repetition of posttraumatic symptoms, such as flashbacks, nightmares, etc. can subside. Paraphrasing Freud, the impact of trauma is

such that *the subject knows that something has profoundly disturbed them but does not know what is disturbed in them.*²⁷

The topology of the hollowed structure demonstrates how each level is inherent in the other scale: the subjective structure is situated within the sociopolitical scale, because the Other of language and culture is simultaneously affected by a subject impacted by trauma, as has been illustrated by Eyerman who, regarding African American slavery, renders social trauma as an affectation of the “social tissue,” which involves not only those directly injured but the larger society by the fact that trauma is represented and mediated (Eyerman in Bistoën, 2016, p.163).

The impossibility opened by trauma then affects both the individual and the collective, because despite the great deal of symbolic texture produced after a traumatic event, larger aspects remain inapprehensible. This relates to what Primo Levi, a Holocaust survivor, once stated relating to the genocide of European Jews: “I must repeat, that we, the survivors are not the true witnesses” (1989, p. 82).

A rupture in the structure, in its disturbing and incalculable effects, brings forth a form of repetition that reorganizes the symbolic space and consolidates further (over)significations. Why would we say that trauma is a form of repetition, even when the event is a contingent accident? This assertion is supported by Freud’s theory that explains that at least two events are linked by means of retroactive signification and affect: the repetition resides in the fact that a first event —what I have been rendering as the constitutive, structural, or transcendental trauma— is conjured up and again repeated in every rupture therein. The ‘small’ accident or the collective disaster will always be signified according to the individual and/or community struggles of the past. The contingent trauma is also deemed as repetition due to the temporality known as *tuche* that Lacan developed in Seminar 11 as his version of the Aristotelian categories of repetition: *tuche* (chance) and *automaton* (automatic repetition). *Tuche* refers to the odd event that occurs by chance, such as what Freud called the “neurosis of fate” (Freud, 1920/1973, p. 23). In this neurosis, people end up in apparently haphazard repetitions of uncanny events —accidents, the same types of relations, losing the exact same item, etc.— but which through analysis can be linked to a certain transgenerational destiny,

²⁷ Freud said about melancholia that a person “knows whom he has lost but not what he has lost in him.” (Freud, 1917/1973, p. 245)

unconsciously bound to be repeated. I claim that *tuche*'s repetition is an insistence of the Lacanian letter, which, as the "material support" of social discourse (Lacan, 2006, p. 413) and which, in the experience of trauma, appears as *destiny*; yet such an unlucky occurrence, as with any other letter, is "waiting to be rescued by a subject who will take agency of it" (Fernandez-Alvarez, 2020).

6.3.1. Anxiety: threat, hopelessness and helplessness

The forceful repetition of a letter, by the haphazard contingency of its appearance, constitutes a hole that intrudes from the Real into the Symbolic. The evincing inconsistency of the Other constitutes a structural element of traumatic suffering because a barred Other collapses the assumptive world and causes the subject to experience the Freudian *Hilflosigkeit*. This term refers to a sense of hopelessness and helplessness which can be experienced at the individual or at the social level, resulting in ontological anxieties. Freud develops *Hilflosigkeit* in relation to the fact that the human animal, compared to other animals, is biologically premature at birth (Freud, 1926/1973, p. 168) and this for Lacan constitutes the foundation of the traumatic experience (Lacan, session 12.11.58).²⁸ As the infant cannot meet her own survival needs at birth, and in light of the occasional or persistent frustration of her needs by an Other who is in charge of the infant's care, anxiety will appear as a reaction to the infant's sense of impotence (her lack) and helplessness (the Other's lack and non-absolute reliability). Analogously, this early experience of profound destitution is repeated in traumatic events, such as those caused by war, where Freud mentions that a person might feel abandoned by "the powers of destiny" which will no longer have "any safeguard against all the dangers that surround it" (Freud, 1926/1973, p. 130). At the social scale, material conditions, such as economic, socio-political, or environmental aspects that hurdle possibilities for social bonding, produce collective experiences of ontological helplessness, or what Samir Gandesha (2003) coins as "ontological insecurity," or an "accumulation and intensification of the anxiety" (p. 5) caused by an inversion of the sociological concept of ontological security, which is the idea that the institutions that we help reproduce through our praxis remains to some extent stable and predictable.

²⁸ Johnston (2013) links *Hilflosigkeit* to Lacan's notion of the fragmented body or *corps morcelé*, "the bodily Real independent of and/or prior to Imaginary-Symbolic mediation" (p. 52), ultimately linked to the "ground zero" of the organism, which I render here as the human flesh.

Because anxiety relates so profoundly to trauma, I will focus on psychical space by reviewing how Freud and Lacan understand this crucial affect. In *Inhibitions, Symptoms and Anxiety* (1926), Freud advances questions of immense difficulty about the role of anxiety in relation to trauma, repression, compulsive repetition, formation symptoms, inhibitions, and psychical pain. Freud explains that anxiety is caused by the effects of psychical overstimulation emerging from the external world —the environment, the Other; and from the internal world —tensions emerging from the drive in the body, or from the superego. For example, the traumatized person can experience psychical flooding, flashbacks, nightmares, etc., by the internal excess of psychic stimulation or by being triggered through an external threat, yet Freud adds that “the protective shield exists only in regard to external stimuli, not in regard to internal instinctual demands” (Freud, 1926/1973, p. 94). Differentiating between the demands imposed by internal stimulation from those of an external source is of clinical importance for what Freud calls “a defusion of instinct” (Freud, 1926/1973, p. 94) to detach and work through the various components, external and internal, that sustain the insistence of the drive. Yet this differentiation is a matter of mere subjective perception because anxiety is *extimate* and thus located between the Other and the subject, as articulated above through the topology of the Moebius band, which explains why anxiety is one of the most contagious affects (an anxious caregiver makes a baby anxious; an anxious teacher makes a group anxious, and so on).²⁹

Freud’s rendition of anxiety, as a discharge of accumulated libido, as a signal of danger, and as a traumatic affect is relevant to the phenomenon of trauma. Through the presentation of phobia, hysteria, and obsessional neurosis, Freud examines the various forms of anxiety according to the symptom at stake: in hysteria, trauma is dealt with amnesia through the mechanism of repression that results in an innervation of part of the body (conversion); for example, in any of the physical illnesses that accompany traumatic suffering. In obsessional neurosis, the traumatic experience may not be forgotten but rather managed through mechanisms of reactive formations; for example, one action is cancelled out by a second, as happens in obsessive thoughts or ritualistic actions; or the connection of body and mind is compartmentalized and isolated (Freud,

²⁹ Freud also reads anxiety as *extimate*, when differentiating realistic anxiety, emerging from the external object, from neurotic anxiety, emerging from the instinctual demand. He says that: “the external (real) danger must also have managed to become internalized if it is to be significant for the ego.” (Freud, AE, p. 157).

1926/1973, p. 119). In phobia, the source of trauma appears less hidden and thus shows an acknowledgement of that what is feared (Freud, 1926/1973, p. 122). This fear is organized around the phobic object by means of a sliding in the signifying chain, as in the case of the little Hans, in which his constitutive trauma resulting from an original encounter with sexual difference triggers fears of castration in the form of a potential bite of the horse that would cause him to lose his penis. Each of these logical formations is indeed a *symptomatic* organization and requires a different clinical strategy to defuse the compulsive repetition caused by the insistence of the drive within trauma.

Freud states that in veterans of WWI the fear of death was “analogous to the fear of castration” (Freud, 1926/1973, p. 130), which caused those survivors to experience a constant anticipation or expectation of danger that would result in helplessness. Thus, the traumatized subject, whose experience links structural to contingent trauma might remain anxious as per the subject’s potential loss of life, safety, care, love, or self-respect. Part of the problem of anxiety, as Freud explains it, is that there is a sequence of anxiety-danger-helplessness, which tends to be circular because “being a reaction to helplessness, [anxiety] is reproduced later in the danger-situation as a signal for help” (Freud, 1926/1973, p. 167). That is why in traumatic reactions anxiety acts as a strategy to cover trauma, yet increases the anxiety or reexperiencing of surplus trauma, as one research participant, who I call Joe, explains:

I know trauma inside and out. I know how to operate in trauma. I know how to get by in trauma. Trauma gets me out of bed in the morning, where life doesn’t a lot of time. But if I’m in trauma mode, if there’s something to worry about or a fear or be angry [sic] about or etc., trauma can actual [sic] help me. (A17)

Thus, anxiety can be a reaction to *Hilflosigkeit* as much as a call for help and it can perpetuate its cycle by way of its connection to life and competence, as in Joe’s case.

6.3.2. Anxiety as the lack of a lack in proximity to desire.

Lacan elaborates anxiety differently to Freud’s own approach. In Seminar 10, Lacan states that anxiety is indeed a sign of danger but only because the subject is lacking a lack, which turns a potential desire into a threat. The subject is not anxious because there is a lack of the object of desire, on the contrary, Lacan uses the example

of the mother, who rather than absent she is *too close*, overly present: “[a]nxiety isn’t about the loss of object, but its [overwhelming] presence” (Lacan, 1962/2014, p. 54). Without lacking a lack, the subject cannot find enough space to carve their own desire, and instead the overpowering desire of the Other confuses the subject about whose desire the anxiety is signaling, is it the subject’s or the Other’s? This proximity to desire is the reason why Lacan considers anxiety as the *only* affect “which does not deceive,” (Lacan, 1964/1998, p. 41). Desire in Lacanian psychoanalysis is not the same as a “want” or a “wish” but refers to the very emergence of the subject by means of sustaining its own split. Because anxiety only confronts us with either the imminence of the Other’s desire or with nothingness, no guidance, radical aloneness, a subject needs to emerge to make oneself present with others despite the Other. The process of desire then always produces anxiety.

While Freud asserts that anxiety has no clear object, Lacan states that anxiety is never without an object, because the subject has unconsciously *incarnated* the very object *a*, as a substitution of the absence of phallus (as minus phi) (Lacan, 1962/2014, p. 107), hence locating herself in the field of the big Other to preserve its integrity, for anxiety is constituted by the fear of castration. Therefore, anxiety and desire are entwined and to exist as a subject one must dare to leave the Other in lack and face the mutual castration; to overcome traumatic suffering the subject needs to emerge as an effect of their ability to respond (*response ability*) to the unconscious desire that inhabits them. And the subject often does not respond because of the radical need of the human subject for recognition and love, which has led them to identify as the object of desire that could satisfy the Other’s demands; these demands being mostly idealized or debasing versions of the self. Desire might be of grave danger and cause great anxiety because the subject requires the untangling of the knot that fixates their libidinal force to a certain object cause of desire. By virtue of this identification with the object of desire, the subject disappears and the only way to regain subjectivity is by finding a plausible response to the desire of the Other.

But anxiety not only signals the dangers of desire, it also structures action to facilitate the possibility of becoming a subject, moving away from the object position. Anxiety demands from the subject to act within a spectrum of increasing difficulty and increasing demand for active movement, which can result in acting out (impulsive action addressing the Other), *passage à l’acte* (the subject lets themselves fall into erasure), or

an act of desire. Desiring risks a lot because the subject can fail and they can persist in occupying an object position for the big Other, either by being trapped in the Other's mighty gaze (scopic drive), which causes shame; by the Other's voice turned superego (voice as drive); or perhaps risks dependency (oral drive) or rigid control by the educational demand of the Other (anal drive). When desiring, the subject even risks being entrapped by the Other as a sexual object for their enjoyment (sexual drive). Thus, anxiety "will not be absent from the constitution of desire" (Lacan, 1998, p. 175) and in trauma is the first opportunity to find a way out of repetition. The logic of anxiety is crucial to understand trauma as it focuses on the subject's body (home of the drives), as Lacan expresses in his later work:

What are we afraid of? Of our body... In our body, precisely, anxiety is situated somewhere other than fear. ...It is the feeling that arises from the presentiment that we are being reduced to our body. (Lacan, 1974/2019, p. 104)

Could anxiety in its *extimacy* be conceptualized equally in the individual and the collective? In many ways it could, as the ontological insecurities of the present, caused by various conditions of a socioeconomic, environmental, or spatial nature, confront societies with the pending task of how to actualize a collective desire. For example, when approaching geopolitical crises of health, environmental nature or security, "landscapes of fear" (Tuan in Proudfoot, p. 194) emerge and the body politic experiences profound ontological anxieties that at core constitute a demand to act. At the appearance of the Other's castration, understood here as the state's inability to sufficiently address crisis, a collectivity feels abandoned, as, for example, in the testimonies from the Rwandans, Syrians or Afghans who faced global indifference when internal military conflict exploded, leaving civil societies in grave hardship. Being an organizer of action, anxiety at the collective level aims to find a new decidability of events to change the immediate conditions that cause the anxiety in the first place. Yet, social bonding protects the lack in the Other via semblance, forcing those participating in exchanges to collude with the master signifier that ensures compulsive repetition. In the above-mentioned tragedies, perhaps the lukewarm responses from powerful nations protected the master signifier of the capitalist discourse, as they did not engage in actions due to the lack of profitability or political expediency. To summarize, the problem of anxiety at the collective scale relies on two aspects: the conditions for action are grasped within linguistic structures that deftly hide its cause; and collective desire, which

is what might allow to deem humans as subjects rather than as a number, has to work against the pervasive force of the drive that enjoins societies to keep enjoying, that is to say, to remain in the position of objects for the Other's mere enjoyment, the problem of surplus jouissance, which will be one of the axes of my contextualization of healing in the next chapter.

Anxiety perpetuates the conditions of suffering because it serves as an avoidance of desirous action, and thus the subject and their collectivity might dwell in the impotence of inaction rather than throwing themselves in an assertive act to affirm their desire. This is not a matter of courage or will, but rather of the conditions that afford the possibilities of emerging as a subject within a social link. That is why, to actualize desire, one requires a dialectical understanding of the conditions that have been the source of the subject's oppression, for desire is conquered by means of resolving the inquiry that anxiety constitutes.

6.3.3. Fantasy: a response to the anxiety caused by the lack in the Other

As we have seen, anxiety prompts the subject to activate a certain reaction, and Freud proposes the symptom as one of the most effective responses to anxiety, as it allows for the "bind[ing of] the psychical energy which would otherwise be discharged as anxiety" (Freud, 1926/1973, p. 144). I will now focus on the importance of fantasy in trauma, which at the level of the individual refers to staging the conditions of desire and jouissance, and at the social scale as constituting the ideological grip.

Fantasy at the individual level commonly appears as either 1) phantasmatic prelapsarian smoothness that may tint memory, and/or 2) the core of the subject's identity being deemed as unchangeable yet staging desire and jouissance. In the first instance, past experiences before a traumatic event are rendered as almost ideal in contrast to the circumstances experienced afterwards. This aspect inheres the topology depicted in Figure 6.1., as the subject of the signifier enters a wide open *nospace* because of the eventual impact, and such an expansion of the Real requires closure. Relying on a prelapsarian smoothness of the symbolic order allows the subject to search for some consistency, but ultimately is a fantasy, as the Other is indeed castrated for its inability to provide ontological consistency. In the second instance, fantasy can be

approached by the Lacanian formula $\$ \diamond a$, which refers to a subjective logic that connects and disconnects the subject with the object *a* cause of desire. Loosely retaking the categories of Aristotle (de facto existence and logical existence), Lacan introduces fantasy as a “prêt-à-porter” written logic, and thus situates the issue not so much as a psychological myth but rather as an unconscious logic “handle[d] by signifiers” (Lacan, session 16.11.1966). Fantasy, then, is a logic that asserts a radical belief of what the subject’s being is and that their existence “cannot be otherwise;” fantasy is *a priori* valid, impossible to doubt by virtue of its apparent self-evident nature. Thus, a subject’s fantasy presents their being as fixed, either as untouched before the impact of trauma or as perpetually damaged. This is the case because the subject might conjure up consistency by imagining a reliable, trustworthy, ideal Other; or the subject could imagine the consistency of the Other by overgeneralizing its evil and predation.

Either way, fantasy as a logical design of early experiences, reinforced by the traumatic event, will always be supported by a proposition articulated in language, which creates the conditions for the subject to protect themselves from the awful sense of helplessness and anxiety. But fantasy will always fail at some point because in its radical singularity it aims at sustaining the One of the sexual non-relation, which is the One of totality I discussed before as spherical thinking. In fantasy, the subject identifies as the object causing desire, and it does so according to the singular signification that the subject’s tradition and history inherited them.

From an optimistic phantasmatic standpoint, the subject perhaps fantasizes to be socially “the best,” the most beloved and popular, yet many affected by traumatic sequela might identify themselves as an abject object, as the object for the Other’s abuse, repeating the same fantasy in every other social interaction.

At the *social* level, the Lacanian fantasy has been conceptualized as ideology by Žižek, which he portrayed as the attempt to cover a traumatic leftover produced by an antagonism between the Symbolic, which searches for naming and signification, and the Real, which resists signification. Fantasy, for Žižek, mainly masks a void (2009b, p. 26) which coincides with the lack in the Other, as ultimately related to the Law because:

it is precisely this non-integrated surplus of senseless traumatism which confers on the Law its unconditional authority: in other words, which — in so far as it escapes ideological sense — sustains what we might call the

ideological *jouis-sense*, enjoyment-in-sense (enjoy-meant), proper to ideology. (Žižek, 2009b, p. 43)

Fantasy in the social, then, becomes ideology, the prefigured stage that provides a community with a coherent sense of identity and purpose. Sheldon George (2016) approaches fantasy in the context of race, rendering fantasy as the source of surplus *jouissance* that is linked to the fantasy of being, understood as a fantasy because “being” in Lacan refers to *manque à être*, a lack of being because there is no essence or substance, no *hypokeimenon* that underlies the speaking being.

Drawing on the Lacanian polarity between being and existence, whereas the first is organized symbolically through lack, and the latter an entity of reality, George analyses how the slave’s identity, conceived as an injured body by the brutality of the master’s whip, creates “an illusory fantasy of a lost totality, which reinforces the attachment to trauma” (p. 20). He explains:

What is stricken from the slave here, and is read as a blow to his or her sense of identity, is more precisely the slave’s fantasy of being. Being can be understood as an illusory, lost state of wholeness and ‘totality’ that never existed to the subject but that the subject ever pursues. (p. 21)

Yet fantasy is necessary for subjects and communities, because the Real is always traumatic in its complex relation to the symbolic order, because in such relation the void is opened and requires a way to patch it. But when bringing the ideology of trauma into discussions, we bring in politics as well. Bistoën reflects on fantasy to account for the *jouissance* involved in the function of fantasy because it creates “a shared sense of identity, community and common consciousness” (2016, p. 114) and it structures, in *extimacy*, the narratives built by community which are reinforced by other associated fantasies. The function of the fantasy is important for working towards healing. In Chapter 7 I discuss the clinical challenge of rehabilitating the fundamental fantasy while its totalizing view is challenged. Now, I turn to developmental trauma and its intergenerational transmission.

6.4. Developmental trauma as the effects of the drive

The term developmental trauma refers to *repetitive and prolonged* stressors occurring at a developmentally vulnerable time in a person’s life that caused direct harm, neglect, and/or abandonment by caregivers (Courtois & Ford, 2009, p. 1). This form of

trauma is what the ICD-11 calls complex posttraumatic stress disorder. Developmental trauma starts with a child who experiences an abusive other exerting repeated oppressive power, rupturing perhaps the idea of what a family, a parent or caregiver should be, and shaping the linguistic anchoring that signifies the subject's own value as human. This form of trauma is often perceived by the individual as a matter of personal misfortune, a private tragedy or intimate drama, often disconnected from the fact that such duress also emerges within a specific contextual space that links history to story, in the "intersection of the singular and the plural," as Davoine and Gaudilliere indicate (2004, p. 11).

Lene Auestad, drawing on Sandor Ferenczi and Michael Balint's writings on trauma, explains three phases that pertain to developmental trauma:

In the first phase, the child is dependent on the adult and is in a primarily trustful relationship. In the second phase, the adult, either once and suddenly, or repeatedly, does something highly ex[c]iting, frightening, or painful. The trauma is only completed in the third phase, when the adult acts towards the child as if nothing distressing or painful had happened, thus depriving the event that took place of its reality. Since what happened has not been acknowledged, not recognised, it continues to exert an influence in the present. (2017, p. xix—xx)

In my research, few participants spoke about developmental trauma and the difficulties faced, especially when associated with isolation and the compulsive repetition of further trauma. Charles (pseudonym), a participant of a mental health team explained it in this way:

Trauma is after an experience you may go psychotic or become very isolative because of a lot of those experiences in my past... there's been sexual abuse in school, there's been child abuse at home when I was a kid, there was sexual abuse from strangers. (A13)

He explained that the antidepressants caused him to experience intense suicidality, and thus the treatment of choice was electroconvulsive therapy (ECT), with significant side effects of memory loss. I asked, what could have worked better than the ECT? And he responded: "Well, I don't know... I guess if I wasn't so isolated perhaps, I would feel better about myself... But I'm isolated because I don't trust" (A13). Another analysand, Aurora, expressed that "I have this trauma involving authority figures, so I will do whatever it takes to please the doctor to make sure that they are happy with me and that, of course, can get in the way of healing" (A15). Also, Joe, who said:

I think some things happened that I don't remember, but I remember parts of someone holding me down when they were naked, an adult when I was a young boy, and I remember that. That's a trauma to me, always has been a trauma. Why that person, who was supposed to be trusted, did that. I'll never quite remember the circumstances completely, but I do know that a lot of the situations that I'm attracted to or that I come around to are similar circumstances. (A17)

Developmental trauma affects people in their ability to "regulate" reactions arising from the drive on the body, in the insistent recriminations emerging from the superego, in the difficulty in trusting others, or through the overwhelming affect of the Freudian *Hilflosigkeit*, which causes a sense of doom or hopelessness.

These statements from the research participants speak to the great complexity of trauma and the difficulty in understanding its scope, if focusing only on the individual-private or only on the collective-public. Furthermore, these aspects speak to the great responsibility a mental health institution bears to implement more nuanced and sophisticated theoretical understandings, to develop parameters that can attend to those embodied spectralities that carry so much weight in a person's life. In each instance, what Charles indicated as isolation, Aurora as the submission to perceived authorities in health contexts, or Joe's very crucial aspects of trust, the injury involved a community, and thus instead of focusing on the individual alone to deal with it, the social dimensions need to be integrated to respond appropriately to the complexity of suffering arising from trauma. This intricate relation of subject and Other, individual and collective, is what is at stake when we aim to acknowledge the tragedy of developmental trauma. But as the lived experiences of the traumatized body are inaccessible to signification, an ongoing lament, loud or quiet, struggles to find symbolic means to express differently. The subject needs to find the potency of the signifier, by various means beyond speech, or else the lived experience that resides in the body will insist on compulsive repetition, a function whose origin is found in the Freudian drive.

Any psychic manifestation, from "normal" functioning to trauma sequelae, is animated by the force of the drive as it feeds the energy for all psychic manifestations. Freud located the drive as "the frontier between the mental and the somatic, as the psychical representative of the stimuli originating from within the organism and reaching the mind" (Freud, 1915b, p. 121-122). For Lacan the drive is a myth, a fiction or a montage, but mostly, a fundamental concept to understanding the subject of the unconscious in its relationship to compulsive repetition and *jouissance*. The drive has

various characteristics such as thrust (*Drang*), a constant force that builds tension to unpleasurable levels and is the motor factor that pushes for a discharge of internal excitations. The drive also has a source (*Quelle*), which, emerging from the rim-like erotogenic orifices such as the mouth, the anus, the vagina, the eye, the ear, etc., engenders libidinal energy that participates in the exchanges between the internal and external worlds. This is crucial to understanding the somatic elements in traumatic experiences because the drive always involves a source, a body part that participated, actually or by signifying displacement, in the traumatic event. The force of the drive within the body searches for an object (*Objekt*), which Freud considered of little importance, because as Lacan explains, the core of the object of the drive is object *petit a*, cause of desire, around which the drive circuits to gain a partial satisfaction that alleviates the pressing displeasure (Lacan, 1964-1998, p. 168). Furthermore, the search for an object in traumatic suffering sustains the compulsion to repeat as the drive's aim (*Ziel*) seeks satisfaction "by removing the state of stimulation at the source" (Freud, 1915b/1973, 118). Lacan, contra Freud, expands this view by indicating that the satisfaction of the drive, if any, resides in the very detour around the object caused of desire, as that is precisely its very aim (Lacan, 1964/1998, p. 166), as is depicted in Figure 6.2.

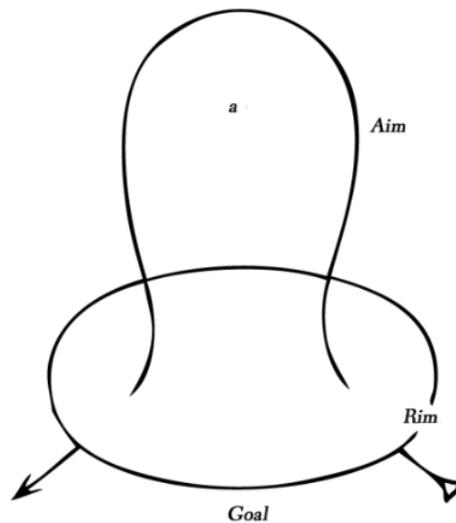


Figure 6.2. Topology of the drive (Lacan, 1964, p.178)

While the drive is a useful concept in both scales, the drive cannot be thought of in the same way. Both scales experience the drive as a constant force emanating from the human body and circuiting around an absent object. But the source, for example,

cannot be thought of equally in the social because is not constituted by a specific erotogenic part but encompasses the body politic at large. Lyotard renders perhaps the most poetic version of the drive whose force entwines the scales of the individual and the social:

You cast away a flower wilting on your table. But what if a rotten odor emanates from your very lungs and lingers over the world around you? Or from your liver a melancholia? You will be asthmatic; or you will have hepatitis. But, also, you may produce a musical work, which may be of heavenly inspiration, or poems out—of—breath or diaphanous watercolors, or xenophobia, or irenism. The pulsion [drive] cannot be eliminated as a stimulation originating outside because it does not have its own efferent channels ready to be used. The physiology of the organic body is not sufficient to regulate the discharge of the pulsion. (1997, p. 82)

Lyotard's poetic rendition of the drive supports the idea of the drive at the level of the social, as a force that nourishes both creativity and destruction alike, as, for Freud, there are two classes of drives: the erotic drive charged by *libido* and the death drive charged by the very same force turned to *destrudo* (Lacan, 1959/1992, p. 194). The erotic drive is aligned with libido, the sexual force of life, while the death drive tends to the Nirvana principle, seeking the return to a full stasis to restart again. Lacan, however, rejects this polarity by emphasizing the *continuity* between the two, as there is an "essential affinity of every drive with the zone of death...[that] makes present sexuality in the unconscious and represents, in its essence, death" (Lacan, 1964/1998, p. 199). In this periphrasis, the drive encounters some possible vicissitudes: repression, the core of the symptom; displacement of the drive into contrary actions, such as passivity and activity, masochism and sadism; or the adored path of sublimation, where the object is elevated to the dignity of *the Thing* and the drive charges fully into creativity. Is the drive this unbeatable force of life and death, whose knowledge escapes the Symbolic? Is the drive a core element in the transmission of trauma from one generation to another? This is discussed next.

6.5. Transgenerational trauma and its transmission

Every trauma involves intergenerational transmission, passed from one generation to another in various lines, similar to the concept of multiscalar mobility (Burnham, 2021, p.188). Instead of moving from one to other tangible spaces, trauma moves transgenerationally by the pulsating effects of the drive that follow libidinal lines of

transmission and which, in trauma, manifest destructive aspects of “the evil” of jouissance (George, 2016, p. 27). Each human being carries the seed of violence within their own drive, in the singular interstices of their bodies and their souls, by the violence inflicted on their lineage at the time and space in which their kin experienced life. The individual’s upbringing, like Russian dolls, is carried within their caregiver’s upbringing, and this legacy leaves a trace in the Real of the body.

Jouissance denotes both punishment and enjoyment, a morbid or mortifying pleasure obtained through the sexual body of a subject who speaks. Both aspects are well exemplified by clinicians in this research: regarding the individual scale, the singularity of the body of jouissance could be read in the following statement that defines trauma as “that sense of horror... and then the sequelae of it... I see it as a continuum and somewhere in the middle parsing out how much is the individual’s sensitivity” (CI2). Another example: “...generally it’s the personal experience of being in a near-death situation, or witnessing that, or an experience where you didn’t have control and it could have been some very serious damage to you or your loved ones” (CI3). The second aspect, referring to the collectivity and the body politic affected beyond the share of the protruding void, is well instantiated by a participant of the AWP, who suggests that the Indigenous perspective of trauma “is connected to colonization and attempted ongoing genocide,” and its complexity “involves historical, collective and transgenerational” elements because “the problem does not occur with the Indigenous individual but in the systems and structures of settler society and in processes of ongoing colonization” (CI7).

Jouissance occurs in the private and public spheres of human interactions, and within discourse; at the individual level, jouissance is located in the intensities, affects and experiences in body and mind. On the social scale, jouissance as a concept “helps consolidate and divide social groups through rapture, antagonism and sacrifice” (Kingsbury, 2010, p. 717) and it is a position that can be traced in discourse through the place occupied by the recipient or Other of discourse. One illustration of the embodiment of jouissance at the collective scale is provided by George in his analysis of the African American slavery. Approaching from Hegel’s master-slave dialectic and aided by Lacan, George states that as a consequence of the master’s denial of Black slave’s emotional and intellectual capacities, his identity was reduced to mere jouissance and consequently could not access the compensation given by fantasy, consequently “let[ing] loose a terrifying psychic jouissance of the Real, one that significantly impacted

both slave and master” (2016, p. 27). Such mutual jouissance, George argues, blurred the psychic distinctions between self and other. Crossing the boundaries and limits of self and other by the experience of jouissance is crucial in trauma and its manifestations in the clinic are both delicate and very difficult to grapple with. The transgressive violence of jouissance erases boundaries between individuals, and perplexities emerge in both scales when a subject or a community ponder: Is it my violence or the Other’s? Is it their enjoyment or mine?

Such a question pertains to generational transmission of trauma through the unsayable that equally overwhelms the body and the mind. Marking each generation, that which cannot be said finds its way to being transmitted through silences and implicit memories in the body. In what follows, I propose a psychoanalytic reading of the intergenerational transmission of trauma, which involves:

- 1) the unsayable Real: assuaged by the drive, human flesh encounters the positive spectrality known as object *a* (residual in discourse), and transmission is guided by *lalangue* as the rhythms of language in the body.
- 2) the Imaginary, how the body remembers and envelops the body with an image, which Didier Anzieu (1995) expresses best with a metaphor he calls the Skin-ego which relates to a phantasmatic reality as an imaginary space in which phantasies, dreams, thought, and all psychopathological formations are set up (p. 4).
- 3) the Symbolic, via language, in the appearance and disappearance of signifiers and in forgotten memories, which enveloped the image of the body with signifiers to represent it.

6.5.1. Real transmission: excess of the protruding void

The intergenerational transmission of trauma is not consciously known to the subject, yet its discursive mechanisms design positions for individuals to embody spaces. The crosscap model instantiates the topology of the protruding void, which, as depicted in Figure 6.3., shows that the immobile Real (*das Ding*) has already been bent by the systematic shock of the Symbolic, reconstituting the Real that impacts speaking subjects and their communities.

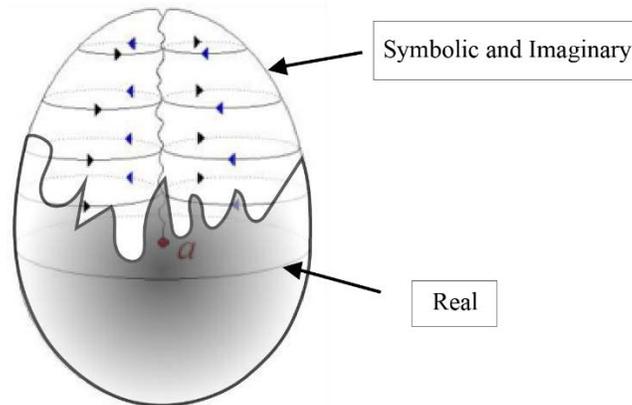


Figure 6.3. The topology of the protruding void, demonstrated by the crosscap, shows that collective and intergenerational spaces of trauma overstretch the Real —indicated by the shaded surface— beyond the place preassigned to it by discourse.

The topology of intergenerational trauma could be thought of as what has extended beyond the built-in places that a discourse has provided for residues of the Real. The protruding void, as a psychosocial space of trauma, corresponds to the Real conditions that affect those who share material, socio-spatial, and political conditions; yet, what constitutes the dimension of trauma depends on the share of the residues of object *a*. Transgenerational trauma presents the excess of void for which the protrusion cannot contain the Real, consequently assimilating a larger space of the social “accursed share” (Bataille, 1967/1988, p. 59). In other words, transgenerational transmission of trauma carries a surplus of the death drive, which is the experience of violence (such as that expressed by Charlie or Joe above) or any other form of social or emotional inequity (as in the case of authority anxiety for Aurora). Communities that carry collective trauma accumulate more “void spaciousness” (Kingsbury & Secor, 2021, p. 3); that is to say, hold larger shares of losses and excesses within their sociopolitical context, as described below regarding Indigenous peoples in Canada.

The transmission of trauma might affect every aspect of a person, even their molecular materiality, as the field of epigenetics has demonstrated that exposure is not necessary for a traumatic event to leave genetic marks in a lineage; for example, a few studies on victims of famine show that starvation effects in pregnancy affect offspring up to the third generation and can cause obesity without requiring direct exposure to the traumatic privation. Other studies found immunosuppression in children and adolescents

who have suffered developmental trauma, which causes them chronic medical issues.
(cf. 2.3.3)

The intergenerational transmission of trauma is shaped by the environment and thus pertains to the realm of language. Magistretti and Ansermet (2016) explain the connection of body and mind through the Freudian concept of the drive, whose anatomical seat they locate in the insular cortex. This part of the nervous system, which processes sensory signals, creates the representation of somatic markers which generate symbolic re-representations that are “equivalent to the Freudian *Vorstellungsrepräsentanz*” (p. 144). The latter, representative representation, also known as the ambassador of the drive, is key to shaping those representations of stimuli coming from the internal organs (proprioceptive) as well as from the environment (exteroceptive) that culminate in a form of discharge (motor actions) that allow functional homeostasis. Among various discharges of the drive, one of the most significant is through the parallel actions of speaking and naming. This is to say that representations of the flesh are mediated by the big Other of language (culture, caregivers), which is internalized in the very core of the *parletre* (being of language, lettered subject), yet it requires an image, a body. The mirror stage, a concept invented by Lacan, claims that an infant establishes the logic of an integrated body, beyond its fragmentation and discoordination, between the ages of six to eighteen months, through mirrors, real and metaphoric, that provide the human subject with a “jubilant assumption of his specular image” (Lacan, 2006, p. 76), constituting a virtual consistency (as it is an image) of their ego and body image.

Beyond the mirror stage, the *parletre* in their symbolic upbringing learns how to conceive of their body, and also how to discharge the Real tension accumulated. Through the Other’s code —signifiers, silences, and residues of object *a*, such as gaze or touch—the subject is incarnated by the apparatus of representations that while *being sensual is nonsensical*. This is what Lacan understands as *lalangue*, which I read mostly as a cadence of the Real, a babbling response to a lullaby, a language of love, perhaps of hate too, that elicits a certain body musicality acquired from “the somatic echoes of the said” (Lacan, session 18.11.1975). This psychosomatic partiture of flesh, letters, and silences insists on spaces of sociality and is linked to discursive forms that open the subject to jouissance. Lacan renders *lalangue* as an invocatory drive due to the superegoic imperative that inheres this phenomenon in which the subject is summoned

to listen to their own life and death pulsations, leading the subject unto unrecognized desires written on their body. *Lalangue* does not have access to a symbolically articulated knowledge, it only gives the possibility of accessing a *savoir-faire* or *know-how* to do with it. This is why transgenerational trauma is split between knowledge and truth, because the experience of *jouissance* does not meet signification.

In a different theoretical note, but to the same effect, Roger Frie suggests that learned and lived memories are split (2017, p. 183). We learn history through informational knowledge, we have facts and dates, narratives, and “family romances” (Freud, 1909/1973, p. 239). Yet there is another history that lacks knowledge, whose hidden truth has been coded in silences and in what has remained *unsaid*. This lived memory palpitates in the body and is expressed through affect and repetition, for traumatic memories are silently transmitted through family lineage and tradition. How do we carry the *unsaid*? How does the intangible transmit through generations? That is what I respond to next.

6.5.2. Imaginary transmission: a body to envelop the flesh

The body is a matter of great complexity and of significant relevance in trauma studies, because “the Real of the trauma is inscribed onto the body itself” (Verhaeghe, 2004, p. 316). The body in psychoanalysis involves three registers, as it is a knot of flesh (Real), language (Symbolic), and an image that adds to the aesthetic experience (Imaginary). The Real body is the flesh³⁰, a *sac of organs* that connects in semiotic flows, being chemical, electric, or physical, and is the site that language writes on to envelop it. Jacques Allain Miller proposes the concept of the “speaking body” as a surface on which the “sign slices up the flesh, devitalising and cadaverising it, and then the body becomes separate from it” (2014, n.p.); as such, the Millerian speaking body is the Real body that was taken over by language.

The imaginary realm is where the body is created, not only the body image as a visual snap of the self, but also as the spatiotemporal sensual experience—its rhythms,

³⁰ Jean Luc Marion (2003) illustrates the phenomenon of “flesh” and “taking flesh” from a phenomenological position, as a temporal assumption of being that allows one to be reached by others: “There where my flesh exposes me, I am”. (p. 39). My rendition of the flesh, in contrast, refers to the Real of the organism.

positions, and thresholds—which gives form to the subject’s own flesh, albeit always in the direction that *lalangue* dictates. The image of the body, as Lacan sees it, and which I render here as an aesthetic experience, in the Kantian sense, is indeed what creates the body, as it provides a *virtual* cohesive somatic sense of self, vital for the formation of an ego and the provision of somatic agency. Without the image of the body, the drives would cause a constant experience of fragmentation, which might result in dissociation or confusion, as with those who experience it in psychosis or in severe body transgressions, such as those experienced in rape or torture. Kamila Jelinkova and Laura Tarafás (2020), engaging the Borromean knot, discuss the relevance of the body image in their clinical work with traumatised asylum-seeking subjects who had experienced torture. Their insight of what occurs to the body in those extreme experiences is expressed through the concept of “holding at bay,” a defense mechanism similar to what the DSM V refers as dissociation, and which allows the person to disengage the imaginary aspect of the body, while enduring the brutality, to prevent a total subjective collapse:

It could be asserted that in such cases the Imaginary is not “lost” per se but held at distance for a certain time-period so that there is not a complete collapse of the Borromean knot but rather a temporary disconnection of the Imaginary ring. This then tallies with the earlier assertions regarding OBE’s (Out of Body Experiences) characterised by a similar holding at bay of the Imaginary register. (p. 82)

The latter brings important aspects to be considered in trauma treatment, as the imaginary aspect of the body requires focused engagement. Yet if we consider the collective body or body politic, the very same imaginary dissociation of body and self is approached by Dupuis-Rossi and Reynolds as rather a consequence of the systematic, state-sanctioned violence because “[c]olonial oppression forces Indigenous individuals to develop ways of *not knowing what we know* in order to be able to survive intolerable and overwhelming violence and oppression” (2018, p. 295).

Finally, the body in the symbolic can be read as the repetition of temporal ‘emplotments’ of cultural images and narratives, as Fernanda Magallanes proposes, for example, regarding the body submitted to the patriarchal order in the Oedipal plot (2018, p. 9). Notwithstanding, the body as a materiality impacted by discursive formations cannot be exhausted symbolically, as social constructivism has it, because such flesh also carries a kernel of impossibility that is singularly produced. The body is not

exhausted by the cultural norms of a society, neither by the imposition of hygienic habits (mindfulness, eat and sleep, etc.) to maintain its homeostasis, because the central split between knowledge and truth leaves a task to be resolved by means of accessing what the body knows but the person is unable to articulate. To better understand the symbolic aspect of the body, I move to the discussion of memory as that which is symbolically traceable in the speaking body.

6.5.3. Symbolic transmission: the unconscious is the memory that forgets

While there is transgenerational transmission of trauma in the Real, rendered above through epigenetics and the drive, and there is also transmission of trauma through the image of the body, transgenerational history is traceable *in language* and memory has an enormous role in it. In this section, I approach memory at the individual scale and remembrance at the social scale.

At the individual level and under regular conditions most of our memories become unconscious, for which Lacan defines the unconscious precisely as “the memory of those things he [the subject] forgets” (Lacan, 1959-60/1992, p. 231). Yet Freud, in his early work, discovered apparently insignificant psychic productions of vivid early recollections, that he called “screen memories” and which owe “its value as a memory not to its own content but to the relation existing between that content and some other, that has been suppressed” (Freud, 1899/1973, p. 320). Thus, these early memories, in which the subject often sees themselves as a child, “as an observer from outside the scene” (Freud, 1899/1973, p. 321), suggest to Freud something corresponding to the manifest content of dreams, and also as “evidence that the original impression has been worked over” (Freud, 1899/1973, p. 321). Memory, then, is always about a past that is reconstructed through images and little sparks to sustain a historical narrative of the self within a signifying chain. Lacan indicated that the subject’s unconscious is precisely the subject’s very history (2006, p. 52), even if, and precisely because, they might not remember. If one does not remember, as Freud put it clearly, one instead acts the memories out (Freud, 1914/1973, p.150).

Memory, with its imprecisions, inapprehension, and vagueness, shows its raw power in the most severe symptoms of PTSD, where no screen covers the traumatic;

rather, the person is flooded by vivid terrifying sparks of mental and bodily memories known as flashbacks. About traumatic memory, Freud said that “the psychical trauma — or more precisely the memory of the trauma — acts like a foreign body which long after its entry must continue to be regarded as an agent that is still at work” (Freud, 1893b/1973, p. 32). The traumatized subject then cannot establish a sense of history which would allow them to forget the trauma. The flooding of memories that position the traumatized subject as passive receptacle has not found a way to close the open hole of the Real. The alien invasions of traumatic memories repeatedly prevent the formation of screen memories, and hinder the production of historical subjectivity, however phantasmatic, that allows the subject to forget the traumatic elements of the Real experience. Reminiscences of the traumatic event are the cause of suffering and thus, at the individual level, memory presents a paradox because, while crucial to producing a historical sense of self, it requires that the subject forgets the Real.

In the transgenerational transmission of trauma, memories might have been partially forgotten, necessarily repressed to continue life, and they are silently transmitted through the family lineage and tradition. The forgotten memories that are passed to other generations remain present in the subject’s naturalized significations that shape their embodied positions towards several potentially traumatic social aspects, such as class, race, gender, age, sexual orientation, body weight, physical appearance, etc. Our positions are informed by historical unconscious reason, and it is in those aspects that the individual, the subject, and her immediate transgenerational history is traceable in language, usually to three generations. As I claimed elsewhere:

In approaching the relationship between the social and the individual we can see the rope of the collective but not the quality of each of its fibers...The procedure of how repression works, are intractable in the total aggregate of the one plus one” (Fernandez-Alvarez, 2020, p. 148).

Such a lack of representation of the subject can be mapped through the discursive accommodation of the non-said, through silences. A powerful example of the entwinement between individual and collective memory, where story meets history, is found in the work of Roger Frie (2017), who writes about the discovery of an unspoken Nazi history in his German family. Confronted with his family’s past when he found a photograph of his beloved grandfather wearing a Nazi pin on his lapel, Frie faced the crucial question that all of us face at some point, of whether or not he wanted to know

about the past trauma of previous generations, saying that “if we listen carefully to what history tells us, we may hear whispers of an unspoken past, of calamitous events that are hidden by silence” (p. 45).

Lacan speaks about the configuration of desire within a tragic logic of sacrifice (1960/2015 p. 295). This approach might account for the transmission of traumatic content through a signifier, appearing and disappearing within a lineage in a three-stage intergenerational process that is shaped by debt and guilt: In the first generation, of our grandparents, a letter or a signifier is born, tied to a certain way of enjoyment of life and death, which in Frie’s rendition refers to the shame and moral responsibility *not* experienced by the grandfather regarding Nazi crimes. There is no signifier of shame in this case; it appears in the negative, as a letter of enjoyment. The second generation, Frie’s parents, repressed those letters and yet the absent signifiers are passed to their children through the “the gaps and silences of family narratives” (2017, p. 216), through what is said and not said about the participation of the family in Nazi Germany. The third generation, of which Frie is a member, receives the effects of the signifier, which reappear as the *return of the repressed*, which once discovered or revealed demands to be inscribed or else will be expressed in symptoms. This linguistic transmission of trauma occurs within a network of relations that create discursive traditions, which are the support of material practices.

If the person with PTSD symptoms needs to forget the Real to be able to function, on the collective scale, instead, memory needs preservation and is better approached through remembrance, the act of remembering or recollection. When trauma concerns the collective, as Giesen states, a “ruminating memory of a past... suddenly confronts a community with the abyss of incomprehensibility” (2001, p. 14474). However, as Auestad has adequately proposed, those who dare to voice traumatic memory out in the public “are represented as being the problem —to a social unit that aims to forget, those who remember are seen as thorns in the flesh of the social fabric” (2017, p. xx).

Given the conditions of its emergence postwar, the Frankfurt School privileges the theme of memory, and Walter Benjamin’s harsh yet poetic critique of historicism invites us to look “crudely” (Arendt in Benjamin, 1968, p. 15) to the image of history. His proposal that “there is no document of civilization that is not at the same time a history of

barbarism” (Benjamin, 1968, p. 256) is an urgent call to look to the image of history so as not to compromise critically the horrors he and his contemporaries were facing with Nazism in 20th century Europe. Benjamin encourages remembrance as for “every image of the past that is not recognized by the present as one of its own concerns threatens to disappear irretrievably” (Benjamin, 1968, p. 255). The key to the future, or so Benjamin seems to claim, is to hold and care for the past so as not to forget, as in the powerful metaphor he utilizes of the print he owns of Paul Klee’s “Angelus Novus” (Figure 6.4):

His face is turned toward the past. Where we perceive a chain of events, he sees one single catastrophe which keeps piling wreckage upon wreckage and hurls it in front of his feet. The angel would like to stay, awaken the dead, and make whole what has been smashed. But a storm is blowing from Paradise; it has got caught in his wings with such violence that the angel can no longer close them. The storm irresistibly propels him into the future to which his back is turned, while the pile of debris before him grows skyward. This storm is what we call progress. (p. 258)

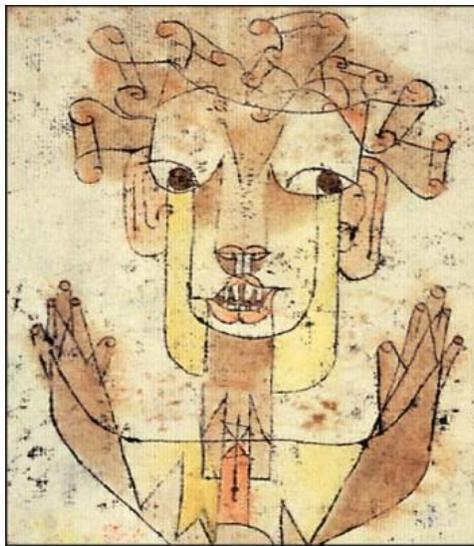


Figure 6.4. Angelus Novus. Paul Klee (1920)

For one to be able to articulate the past, and I would argue, to look at the future with hope, trauma requires temporal-spatial coordinates that articulate the spark of a memory within the context in which it occurred for it will impact the possibility of its inscription of the aspects that involved both the “content of the tradition and its receivers” (Benjamin, 1968, p. 255).

If, at the individual scale, traumatic memory requires protection from the Real, grappling around, repressing to be able to continue life and produce a historical sense,

social memory requires, instead of repressing memory, to collectively witness it, it demands testimony (Caruth, 1996/2016, p. 8).

6.6. State-sanctioned trauma

As we have seen thus far, people can be affected due to one single accident in which a contingent traumatic event adds to the subject's transcendental traumas. And trauma can also emanate from the repeated violence inflicted on an individual by others (social) and the Other (figures of power) in developmental trauma. We have seen that in each of these forms, the individual is entwined with society, and also that the unsayable is transmitted across generations through the flesh, the body and language. In this section, I bring the autoethnographic experience of my research relations with the Aboriginal Wellness Program to approach state-sanctioned trauma.

Autoethnography is a method that brings forward a form of subjectivity that the university discourse, in its know-it-all fantasy, rejects because it relies on an experience deemed unworthy, as per the lack of supposed "objectivity." Relying on the self-reflexivity of thoughts, affect, or sentiments can easily be dismissed by traditional positivistic research as an "impediment" to objectivity (Parker, 2005b, p. 25), as if contaminated by the experience of the researcher. Nonetheless, various scholarly traditions argue against positivist methodologies and indeed allow the inclusion of subjectivity within the research project, such as feminism, phenomenology, hermeneutics, poststructuralism, psychoanalysis, or Indigenous studies (Rose, 1997; Haraway, 1998; Parker, 2005b; Wilson, 2008). In these traditions, the researcher's positionality or standpoint allows various identity marks to be placed (race, sexuality, gender, history). Jesse Proudfoot, who conducts research through psychoanalytic reflexivity, indicates that "the unconscious is an integral element of qualitative research, especially in methods such as ethnography, which involve long periods of time in the field and close personal relationships with participants" (2015, p. 3). The use of psychoanalytically-oriented autoethnography demonstrates, as Parker indicates, that "[e]very claim to objective truth is also simultaneously the reflection of the historically-embedded subjective position of the researcher in what they are studying" (Parker, 2005b, 27).

To conduct research with Indigenous communities in Canada, we must observe the four principles known as OCAP, which stands for First Nations' *ownership, control, access, and possession* of research conducted in their communities. With respect to *ownership* and *control*, my research approach emphasized a detailed consultation in all aspects of the research process, and followed the recommendations and decisions made by the Aboriginal Wellness Team. With respect to my research advisor, whose name appears below, I granted her consent permission to use my research experience with her to inform this report, and I also consulted with Elder Roberta Price regarding whether this process was appropriate. Access to research results was created in the form of research reports: the Team Grant report was distributed to the AWP's participants and the report of this chapter has been distributed prior to wider publication. The *possession* of the data does not apply here as per the nature of the results (there is no data gathered from AWP's clients).

Research that concerns identity politics directly or indirectly —Indigenous in this case— and whose researcher does not belong to the studied identity can, on occasion, lead to compensatory movements to deal with guilt for not belonging to their community, or potential fears of being called out, and so on (Gandeha, 2018, p. 160). Overpraising, tokenization, romanticization, or an assigned sense of superiority are unhelpful and deny the rightful complexity and singularities of the subjects that belong to the identity in discussion. I aspire to avoid the above-mentioned pitfalls. My approach is one of respectful intent, and the result of what Haig-Brown calls a “deep learning” (2010, p. 927) that aims to honor the research relations that emerge with this community.

A first approach to state-sanctioned violence is described by Riel Dupuis-Rossi, in an article cowritten with Vicky Reynolds, who asserts that that Indigenous peoples in Canada have been “dispossessed of their traditional territories, ways of life, governance structures, cultural practices, linguistic and epistemic worldviews and beliefs, as well as their communities” (2018, p. 300). It is with this background that I present the following research experiences.

6.6.1. Kelly Elliot

Kelly Elliot is an Indigenous woman from the Tsimshian nation who collaborated on this research project as an advisor. She was suggested by the Vancouver Coastal

Health Community Engagement Advisory Network (CEAN) to provide feedback from a patient perspective. Kelly and I agreed to meet about every two weeks to talk about my research, for which I compensated her time with a symbolic honorarium of 20 dollars per hour and took her for lunch. For a period of a year and half, Kelly and I met regularly for sushi lunch, and throughout these meetings we got to know each other, learning about each other's families and personal history. We often laughed together, but our conversations were also deep and somber, because in every meeting she recounted memories of friends and acquaintances, many living in the Downtown Eastside (DTES), whom she had lost that month or that year due to mental illness or addiction.

On November 22, 2018, I arrived at our lunch date and Kelly was not outside her place waiting for me to pick her up as she usually was. After texting back and forth I realized she seemed upset but said she would join me at the restaurant. Compared with her joyful, relaxed self, she arrived looking physically and emotionally unwell, distressed and complaining of serious stomach pain. "There have been some very rough times," she said, having some difficulty breathing, and she mentioned that she lost her estranged son to suicide, and also had other recent losses of significant others, some related to the opioid crisis that has devastated the city.³¹ I offered my condolences and asked her in what way I could help on that day, and she said, "just drive me to my supports after lunch." She stated that she was trying to maintain her sobriety and her mind, and I acknowledged her strength. She said she knew she was a "warrior." While we ate, her tension appeared to have subsided slightly, and we did some breathing together, after which she told me about a traumatic experience she had experienced long ago. It was of such intensity that I felt shocked. I asked her if she was sure she wanted to tell me about it, given the circumstances in which she found herself at that moment. Also, if she was okay sharing that with me, "perhaps is too much?" I asked. Kelly said that, on the contrary, talking about it helped her to "process" the trauma. Kelly's words stayed in my mind for a long time, but right there and then I realized that *I would never dare to repeat in front of anyone what I heard from her*, because it is not

³¹ In Chapter 3, I mentioned that the Fentanyl overdose crisis in Vancouver affects people with greater socioeconomic disadvantages. Around the time of my meeting with Kelly, the death count for overdoses was about 1510 deaths in 2018. (Darcy, 2019, p. 5; CBC News, 2021).

only her right to privacy, but also it is her story and only *hers* to tell. It cannot be appropriated.

On December 11, 2018, I met with Elder Roberta Price for the second time, with whom I was consulting about how to go about my research with the AWP. Without telling any details of Kelly's experience, I told Elder Roberta about how intense my experience with my research advisor has been and I shared some insights about how this relationship to Kelly was shaping my own incipient understandings of trauma. I have heard many stories of trauma throughout my professional life, I told Elder Roberta, and I have been shocked and moved many times before, but in what Kelly said that day I found a new understanding of why trauma caused by colonization is different from developmental trauma. Elder Roberta listened to me while she invited me to make some little pouches of Indigenous medicine, one for each member of my family, made of cedar, pine, and lavender, which I fastened with a little pink ribbon. We discussed aspects related to the various forms that racism takes within health practices, such as ignoring, patronizing, or assuming pre-given perspectives for Indigenous patients. She also mentioned the dehumanizing aspect of bureaucracy and its abundant "checklists" that impede relational approaches to health. In this conversation, I felt profoundly supported: It is a strange feeling of deep, unpretentious, unspoken support, one I have experienced in my personal life with people I love and with whom I have a relationship, but I have rarely experienced these emotions at work with people with whom I do not have a personal relation. It is a feeling of relief, as if I am not carrying certain traumatic burden alone.

6.6.1.1. *Homo Sacer*

My experiences with Kelly Elliot and with Elder Roberta made me realize the importance of community relations to provide support during traumatic emergencies. But they have also allowed me to understand the drastic difference that state-sanctioned violence exerts on people in contrast to other traumas. If developmental trauma is often experienced as a criminal event because it goes against judicial or ethical laws (incest, rape, negligence, emotional or physical abuse), state-sanctioned violence, such as those against Indigenous people, presents a different surplus engendered from a different cause. The child or adolescent who suffers developmental trauma, even in their impotence and horror, might know that someone out there —the police, health care

workers, etc.— could validate their suffering as a wrongdoing; in the violence sanctioned by the state, such an escape is limited because the events that might cause trauma have been legitimized by the state. That is what I hear in Kelly's recount, that the political system has effectuated a mark over the specific group to which she belongs that results in impunity if attacked. This is what Agamben named "a state of exception" or a certain quality of the beyond law: the *Homo Sacer* (Agamben, 1998, p. 47). This critical term refers to a social curse that indexes "the person whom anyone can kill with impunity" (Agamben, 1998, p. 47). In Kelly's story, as well as in the many moving testimonies given to the Truth and Reconciliation Commission of Canada (TRC, 2015b) or the National Inquiry into Missing and Murdered Indigenous Women and Girls (MIWG, 2015), I have heard such injunctions, an idle brutality that pretends to go unpunished.

David Gaertner (2012) reminds us that,

in 1920 Duncan Campbell Scott, the official figure behind the initiation of Residential Schools, declared that: 'Our [the Canadian Government's] object is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian department'. (Gaertner, p. 61)

Such racist absolutism does not *explicitly* state that people can identify Indigenous people as *homo sacer* and kill them without impunity. However, it is implicit in the effects produced by a master signifier of white settler supremacy. While Agamben's *homo sacer* claims that the sovereign state causes the ban that calls upon those who can be killed with impunity, Foucault counterargues that the instrumental reason of power should not be looked only through the sovereignty of the state and discourses of rights, but rather in the very mechanism of the relations among subjects, within the very biopower circulating among bodies. Understood this way, power for Foucault is not a final impasse or omnipotent, but rather, because has a "multiplicity points of resistance", it "has always been impotent" (Foucault, 2003, p. 280). Notwithstanding, working on the relation between biopower and eugenic extermination, exemplified by Nazism, Foucault asserts that power requires another order to find support. Anke Snoek (2010) summarizes clearly:

In order to re-claim death, to be able to inflict death on its subjects, its living beings, biopower must make use of racism. Racism is the thanatopolitics of bio-politics. Foucault states that racism is precisely what allows biopower

to fragment the biological domain whose care power had undertaken. (p. 49)

Thus, with Kelly Elliot, I could understand for the first time that racism and genocidal practices cause state-sanctioned trauma, often layered unto developmental traumas. As such, the violence exerted on the Indigenous peoples is beyond the state or those exclusively in power, but instead the state's injunction extends to every citizen who engages with the mortal disease constituted by the blind support of a master signifier of white settler supremacy. This is only compounded by the hegemony of MHEBP, which cannot fully address the multiple traumas inflicted by settler colonialism, because biomedical and psychoeducational reason, as Dupuis-Rossi, & Reynolds assert constitute a professional distancing that "allows us to abdicate our collective responsibility to change the social structures that make this oppression and suffering possible." (2018, p. 294). Social bonding through the "know-it-all", as I will continue discussing in Chapter 7, not only erase the unconscious, but subjectivities and socio-political contexts at large.

6.6.2. Elders Council at Vancouver Coastal Health

In the process of negotiating the inclusion of the Aboriginal Wellness Team in this research, I met with the Vancouver Coastal Health Elders Council on Wednesday, January 30, 2019. The following Elders were in attendance:

1. Doris Fox: Musqueam Nation
2. Iggy George: Tseil—Waututh Nations
3. Martha (Marr) Dorvault: Gitxsan Nation
4. Divina Ridley: Nisga'a, Tsimshian, and Gitksan Nations
5. Roberta Price: Cowichan and Snuneymuxw Nations
6. Glida Morgan: Tla'amin Nation
7. Ruth Alfred: Namgis Nation
8. Blair Goodwill: Dakota Sioux Nation

Prior to the meeting, I had introduced myself via e-mail as a Mestizo woman from Mexico, explaining that in my country of origin:

there is a great amount of mixed ancestry and so indigenous culture is embedded in the food we eat, in many words we speak and in our looks. However, very unfortunately, mainstream culture has privileged Mexico's European roots which has resulted in isolating Indigenous peoples from participating in the larger sociopolitical life. At a personal level, this has

resulted in my growing up without a deep learning of the original cultures I come from (Research notes, January 25, 2019).

I explained that my current research “looks at the way spaces —physical, but also emotional, social, or political— affect the phenomena of trauma,” and that I have decided to start this project because:

I am concerned with the services VCH provides to survivors of trauma, at least for the mental health population. We are entrenched in a system that no matter how well-intended individuals are, how diversely trained and passionate about their jobs workers are, the system relies on the replication of desubjectifying practices. (Research notes, January 25, 2019)

On the day I met with the Council of Elders, I was seated in the waiting room, my mind unwinding from the many thoughts about the analysts I had just seen before that meeting and pending aspects of my research. When I entered the room, unobservant of protocol, I offered the Elders some pouches I had prepared the night before with Cuban tobacco; they smiled and were welcoming. When I finished the tobacco offering, I sat beside Elder Roberta and before she could start guiding me regarding protocol, I burst into sobbing tears for about a good three minutes while attempting to account for it in front of them. I did not understand what was happening to me, but I could recognize the profound feeling of shame. After this unforeseen rupture, welcomed with a casual comment by Elder Doris Fox, “thank you for bringing the water” (Research notes, January 30, 2019), Elder Roberta supportively prompted me to ask permission to Elder Iggy George, presiding, to speak to the Elder’s council. I followed suit and found myself calmer and able to have a discussion.

6.6.1.2. “*Guilt and shame is the language of the settler.*”

“Guilt and shame is the language of the settler” (Research notes, January 30, 2019), said Elder Iggy George when we were discussing my shameful reaction in the meeting with the Elders Council. This phrase is rich and ambiguous, and with it I want to enter the discussion of my experience with the Council of Elders.

One could be annoyed by my emotions and understand them as no more than “white guilt,” the performative aspect of a subject who identifies with the guilt that those exerting genocide could not identify or experience, which is the basis of what Ferenczi calls “identifying with the aggressor.” Or this event could be seen as the burdensome

demand of a settler to be consoled by an Indigenous person.³² It could also be read as a hysterical identification, imaginarily captured, in which I would identify with Indigenous people for what I believe is their lack, with the purpose of participating in their pain, to experience some of their struggles and to protest in their favor. One more reading could take this as an affect for the mere gain of “feeling good about feeling bad” (Kizuk, 2020, p. 171). All these explanations could well inform parts of my reaction, such as feeling safe enough to be consoled for my own shame or experiencing an identification of solidarity with Indigenous people for my desire to acknowledge their struggle, or even the fact that, indeed, every intensity carries a seed of potential of enjoyment as *jouissance*. Yet, the process that unfolded after my meeting with the Elders exceeds these explanations. I am still puzzled by this event and the surprising overwhelming feeling of shame, which changed my assumptive world as I was able to articulate to the Elders, right then and there, my foreclosed Indigeneity. Foreclosure refers to the mechanism that Lacan locates in the psychotic logic, in which an element of reality is completely out of symbolization or imaginization, which is to say, outside of the unconscious (Lacan, 1955/1997), and if it returns, it is only as the traumatic Real, traumatic because there is no way to locate such an element within the signifying chain. My own Indigeneity, long buried by racist Mexican culture, appeared right there in front of the Elders. I experienced this event with profound shame at not ever having the opportunity to be seated in front of any Indigenous council in Mexico, to treat the Indigenous Elders of my country of origin with the respect I offered to the Elders at that moment. Shame because, having journeyed through three psychoanalytic processes, the question of my Indigeneity never came up, not out of repression, but because Indigeneity *was not even a question* due to the privilege of not needing to ever ask myself the question. I explained to the Elders that in Mexico “the Indian” is a subclass, that most mestizos of lighter skin, like myself, would never dream of exploring their Indigenous heritage, because it is seen as shameful and unworthy, and instead most people boast their European heritage, as an extension of the pervasive white supremacy of colonial discourses.

³² I remember few years before the TRC was launched and I had an incipient knowledge about the pervasive colonization of Indigenous peoples in Canada, a VCH colleague, back from a community meeting that heard Indigenous peoples' testimony, told me how sometimes the burden of emotional labour falls on the Indigenous person when the settler experienced “white guilt.”

In front of the Elders, I felt profoundly moved at the power of this research experience. A crucial question, when conducting research with Indigenous populations, is how to locate the return or benefit to the Indigenous community. How would my acknowledgment of my own existing racism impact Indigenous peoples positively? If we approach this with a crude pragmatism, we could say that it does not have any direct benefit to them. Such a position would ignore the conceptual axis of this research that locates the spatial entwinement of the individual and society through language. How could this singular experience return a benefit to them? To answer that question, I want to discuss shame as an affect and its relation to the possibility of social bonding.

Compared to guilt, which is a consequence of having done something morally questionable, shame is an affect that refers to *being* more than to *actions*. In its various etymologies, it is associated with the quality of being exposed or seen, and Russell Grigg delineates shame “in the register of the specular, the visual. And not in the field of speech and language” (2005, p. 7). Copjec states that shame, rather than being an effect of a guilty superego, is an eruption of the lack in the Other, which leaves the subject naked in confronting its very absence: “In shame, unlike guilt, one experiences one’s visibility, but there is no external Other who sees, since shame is proof that the Other does not exist” (2002, p. 128). The self-exposure is an excruciating experience because the subject finds herself alone with her gaze, which requires decidability regarding the values of truth that, up to that point, the subject held without rational articulation. Shame as a *moving* experience has emerged in Lacanian psychoanalysis as a value that correlates with the virtue of modesty, humility, or *pudeur* as demonstrated by contemporaneous texts (Watson, 2018; Hernandez, 2016; Copjec, 2002; Webster, 2011). Shame is valuable because it “recognizes limits” (Copjec, 2002, p. 217), it is incurable and thus requires ongoing care (Hernandez, 2016, p. 69), and because “[t]he closer one gets to shame, the closer one is to the hole in the real from which a new truth might arise” (Webster, 2011, p. 130). George’s work on slavery indicates the social function of shame by describing how the gaze of the slave and their community failed to conjure up shame in the slave’s master, with destructive effects:

[w]ithout such enabling restrains [shame] placed on *jouissance*, the subject, who is most properly a desiring subject founded upon lack, devolves into a subject merely of the drive, advancing precipitously toward a destruction of both self and other. (2016, p. 30 original emphasis)

Shame, then, is an affect that demarcates spaces and limits, and is also a *dephallicizing* affect, because it unambiguously assumes that the Other and oneself are both lacking, that is, shame extracts the inherently oppressive power from the master signifier and calls for the lack of being (Hernandez, 2016, p.63). Shame, when cared for, has a sobering effect that ruptures all the granted assumptions of being, name, identity or the phallus, assuming a different position from what the master signifier has programmed for the subject, and this loss allows for a certain humility to emerge.

Shame, however, has been harshly criticized in the context of colonialism by Sara Ahmed (2004), who sees it as both “a mode of recognition of injustices committed against others, but also a form of nation building” (p. 103), resulting in a process of reconciliation mainly of the nation with itself. Sarah Kizuk (2020) follows a similar research line, citing that about “58% of Canadians feel ashamed about some events in Canada's past, with 32% reporting feeling specifically ashamed of the treatment of Indigenous peoples, and a further 16% reporting feeling ashamed about the Indian Residential School system” (p. 162). Kizuk deemed the phenomenon of settler shame to be ineffective in confronting racism or settler colonialism, as introspective work is seen as allowing for a self-serving “feeling good,” rather than “challenging the organization of power that fails to recognize them [Indigenous peoples] in the first place” (p. 171). I understand these statements as emerging within the context of critical colonial studies, whose focus is on the social scale, aiming to move from recognition and reconciliation towards material restitution, yet when Kizuk’s analysis relies on individual experiences of shame generalized to the whole nation, it loses nuance by short-circuiting her analysis of shame-feeling pride-feeling good, which contradicts what the experience of shame presents clinically. This critique might also invite a reflection on the structure of the hysteric discourse at core in any protest. If based itself in blaming enjoyment (“they feel good by feeling bad”) such critique disavows the fact that any critique, as any intensity, participates in *jouissance*, including belligerence and moral righteousness, which often makes people feel good about themselves without necessarily benefiting, tangibly, the cause defended. Compared to social constructivism, psychoanalysis unburdens itself of moralistic pretensions by accepting that enjoyment, even and precisely in its morbidity as *jouissance*, inheres in every speaking subject; acknowledging *jouissance*, however, is not cynicism. Quite the contrary, we can understand that caring for the subject’s shame, anxiety, or trauma, is caring for their community’s shame, anxiety, or trauma, and vice

versa. If, as Elder Iggy George stated, guilt and shame are languages of the settler, maybe the task consists precisely of untangling the affects link to signifiers that were unbeknownst to the subject, so then a symbolic articulation can ensue.

6.6.3. Attrition of client participants from the Aboriginal Wellness Program (AWP)

After a thorough consultation with the AWP and its community (the AWP's Team, Elder Roberta, the VCH Elders Council), the AWP decided not to allow the inclusion of client participants in this research, despite having welcomed my initial research proposal, and despite my having established a deep dialogue with members of the community, received the blessings from the Elders, and secured the ethics review. On September 10, 2019, I met with Leslie Bonshor, VCH's Executive Director of Aboriginal Health, who jokingly refers to her position as "Chief Disruptor of the Colonial Bureaucratic Health System" (Research notes, September 10, 2019), and we had an enriching conversation for about two hours. I was surprised by the generosity of her time, being surely very busy in the position she held. In that meeting, she told me that the team felt that my research, despite having accomplished all due process, has some aspects that make it not feel thoroughly "right." Consequently, the team recommended that I would not interview any analysands from the team and that other conditions were observed, such as instead of the pending voice-recorded interviews with clinical participants, I needed to email the questions and receive a hard copy of their answers. I accepted the decision and the conditions they recommended for the continuation of the research with the team, not without feeling upset about how I was going to proceed. Retrospectively, I believe that the AWP's participant attrition is one of the most significant and productive findings of my research. I have understood this exchange as a clear message that the preservation of Indigenous struggles and successes belongs to their own communities, and that the "nothing" of their stories, as a presence, speaks louder and perhaps clearer than having their stories reflected.

6.6.3.1. *The gift of silence or "who gave permission to define me?"*

One approach occurred to me when a dear friend recommended reading Tuck and Yang, two postcolonial scholars from critical studies of settler colonialism who pose the term "refusing research," which refers to a humanizing positionality within social sciences research that studies collective stories of pain and humiliation. Tuck and Yang

(2014) highlight a paradox regarding the attempt to transmit collective wisdom: while there is a need to name the violence experienced by the populations we approach, in this case Indigenous peoples in British Columbia, Canada, there is always a risk “to portray/betray them to the spectacle of the settler colonial gaze” (p. 223). Tuck and Yang asked the crucial question of “[h]ow do we develop an ethics for research that differentiates between power—which deserves a denuding, indeed petrifying scrutiny—and people?” (p. 223). Tuck and Yang exemplify their point with the series *Erased Lynching* (2002–2011) by Los Angeles-based artist Ken Gonzales-Day (2006), who reproduced pictures of lynching events between 1850 and 1935 in California, which included African American, Asian, Latinx, Native American, and white victims. These events of public spectacle attracted wide audiences and were photographed professionally, and the pictures of these atrocities circulated in the US and the world as mementos to immortalize “the murder beyond the time and place of the lynching, and in their proliferation, expand a single murder to the general murderability of the non-White body” (Tuck and Yang, 2014, p. 240). What Gonzales-Day did in his brilliant series is to show the pictures without the ropes or the bodies of the lynched, instead bringing the attention to those who attended the spectacle.

The attrition of AWP’s client participants, their refusal to share their ideas about trauma and healing in my research, is a generative *cultural intervention* that places a limit on a possible epistemological colonization. Elder Doris mentioned in the council meeting, “when we tell our stories we want to be named on them” (Research notes, January 30, 2019). By refusing research, the community cares about the implicit risk of banalizing their people’s struggle by anonymizing their pain, as per the ethics review parameters, or by being represented *exclusively* by their suffering, instead of by their diversity and singular voices. My research shows the power of an absence and of silence as a way of intervention, something well known to most psychoanalysts, as it creates in the analytic space the conditions for the analysand’s verbal free association, the only way to allow speech to unfold. The silence of the AWP’s clients in this research forced me to find and produce ways to speak of this absence and its potential causes. In a different context and circumstances, my research shows an absence, similar to what Gonzales-Day did with his series, and instead of Indigenous people’s pain, I highlight the

relations with the community, allowing me to find their struggles through the strength of their cultural ways: direct, warm, and relational.³³

Tuck and Yang encourage desire-based research, as they present it as an antidote to damage or illness-focused narratives, not to deny the experience of tragedy, trauma, and pain, but to situate such empirical knowledge as wise (2014, p. 231). This is a whole turn in many approaches to trauma; for example, in the Collective Trauma Summit, a rich conference of large scope, organized by Thomas Hübl, that gathers renowned speakers and artists reflecting on various aspects of collective trauma. In the last conference of Fall 2021, Gabor Maté presented his documentary *The wisdom of trauma* (Benazzo & Benazzo, 2021), for which he emphasizes the value of wisdom acquired after a traumatic event.³⁴ I believe in the power of knowledge and wisdom and in people's ability to find a way to know, *connaissance*, and to know-how, *savoir*, what to do with hardship endured. I also understand that at the collective level political and scientific revolutions, for example psychoanalysis, the Copernican or the French Revolutions, could be deemed traumatic as per their eventual nature, even, and precisely, because they created important historical transformations. Yet, at the subject scale, I prefer to maintain myself at distance from the generalizing tendency that trauma intrinsically relates to wisdom or growth because over-emphasizing a positive underside, as any master signifier does, can quickly transform this value into a form of dogma that is forced upon analysands. Any fixed understanding of what trauma *is* or *should be*, as well intended as it can be, constitutes a demand made on analysands by the therapists, who inadvertently might focus on accomplishing the vision of such an understanding (wisdom, resiliency) instead of following the singular logic of the subject they need to listen to.

³³ Shawn Wilson highlights the ontological and epistemological relevance of relationality for Indigenous peoples, through quoting his friend who says: "It's collective, it's a group, it's a community. And I think that is the basis of relationality. That is, it's built upon the interconnections, the interrelationships" (2008, p. 80). Relationality that involves not only humans but also the very land.

³⁴ Maté has immense charisma and enjoys world acclaim for his work on trauma, yet at times he strikes me as occupying the role of a prophetic figure or the Master position by providing with great authority a generalized and unnuanced meaning of people's suffering, rather than relying on a true ethical exploration of the complexities of singular and societal causalities.

6.7. Conclusions: other trauma discourses

Once I have reviewed various aspects that pertain to individual and social trauma, I next conclude by discussing two main discursive forms that define social bonding in trauma: victimhood (trauma discourse) and perpetration (master's discourse). Other discourses might have emerged to make sense of trauma. However, I claim that these two modalities (victimhood and perpetration) as discursive modalities organize the structural bond that accommodates various narratives (e.g., cognitivist, behaviouralist, narrative, and biomedical).

6.7.1. Victimhood or trauma discourse

One of the main structures through which trauma becomes discourse is victimhood. Roughly defined, a victim is designated as a person who has endured an underserved suffering according to the values of a society. Discourses based on victimhood require that an individual or a group in society is positioned as a victim, which inadvertently inheres the repetition of the place of abjection or residue that the individual is summoned to embody.

Either as an identity or as a label, the signifier *victim* is germane to trauma studies, and there are important controversies surrounding it. This term is derived from the Latin *victima*, which means “to sacrifice,” and it is used in most Western languages to refer to those affected by crime, as Van Dijk states, “with words denoting sacrifice and/or sacrificial objects,” different from other languages, like Japanese or Chinese, which use “harmed party” (2009, p. 2). Fassin and Retchman wrote a book on the place and function of victimhood in trauma, rendering it as a recent historical idea that has various political uses (2009, p. 8), one being to socially legitimize the persistent burden of suspiciousness that has accompanied the victims of trauma. But Gilligan (2009) criticizes this term as follows: “The idea that we humans are defined by what is done to us, rather by how we shape the world that we inhabit, is powerfully articulated in the prominence given to the ‘victim’ in contemporary Western culture” (2009, p. 129). Wright rejects the term, as he sees that “[t]rauma is linked, after all, to the figure of the victim, to the victim’s rights in a compensation culture, and ultimately to the geopolitics of human rights” (2021, p. 236). For Verhaeghe, the term “victim” is problematic because it facilitates the belief that the person suffering from traumatic abuses is in “no way

whatsoever implied in their situation” (1998, p. 88). Some other perspectives expand on victimhood through the signifier “embitterment,” which parallels what in the early 20th century was known as “sinistrosis” or “claimant disease” and that Linden and Maercker define as:

Having been let down or been insulted and a feeling of being a loser, combined with a desire to fight back and, at the same time, a feeling of being cornered and helpless, which subsequently causes an individual to have fantasies of revenge and aggression towards him or herself and the environment. (2011, p.1)

This term was considered since ancient times by Aristotle who defined this affect in less operational terms as follows: “Embittered are those who cannot be reconciled, who keep their rancour, they hold their arousal in themselves, not coming to rest unless revenge has come” (2011, p. 1).

The controversies regarding the term “victim” are important for the scalar analysis, which is obliged to assess the divergent relevance of this term: while victimhood must be resigned to the individual level, or else no path to subjectivity will be cleared, at the social level this label might be helpful in collectivizing demands for restitutive justice for those individuals exposed to a rupturing sociopolitical event. Yet even those who successfully collectivize their rightful claims find this term highly problematic because it renders the person to be “passive” and “helpless.” Thus, within feminist as well as Indigenous traditions, the word *survivor* is preferred because, as stated in the TRC:

A Survivor is a person who persevered against and overcame adversity. The word came to mean someone who emerged victorious, though not unscathed, whose head was “bloody but unbowed” (2015c, p. xiii).

Generalizing the value of victimhood based on the requirements of one or the other scale can lead to potential cynical or romanticizing renditions. My perspective is that victimhood is not merely a matter of individual choice or moral value, but rather is a structure of social bonding, with linguistic exchanges that preserve the production of a master signifier that requires counting a subject in the position of victim. As such, any type of trauma —transcendental, accidental, developmental, or of violence by the state— can be assimilated to this discursive net in which a human subject is forced or coerced to remain a victim, as described in Figure 6.5.

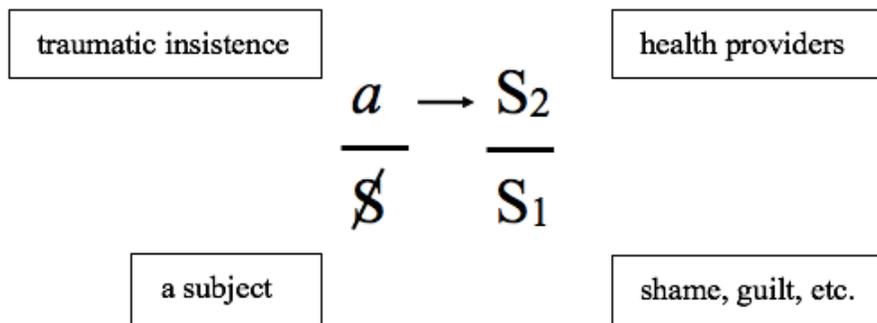


Figure 6.5. Trauma discourse: victimhood

The structural arrangement of victimhood reads as follows: The insistent repetition of traumatic disturbances, embodied by a speaking body, addresses someone in a position of knowledge, which in the mental health institution could be occupied by any health practitioners, who host the place of expert knowledge that signifies jouissance.

When I asked research participants that provide mental health services at VCH about their practices regarding trauma, their responses range from assertions of competence, such as: “So the protocol is very specific and cognition based, and so you’re taking them through a manual... they’re manualized treatments,” (C12) to expressing frustration and critique: “In mental health we are trained to have such a critical eye on people and really censor everything they do and look at it from it potentially being a pathology, which is really not helpful” (C14); “I feel we do not address the root or cause of the addiction or the mental health distress. Instead, we tend to medicate or give some coping skills for the moment” (C11). We learned in these voices that when a person presents trauma, they address a clinician or service provider as someone occupying a position of knowledge to help them deal with the effects of the Real in their bodies and minds. Although some clinicians shelter the anxieties in the manual, most of these clinicians are overwhelmed by the narrow possibilities that the biomedical and psychoeducational provide to conceptualize the incredible complexity of the phenomenon of trauma.

Although the discourse of trauma is caused by the truth of a subject, the subject remains hidden because object *a* —for example, the repeated physical or emotional abuse endured throughout development, the brutal effects of dispossession or white settler supremacy in colonial trauma — is in the position of semblance or agent. By its

very nature this remainder of object *a* constitutes an impossibility, as object *a* cannot make semblance except in the analytic discourse, where transference and the focus on subjectivity allows for its elucidation. Yet, and this is my assertion, the insistence of trauma as the main point of departure to any of the linguistic exchanges within a community that deals with trauma, by default makes the traumatic insistences perpetuate themselves. It perpetuates when the therapeutic approach, increasingly commodified in the global scene of the mental health services, is about treating the “traumatized brain” with manualized mindfulness and similar practices. Victimization continues when service providers aim to treat a brain or providing a technique only, rather than listening and treating an ethical social subject who speaks. Victimization is perpetuated when the clinicians of an institution make sense of trauma suffering according to their theoretical³⁵ reified idea of what recovery looks like for a generic individual, instead of listening to the radically singular way by which a subject articulates, through signifiers and absences, the social logic that inhabits their speaking body. And victimization continues when there is not a theoretical and methodological understanding of a way language traps significations and thus contingencies offered in language are missed.

As a result of these linguistic mechanisms circulating in an institution, there is a surplus, which, against most of the clinician’s good intentions, produces a master signifier that imposes signifiers that hinder subjectivity. The master signifier that imposes victimization can be anything that, in the need of classifying or recognizing the duress endured, perpetuates its insistence. As the mental health clinicians expressed above, traumatic suffering is heard often as a pathology, most often as brain-based hyperarousing signs that require *mostly* homeostasis. The effects of these linguistic exchanges reinforce victimization by the fact that a discourse searches for recognition and thus, the mental health focus of engagement is via suffering, supported by the circulation of terms in discourse, signifiers that are initially brought about by the clients themselves, such as shame and guilt, or by occupying an objectal position for the Other’s enjoyment. This residual master signifier cannot organize a discourse outside the insistent disturbance because rather than a subject as an agent (as in the case of the hysteric/protest discourse) or the subject as a receiver of the inquiry (as in the case

³⁵ Elsewhere, I have critiqued the ideological grip of theory (Fernandez, 2014).

of the analyst's discourse), the agent remains object *a* whose traumatic nature conjures up a master signifier that fixes victimization. Instead of including a subject who inquires ethically the response-ability they have in trauma, they are erased by discourses that reify suffering through the brain, the diagnosis, or the lack of skills. In simpler terms, the subject is absent when there is not a subject in the sentence; for example, in the case of a young analysand who struggles to find some peace after a traumatic event and when I asked her about how she could phrase what she struggles with she says, "things happened." I signal to them that there is no subject in that sentence, and they say, "things happened to me." I again signal that there is no subject in the sentence and they say, "I do not want to accept the trauma as something that I happen to experience because then I would need to deal with it" (Research notes, July 30, 2021). What sort of social approach would be needed to allow the emergence of a subject? What could allow a person who presents with traumatic suffering to stop being caught up in the automatic repetition of a preassigned victim position? I provide a response to this in Chapter 7.

6.7.2. Perpetration as the master's discourse

People affected by traumatic suffering endure a form of injury because of the actions perpetrated by something or someone, this being a family member, a stranger, the environment, or the state. The etymology of perpetration comes from the Latin voice *perpetrare*, "to carry out, execute or perform," and is related to *patrāre*, as in "to father, to bring about" something such as a crime or deception (Merriam-Webster, 2021). Executing or performing an act of violence as perpetration involves the symbolic and often the judicial Law.

This chapter opened with information about the ominous discovery of 215 unmarked graves in British Columbia. The residential school project, where these children died, was constituted by 139 state-sanctioned, federally run facilities managed by Catholic and Christian congregations between 1920 and the 1990s and was mandated for children ages seven to fifteen. Most residential schools stopped operating in the mid-1970s (TRC, 2015A), and the last residential school (The Muscowequan in Saskatchewan) was closed in 1997 (Canadian Geographic, 2021).

The human remains of about 6,000 children (TRC 2015b) who were buried without their traditional ceremonies, acknowledgements, or memorials constitutes de facto a traumatic event as it breaks down the symbolic pact of a collectivity, as it disavows the sacredness of burial, identified in most human traditions as a civilizational ritual. The spatiality of the unconscious is central in accounting for how the past and present connect, what Clint Burnham (2021) renders as the geographical unconscious, because it marks the spaces of difference to take possession of land, which leaves and maintains traumatic sequelae (p. 177). Here I present how this perpetration is structured *linguistically* in the produced social bonding, via the state.

Perpetration corresponds to Lacan’s Master’s discourse, and it aims to dominate by organizing any signification and exchange, as much as making sense of the spatial difference. The settler nation is organized through a racist master signifier, necessary to establish the *homo sacer* ban that allows settlers to occupy land. Thus, the structures depicted in Figure 6.6 read as follows: a subject in the place of truth (Indigenous subject) causes a Master signifier (white settler colonialism as semblance) to command knowledge (state apparatus as place of jouissance); this last position of knowledge can be traced in the past as well as in the present.

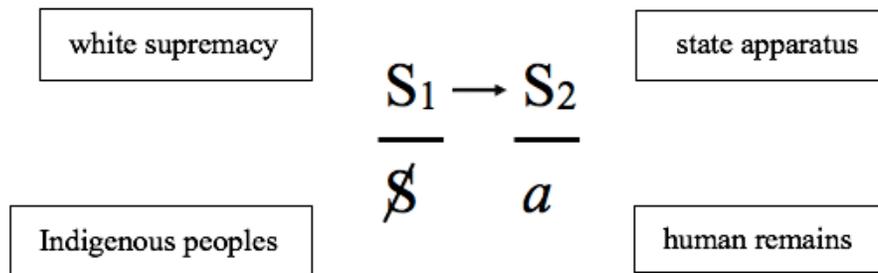


Figure 6.6. Lacan’s master discourse: perpetration

If we read this structure as part of history, as an artefact of the past, the master signifier is embodied in the words of Prime Minister John A. Macdonald, who mandated residential schools by articulating the following argument: “[W]hen the school is on the reserve the child lives with its parents, who are savages; he is surrounded by savages, and though he might learn to read and write his habits, and training and mode of thought are Indian” (Burnham, 2021, p. 186). This mandate created conditions that lead directly to the death of the children buried in unmarked graves.

The TRC³⁶ (2015b), reveals the spatial conditions of this industrial project constituted by uninviting places, true landscapes of fear, manned often by underqualified staff who performed as teachers and which provided below the average living conditions of the settlers, such as reduced accessibility to regular medical attention and poor quality of food. The violence exerted on the Indigenous peoples of Canada included the sequestering of children from their families and the killing of their languages —of the language that allows a person to represent oneself in front of others. There were acts of corporal punishment for speaking their own languages, for laughing, for going to the washroom in the middle of the night. They were acts of ongoing public humiliation, unwarranted violence and even rape that created excessive psychical and bodily experiences of great destructive impact against their peoples.

The residual production of the connection of S1 (Macdonald's mandate of residential schools) to S2 (knowledge position of the Christian and Catholic congregations, as *jouissance*), corresponds to object *a* whose material referent is the human remains of the unmarked graves. The latter constitutes a return of the repressed which is always a symptom that brings the past to the present. These residues of the Real unearth evidence of a thanatopolitical space (Foucault, 1975-76/2003) that urges the curtailing of ongoing repetitions of the same structure that sustains systematic domination. Colonial practices, deemed by some to be a matter of the past, unfortunately continue at present in systemic economic, social, and political marginalization. Pamela Palmater states it clearly:

Today's racist government laws, policies and actions have proven to be just as deadly for Indigenous peoples as the genocidal acts of the past. What used to be the theft of children into residential schools is now the theft of children into provincial foster care. What used to be scalping bounties are now Starlight tours (deaths in police custody)... Racism for Indigenous peoples in Canada is not just about enduring stereotypical insults and name-calling, being turned away for employment, or being vilified in the media by government officials — racism is killing our people." (National Inquiry, 2019, p. 53)

³⁶ The TRC was established in 2008 as a result of the 2006 Indian Residential Schools Settlement Agreement, the largest class-action settlement in Canadian history. The TRC gathered the testimonies of more than 6,500, compiled in a six-volume final report, from Indigenous people all over Canada who had been taken from their families as children and placed in residential schools.

As I close this chapter, a symptomatic aspect of the body politic emerges to instantiate how the discourse of perpetration, the master's discourse that has afflicted Indigenous peoples in Canada, regardless of mobility over time and space, sticks to its dominant structure. Although not at all comparable by means of individual intention or even signification, the structural form repeats the past in the present. On the *first* National Day of Truth and Reconciliation, on September 30, 2021, an inaugural event of grave importance for a national process of reconciliation, Prime Minister Justin Trudeau travelled to Tofino, BC, on vacation with his family. This event agitated a great deal of protest over social media outlets, including the comments of Lynne Groulx, CEO of the Native Women's Association of Canada, regarding how these actions "d[o] not match the words" (Maloney, 2021, np.). Every person, regardless of their position, requires rest and time for replenishing, family time and privacy, yet the fact that the Prime Minister *miscalculated* the importance and significance of this commemorative event for the restitutive justice process required in Canada in respect to Indigenous peoples, could indeed be considered an acting out. An acting out is an action prompted by anxiety in which the actor erratically expresses to an Other something that has not been acknowledged. In this case, the Prime Minister's ensuing apology confirms that the structure sticks, independent of individual actors. Discursive analysis does not seek the blaming of people, as much as this could be enjoyable, but rather finds the cause of certain exchanges that support the structure, to unveil its form and to show unconscious bundled actions, forgetting, or miscalculations involved in the unconscious repetitions at stake.

In the next chapter, I provide the research results regarding healing, and I contextualize crucial questions and challenges pertaining to each register of the human experience, the Real, the Symbolic, and the Imaginary, to inquire interventions in trauma.

Chapter 7.

Re-spacing trauma: Healing as a bending of discourses.

Nobody imagines that what is interesting in a wound, is the scar.

Lacan, session 10.05.1967.

7.1. Introduction

As discussed in Chapter 1, my research questions aim to understand the meaning of trauma and healing for service users and providers at VCH, as well as to point out the divergences and intersections of these understandings between and within spaces and levels of service provision: analysands, mental health clinicians, and leadership. Have I answered the initial questions of my research? Partially so: still pending is the presentation and discussion of the general beliefs, conscious and unconscious, regarding healing and recovery as understood by the research participants. In this last chapter, I will discuss those results as well as specific challenges and opportunities for trauma recovery practices within VCH.

The main results of this research study suggest that, to varying degrees, 6 out of 7 participant clients recognized having benefited from their involvement with the mental health and substance use services at VCH. They valued the professional help received from the clinicians, such as medical, group, and individual services; the facilitated access to services outside the institution; and some participants recognized improvement through hospital care. VCH excels at key aspects of service provision such as providing solid psychosocial rehabilitation, case management, and connection to social services for users of the mental health team services. This research reveals that there is a generalized awareness of trauma-informed care among service providers at every level—analysands, clinicians and leadership—within the participant sites. Also, along with most service providers there is an agreement that there are at least three stages in the provision of trauma specific services (TSS), which a clinical supervisor summarizes in the following way:

[The] first stage is really focusing on safety and resourcing ... supporting the person to either reclaim or develop skills to support their ability to self-regulate and to manage their day-to-day life. Once that is established, is ... trauma processing, that can only safely be done typically if there has been [the] first stage of building safety, skills and resources. The last stage of course is looking at who am I now and how do I live my life now ... having my story witnessed ... and having addressed the trauma story and the trauma experience, what does this mean for my future? (Ld1)

Clinicians and leadership appeared committed to provide first-stage trauma-specific services—psychoeducation—to as many people as possible, to their best ability. There are some programs that provide second-stage TSS, such as the START women’s day treatment program for MHSU issues in South MHT, individual therapy at SAFER-MHSU, PRISM at 3BSU, and the whole of AWP. Most of the mental health and substance use services at VCH are first-stage TSS, through predominantly sequential, psychoeducational, skill-based groups. This model of service delivery is understood as partially due to the temporo-spatial demands posed by increasing need, high complexity, and acute presentation in the population served; but it also involves the psychotherapeutic protocols in use, which provide a fast response but insufficient conceptualization of the complexity of trauma.

To approach the various scales of concerns and opportunities, I present and discuss the results through an analysis of the Real, Symbolic, and Imaginary socio-spatial and clinical challenges of service provision that are of vital importance if VCH desires the implementation of treatments that encompass human subjectivity. My interrogation is organized as follows: I first approach the challenges of the Real register, understood *qua* structure, as the challenges of the temporo-spatial demands of service provision, the social determinants of mental health, and surplus jouissance. The Real register, *qua* impossibility, refers to the traumatic proper, which I discuss through symptoms, anxiety, and inhibition as challenges posed by compulsive repetition. The Imaginary register frames my discussion of safety, pleasure, and the body. It also allows me to articulate the importance of creating meaning within traumatic suffering, which supports my proposal of diversifying current practices at VCH to increase access to one-to-one therapy, process groups, the arts at large, and complementary therapies of somatic relevance that emerge from alternative epistemologies. The Imaginary focus also affords discussion of how therapeutic landscapes should include service provision inside and outside institutional places. My interrogation of the Symbolic register, in

contrast, situates the conditions for the emergence of the subject, which leads me to differentiate the procedures of psychotherapy from those of psychoanalysis by discussing how an analytic position gets established. On the other hand, the demands of clinicians and leadership regarding better supervision allows me to articulate the importance of critical pedagogies and the democratization of decisions. I finish this chapter by proposing the clinic of social link, which leads me to introduce Lacan's analyst discourse as what facilitates re-spacing trauma to disrupt discursive formations, via the logical mechanisms of inscription and re-inscription.

7.2. Recovery or Healing?

The thematic analysis of the analysands' understandings about recovery from trauma, summarized in their various voices, presents it as a healing journey, a "gift" that they believed takes time, requires trust and sustained empowerment, and comes from an acceptance of trauma and its effects, the connection to their own truth, and the ability and confidence to develop social connections:

it's ... a gift a person can give to themselves. It takes time. It takes honesty. (A15)

So, I don't think time heals. I think it's like time in conjunction with treatment and working through it and talking about it and examining what you're going through and also realizing that your responses are normal. (A17)

Early feedback from advisors suggested that I change my research title from *recovery* to *healing*, as the latter appeared "esoteric" (Research notes, October 17, 2018) rather than aligned with the current guidelines for recovery-oriented practices (MHCC, 2015). Healing comes from *heal*, a verbal noun that emerged in the early 13th century, which refers to the "restoration to health, from an Old English *haeling* ... [f]igurative sense of 'restoration of wholeness'" (Online Etymology, 2021a). Recovery, a term from the mid-14th century, connotes "'a return to health after illness, injury, misfortune,' etc., from Anglo-French *recoverye*, 'remedy, cure, recovery'" (Online Etymology, 2021b). Both signifiers—healing and recovery—indicate the pursuing of *health*, a signifier of English etymology associated with "wholeness, a being whole, sound or well" (Online Etymology, 2021c). Recovery and healing are concepts of an ideal nature and their etymology strives for a total recuperation of a loss, and thus these

terms participate in spherical thinking (cf. 5.1). Some totalizing aspirations were voiced by both service users and providers in my interviews:

H- what does it mean to you that someone has overcome trauma?

A - It means that someone has perfect health.

H - Perfect health? Is there such a thing as perfect health?

A - I hope so... You know, you need to be told that you are amazing basically. (A11).

It is so imminently possible every time I've ever seen it... and when I say recovery, I mean literally the same thing I mean for every patient, which is helping them get to a place where they are becoming who they feel they are meant to be, with the life they want. (C12)

Is such an "imminent" promise of wholeness for "every patient" sustainable?

Various service users voiced the opposite view:

A - Do you think I could overcome all of those things?

H - That's a very important question, yeah. I don't know.

A - I don't think so. (A13)

I don't think there is a healing for trauma. So, it's all sort of gradient. (A17)

certain things are always going to be with you; there's going to be scars, just like physical scars, but physical scars don't necessarily have to hurt any more. I think that's equivalent with emotional trauma too. (A14)

What does MH policy say? *Recovery* is a philosophical approach that proposes the self-determination of the individual, conceived as unique and affected by various intersecting factors, such as the biological, psychological, social, economic, cultural, and spiritual, that influence mental health and well-being (Bradley in MHCC, 2015, p. 4). Recovery is also rendered possible "when our voices are heard, and we get to speak our stories of courage and resilience" (Calixte in MHCC, 2015, p. 6). The latter concern is reflected by Morrow and Weisser (2012), who believe that the term recovery has distanced itself from service user grass roots activism and urge others to understand this concept within a social justice framework and through intersectional lenses, attending to the many different variables that contribute to discrimination, oppression, and exclusion (2012, p. 28). The radical need for stories to be listened to as singular and the assumption of intersectional lenses in connection to the social, however, does not guarantee that the conditions of service provision are actualized, as another voice from

MH policy stated: “a great deal of trendy words can sometimes become empty vessels that certain people will fill with their own interests, whether political, economic, corporate or clinical” (Vigneault in MHCC, 2015, p.7). Morrow and Weisser consider that structural aspects exert power over people, such as neoliberal policy regimes, as well as “biomedicalism, racialization, sanism, sexism, ageism, heterosexism, etc.” (2012, p. 28). Sanism is of particular interest to our research on trauma as it refers to a form of discrimination based on mental health diagnoses that create stigma and psychiatrization of a person, based on deleterious assumptions about rationality and normality (Ingram, 2011 and Fabris, 2011, in Morrow & Weisser, p. 29).

In my work experience at VCH, the main problem emerging from the use of the term recovery is the enormous emphasis on behavioural change, despite MH policy encouraging “maximum autonomy and self-determination during assessment and in the coordination of service referrals” (MHCC, 2015, p. 32). In practice, the studied sites approach recovery in rehabilitation, counselling services, and case management through the implementation of a common acronym known as SMART, which renders therapeutic goals as specific, measurable, achievable, relevant, and time-bound. The predetermined focus on a specific outcome obstructs the possibility of listening to the subject, missing opportunities for subjective assertions and creative acts: sometimes the fact that a person with psychosis starts dreaming or writing poetry represents enormous advances that might be completely ignored; other times, occurrences considered as negative by default, such as a drug use relapse, or a person quitting a job or stopping their medications, might constitute, for the analysand, the best outcome possible to support their subjectivity. Instead, predefined outcomes become the treatment’s goal and can pose a hefty demand on the service user, as expressed here: “I’ve done a lot of things, but I feel like if I don’t do what they want, then they won’t give me follow up or whatever” (A13). Behavioural measurement can’t be the focus of mental health services if the institution wants to honour a space that fosters connections to personal stories and meanings or explores the effects of histories.

Many roadmaps are offered to navigate the itinerary of healing, such as those which highlight an integrative approach to TSS, particularly regarding complex trauma, by sequencing multimodal interventions of various stages of service (Curtois, 2008; Mahoney & Markel, 2016; Kaminer & Eagle, 2017; Cloitre et. al., 2011; Edwards, 2013). An outstanding compilation of community-based practice research about trauma models

by Poole and Greaves (2012) provides various guidelines to navigate TSS. Other models focus on the whole of the institution, such as *Sanctuary* (Bloom and Farragher, 2013), a thorough trauma-informed model of the institutional organization that combines trauma theory, business theory, systems theory, organizational systems, and clinical experience (Sanctuary Institute, 2021).

In my view, a roadmap can be an important tool for planning interventions and meeting goals in certain projects, but when applied to TSS and to complex trauma, it provides a false consistency because, as Lacan explains using the ideas of the mathematician Desargues, “the infinite straight line is in every way homologous to the circle” (Lacan, 13.05.1975). Roadmaps and spherical thinking present an illusion of knowing-it-all, which falls into idyllic and unrealistic expectations. In what follows, instead of a roadmap, I contextualize questions pertaining to the Real, Imaginary, and Symbolic registers, force fields affecting TSS provision. By contextualizing the challenges and opportunities at VCH, I invite others to think about how a program could knot these registers to create a model that acknowledges the great complexity of trauma treatment. As I have done in most of my dissertation, I approach these questions by alternating the focus on the clinical challenges of the scale of the subject with the socio-spatial difficulties posed by discourse.

7.3. How to understand the Real psychic and social conditions of people suffering traumatic sequelae?

Can we understand the socio-spatial and psychic conditions of those who seek mental health services for trauma sequelae? To some extent we might understand the nature of war zone, ethnic antagonisms, patriarchal structures of violence or an unfortunate catastrophe, but to understand in what way a person or community is psychically and socially impacted by trauma is difficult. We only can *try* to understand its effects because trauma is, as Žižek rightly points out, “the Freudian name for the ‘unknown unknowns’” (2009, p. 124). Within the Lacanian psychoanalytic tradition, a quick understanding is to the detriment of any clinical practice because understanding “ineluctably lead[s] us to reduce what another person is saying to what we think we already know” (Fink, 2007, p. 6).

To the question “who knows about trauma?” service users unanimously agreed on the weight of their own knowledge: “people who have experienced it already” (AI3); “Me” (AI4); “a combination of ... people who’ve had to do it in order to survive and the people who spend their days learning about it and studying it” (AI6). Knowledge resides primarily on the side of *those who have experienced a traumatic event* and the labour of understanding is always on the side of the analysand. From a psychoanalytic perspective, understanding facilitates a way to nominate themselves in the social, more so than insisting on naming that which resists symbolization. Understanding trauma in the field of mental health constitutes a wager, in the hope that the analysand could cut the deadly insistence of the drive, within therapeutic relations, to articulate a subjective position regarding the horror endured. A psychoanalytic approach also bids on bringing back to society a portion of the Bataillan *accursed share* (1967/1988, p. 9) that unequally affects the traumatized individual, for which the clinic must be one that facilitates social link, which I will articulate at the end of this chapter.

In this section, I focus on the challenges posed by the Real. The Real register, *qua* structure,³⁷ presents socio-spatial challenges such as the temporo-spatial demands of service provision, the social determinants of mental health, and surplus jouissance, which alludes to the material conditions in which service provision operates. The Real register, *qua* impossibility, hence of a traumatic nature, poses significant challenges to healing suffering in the clinic, such as individuals’ unique historical legacies as they appear in their symptoms, anxiety, or inhibition, or the phenomena of compulsive repetition. The conditions of the Real demand of the institution acknowledgement and should be considered when planning psychotherapeutic projects within mental health teams, if there is a commitment to facilitating a healing journey that addresses the complexity of the speaking subject facing posttraumatic suffering.

7.3.1. Social determinants of health

The guidelines for recovery-oriented practices indicate that various social determinants are key for mental health, such as “[h]aving a stable adequate income,

³⁷ I demonstrated in Chapter 4 that the socio-spatial linguistic structure can be partially explained as an imaginary and symbolic creation in the axis of representation, but when analyzed from the axis of production, the structure is Real, for it compulsively reproduces conditions that appear impossible to change and produces traumatic residues (cf. 4.2; 4.3.1).

safe and affordable housing, access to health and social services, the support of family and friends, secure employment, livable communities and dependable transportation” (MHCC, 2015, p. 42). These determinants of a social nature are not achieved by a willful subject in possession of ego strength, but rather by opportunities to establish social links offered by a collectivity and a state. The predominant biomedical and psychoeducational models in the global mental health field have ignored, as Morrow poignantly argues, that mental suffering, and by extension traumatic suffering, “is intimately tied to social inequalities like poverty, homelessness, racism, homophobia and sexism” (Morrow, 2007, p. 73) and this link situates that mental suffering has a profoundly geographical dimension]

Various service providers have acknowledged the importance of treating trauma as a root cause, what is known in geography as upstream or root causality (Moon, 2009; Smith, 2009), rather than only treating the symptoms: “It is more cost effective to VCH in the long run, I believe ... there is not typically a return if they have done trauma processing” (Ld1). However, the precarity of life is a dramatic reality for some service users and public mental health workers confront it everyday:

how are we going to be doing trauma processing with people when they do not have a place to live, when their finances are not secure, or if they do have a place to live, they are hiding out there terrified and having nothing else in their lives. It is not realistic. We have to look at the whole situation not just the trauma; the whole person in their context (FG C13).

This eloquent statement brings forward a twofold concern: on the one hand, it highlights the immense challenges that some people with trauma sequelae suffer, and the importance of designing programs that question the capitalistic and neoliberal regime to offer a material response to treat life in its bare form, life in its unjust insulting conditions³⁸; on the other hand, this statement highlights the fact that at the social scale, “trauma processing” in the presence of precarity is not a matter of an office-based intervention with an individual, but is constituted by various forms of politics (cf. 7.7).

³⁸ Agamben establishes a differentiation of life as *zoē* (biological life) and life as *bios* (quality of life). *Zoē* refers to an inclusive exclusion of political life: inclusive because even as a bare manifestation of life, it is still part of society; exclusionary because it prevents access to the symbolic status of life as *bios*, “the form or way of living proper to an individual or a group” (Agamben, 1998, 9).

As discussed in Chapter 3, Canada spends less on mental health (7% of health care total) compared with most Organization for Economic Co-operation and Development (OECD) countries, which range from 8 to 15% (CIHI, 2019a, p. 13). And even though Canada's annual increase in mental health expenditures (4%) is disproportionately higher than the country's overall annual increase in health expenditures, the Canadian mental health system has followed a neoliberalization model over the past 50 years, moving away from a community-based services model (GVMHS) in praise of what Masuda and Chan (2016) coin as a "rationalistic model of health system access" (p. 590). Within British Columbia, VCH is the region most impacted by the provincial mental health and addiction crisis, which includes the opiate crisis, housing crisis, and increasingly complex and acute mental health demands. VCH tries to meet those immense mental health challenges by relying on a biomedical model that Masuda and Chan (2016) describe as reflecting "an ideology of individualization, austerity, corporate governance, and a reassertion of a technorationalist biomedical model of health *over a relational socio-ecological model of well-being*" (p. 590, my emphasis).

I explained in Chapter 3 that VCH rely on a hegemonic biomedical model and the emotional literacy of the mentally ill as preferred treatments, and thus VCH's emphasis on recovery is on an atomized individual *qua* brain, rather than a subject that has existential questions and is connected to a social milieu. Economic decisions of service provision are based on the instrumentalization of a reason that praises increasing efficiency—even as self-fulfilled fantasy (cf. 5.7)—and cost containment, rather than attention to communities of care, a sense of place, and democratic and critical practices (Masuda and Chan 2016; Morrow 2007). Economic decisions are stubbornly made from the top-down, with resistance to epistemologies other than the biomedical. I wonder if those making the big economic decisions at VCH have ever been in a psychiatric ward? Have they tried to help a person in a psychotic state or in a suicidal crisis directly? I do not know. However, I do know that there is a lack of democracy in program design. For example, in the VCH team that I worked with last, there were about 40 to 50 people representing 6 disciplines, and yet only 2 to 3 people from 2 disciplines designed the psychotherapeutic mental health treatment delivered to service users (Research notes, August 6, 2019). A MH program redesign is underway, but regardless of vast consultations, some participants believe it will preserve the exact same model:

I lose a bit of hope in a way because it is hard to feel, as a clinician, that you can make change in such a big organization. It is hard to feel that you can be a part of, let's say, this redesign. So much of when it comes to treatment everything is kind of passed down to clinicians. There is no collaboration or conversation, especially with clients. (FG C12).

After the crisis of Covid-19, this urge is even more dramatic, so mental health care “should be specifically designed to mitigate disparities in health-care provision” (Moreno et.al., 2020, p. 813). The social determinants of health are connected to the Real *qua* structure of the political economy and exceed the temporo-spatiality of VCH, because the globe is afflicted by a voracious neoliberal capitalistic model that, based on individualism and ahistoricism, prevents community strategies that bring forward cultural, artistic, and diverse epistemologies to heal trauma from being taken seriously.

7.3.2. Time and space challenges

One concern identified by service providers in my research is that of *budgetary time-space constraints*, a result of highly complex caseloads and abundant referral numbers that restrict the relational approaches crucial for developing trustworthy therapeutic relations to work on root causality. These constraints are expressed in the following way:

my current caseload is over 60 people ... with everything else that we are doing as a case manager, looking over medications, housing, anything that comes up. There is not enough time. (C11)

these days managers have multiple sites and I do not have the relationship with my front-line staff that I would like to have or that I had with my manager reversing back 8 years ago when the managers weren't spread so thin ... I don't think I am supporting my team as much as I could if I had less sites to manage or less programs. (Ld7).

there's a level of burn out that's going on that isn't being recognized from the intense and high caseloads and sometimes the frustrations of working ... how do we divide up our resources to be able to match the demand and the need in Vancouver? (Ld6).

The frantic efforts to focus on pragmatic interventions affects the experiences of service users, as this participant voiced:

they have so much work that ... everything's compacted very much and just 'get this,' you know ... 'does this work? does that work?' ... those things don't give me real support (A13).

The demand for services within the level of trauma complexity overwhelms VCH's ability to respond and poses a double risk: service providers' burnout, and "putting a Band-Aid on the problem" (Ld2) for service users. The constraints on space and time found at VCH are intrinsically connected to the subject's temporo-spatial conditions for healing, because healing requires time. How can we think through this central challenge?

Through what Lacan calls his sophism, he demonstrates three logical moments crucial to understanding the temporality of healing: the *instant of the glance*, the *time for comprehending*, and the *moment to conclude* (Lacan, 2006, p. 167).³⁹ Lacan affords us a logical consideration that, albeit not a roadmap, can help to contextualize the challenges of the temporo-spatial provisions of TSS to see the trajectory necessary to reach a conclusion. The three logical times can be further defined as:

1. the *instant of the glance*, which is a fulguration of time, a moment of an instantaneous acknowledgement of evidence (Lacan, 2006, p. 167).
2. the *time for comprehending*, which corresponds to moments of meditation, intuition, the creation of a causal hypothesis and of doubt.
3. the *moment to conclude* refers to an assertion of self, in which the subject makes a judgement that ends in an action that moves towards a conclusion, even if the consequences can't be known.

These logical times are useful in thinking about a healing journey that concludes on a subjective assertion, which means a subject standing on the side of desire, not on the side of self-objectifying jouissance, which entails submission to the oppressive preconditions of the Other's linguistic code. Yet two conditions are required for the subject to conclude: *first*, the subject must *act* by overcoming infinite doubts, trusting in the verifications that they could afford to emerge as a subject, retroactively signifying the

³⁹ The sophism reads as follows: A warden is required to free one of three prisoners, and to decide which one must go, he submits them to a test: the warden puts a circle on their backs—three disks are white and two are black—and the prisoners must guess what colour the disk is, providing a logical explanation to support their decisions. The solution envisioned by Lacan is that the three prisoners walk out simultaneously, articulating the same rationale. Yet the sophism is an aporia, Lacan argues, because there is an inherent logical error that prevents the finding of a solution when the conceptualization is embodied in space and movement (Lacan, 2006, p. 161).

previous two temporalities, “perhaps incorrectly, perhaps correctly,” (Lacan, 2006, p 172). And *second*, in their acts, the subject never acts *ex nihilo*, because even if the acts and the consequences are carried out by the subject alone, “no one can get there but by means of the others” (Lacan, 2006, p. 173).

Could we see the temporo-spatial service constraints at VCH through the same lenses? Could these scansions or hesitations inform a way of approaching the serious issue posed by the Real structure of MH service provision? While the analysand must traverse those temporalities in their healing journey to emerge as subject of the unconscious desire, so does the institution necessitate temporal logical timing to assert the needs of service providers. These temporalities concern the body politic, which needs to act on collectivizing ongoing concerns, finding political agencies within the institution to work together in targeting the grave and increasing temporo-spatial challenges of service provision. Equally, the institution should reconsider a different model, less managerial and more relational, that strengthens the social value of collective decisions and community-based organization, instead of frantically trying to regulate organizational relations between the economy, policy, and society “as a way of responding to capitalist crises” (Barnett & Barnett, p.58).

7.3.3. Surplus jouissance

In addition to the social determinants of health—global scale, and the temporo-spatial concerns of service provision — national and institutional scale, there is yet another challenge of the Real posed by surplus jouissance, a conceptual lynchpin that connects the Real of the structure and the impossible Real because, at its core, it refers to the notion of the drive within discourse.

Surplus jouissance is akin to both the subject’s body of jouissance and the force of the body politic, as the drive—a liminal concept between the organism and the psyche—pushes the subject towards a paradoxical excess of enjoyment that results in a loss. Lacan says that “[w]e are being born of surplus jouissance, because of the use of language. It is language that uses us. Language employs us, and that is how it enjoys” (1969/2007, p. 66). The logic of jouissance is instantiated by Lacan via the myth of the

Danaides,⁴⁰ women of ancient Greek myth who had to pay for their sins by perpetually filling leaky jars of water, which allows Lacan to highlight the dialectics of accumulation (excess) and expenditure (loss). How does language create a surplus that structures the material conditions in which we live?

Surplus jouissance is different from jouissance in that the former is a residual loss within discourse, able to be located, that launches the drive again. Jouissance, in contrast, albeit circulating in discourse, does not provide access to what caused it in the social. This concept can be framed in psychoanalytic theory through Freud's two topographies: the *first topography*, sometimes known as the structural topic, pertaining to the unconscious, preconscious, and conscious; and the *second topography* or dynamic metapsychology of the ego, id, and superego, added to the apparatus of the libidinal economy, which is based on the antagonism of the drive's cathexes that incorporate notions such as quantum of affect or sum of excitations (Freud, 1895b/1973). Surplus jouissance in Lacan is accounted for by the topology of the drive added to the theory of discourse.

Psychoanalysis and Marx's historical materialism both signal *Unbehagen*, the discontent in society, which finds its epitome in the mental health institution since suffering is a result of the relations a society allows for subjects. Freudian-Marxism explains such malaise as a result of the alienating structures in which we live, and Lacan imparts a twist, already in Freud, by articulating how suffering involves a certain form of morbid enjoyment because we are "seemingly able to obtain intense libidinal satisfaction (jouissance) from doing things that are excessive, compulsive, and even harmful" (Kingsbury, 2017, p. 3). When describing structuralism as "simply seriousness" because it looks for the cause of discourse, Lacan equates the principle of surplus jouissance, the psychic mechanism that is launched intersubjectively in discourse, and the principle of surplus value, the excessive capitalistic production that abstracts labour while it obscures it, and renders them as sharing the same logic, as homologous (Lacan, 1968-

⁴⁰ The Greek myth of the Danaides, recorded by various ancient writers such as Euripides, Ovid, and Plato, tells the story of the fifty daughters of Danaus, a King of Egyptian and Greek lineage, who are forced to marry the fifty sons of Aegyptus, Danaus' twin brother and enemy. The marriages of the Danaides have tragic fates because to free themselves, they follow paternal advice and slay their husbands with daggers on their wedding nights, later beheading them and throwing their heads into a marsh. Because of these acts, the Danaides were condemned to the lower world to expiate their sins by eternally filling leaky jars with water.

69, session 13.11.68; Tomsič, 2015, p. 98). If we assume that both mechanisms are not only logical but spatial, we could imagine them as *homotopic*, as sharing the possibility of being deformed one into the other.

What is surplus jouissance then? If focused on from the subject's perspective, we can understand it through the logic of sayings such as “the hair of the dog that bit you,” an English proverb that prescribes the use of alcohol to cure the intoxicating effects of a hangover; or the yuppie motto “work hard, play hard.” The idea of surplus jouissance is to cure the excess of lack with more excess, to *up the ante* by fabricating a phantasmatic gain that attempts to cover a loss. If focused on from the perspective of discourse, surplus jouissance constitutes a residual loss that makes discourses turn or be relayed by another discursive form. Each discourse produces enjoyment by the mere act of speaking and social bonding always produces a residue that exceeds the structure; hence, the site of surplus jouissance is where the negative—excluded or rejected—actualizes, and this very site constitutes the opportunity for another discourse to be initiated. Lacan says: “the expense of jouissance [necessitates] the surplus enjoyment (*plus-de-jouir*) for the [discursive] mechanism to turn” (p. 22). In other words, the social link breaks and restarts where the Real proper emerges.

Alongside the existence of a preassigned place that contains the traumatic Real—object *a*—in every discourse, there is always a place of *discursive residue* that works in each instance of social bonding. Surplus production in the *university discourse* (the know-it-all), illustrated in my research by the master signifier MHEBP, corresponds to a specific kind of subjectivity that, if it dares to question the dominant epistemology, will be excluded. The *hysteric discourse* (protest), which I explained with Case A, obtains knowledge as residual production. For the *master discourse* (perpetration), instantiated by the state-sanctioned trauma of Indigenous peoples in Canada, as well as the *capitalist discourse*, exemplified by Cases C and D, the surplus production corresponds to the abject and death. Finally, in my proposed *victimhood discourse* the surplus production is a master signifier that perpetuates a signification of shame and guilt because it is not addressed to the subject but rather to those who supposedly know. Yet there is another way of producing a surplus, detailed below, constituted by a master signifier subjectively produced in the *analyst's discourse* (bending the structure to inscribe). The site of the residual is favorable to relaunching discourse in different directions, and hence is a place where value gets decided.

Various Lacanian authors have rendered surplus jouissance as fantasy, which is the constitutive field that covers the traumatic lack in the Other that permits the staging of the subject's conditions for desire and jouissance (cf. 5.3.2). Will Greenshields, when working topologically on Lacan's theory of discourse, depicts surplus jouissance as "a circular disc which can 'supplement' the Moebian structure of the subject and, in doing so, grant his fantasy a fictive consistency and coherence" (2017, p. 3). The logic of surplus jouissance has also been presented by George (2016) when discussing African American slavery trauma as a fantasy regarding "being;" it is a fantasy because the subject's existence lacks a tangible being, by the very fact of their capture in language (cf. 5.3.2). Surplus jouissance has also been rendered by Dries Dulsster and Stijn Vanheule as a "make believe" fantasy of communication by making us believe "that speech, which primarily echoes corporeal tension and enjoyment, has a [primordial] communicative function" (2019, p. 59).

But surplus jouissance can't be fully conceptualized by a qualitative concept such as the logic of fantasy; it is of utmost importance to articulate economic aspects of this phenomenon if one wants to approach concerns of libidinal transformation. The economic aspects of surplus jouissance, based on the topology of the drive, refer to the dialectics of lack, excess, expenditure, loss, and residue that sustain the libidinal economy as much as the socioeconomic material conditions of inequality in society. Recalibrating surplus jouissance goes beyond a magical quantitative energetic redistribution, as it is rather an effect of a qualitative intervention that conjures up a limit and brings satisfaction by linguistic means. In psychoanalysis, the *quantitative condition of the drive* is possible to defuse only by *qualitative means* (Freud, 1926/1973, p. 94), such as when the analysand finds a word to dislodge from fantasy or decode the ciphering of a symptom.

Slavoj Žižek and Samo Tomšič are perhaps the Lacanian scholars who have explored surplus jouissance the most, with a focus on the economic dimension of the phenomenon of enjoyment. Translating 'jouissance' as 'enjoyment' is not particularly useful because it can get confused with the pleasure principle, leaving aside important connotations that the word jouissance affords, such as property, the sexual nature of pleasure, and the morbidity of loss and excess. Žižek explains surplus jouissance as a "mature" notion of Lacan's *objet petit a*, and as the Freudian *Lustgewinn* or "gain of pleasure," (2017b, p.7) and writes:

if there is a surplus (excessive wealth) on the one side and a lack (poverty) on the other side, why can't we re-establish the balance by simple redistribution (taking the wealth from those excessively rich and giving it to the poor)? The formal answer: because lack and surplus are not located within the same space where they are just unequally distributed (some people lack things, others have too much). The paradox of wealth resides in the fact that the more you have the more you feel the lack—it's again the superego paradox (the more you follow the injunction, the more guilty you are). (Žižek, 2017b, p. 15)

Thus, is not simply the redistribution of wealth what needs to be disrupted, but the libidinal economies in their relation to lack and excess. Žižek presents a simple but illustrative example:

Imagine a Walmart store closing in the evening, with many shopping carts full of items thrown into them found among the shelves; they were mostly abandoned there by members of the newly impoverished middle-class families who are no longer able to buy things. (2017b, p. 9)

Žižek explains that the production of surplus jouissance occurs by shopping for nothing, an absence, which is an enjoyment that sacrifices a real enjoyment, and he instantiates other forms of the surplus, among them activism, militancy, and communism. On his part, Tomsič (2019) connects the problem of enjoyment to labour theory and exploitation by discussing the hidden links existent among “the reproduction of the relations of domination by means of the production of enjoyment” (p. 15). Elsewhere, I have engaged with this concept through the analysis of the master signifier in relation to environmental devastation and the rise of extreme right wing political movements across the globe, proposing the politics of the inscription of traumatic residues (Fernandez-Alvarez, 2020). I have also approached surplus jouissance through the phenomenon of the Aokigahara forest in Japan as a popular destination for suicide tourism (Fernandez-Alvarez, 2021). Both texts are concerned with the inscription of residues—inscribing the leak, a senseless loss, a traumatic absence of signification. I will substantiate the importance of the politics of inscription (7.7), yet another vantage point of intervening surplus jouissance even before it turns into a residual production, is at the site of the thrust or force that pushes the topology of the drive (expenditure) which coincides with the process of valorization, as depicted in Figure 7.1.

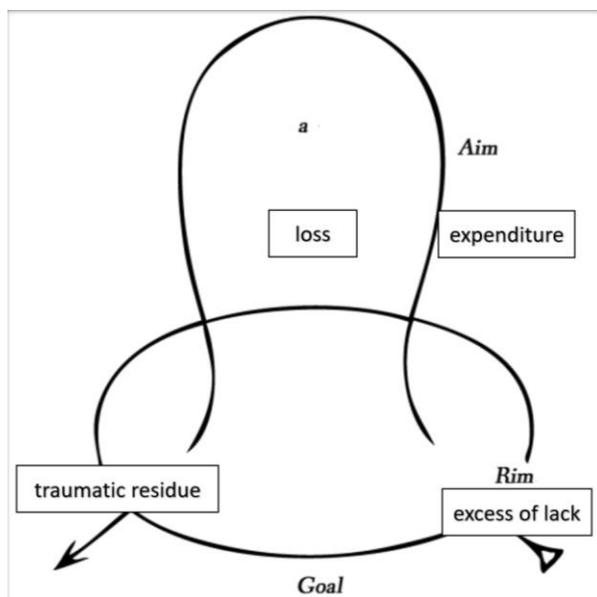


Figure 7. The topology of the drive shows the thrust of the drive’s aim as a place of valorization, consequently a privileged place of intervention.

The valorization of self as *object* of the Other’s desire is, for psychoanalysis (Lacan, 1962-63/2014), what the valorization of self-consciousness—or the “life-and-death struggle” for recognition—is for society (Hegel, 1807/1977, p. 114). Both correspond to what is at stake in surplus jouissance: we produce excessively because we want to be an object of love for the Other and recognized as such by others. Meanwhile, the lack of surplus value, always needed according to the capitalistic principle, is what pushes the obscene self-valorization of capital (Marx, 1867/2013, p. 127), as capital is nothing but accumulated surplus value which generates an infinite desire to produce more. Are these two accounts of surplus production reconcilable? Although sharing spatial and logical continuation, these two notions of excess—value and jouissance—are not the same. For Marx surplus value is a consequence of human alienation of the means of production, and it is a historical rather than an ontological condition. For Lacanian psychoanalysis, surplus jouissance is the *sine qua non* condition of human subjects, which is both a transcendental and historical condition for each speaking being. Therefore, the heuristic dimensions on how to deal with psychical and politically economic—excess and residues—constitute one of the central aspects of human ethics, as I will discuss in the conclusions to this chapter.

The valorization of subject and society are the precise sites, as it is showed by my clinical experience, where surplus jouissance can be launched differently, and

consequently the possible subversion of exploitative modes of value; not because there is a pre-given answer to this subjective, social, and economic curse, but because the question can be pushed in totally different directions.

How does valorization help us to understand MH service provision at VCH?
Some clinicians voiced it like this:

It is not that there's not the resources it's just the current silo model ... some of the alternative services that I have seen are really helpful for people [but] are not covered for MSP, so it would require a willingness to fund the services that are not covered. (Ld1)

Decisions are made around mandates, around economics. Economics are the first priority which can really be a challenge ... You are trying to be there for them [clients] but the mandate limits that. For me that is the biggest challenge. (FG, Cl4)

That means that the mechanisms that reproduce the current economy and that affect the decisions for service provision at VCH can be also a continuation of how discourse organizes expenditure within the institutional constituency: who enjoys providing the hegemonic treatments, what is the subjective cost of them, what are the residues? Surplus jouissance will not stop, it is the force of life and death, it is part of the subjective catastrophe, or being humans trapped in language among other speaking beings. But valorization is a site where surplus jouissance can be released differently and transform the libidinal economy towards *desire*, the only notion we know that can provide a form of satiation or satisfaction to the voracity of the subject, even and precisely because desire assumes the lack and accepts loss (cf. 7.4.3.1). I will frame some further questions about surplus jouissance in the conclusions of this chapter. For now, I will turn to the discussion of the Real challenges for trauma treatment at the scale subject, which refers to compulsive repetition, the most compelling difficulty in clinical intervention.

7.3.4. Symptoms and inhibitions as an alternative to anxiety

In the focus group I asked: "How do you intervene therapeutically when people continue experiencing or seeking the repetition that brings them suffering?" (Appendix D). The clinicians in the Focus Group connected compulsive repetition with the following themes: something unconscious that can't be changed easily (FG Cl3); self-judgement and shame (FG Cl1, Cl3, & Cl6); fear of change (Cl6); a gain obtained every time

someone repeats (FG C14); and something that needs to be answered with compassion (FG C11, C13, & C16). Specific to the Indigenous population, compulsive repetition was also perceived as requiring externalization to identify colonial violence and understand why and how they repeat (C16).

Compulsive repetition is at the core of any suffering and constitutes a Real challenge at the subject scale. Many analysands I have worked with express the impasses of repetition in common parlance: “what is the definition of madness/insanity? Doing the same thing, over and over again, expecting different results.” Compulsive repetition is known by every speaking subject because it is a push of the drive—the source of life and death, the force that links body and mind—which nourishes psychical and physical manifestations, such as anxiety, inhibitions, and the symptom (cf. 6.3.1 and 6.4).

I have rendered the Freudian-Lacanian perspective on anxiety (cf. 6.3.1) as an extimate affect that signals the grave danger of blurring the subjective space of inside/outside, foreboding a menacing proximity of the Other, causing the subject to feel disoriented and helpless as they experience themselves as an object for the Other’s enjoyment rather than a subject of their own desire. Yet traumatic events do not necessarily cause PTSD (Summerfield, 1999; Young, 1996; Bracken, 1995) for the reaction to trauma is quite singular, as a participant expressed:

trauma ... it’s in the eye of the beholder. I don’t think there’s a specific thing that can have a traumatizing effect on somebody, and I don’t think there’s a specific person that can be identified that would be predisposed to experiencing trauma. (Ld5)

Verhaeghe (2004), however, articulates a specific vulnerability for developing PTSD by situating posttraumatic suffering on the interstices of neurosis and *actual pathology*. Freud differentiated “actual neurosis” from psychoneurosis in that the latter refers to those neuroses that create a partially decodable symptom and whose origin is found in early childhood (Verhaeghe, 2004, p. 290).⁴¹ Actual neurosis, instead, is not located in infantile development but rather in a sexual conflict—understood in the ample

⁴¹ Verhaeghe writes that actual pathology can be present in any subjective position (neurotic, psychotic, and perverse) (2004, p. 316). Verhaeghe also explains that while Freud’s theory of actual neurosis was underdeveloped, he continues “to confirm its existence right to the end” (2004, p. 291).

sense of the sensual and erotic body—caused by an accidental trauma of a more recent occurrence. Typical presentations of actual neurosis are compatible with PTSD: for example, marked generalized anxiety or somatic phenomena, such as immune suppression, physical illness, chronic physical pain, or fibromyalgia (cf. 2.3.4). This reveals an overwhelming charge of the drive that has not been coded through the Symbolic (signifiers to name things) or the Imaginary (images that can create a body). In another paper, Verhaeghe and Vanheule (2005) indicate that PTSD, in its pervasive and disturbing effects, occurs within pre-existing circumstances that prevent associative memory from creating meaning and a sense of history and agency as a result of the absence of a caring Other, who could assist the subject with symbolic mediation of the drive's arousal. This premise is identical to the tenets of attachment theory (cf. 2.2) because early dyadic models shape interpersonal relations and identity and necessitate an Other of care to whom the subject develops a form of attachment. The main difference, Verhaeghe and Van Heule agree, is that the nature of the drive is beyond articulated knowledge, posing the great difficulty of processing traumatic truths that can't be mentalized (or represented by imaginary and symbolic means) and have not yet been put into a dialectic that is, they lack symbolic mediation with an Other.

People with posttraumatic suffering are captured by anxiety due to the inability to represent the traumatic event. They must have strong historical reasons for that; perhaps the Other of care was too proximate, perhaps too absent, profoundly affecting the way the subject deals with the affective effects of the drive. The multiple signs of incapacitating anxiety are unanalysable because the underlying affect or energetic force of the drive remains “unbounded” to signifiers, and thus the subject's logical structure can't find a remedial mechanism to transform the traumatic event into the unconscious. Paradoxically, while anxiety impedes the metaphorization of a traumatic event, anxiety is simultaneously required to organize an action. One of the first psychoanalytic tasks posed by traumatic anxiety is how to probe the right questions and interventions to disclose its logical mechanism so that the subject can transform anxiety into a symptom—in the psychoanalytic sense—or into an act. How can a subject use anxiety as an organizer of desire rather than as a shattering of it?⁴² To approach that question,

⁴² Elsewhere, I worked on the mechanism of anxiety in suicidal individuals who experience death anxiety—instead of its absence—affording them an active organization to self-preserve their own lives (Fernandez, November 2015, p. 36).

in what follows, I discuss how symptoms and inhibitions are formed, successfully bypassing anxiety.

Freud established a profound connection between trauma and the symptom, as “the endeavour to undo a traumatic experience is a motive of first-rate importance in the formation of symptoms” (1926/1973, p. 120). A symptom for Freud is always “*the return of the repressed*” (1915d/1973, p.154, my emphasis) and its mechanism is described as follows:

to fend off an incompatible idea, he [the subject] sets about separating it from its affect, then that affect is obliged to remain in the psychological sphere. The idea, now weakened, is still left in consciousness, separated from all association. But its affect, which has become free, attaches itself to other ideas which are not in themselves incompatible. (1915d/1973, p. 133).

The drive or libidinal force, known only through the *Vorstellungrepresentanz* or the “ambassador” idea, captures a significant quantum of affect or sum of excitation and channels it in the metaphoric mechanisms of substitution and displacement of an idea (or signifier) to another idea (or signifier). This substitution is the metaphoric core of the symptom and hosts, simultaneously, the unacceptable tendency and the defense. Thus, the psychoanalytic symptom constitutes a literal *formation of the unconscious* because it creates repressed contents—the unconscious proper—by masking initial drives that were intolerable to the ego of the subject and providing the possibility of decoding it in treatment. As Bruce Fink states, a symptom is a “saying that has never been put into words before” (2007, p. 86).

Magistretti and Ansermet (2016), a neuroscientist and a Lacanian psychoanalyst, respectively, claim that conscious somatic states known as “S” (interoception, stimuli coming from the source of the drive) are associated with representation “R” (language) and that “the reestablishment of homeostasis will be constrained by the content of the representation R and therefore engage an action related to it” (p.140). In other words, to calm the insistence of the drive, the subject requires a linguistic representation such as a word, a gesture, or an action to discharge the excess of the drive and gain a minimal somatic homeostasis. The anatomic seat of the drive, according to these authors, is the insular cortex, a part of the cerebral cortex whose functions include sensory processing, affect representation (feelings and emotions), autonomic and motor control, decision-making, as well as bodily and self-awareness, among others. In that way, the drive

constitutes a neurobiological and subjective site of contestation where functions such as representations of the drive (*Vorstellung*) and re-representation (*Vorstellungsrepräsentanz*) are key to resolving anxiety and symptoms so that the subject can unconsciously decide how to act at the insistence of the drive.

According to Freud (1926/1973), symptoms direct the brunt of the drive differently according to the main clinical structure: in hysteria, trauma is dealt with by amnesia through the mechanism of repression that results in an innervation of part of the body—for example, in specific physical symptoms such as paralysis or localized pain—but it also involves interpersonal conflicts in which the body must deal with the social other. In obsessional neurosis, trauma may not be forgotten but rather is managed through mechanisms of reactive formation; for example, one action is cancelled out by a second, as in obsessive thoughts or ritualistic actions; or the connection of body and mind is compartmentalized and isolated, forming intrusive, harshly judgmental, or persecutory thoughts (p. 119). In phobia, the source of trauma is apparent and there is awareness of what is feared (p. 122), presenting avoidance of a specific object that is literally or semantically connected to the trauma, as in the example of people with combat trauma who avoid events where fireworks are involved out of fear of triggering traumatic memories. Psychosomatic symptoms, psychosis and perversion each direct the drive differently, by incarnating anxiety in the body (psychosomatic), by becoming the content of the anxiety (psychosis) or by covering the anxiety with a fetish (perverse). The detailed articulation of these mechanisms exceeds my current discussion, what is important to mention for now is that to be able to work on post traumatic suffering, the analytic work starts when the suffering has the form of a symptom, understood as a question and as a demand.

Freud also writes that like the symptom, inhibition can direct the drive, due to the fact that they both “represent a relinquishment of a function because its exercise would produce anxiety” (p. 88). Inhibitions refer to an overall “restriction of an ego-function,” (p. 89) which manifests a renunciation of a certain function—eating, excreting, moving, working, having sex, or thinking—to avoid further psychological conflict. We can understand inhibition as the repetition of an absence—repeating what is *not happening*—as in the case of procrastination or social disengagement.

Inhibitions and symptoms have the purpose of avoiding a twofold conflict: on the one hand, these symptomatic formations avoid conflicting *the ego with the id*. For example, a subject who had a traumatic loss might avoid falling in love to prevent being hurt and have to renounce it later by forcing repression *once again*; or the subject might sustain a symptom or inhibition to avoid taking responsibility for their true desires. On the other hand, symptoms and inhibitions also avoid conflicting *the ego with the superego*, saving the further infliction of self-punishment. For example, someone might prefer to avoid their desires to prevent self-doubt or external and internal criticisms. For Lacan (1926/1973), inhibition “lies within the dimension of movement, in the widest sense of the term” (p.10); hence, it functions as a defence against acting on desire, for instance, by not wanting to see or to know their true desire (p. 319).

While symptoms and inhibitions are ways of closing the gaping hole opened by trauma so the person can reach minimal stability, something that anxiety can hardly afford, they are not the only ways to deal with trauma. Below, I'll discuss other forms in which a traumatized individual can find a subjective nomination via a creative act (cf. 7.4.2). But before that, in the next section, I will discuss jouissance, which has commonalities between symptoms, inhibition, and anxiety, to highlight some questions posed by such a challenge by the Real.

7.3.5. Jouissance agitated, the production of symptoms, inhibitions, and anxiety

Both the body of the subject and the body politic experience jouissance, which “presents itself as buried at the centre of a field and has the characteristics of inaccessibility, obscurity and opacity” (Lacan, 1998, p. 209). Freud articulated this form of paradoxical and repudiated enjoyment through the case of the Rat Man, who suffered from an obsessional fear of being submitted to a type of torture practiced in the East that consisted of introducing a rat into the anus; Freud could hear the Rat Man narrating it with a “pleasure that can't be recognized as such” (Freud, 1920/1973, p. 11). Jouissance explains the enjoyment of compulsive repetition, which Freud identified as a human trait of fundamental masochism, of “pleasure in pain, moral masochism as unconscious guilt” (Freud, 1924/1973 p.166). This peculiar form of enjoyment says the subject's sexual truth, that which the body enjoys despite the individual's morals (superego) or consciousness (ego). The meaning of the experience of jouissance involves the

sexuality of the subject (suffering and enjoyment together), understood in the Freudian sense not only as genitalia, gender, or the sexual act, but as an extension of the drive in the body, and is inaccessible to full symbolic articulation for it constitutes a hole in the linguistic structure caused by a constitutive trauma.

Darian Leader's rendition of *jouissance* is relevant to trauma sequelae when he says, "the body's pleasure zones are transformed by frustrations into displeasure zones, fusing hate and love, and stimulation of them will be 'resented as an insult and dreaded as a danger, as well as welcome'" (Leader, 2021, p. 15-16). The latter clarifies the paradoxical nature of hate and love, want and repulsion, that often comes together in traumatic suffering. But *jouissance* is never solipsistic, as it always involves an "Other's presence or absence" (Leader, 2021, p. 17). The latter is well-instantiated in the conflicts faced by people who have suffered physical, emotional, or sexual abuse, who are required to negotiate ambivalent feelings with those others who harm them and were figures of love, Others of care that contributed to the subject's own relation to language.

As Freud (1923/1973) states: "The erotic instincts and the death instincts would be present in living beings in regular mixtures or fusions; but 'defusions' would also be liable to occur" (p. 258). What makes a drive pleasurable or destructively enjoyed is the increase and decrease of a quantitative stimulus tension (the libidinal economy), yet the decisive aspect depends "on some characteristic of it which we can only describe as a qualitative one. If we were able to say what this qualitative characteristic is, we should be much further advanced" (Freud, 1924/1973, p. 160). This quality *is* language, which is the inherited code of the Other that shaped the drive's form in the first place. Freud discovered three possible vicissitudes of the drive as: 1) repression, which is the core of the symptom and inhibitions; 2) displacement of activity, where the organism directs the drive's discharge inwards or outwards, such as switching passivity to activity or masochism to sadism, as when people with traumatic suffering sustain themselves by fighting others instead of continuing to beat themselves; and 3) sublimation, where the drive is transformed, which I discuss below (cf. 7.4.3.2).

If *jouissance* strains the subject's speaking body between life and death forces, how can the subject extract part of the death drive to be able to engage with life? To defuse the drive—that is to say, pull it apart to cut its deadly insistence—the therapeutic process requires that the subject encounter, rather than search for, the signifiers that

thrust the drive. One avenue is working on the castration complex. For Lacan, “[c]astration means that jouissance has to be refused in order to be attained on the inverse scale of the Law of desire” (2006, p. 700). For the subject to give up jouissance, excess *par excellence*, an inverted ladder of steep descent must be traversed by losing, not by gaining any further excess. On the top step of the ladder, we find the subject as an object of jouissance for the Other, full and uncastrated; descending the ladder, we encounter the Other’s desire, which introduces anxiety by the lack that inserts in the subject, constituting a signal of danger—Other’s desire—and also an organization of desirous action (Lacan, 1962/2014, p. 161). Finally, at the bottom of the ladder, we find *desire*, which has an effect of actualizing the castration complex.

An issue with posttraumatic suffering is that anxiety hardly works as an organizer of action because it itself constitutes an agitation of the drive, a perpetual intensifier of jouissance. When a person is *in jouissance*, it prevents their very emergence as a subject because it remains in the object position, supported always by a phantasmatic sense of individualistic completion, either by submitting to the oral demands of an almighty Other, or to his gaze, voice, or rigid educational demand, which the subject insists on complying with in order to, hopefully, gain reassurance of being loved. In traumatic suffering, jouissance presents “the topology of the drive accelerated and overstretched” (Fernandez-Alvarez, forthcoming) and constitutes a superegoic command, a production of “what should not be” (*qu’il ne faut pas*) but which simultaneously “could never fail” (Lacan, 1972-73/1999, p. 59).

The stressed body is a sign of jouissance and although unconsciously *known* in the body, the subject consciously ignores the *cause* of their jouissance and can’t articulate it. Most definitely, service providers *truly ignore* the springs that move the subject’s jouissance, which coincidentally is what most often leads people to request mental health services, Fink (2007) calls this the “jouissance crisis,” “in which the analysand’s former ways of enjoying himself (whether in an explicitly sexual manner or otherwise) have broken down and he comes to analysis asking the analyst to help him restore them to their former efficacy” (p. 91). Most people dealing with posttraumatic sequelae require a comprehension of what mechanisms lead them to such a crisis to recover minimal homeostasis. How do we go about it in MH treatment? Mostly through biomedical and psychoeducational strategies, which I will discuss in the next sections.

7.4. Imaginary challenges: How to reconstitute the pleasure principle in the body and rehabilitate the fundamental fantasy?

The structural rupture of trauma causes a fragmentation of the Imaginary register, which refers to the field of the ego, the image, and the fantasy of self. Flashbacks, nightmares, hypervigilance, or hyperarousal to various stimuli are invasions from the Real that activate unrepressed and unrepresentable contents that create a rupture in the sense of self, prompting the fragmentation of body, often experienced as annihilated, dislocated, or unworthy. The body, stressed and fragmented, is central to therapeutic work with those who suffer from trauma, and such labour comprises mostly the Imaginary register. The Lacanian three registers share equal importance, and it is the knotting of Real, Imaginary, and Symbolic that gives human experience consistency. Lacan says that “There is no Imaginary which does not suppose a substance” (17.12.1974) and when dealing with traumatic sequelae, the imaginary substance is nothing other than the body.

While psychoanalytic treatment aims to confront the subject with the imaginary traps and misrecognition produced by the ego, consequently shattering semblance to facilitate an imaginary decline, in posttraumatic suffering the recuperation of the imaginary is crucial, via the creation of a body of pleasure and the rehabilitation of the fantasy. Jelinkova and Tarafás (July 2020) have instantiated the former in their experiences with tortured asylum-seekers: for subjects to survive such shattering experiences, they had to create a momentary suspension of the Imaginary ring by literally exiting the experience of the body, known as an out of body experience or what they call “holding at bay” (p.62).

The fantasy deemed unchangeable and rendered previously as the core of the subject’s identity, is seriously affected in posttraumatic suffering. Rehabilitating a collapsed fantasy entails gaining a sense of identity and meaning, which is crucial for the person to be able to *nominate* or pronounce themselves in the social (cf. 7.4.3.2); yet, the fantasized prelapsarian smoothness or the idea that everything was working well in their lives before the event of trauma, or the comparison of self to others as if they are “incomplete” and others are “whole” should be interrogated, as the searching for “wholeness” is indeed a fantasy that, far from supporting the recovery of a person, might

seriously hinder it, because it denies the limitations, conflicts, and lack that every speaking being inherently encounters.

Supporting an imaginary rehabilitation in therapeutic work with traumatized subjects involves the restitution of the two Freudian principles: pleasure and reality, which brings safety, recreates the body, relaunches the fundamental fantasy of identity, and creates meaning at the subject scale. Meanwhile, at the social scale, pleasure and reality principles are established through therapeutic landscapes inside and outside the institution, and a sense of belonging is established through various practices.

7.4.1. The body of pleasure

Much of the professional jargon to justify MH interventions at VCH, such as emotional regulation or distress tolerance, aim to restore the two Freudian principles that regulate mental functioning: pleasure and reality. Seeking pleasure, avoiding displeasure, and accepting an external reality that opposes fantasy, Freud explains, has to do with mechanisms of consciousness, sensory perception, attention, register of memory, judgement, action, and thought (1911/1973, p. 218-221).

The attainment of pleasure, happiness, and well-being has constituted a core moral pursuit since ancient times and is the mechanism that the subject must activate to find minimal homeostasis. Pleasure functions, or so Freud tells us, as “the watchman over our life rather than merely over our mental life” (1920/1973, p. 159), but while it saves us from death, pleasure paradoxically also leads us to death through the inherent entropy of the drive’s topology, which commandeers the subject’s pleasure and turns it into *jouissance*. As Lacan puts it: “once you have started, you never know where it will end. It begins with a tickle and ends in a blaze of petrol. That is always what *jouissance* is” (1969/2007p. 72). Pleasure is hard to sustain because it can easily lead to boredom or excess and moreover, the individual’s volition can’t assure its homeostasis. As a principle, pleasure requires differentiation from the principle of constancy, which can be read as either the constancy of energy that drives life at large (Laplanche, p. 308) or the death drive—the Nirvana principle that returns to the inanimate and to minimal stimulation. This Freudian problem was framed by Tomsič (2019) as a divided *resistance* of life: the “resistance *to* death (self-preservation) and resistance *of* death (death drive)” (p. 203).

The reality principle, for its part, corresponds to the attention and perception of the external world, and Freud initially proposed an opposition of the two principles by way of the ego's cathectic split (*Lust-Ich*, the ego-pleasure and *Real-Ich*, the ego reality); "Just as the pleasure-ego can do nothing but wish, work for a yield of pleasure, and avoid unpleasure, so the reality-ego need do nothing but strive for what is useful and guard itself against damage" (Freud, 1911/1973, p.223). The reality principle, also known as the "reality test," generates the differentiation between external and internal realities or between object (unpleasure) and subject (pleasure) (Freud, 1911/1973, p.221). Following such logic, the subject identifies with the pleasurable aspects of the outside and introjects them, while expelling, rejecting, or projecting the unpleasure outside; it is a mechanism that brackets any moral understanding of the reality principle, because it is always connected to how an "ego" perceives what specifically works for their pleasure and unpleasure. This could be instantiated through a succinct yet meaningful list given by a participant in response to what helps him overcome the experience of trauma: "Alcohol. Drugs. Breath. Tears. Discussion. Anger. Food. Sugar" (A17). The reality principle is connected to the pleasure principle and is highly subjective.

How does pleasure work? What are the structural conditions that facilitate gaining a sense of pleasure? A key concept to understanding pleasure is *das Ding* or the Thing, a term that Lacan borrows from early Freud to elaborate ethical and aesthetical aspects. As "beyond-of-the-signified" (Lacan, 1959/1992, p. 54), *das Ding* constitutes the primordial object that allows us to apprehend beauty and life in the figure of an absolute primordial Other that becomes the ulterior reference of any wish and expectation (Lacan, 1959/1992, p. 52). The Thing is located beyond the world represented (*Vortworstellung*) or presented (*Sache-vorstellung*), exceeding the subject's conscious perception, constituting the radical exterior, outside of the Symbolic-Imaginary unconscious, that simultaneously leaves the first imprint of the good, that causes a *tropism* or orientation towards the pleasure principle, towards life and desire (Lacan, 1959/1992, p. 52).

The paradoxical nature of *das Ding* is relevant to discussions of the challenge of the Imaginary register in the work of trauma: while on the side of life and pleasure, *das Ding* is also a radical exterior, so its complete access is forbidden. The absolute pursuit of *das Ding* must be given up, it requires sublimation or else such an object becomes destructive; for example, this occurs in the phenomena of addictions, where the subject searches for the Freudian oceanic feeling (1930/1873, p. 67), the absolute object of *das*

Ding, instead of sublimating it. Elsewhere, through the aesthetic phenomenon of the Forest (Fernandez-Alvarez, 2021), I assert that when one experiences an aesthetic experience, such as a hike in the forest, one *mirrors* the object *das Ding* and sublimates it, renouncing a fusion with the Thing. What is most important for trauma work is that in contemplating the immensity of the ocean, breathing mindfully, or admiring an eloquent piece of art, the calmness, aliveness, and peace that comes from pleasure *lives within* the subject; once again, is an extimate phenomenon, if only the subject can find a way to access it *on their own terms*.

Before moving into the discussion of what elements might facilitate regaining imaginary aspects of vitality that work against the death drive, we must identify what agitates the drive in the body. Elsewhere, I explore the spatial-temporal agitation of the drive and its possible redirection or cut claiming that “the agitation of the drive refers to the clinical challenges in which a subject is unable to activate a *savoir faire* or know-how to preserve the drive within limits, which prevents the subject’s engagement with the side of life” (Fernandez-Alvarez, Forthcoming). While the drive is agitated by the temporality of repetition itself (*automaton and tuche*), the body is agitated in imaginary spaces such as the ideal ego or cut—a phallic aspiration of a certain self-image—that can’t but be deficient in covering the subject’s structural lack. The materiality of the body also agitates the drive: through illnesses, hormones, stress, or psychosomatic symptoms; even the external world can agitate the drive through financial or emotional duress. The agitation of the drive in the body is a common occurrence in trauma; to gain a calmer embodiment, the traumatized subject must *recreate* their body in a way that allows separation from the Other’s *jouissance*, or else the subject remains an object. In what follows, I will bring out some of the participants’ voices to explore safety, the somatic taming of a gaze, and compassionate approaches as strategies to calm the agitation of the drive in the body.

At VCH, the approach to the pleasure principle prioritizes emotional literacy rather than an aesthetic exploration of the inner creative life or the articulation of sensibility. The focus is on training people in a predetermined set of skills to gain emotional regulation and competency in coping. While these competencies are important in calming suffering in a person, the manualized outcome expectations can become trivial because they do not observe the subject’s own timing or their very own relation to pleasure. Sometimes the goals are not internalized or wanted by the service

user, which results in a meaningless intervention, and even the therapist's expectations can turn into the heavy demand of a moral prescription—sanism—that can be oppressive, as this participant stated:

sometimes I sit through those classes, and I don't want to hear this. I don't want to hear how to deal with it. I want to reject any solution. I mean, this is a head full of awareness here. I'm actually aware that I don't want wellness sometimes. (A17)

Freud's term "*furor sanandi*" (1915c/1973, p. 171) or the passion for curing people is suitable in this context because when facing the analysand's suffering, the therapist might experience anxiety. Confronted with the analysand's suffering, the therapist responds with cascading suggestions of supposedly optimal ways to calm that suffering, begging the question: who are the suggestions for? For the sake of calming the therapist's own anxiety? Or to help the subject understand their own complex relations to pleasure and their own logical time? Tomsič (2019) explains that the "subjective ideal[s] shared by ethical doctrines as different as Aristotle's *eudaimonia*, Bentham's utilitarianism and contemporary neoliberalism with its imperative of happiness" (p. 21) can cause exhaustion and anxiety.

Worth noticing is that the imperative of enjoyment is not only imposed from the exterior world, it also has been internalized through the superego via an imperative to "Enjoy!" instantiated by social demands that value life only in relationship to a supposed measurement of enjoyment. When the subject hears such imperatives, Lacan says, they only can (*j'ouï*)ssance, listen to it, before asking what the imperative is about. Therefore, the knot of pleasure/jouissance is a difficult one; while the pleasure principle—linked to desire rather than enjoyment—sustains a subject after trauma, the ubiquitous imposition to enjoy leads to destructive jouissance. While the speaking human animal is not quite homeostatic, some people have greater trouble than others in letting go of jouissance to access the pleasure principle: perhaps the internalized Other of culture and language, itself a constitutive and constituted formation of the superego, might push the subject towards punishment by burdening them with shame, guilt, paranoia, obsessiveness, narcissism, or perhaps a well justified hate that stubbornly impedes them in regaining a sense of pleasure. Perhaps it might be difficult to search for pleasure because, by renouncing jouissance a separation from the field of the Other is actualized, and perhaps the subject is unready to accept the logical shift to traverse such an embodied loss. Perhaps it is unsafe to even pose the question of how to gain a sense of pleasure

because pleasure might be tainted by the traumatic event, as in sexual trauma. Or it might be difficult to grapple with the question of pleasure because pleasure requires articulation of the problem of excess, satisfaction, and limits, which a person might prefer not to know about. These difficulties in accessing the pleasure and reality principles are complex issues that call for a focus on the Symbolic (cf. 7.4.3.1), the field of the subject and desire. To sustain the minimal regulation of the organism and its psychic functions, the subject is required to emerge and ethically decide on the contingencies that are presented to them by life, and this is the reason for which the Imaginary can't ever be a sufficient intervention. The horizon of the Imaginary intervention must be the involvement of the Symbolic register; hence, one central challenge within the Imaginary register is: how to intervene in facilitating the subject's pleasure, without imposing predigested agendas about what constitutes pleasure and how to get there? In what follows, I discuss some of these elements.

7.4.1.1. Safety in trauma

Psychoanalytic geographers Blum and Secor (2014) analyze the concept of safety in trauma by discussing Freud's early cases of hysteria, as well as studying Pynoos and Nader's case (1989) which showed drawings by children exposed to a shooting attack in their elementary school in the US. Blum and Secor explore the relation of space memory, the material location where traumatic events happened, and psychological memory, what children recreated in their drawings, and render the interaction between these two memories to be at constant odds and in mutual co-production. Blum and Secor's analysis also emphasizes the creation of a *safe location* necessary for the subject to avoid retraumatization, and they argue that such a location is not obtained through a topographic solution—that is, not by moving from one room to another, but in transforming the psychic space by means of the topological properties of “boundedness, orientability, decomposition and connectivity” (p. 109). For example, children who were more highly exposed to the shootings drew a map where their positions were further away from the site of higher risk of injury or death, which instantiates how a topologic solution—a different spatial composition, a renewed connectivity—can produce a safe location. When Blum and Secor discuss Freud's cases, they highlight Freud's realization that there is:

a kind of resistance to the suppression of the traumatic scene, a refusal to evacuate or to move to a 'safe location'. Freud's work is thus to overcome

this refusal in order to transform, topologically, the space of trauma into a qualitatively different space. (Blum & Secor, p. 107)

These authors' perspective has relevant therapeutic value because to transform jouissance "[a] new topological cut or connection must be made in order to escape the repetition of the traumatic constellation" (p. 107). For the subject to find a *safe location* and to transform the space of trauma, the first hurdle is that of structural resistance—the drive's own topology—that returns to the same point of departure only to relaunch itself, once again, in another loop (cf. 6.4). How is the key notion of safety in trauma achieved? What are the minimal requirements of facilitating a safe location? Safety, at core, signifies protection against violence, which can be physical, psychological, social, or moral (Poole & Greaves, 2012; Bloom & Farragher, 2013, Herman, 2015). The user of MH services requires reassurance that they will be treated with dignity and respect when accessing services and won't be physically attacked, psychologically undervalued for their beliefs, or judged morally for choices they have made in life, and will not be burdened by imposed views on how they should go about their life. Yet safety also necessitates that the person be able to manage their reactions to psychic and bodily stimuli, emergences of the Real, an ability that is often impaired in a person with traumatic suffering.

A transtheoretical golden rule regarding the temporal management of therapeutic traumatic disclosure details that early disclosure of trauma might "retraumatize" the person if there is not yet a solid therapeutic relationship or a transference agreement that frames the limits of the inquiry (Poole & Greaves, 2012). To be able to talk about trauma, a symbolic pact and an imaginary protection against the intrusions of the Real are vital aspects of safety, as voiced by a participant, who stated what he found helpful:

Well-defined parameters. What we will do, what we won't do. How, if we do go to a point where I'm in trauma mode to any greater extent than necessary, that I'll be taken out slowly and that I can't just up and leave from the session if I'm in trauma mode. So, it's kind of like laying out the ground rules, and that's helpful to me, because I know if I go into trauma mode, all I have to do is be honest, and I think that's my primary role. Like, for them, their primary role is to make sure it's carefully navigated ... And when those two things come together, it should work. (A17)

Safety was also presented as a very important aspect among service providers: "It is really important to create space for the client to choose how much they want to

share and when they want to share” (FG, CI3). Bloom and Farragher (2013) quite relevantly indicate that safety in the context of an institution not only emerges between the service user and the provider, but also reflects trust among service providers within the institution itself.

In the literature review there is consensus on preventing retraumatization, as premature disclosure of trauma can lead to self-harm, drug use, dissociation, or re-enactment of violence, specifically with vulnerable populations burdened by more intersectional disadvantages (Poole & Greaves, 2012). It is crucial to be aware of this unwritten therapeutic rule; however, in the spirit of fighting spherical thinking that brings totalizing principles and persecutory guidelines I want to make a disclaimer: safety can't ever be fully granted because language, as what structures the unconscious, is always subjected to contingencies, and sometimes the subject is being internally pressured to disclose trauma, which might be difficult to halt because nothing is one hundred percent preventable. Safety is not a matter of prescription but rather is an embodied practice that finds a topological solution—a new linguistic exit or connection—to the repetition of the same. I had two experiences in the institution in which safety failed. The first was with a woman who, within the first 5 minutes of the initial assessment, told me quite explicitly about the deleterious effects that ongoing sexual abuse in her previous marriage had left in her body; in response to my attempts to slow down the conversation, the woman stated that talking about it helped her a great deal, and I understood that she needed to be witnessed. The second experience was with a young man who, in the second session, revealed the physical abused by his father he endured. Although we discussed safety in the first session, the flooding of memories and affect occurred despite my efforts to slow down his agitation; for an unknown reason, he needed to force out traumatic details and he, unfortunately, never returned to therapy. In my view, even more than rigid hypervigilance about what a person can or cannot express about their traumatic suffering, what is most important is first inquiring about how a person experiences safety and trust, offering reassurance that actual violence won't affect them during the time and space of the therapeutic encounter, but also acknowledging that reliving the experience can bring psychic violence and that can't be fully prevented, which calls for discussing some agreements on how to deal collaboratively with such a possibility.

From a psychoanalytic perspective, the possibility of a *safe location* can occur, at the scale of one-to-one, when the therapist occupies a specific place—the ethical position of the analyst that radically inquires about the analysand's desire (cf. 7.6)—without imposing the therapist's own ideals or visions, and involves probing questions to activate the subject's emergence to step in for themselves. At the social level, safety is gained through relationships that create non-oppressive social bonding, which is a larger question of greater complexity that my research at length aims to articulate (cf. 7.5).

7.4.1.2. *Recreating the body and rehabilitating the fundamental fantasy by taming the Other's gaze*

In the literature review of Chapter 2, we learnt that various parts of the nervous systems—the peripheral nerves, the autonomous system that regulates action and inhibition, and the sensual and epistemic functions of the central nervous system—are the sites in which language writes alongside the semiotic flows of a chemical, electric, and physical nature. Likewise, trauma activates every system: the subject's language, their sensual and perceptual organism, and the flesh, which corresponds to the Symbolic, Imaginary and Real registers of the body. The traumatized body calls for a subject to achieve a minimal somatic agency, which refers to the ability of limiting body jouissance.

Despite having a body, the subject is not in possession of it because there is a somatic alienation in the Real, Symbolic and Imaginary registers. In the Real, alienation occurs by the absolute *ek-sistance* of the body as an unsymbolizable sac of organs and flesh which hosts the object *petit a* (Zizek's pre-symbolic Real); the body is also alienated by means of the jouissance of the organism whose drive has been shaped by the Other, which writes a letter on the subject's flesh (Zizek's symbolic Real). In the Symbolic register, the body is alienated by the signifier and it becomes part of the field of the Other, which produces an obliterated body for another. And finally, the body is alienated in the Imaginary register due to the traps created by the visual image—static yet unembodied—and the narcissistic image of the self, which thrives through adoring mirroring or aggressive competition.

One of the first therapeutic task to address in traumatic suffering is regaining the pleasure principle and working towards somatic agency, which demands from the subject a creative act, *qua poesis*, that injects life into the organism, bringing together a

needed illusive knot of the body as whole. Through imagination and sensual pleasure, the body perpetually (re)creates itself, via a bath, a stroll in nature, a drink, a massage, a sexual encounter, or even talking. Creating a body means that the materiality of flesh, the spectrality of the image, and the signifier get temporally knotted, providing a cohesive yet illusory somatic gestalt that trauma has shattered.

Always threatened by the entropic thrust of the drive, the subject articulates somatic agency through imaginary and symbolic apprehensions of the body, such as movement, sensation, and perception, that recover an embodied experience, even and precisely when speech fails after a traumatic rupture. When one feels a deep breath, when a yoga teacher names parts of the body to engage in a pose, when one makes a drawing, plays a song, walks by the water, or writes a poem, one's subject implicitly *imagines* a body that extracts itself from subserviency to the gaze and the imperatives of a superegoic Other. Although any of the forms of the drive can disturb the subject, for oral, anal, phallic, and even dermal (Brenner, 2022) agitations affect the libidinal economy in traumatic suffering, one of the most persecutory manifestations of the drive of Imaginary relevance is the gaze. The aesthetic experience gives the subject access to a *safe location*, partially away from an oppressive gaze that can fragmentize their body image, load them with self-loathing recriminations, or agitate them neurobiologically.

Lacan articulates the gaze as the scopic drive, which refers to an object of desire within the visible realm that jumps out from a certain radiant point in the environment to reflect an image in which the subject finds itself excluded or absent: it is a form of subjective scotoma. "I see only from one point, but in my existence, I am looked at from all sides" (Lacan, 1964/1998 p. 72). The phenomenologist philosopher Maurice Merleau-Ponty influenced Lacan in the articulation of the imaginary field, key for the formation of the body as gestalt, and in comprehending the visual field. The Lacanian gaze is the point of invisibility where we are seen by things, more so than the other way around; Shepherdson (1997) writes how this approach, drawn from an alternative angle to classic neurological and senso-perceptual theories, opens a certain invisibility at the heart of the visible, something that cannot be seen, that is beyond 'appearance' and 'phenomenon,' but that looks at me as I look at the world, with a gaze that solicits my vision in advance, even before I begin to see. And since it is a matter of being seen, being 'looked at from all sides,' the gaze is not a property of the subject, a power to look or to speculate, but something that comes *from the world of things*. (p. 78)

The gaze gives the mighty big Other such power that “subjective subsistence seems to get lost, to be absorbed, and to leave the world behind” (Lacan, 1998, p. 241). Diverting the Other’s gaze is needed to promote the reintegration of the body’s image as a cohesive whole and to establish somatic boundaries with the Other (and consequently with others), to act as a shield from persecutory and fragmenting images, in which the subject might experience somatic overextension of the self into others or the invasion of others into the self. This is particularly relevant for the experience of trauma in psychosis, where the person struggling with hallucinations or paranoid delusions lacks a clear somatic boundary between their body and the bodies of others, for which interventions with a symbolic focus are crucial.

In the structural rupture caused by trauma the fundamental fantasy collapses. The fundamental fantasy articulates desire and reality “in a seamless texture” (Lacan, 16.11.1966), so it covers the lack in the Other, which can rehabilitate the profoundly damaged narcissism of the subject as well as the sense of self and identity. Covering up the sense of rupture after a traumatic event is necessary to rehabilitate a sense of identity and perhaps makes trust possible again. Reactivating the fantasy is as important as challenging it, so it is deeply connected with the way a clinician can listen, which I discuss below (cf. 7.4.). Let’s discuss how the creation of a safe body of pleasure, the taming of the persecutory gaze, and the recovery of fantasy are aided by diverse modalities that unfortunately are not yet included within the institution.

7.4.2. Various practices to help a subject find a safe location

VCH has access to alternative treatments such as acupuncture, gardening, and yoga for the SU population, although this usually works in coordination with other well-founded organizations (i.e., one participant from SU also receives services at the Dr. Peter Centre and the Infectious Disease Centre, IDC). MH teams regularly coordinate services with other agencies such as mental health housing services, community foundations, and art studios, while MHSU OS is limited to services provided by the team and offers no alternative treatments. Among the various participant teams, AWT is leading the way towards relational ways of service delivery by keeping intentional spaces that provide individualized options for both traditional and Western services in the specific work around historical trauma within their population. Although there is interest in diversifying and providing a wider variety of options for clients, particularly at

AWP and 3BSU, this study indicates that the exclusive use of psychiatric pharmacotherapy and manualized skill-building group training is preferred in most of the MHSU sites at VCH (cf. 3.2). These modalities do not suffice in treating the complexity of trauma because they hinder the possibilities for service users to be heard and to establish relations in a more meaningful way.

The creation of meaning, the display of personal narratives, somatic practices, and a sense of belonging to a community within a therapeutic landscape are practices of an Imaginary-Symbolic nature that can help in rehabilitating the Imaginary register ruptured by trauma. Most people look for safety in their very own way and in their own time; hence, research participants were critical of VCH's modality of "one size fits all" (cf. 3.5). Equally, various service providers stated the importance of diversifying services, for example:

I do not necessarily know that we as a system are designed to be a one-stop shop for trauma ... is it through one-to-one services, is it through group, is it onsite, is it through another service, maybe all of the above so that they have options and flexibility. (Ld7)

there is also real richness in sharing approaches (Ld4).

Also, most service users identified alternative practices that they found helpful in their healing journey: for example, Reiki (AI1), discussion of ideas and books (AI2), art and music therapy (AI7), gardening groups (AI5), choir (AI4), and spiritual and religious practices (AI2 and AI4).

There is abundant literature about integrative practices for trauma (Edwards, 2013; Mahoney & Markel, 2016; Macaulay & Angus, 2019), and diversifying services is a solid recommendation as the highest available standard of care (Triliva et. al., 2020). Lopez (2011) provides a rich example of what a trauma intervention program could look like when incorporating both individual and collective interventions. Even though her trauma research is situated in a conflict zone in Mexico, within communities affected by the violence of drug cartels, her review is relevant as per the incorporation of healing opportunities of an individual and a collective nature. The latter are indispensable in responding to the brutality people must endure on regular basis in violence-ridden regions of the world, but their model can also help in designing programs outside of armed conflict zones. Lopez (2011) quotes varied research that supports the inclusion of a range of modalities, such as body work like yoga, Tai Chi, dance, rhythmic movement,

and breathing techniques; mental practices such as mindfulness and meditative visualization; process work in one-to-one therapies; and finally, “techniques for spirit work [that] include ritual practice, visualization, visiting sacred inner space, dance, meditation, and more” (p. 307). Is diversity of services, for the sake of diversity, a panacea in trauma treatment? Let’s explore various challenges to respond to this.

7.4.2.1. *Therapeutic landscapes: In and out of the clinic*

Spatial and psychic conditions for MH service provision meet in the notion of therapeutic landscapes, a starting point in any response to trauma. Therapeutic landscapes (cf. 3.3) are intentional places where meaningfulness is created by those who inhabit them, as much as a sense of connection and pleasurable peace that avoids re-traumatization and fosters belonging. In this research, some therapeutic landscapes, inside and outside of the clinic, were mentioned by service users, such as the hospital (A12), residential housing for the substance use population (A17), halfway homes such as Venture (A13), and social clubs such as Coast Club House (A12). One clinician mentioned that some institutions in Canada provide crisis spaces where people:

could go to that, had like a lounge chair in that. They could even spend the night there to decompress in a quiet soothing environment with staff around. I thought oh my god, that’s brilliant! Why could we not have that? (FG, C11)

There are countless places that have traditionally been associated with healing, and as Fiona Smyth (2005) indicates, they constitute landscapes of physical (ancient spas, the land, the forest, animals), social (people involved in the site), as well as a symbolic (objects, artifacts, or language) and moral nature (expectations of race, gender, body image, etc.) (p. 490). It is my contention that TSS must incorporate spaces within the purview of the mental health team, but also spaces outside of the clinic to connect to a caring community, as a participant voiced:

H- And why could it be important for you [to meet] outside of the team?
A- Because they have more ... they have time to listen and they are not so heavy on the prescription of drugs and stuff. (A13)

The therapeutic landscapes in this research revealed the need for practices that calm the body and that are compassionate and warm. My critical contribution is that the creation of healing places also requires an ethical consideration of the subject in connection to the sociopolitical atrocities attested to in the everyday.

At the level of the clinic, a space requires aesthetic elements that inject some warmth and welcoming into the space, yet an essential aspect in the creation of a therapeutic landscape is relationality, which I understand as sustaining forms of genuine accountability based on a respectful and trustworthy dialectical relation. In the clinic, people require welcoming places to address the private experience of trauma (one-to-one therapy) as well as support shared public experiences (group therapy) to recreate the pleasure of the body via some imaginary—sensuous—aspects, as well as the creation of warmth, meaning, and act of being witnessed.

At the level of community, a therapeutic landscape must go beyond the mental health clinic to foster ecosystems of care: it should de-medicalize spaces by making them intentional and allow for the collectivization of the public experience of trauma. The latter involves culture and the arts, where people occupy spaces to engage in discussions that concern the public good. To create therapeutic landscapes that extend MH services to include somatic practices, as well as recreational and artistic practices, requires joining the efforts of the clinic and the community with accountability, continuity, and political will from the institution, and assigning a paid position that coordinates in-house services with those in the community, as a participant commented:

Well, in the past we had ... a variety of different approaches that people have engaged with. The challenge with that [was that] it requires a staff person to organize, manage, vet and coordinate all of that. I think in the reality of healthcare, if it is staff based ... someone needs to manage doing that. If it is volunteers then someone has to manage, vet, orient and supervise the volunteers. (Ld4)

Diversification of services to include other epistemologies such as bodily practices and a combination of non-Western and Western forms of healing is a desirable condition for TSS, because “it is the timing of what is useful for each client” (Ld1). Yet diversification for the sake of diversification is not a final solution, as Smyth (2005) writes:

notions of health and its connection to place may romanticize the relationship between the 'landscape' and well-being through claims of authenticity and inclusion in a way that privileges alternative therapies as systems of healing and fails to recognize that, like other therapeutic landscapes, these networks may be exclusionary as well as inclusionary. (p. 93)

Diversification should be implemented through democratic consultation vetted with critical lenses, beyond the instrumentalization of reason that justifies every endeavour on the premise of efficiency and cost containment. The body politic requires fighting against conservatism within the institution, as expressed by a participant voice: “alternative forms of healing would be something that would be outside of anything that would be empirically evidence-based” (Ld1). And why should it be like that? MH policy already has it written: “There is a wealth of knowledge, skills and resources residing in local communities that can be leveraged to support recovery by building service partnerships and nurturing community connections” (MHCC, 2015, p. 42). TSS cannot continue being an exclusive matter of medical health provided at the mental health site; it requires creative forms of sustaining partnerships that provide meaningful, and timely delivered, services for people with traumatic suffering. In what follows, I critically review some of my research results regarding the practices of an Imaginary-Symbolic nature within the institution.

7.4.2.2. *One-to-one therapy and process groups*

When asking for suggestions to improve TSS at VCH, a participant answered: “Umm, counselling; if they had free counselling for people on low income, because counselling is expensive” (A14). This was echoed by a service provider: “I think that there needs to be actual psychotherapy for the initial trauma, because that’s so essential for people” (Ld2). One-to-one therapy was seen as key for 6 out of 7 service user participants, while group process therapy was mentioned as something important for 3 out of 7 analysts and participants. For example:

The entire group today spent probably a good 15 minutes bemoaning the fact that there doesn’t seem to be group process ... everything we know of is more of just kind of a coffee klatch, where we’re going to talk about our traumatic experiences in a nonprofessional setting, maybe in a room in the library, but there’s risks to that obviously. Some pretty serious risks. (A15)

Participants attending MH teams have attended DBT, CBT, and OCD groups, while MHSU participants attended bereavement groups and Change Groups (Rewarding Change and Harm Reduction). Both spaces are important and have specific functions: one-to-one therapy provides a private space to gain some signifiers, to partially cover the rupture left by the traumatic event as much as developing trustworthy therapeutic alliance to elaborate traumatic memories; process trauma group, in contrast, allows

people to connect with others through shared experience of the horror endured, and can contribute to the collectivization of the experience to create communities that act politically. The thematic analysis of research participants demonstrates that some of the interpretative frames perceived as helpful in a healing journey consist of being witnessed with compassion, the creation of meaning, and a sense of belonging.

7.4.2.3. Warmth, compassion, and empathy

Having an unconditional positive regard is a golden therapeutic rule at the core of the client-centered therapy proposed by Carl Rogers (1951), whose humanistic psychology focuses on the good in each human being, the ability to have authentic dialogic rhetoric, and respectful and empathetic understanding among the participants involved in a therapeutic endeavour. The Rogerian humanistic perspective came about in the interviews with various service providers as the preferred alternative to the biomedical model, and below I articulate a critique of the insufficiency of this approach alone.

To my question of how they intervene with compulsive repetition, a focus group participant answered:

They are very harshly judgmental of themselves, and for me, what I encourage or invite is the compassionate understanding ... Let's take a step back and observe what is going on with a compassionate lens. Let's see if we can understand it and then as we understand it together let's see what is going to be useful in shifting the dynamic that you feel needs to be shifted. (FG CI1)

Quoting The Dalai Lama, Gilbert (2010) defines compassion as “a sensitivity to the suffering of self and others, with a deep commitment to try to relieve it” (p. 125), with the purpose of enhancing a “common humanity” (p. 130). And according to Ringel (2019), compassion and empathy occur in mindfulness practices “through a focused visualization process called ‘metta,’ or loving-kindness meditation, which includes the visualization of loving thoughts toward oneself and others” (p. 144).

Compassionate practices were also described in my research as welcoming interactions, sensible and sensitive to the needs of the suffering individual. Participants that use mental health services at VCH expressed various experiences of warmth: “I never felt pushed to share anything, like if I wanted to just sit there and cry ... so yeah, it was really good; it was really comforting, it was really helpful” (AI6); “The staff at the

Segal Centre were very kind; [the] hospital has improved significantly, they triaged me ... I feel very blessed and very fortunate that that resource is available” (A14). For service providers, warmth was also reflected by simplifying bureaucracy: “They did not have to meet all these different people. It is actually best practice according to a lot of research. It’s called the “warm handoff”” (FG C14). My research experience at the AWP could be also considered a warm, compassionate experience, by the way I felt accepted and not judged when I became emotional in a working meeting.

Other participants found compassion, warmth, and empathy through spirituality and religious practices: “my recovery from insanity is a miracle, a gift from God ... It’s like sometimes suffering brings us closer to God” (A14). Or “the Bible has been the most therapeutic thing for me since I feel as though I’ve been traumatized” (A12). Spiritual experiences, however, refer not only to the church or the temple, but to practices that provide empowerment and a sense of belonging (i.e., nature, dancing, singing). Specifically, in Indigenous traditions, spirituality is found in the relations of mutual care with the other-than-human, such as the land, animals, and nature (Wilson, 2008).

Whether compassion is self-directed or actualized by service providers with those seeking help, compassion works on the premise of identification. Even the etymology, from the Latin *compassionem*, means “to suffer together” (Dictionary, 2021d). For example, one participant mentioned that in her last therapy session at one of the research sites, the therapist “told me that her sister had died, not by suicide, ... it was weird because she hadn’t told me before, but as I was working with her, I could tell she had been through a loss as well. It made such a difference” (A16). Yet, when the identification was not proximate enough, the same participant found it quite unhelpful, as in her experience with a previous therapist outside VCH who told her: “Oh yeah, my grandma died, so I get it, this is not the same, like, at all!” (A16). A significant limit of this approach is the reliance on identification: how can a therapist listen through identification, a notion inherently burdened by particular differences among speaking beings regarding jouissance and desire? How can a therapist be authentic in their identifications with those suffering with traumatic memories, when the field of trauma is precisely a radical unknown?

From a Lacanian perspective, a compassionate approach could be considered the rehabilitation of the pleasure principle by identifying and channelling a maternal role

of care and nourishment. This strategy is intuitively accepted when a person is in the process of subjective destitution, suffering profound stress, anxiety, and chaos. Genuine warmth reflects the therapist's desire to do their job, yet the focus on compassion therapies is unsustainable for service providers. The clinician's reliance on their emotional resources and identification constitutes an intervention with "their being"—what one does not have—to embrace the reflective empathetic stand and suffer together, comprising the cause of compassionate burnout or vicarious traumatization (Ringel, 2019). Not only is hearing the suffering of people a hard task when you put your being at stake, but by building one-to-one therapy around compassion, inherent differences between the two participants get erased and most likely the "stronger ego" will impose an agreement on meaning, forcing identification. By encouraging subjective assertions instead of ego-to-ego interventions, psychoanalysis increases the chances of encountering—not seeking—possibilities for transformation, maintaining the warmth and presence that *radical respect* for people's voices provides, while preventing burnout because the analyst does not intervene with her being.

The question of trauma confronts us with a Real impasse and compassionate approaches provide insufficient methodological articulation on how to proceed with the excesses and lacks posed by the Real, and do not provide theoretical tenets—beyond the commonsensical life-work balance—to articulate interventions without emotionally and psychically exhausting service providers. Hence, while the compassionate strategy is sound in promoting connection and stability in moments of crisis, it hinders the larger questions of Symbolic order (critical consciousness, awareness of the subjective split, desire) because it tends to falsely create sameness where there is difference in the therapeutic dyad. Below (7.4), I will describe how psychoanalysis understands support and warmth without resorting to mirroring the suffering person. In Imaginary challenges, however, there are still two pending aspects showed in my research: being witnessed and a sense of belonging.

7.4.2.4. *Being witnessed*

Being witnessed is an important aspect mentioned by both service users and providers:

It's the recognition from the other person. It's like this social aspect, this social part of the therapy that I personally find really, really beneficial. (A15)

What is vital for people ... being witnessed for all of who they are and most critically, how did they survive? What are their strengths? What are their resources? It is often a miracle that people are still here, how did they do that? (Ld1)

Being witnessed and giving testimony provides recognition and companionship so that traumatic experience can be disclosed. Witnessing and testimonials are Imaginary strategies which can reach the Symbolic and Real registers beyond a sense of belonging, such as in political communities that secure restitutive justice for those affected by a collective traumatic situation. Traumatic knowledge is extremely difficult to share due to its potential rupturing of subjectivity, and because it is often found to be shameful, humiliating, and even unbelievable. Being witnessed and sharing the traumatic experience requires confidentiality and privacy when concentrated on the individual (cf. 6.2), while in collective practices that preserve traumatic memory in the social, being witnessed is a public aspect that contributes to the symbolization of a horrific event that has affected many people at once (Adorno, 1973/1998; Edkins, 2003; Fassin & Rechtman, 2009; Bistoën, 2016; Auestad, 2017; Sheehi & Sheehi, 2022). Witnessing and giving testimony prevent the past from being forgotten and caution society about repeating history, yet these important mechanisms have a scalar difference. While the subject with posttraumatic suffering requires the forgetting of the most disturbing memory traces—by either creating a symptom or a desirous act that repositions the memory in the linguistic apparatus—or else they will be stuck in deadly jouissance, at the social scale, sharing memories of the unspeakable is a needed strategy to engage in healing and to collectivize the experience to potentially gain political action. Remembrance for the sake of remembrance does not guarantee much, as often the narratives of individuals who have endured trauma at the social level can serve various political agendas, even to justify further horrors imposed on others (Sheehi & Sheehi, 2022). Also, remembrance as focused solely on human rights issues can become depoliticized and efface those directly affected; as Peng (2017) writes, “there are no more perpetrators, but only victims and philanthropists” (p.125).

7.4.2.5. Meaning through narrative

Even when one-to-one therapy and process groups are deemed necessary to provide opportunities for meaning-making, psychotherapy at VCH is not available to people in the mental health programs (who are diagnosed with psychiatric or mood disorders), only to those struggling with a substance use concern or with non-psychotic issues. A leader expressed it like this:

if you do not have problematic substance use that door to that counseling is not available. I think it is kind of siloed areas that have not kept up with the understanding of trauma itself as a unique issue that needs to be addressed. (Ld4)

Meaning refers to the creation of narratives that facilitate a certain sense of identity, and such meaning is given by the social milieu. From a Lacanian perspective, meaning refers to the signified. As Lacan states:

[y]ou recall that in linguistics there is the signifier and the signified and that the signifier is to be taken in the sense of the material of language. The trap, the hole one must not fall into, is the belief that signifieds are objects, things. The signified is something quite different ... it always refers to meaning, that is, to another meaning. (1955/1997, p.32)

For example, two participants instantiated meaning through the signifier “darkness,” and not incidentally both participants were from a site that provides services for substance use. The service user said:

I can tell that counsellor my darkness, and I do that so that I’m not the only person carrying that darkness around and that they can know and help me by knowing, just by knowing what pain I’ve put myself through. (A17)

And the service provider expressed her view of “darkness” in this way:

whatever narrative you have about yourself, despite it being really dark and shameful and horrible, there is a part of it which is very important to them. Even though it might not be healthy or helpful it is a part of them and to be able to tease that apart and understand where the narrative comes from and what it does to their life; just the storytelling aspect of counselling and being a witness to stories is something that I really hold dear in my practice. (FG Cl2)

Darkness in the voice of the analysand refers to a desire to be known and witnessed, yet in the voice of the clinician it slides linguistically to further associations with signifiers such as shameful, horrible, or unhealthy. The two properties of meaning

are observed in this example: meaning always slides into other meanings, and meaning is based on communication through speech. Lacan proposes an aphorism for human communication: “the sender receives his own message back from the receiver in an inverted form” (2006, p. 246). This is to say that meaning in discourse returns to the speaking subject as already implying their own reply and what they are ready to hear. While one speaks within discourse, a subject assumes a certain identity—a certain position in language that represents them by a given signifier. In this case, “darkness” appears as representing the analysand. At the same time, such positioning contributes to the reproduction of the same signifier, signified as unhealthy or shameful, instantiated by the associations of the service provider. This is the very impasse of meaning that perpetually slides and that regurgitates the meanings of those who speak and hear them, for which the differential power of the therapeutic relation plays a central role: Whose meanings will be established, if we count the way communication works unconsciously?

As important as it is to create a constructive Imaginary-Symbolic narrative for the subject about what, when, how, or why traumatic events have happened to them, significations are structurally caught up in stereotypes organized around master signifiers that attempt to recreate the same meanings shared by a society and culture. An analysand in my private practice is studying counselling and is bombarded by the biomedical, humanistic versions of what a human is, which is creating a great deal of suffering; while attempting to name themselves through mental health diagnoses and good intentions towards humanity, they do not find the possibility to be genuinely themselves and feel increasingly constrained. Other forms of intervention are necessary to prevent the repetition of sameness, which I discuss in what follows.

7.5. Symbolic challenges: How to facilitate the temporo-spatial emergence of the subject?

I have reviewed how VCH’s acute demands for mental health services organizes its response within the registers of the Imaginary, which mostly consists of promoting the pleasure of the body (emotional regulation, etc.) and, in a more limited way, the creation of meaning. My proposal is that such a response requires a theoretical and critical knotting to incorporate, within the clinical intervention, the field of the subject, as well as a critical stand that unveils the cause of discourse in the social field.

Two main complaints about the system were identified among service users in my research: not feeling heard (5 of 7 client participants), and the lack of access to a form of healing they find helpful (5 out of 7), such as one-to-one counselling, group therapy specific to their interests, and outside of psychoeducational approaches, body-based treatments and enough time to process their concerns.

They have their own idea about what should be done ... they don't often take time to ... listen to me, so I ... I've had to make a lot of my own decisions. (A11)

what I believe led to the trauma. They don't agree with me; they don't think that that can lead to trauma. (A12)

In this section, I will concentrate on aspects that emerged in the thematic analysis of the participant interviews, which I will first approach by differentiating psychoanalysis from psychotherapies. I will also discuss the challenges posed by psychoanalytic listening and by desire at the individual scale, while at the scale of the social I focus on the creation of critical and democratic conditions for the design and delivery of services.

7.5.1. Psychotherapy versus psychoanalysis

Faced with posttraumatic suffering there is a demand for a fast and easy solution, as this participant expressed:

I'm coming in to talk to somebody one on one, I'm really looking for a plan of action, almost more like, "Okay, these are the problems I'm dealing with right now; how do I move through the right now?" (A15)

A concrete and clear strategy might be deemed suitable when there is an urgency that threatens subjective destitution, what is known in MH lingo as "decompensation," which can mean a psychotic break down, a serious relapse, a potentially fragmented sense of self, imminent suicide, or extreme precarity. However, even a concrete answer of the most pragmatic nature should conjure up the subject's appearance. Interventions from the Lacanian Symbolic register in the field of TSS refer to the emergence of the subject of the unconscious, understood as the field of desire, ethical agency, and self-critical examination of the constitutive contradictions and splits that inhabit a person and their relation to language and others. Let's see in what way psychoanalysis conceptualizes in radical difference from other therapies.

Mindfulness, breathing meditation, learning about the brain, or meaning making within a compassionate setting are the common therapies readily available in the first level of trauma treatment at VCH. These interventions are focused on the Imaginary-Symbolic, targeting the restoration of the pleasure principle in the body and providing literacy about emotions, with simplistic ready-made answers that ignore the historical and singular reasons for a person's tragedy. These therapeutic interventions are not only a local reality but are a reflection of global mental health systems. I assert that a mental health team requires the incorporation of psychoanalysis, and in what follows I substantiate my claim by introducing the main differences.

Among a multitude of therapeutic modalities, increasing by the hour thanks to the profitable present demand of mental health service turned market, there is a phenomenon, coined by Saul Rosenzweig (1936), as the *Dodo effect*, a metaphor that alludes to Lewis Carroll's *Alice in Wonderland*, where the last Dodo bird bestows prizes on every competitor in a game that could start and end whenever the participants wanted: "everybody has won, and all must have prizes." The Dodo effect stands for supposedly equalizing therapeutic benefits regardless of the theoretical perspective, based on "common factors" (Wampold, 2015, p. 33) such as a trustworthy therapeutic alliance. Is it true that every therapy has similar healing effects? Plenty of psychological research has been conducted for and against that model, contributing to the questionable practices of Frankenstein-like theoretical integration and technical eclecticism (Wampold, 2015, p. 45). Wampold contradicts the common factors perspective and proposes the contextual model instead, which, rather than searching for general effects, as the Dodo effect has it, focuses on the social sciences, highlighting the *eusocial* qualities of the human species for group relations and the cooperative social processes of the human species (Wampold, 2015, p. 50). The contextual model does not see the individual's psychological suffering as a problem of one person alone, but rather pathology is seen to be caused and supported by a society—social constructionism—rendering psychotherapy as "a social healing practice" (Wampold, 2015, p. 52) based, once again, on an empathic relation that clarifies expectations of the therapeutic alliance and change (p. 60). Considering the subject's suffering in deep relation to the social is crucial, yet Wampold's romantic view of evolutionary social cooperation as generalizable to all humans is unsustainable, because if that were the case, we would not have the inherent civilization discontent (Freud, 1930/1973), nor the

abundance of traumatic effects in the world, evidenced in the content of everyday TV news. The times we live in demand a theory and method to deal with the evil within that causes the oppression of self and others.

Davoine and Gaudilliere (2004) discuss the signifier “therapy” as coming from the ancient Greek *therápōn*, whose origin emerged in the context of war as it designated a companion or close friend who would care for the body and soul of a friend in combat, in life and death. Once the friend is deceased, the *therápōn* acts as the double of the deceased in the funeral rituals, i.e., representing the deceased and receiving the farewell of those bereaved (2004, p.153). In such a way, the *therápōn* is in a position of responding to a situation of extreme pathos—understood as piety and sadness for the one suffering—to protect a person from subjective destitution. A psychoanalyst can understand the moments in which the intervention needs to fit the urgency of the situation, by offering not so much compassion—suffering with the other—but presence and voice (cf. 7.4.2). Psychoanalysis, in principle, is not focused on the disappearance of the disruptive, but rather takes it as a point of departure. Psychoanalysis can’t commit to healing or the restitution of wholeness because it assumes that the disruptive is a part of the human animal’s own psychical constitution, the inherent catastrophe of what it is to be a speaking being in an imperfect society. The healing benefit in psychoanalysis comes as an effect, not a goal, as Lujan and Bleichman (2009) indicate: “Psychoanalytic therapy does not preclude therapeutic effects, but it gets them on a different path: they are the effects of the analyst’s position and how he understands the direction of treatment” (p.106, my translation).

The differences between psychotherapy and psychoanalysis start with the concept of the subject, whose structure places general psychotherapy in the realm of the Imaginary-Symbolic registers, while psychoanalysis focuses on the Symbolic-Real registers. The latter is sustained by the fact that the subject is *an answer*, that partaking of the image of the self (Imaginary) and the speech of the Other (symbolic) comes *from* and *of* the Real, as Lacan indicates in *L’Étourdi*: “concerning the analytic discourse, it is the subject that, as an effect of signification, is an answer of the Real” (In Verhaeghe & Declercq, 2002, p. 10). Moreover, the subject is structured by a letter and is an effect of the signifier, split between the I of the *statement* (*énoncé*), and the I of the *enunciation* (*énonciation*); consequently, the subject does not recognize themselves (cf. 1.9.3; 4.3.6). This means that every person is spoken by two sides of language when they speak or

act: one that says a conscious intention, based on the context of the uttered phrase or word, also known as the syntagmatic construction; but also, another side that brings the literal signifier which, extracted from the context of the utterance, opens to unconscious reason. That is why psychoanalysis provide an altogether different approach from any psychotherapy of cognitive-behavioural or humanistic approaches, because it rationally articulates a theory and methodology that focuses on inquiring about the excluded negative.

Freud's maxim synthetizes the aims of analysis: "*Wo es war soll ich warden*" (Freud, 1933/1973, in Lacan, 2006, p. 734), an aphorism with various translations, some of which have misdirected the project of the unconscious by refocusing the analytic endeavour on the conscious ego. Lacan's translation emphasises the becoming of the subject: "Were it [id] was, there must I come to be as a subject" (Lacan, 2006, p. 734). The subject must surface to both manifest their singularity and to ethically assume their enjoyment and desire, yet two elements are troublesome: not only "one does not see oneself as one" (Lacan, 2006, p. 736), but the subject must assume their own causality even when they are not the cause of themselves, as humans are structured through the history of the negative (Lacan, 2006, p. 734). The *I* of the subject is solely a representation, or as Schuster (2016) stated: "The 'I' is not the fount of personality or the agent of speech, but a mere character caught up in a play put on by signifiers for other signifiers" (p. 8). There is no way to find a solid ground of being, except perhaps for what desire is, which I discuss below.

One clinician stated in an interview: "a lot of being a skillful helper is the work one does with their own self" (Ld2). Indeed, self-awareness and critical self-examination are essential to be able to conduct any therapeutic process, but regarding the analyst's being, Lacan states, "the more his being is involved, the less sure he is of his action" (Lacan, 2006, p. 491). As soon as the focus is on the therapist's being (what they are, their qualities, their good intentions or the point of arrival of the endeavour, the outcome) we are in the field of identification, because, as Fink (2007) states: "[o]ur usual way of listening is highly narcissistic and self-centered, for in it we relate everything other people tell us to ourselves" (p. 4). The place of intervention is different in psychotherapy and psychoanalysis. Trauma treatment insists on focusing on strength, resiliency, and a sense of control, all needed aspects of a person, yet this is done at the cost of denying what structured the trauma in the first place. By including the negative, the spectral, and

the rejected as part of what a subject and society are, the analyst rejects the status quo and opens the possibilities of a reconfiguration of repetition, a bending of structures. And by relinquishing a belief in transparent communication, it brackets it to bend the structure of language, which wants to preserve its form perpetually.

The Imaginary is a vital aspect, it is the side of brightness, light, and smoothness which gives temporary safety, stability, and pleasurable feelings. But pleasure for its own sake, without a symbolic, critical, or dialectical development of consciousness, is not conducive to any healing of the destructivity of jouissance; rather, it leads to impotence, because it does not confront the impasse directly. Let's move into the ways in which the impasse of trauma can be listened to from an analytic position.

7.5.2. Listening from an analytic position

A clinician stated that a form of validating a person is “definitely hearing them, validating, and repeating information that you have heard from them so they know you have heard it the way they want you to” (CI1). While this commonsensical statement, “hearing them the way they want to be heard,” is a popular understanding of the “client-centered” approach, in psychoanalysis is a resistance on the side of the therapist to hearing the negative, the thing that does not match or that appears as indicative of the subject's split. For example, a participant said: “I'm going through a lot of trauma just worrying about whether or not I'm going to be caught or whether or not I'm going to be ... you know” (AI7). A clinician could repeat what they believed they understood, focusing on the symptom, a common practice in the institution, one of trauma or paranoia in this case. Instead of concentrating on getting more information or “more knowledge” about the same symptom with other words, a clinician could take the statement “whether or not I'm going to be?” and repeat it back to the analysand with a question mark. This subtle intervention might shift the session towards the Shakespearean question, “to be or not to be,” discussing precisely his position about whether or not to be, directing him to linguistic places that are not yet colonized by the pre-given meanings of trauma-focused interventions that reinforce the emphasis on symptomatic sameness.

An analytic position is a result of the way the analyst listens to the speaking subject as much as the way the analyst responds. The analyst is primordially a logical

function of the symbolic order, who directs treatment and establishes a safe place of radical inquiry by erasing, as much as is humanly possible, the person of the analyst, their own interests, opinions, identifications, and wishes for the analysand, with the purpose of breaking imaginary capture based on ego-to-ego communication. That does not mean that the analyst is a cold robot; quite the contrary, the analyst's subjective erasure relaxes the listening process because there is no superegoic imperative of what a clinician should be, as the full focus is on the analysand's speech. This also avoids the trap of leading to an already defined meaning, which occurs in the taken-for-granted transparency of intersubjective communication. Such a position also permits sufficient distance so that the function of the analyst can activate interventions beyond the analyst's own resistance; for example, asking the hard questions, at the right time, that ought to be asked in any instance of human suffering, questions that bring about the split of the subject as well as investigate about ethical responsibility in the subject's suffering.

The analytic position creates a therapeutic relation, known as transference, formed by a speaking being that has questions and the presence of an analyst who sustains a desire for analysis to happen—disclosing the subjective split, making unconscious desire conscious. The analytic relation facilitates a dialectic actualization of how language reverberates in the analysand's body; in other words, there is an ethical interrogation by a trustworthy other about the split in the subject's speech, which allows the analysand to create their own understanding after hearing the literality of what they say. This means that two participants (the therapeutic dyad) are involved in creating the analytic position, but there is only one voice, the analysand's.

Listening carefully is at the core of the symbolic intervention and fosters a radical site of care; some service users expressed that listening requires trust, respect, and sustained empowerment, for example:

[I find it most helpful] when they understand what I'm getting at, and they respect my opinion. (A14)

I think people who have not been through a mental illness are afraid. They dismiss people's hallucinations or delusions as "whoa, way out there," but there's often always a basis on some sort of fact, something, and I think the best thing you can do is just to listen to each person tell their story. (A14)

A clinician expressed the complexity of listening to trauma in this way:

it requires a cultural understanding and a context understanding of both the person and the experience that happened. I think we need to remind ourselves it's a very complex thing. (Ld5)

These quotes speak about the importance of being aware of how language is handled in every clinical structure (neurosis, perversion, or psychosis);⁴³ yet it is even more crucial in psychosis, due to its specific relation with language. Lacanian theory conceives of psychosis not as a pathology but as a structural affliction of the symbolic register. Vanheule (2011) explains it as follows: "in psychosis a specific signifier, which concerns both law and naming, is absent and as a result the structure of the Symbolic is unstable" (p. 50). This signifier, known as the Name of the Father, is foreclosed in psychosis, for the subject struggles to find their whereabouts in language to be represented for others. Violence can be exerted by the very act of speech for any speaking subject, yet in psychosis the speech of others can be experienced as invasive or potentially diminishing more easily, which requires the most aseptic handling of language by the clinician. In my experience at VCH, the so-called thought and perception disorders (i.e., hallucinations or delusions) are treated as something that should be abolished based on failing the "reality test" of social adaptation. Yet those known as the "positive symptoms" of psychosis are indeed creative strategies to respond to the enigma psychosis poses to the subject and, as the above voice implied, such phenomena are based on a truth that requires acknowledgement.

A caring listening to the specificity of trauma implies, as service users unanimously agreed, the assumption that those who know best about trauma and healing are those with lived experience, followed by those who study it. What type of knowledge is involved in the treatment of trauma, and how a clinician relates to it, so that it does not fall into a know-it-all stand? I analyze that next.

7.5.2.1. *The place of knowledge*

Knowledge in the therapeutic relation refers to the phenomenon of transference, which structurally supposes knowledge in the service provider. Transference, for Freud, is both a repetition of love and a resistance (Freud, 1912b, 1915a/1973). It is a repetition

⁴³ Although I won't focus on discussing the specifics of clinical structures here, elsewhere (Fernandez, 2014), I claim that neurosis, perversion, and psychosis, and their correspondent underlying mechanisms of repression, disavowal, and foreclosure, respectively, are logical forms that organize desire and jouissance, rather than fixed unmovable structures.

because the psychic energy actualizes unconscious complexes in the figure of the analyst; it is love because in every encounter of a therapeutic nature the subject demands—*qua* speaking, in the psychoanalytic sense—recognition as a worthy and lovable being (cf. 5.4); and transference is resistance because such a demand for love directed to the analyst constitutes a way of avoiding larger questions of the actual amorous and destructive elements in the subject's life. Yet for Lacan, the key aspect in transference is the investment of a supposed knowledge that the figure of the analyst—or the clinician in the MH system—undergoes, known aphoristically as “the subject supposed to know.” This imposture is acknowledged by the analyst, or else there is no analytic position, and is deconstructed through the analytic process. In my research, there were some antagonistic views about supposed knowledge, specifically regarding psychiatry:

psychiatry is really not a science but it's, some of it is, but it's very, very slow in terms of advancement, and they don't ... they're not god to me. (A13)

Talk to a psychiatrist and hopefully they will have the discernment to decide whether a person needs to be diagnosed with an illness or not. A psychiatrist has that power. (A11)

The supposition of knowledge is a necessary condition for transference, in its absence there is a lack of trust which hinders treatment; in contrast, if the clinician takes for granted the authority of such bestowed knowledge can lead to the exertion of power, specifically under the parameters reinforced by the know-it-all discourse. Transference, understood as the analysand's supposed knowledge of the figure of the analyst, opens the question to ethical aspects, as various clinicians voiced in this research: “I have so much power in the [clinical] situation, what am I going to do to make sure that I am going to walk both alongside people and give them the space to take agency in their lives” (FG C12); “we have inherent authority in what we do, right? So ... acknowledging that and working really hard not to use that” (Ld7).

In a simplified way, the *subject supposed to know* refers to the actual ability of the analyst in knowing *how to* bracket their theoretical and experiential knowledge to facilitate full attention to the analysand's speech. This might sound counterintuitive to some at VCH, for the privileged know-it-all semblance supports precisely the idea that the clinician demonstrates knowledge to the service user as a sign of competence: “I try to teach people, or I do teach people” (Ld3). Instead, the analyst's suspension of their

knowledge does not mean that they know nothing, they obviously do *know something* through many years of their own analysis, years of seminars, listening to people under supervision, etc. The key knowledge of the analyst, however, is about how to occupy an analytic position to conduct treatment through a clinical inquiry that limits exercising signification for the analysand, so as to preserve possibilities for subjective emergence.

Occupying the place of the subject supposed to know from an analytic position creates an ethical authority that permits the questioning of social and psychic aspects inaccessible to consciousness or that pose an impasse. Transference actualizes the literality of the subject's sayings in the figure of the analyst and contrasts them with a signified content that historically insists on the subject's lineage; the inquiry regarding those connections is a delicate function of the analyst, a function which is an effect of the listening position in at least three ways: 1) the analyst encourages observance of the fundamental rule of analytic treatment known as *free association*—the person must say any thought or impression that comes to their mind, regardless of its apparent relevance or pertinence (Freud, 1912/1973, p. 101); 2) the analyst maintains an *evenly suspended attention* to the analysand's free associative speech, without directing attention to any theoretical supposition, predetermined theme, or therapeutic goal (Freud, 1912a/1973, p. 111) ; and 3) the analyst focuses on the materiality of the signifier—the literal saying that might bring full speech—rather than to proliferating meaning, leading to the empty speech (Lacan, 2006, p. 206) that always abounds when someone is trying to make sense of their lives in a therapeutic environment.

Listening to the materiality of the signifier and to full speech—the manifestation of a true saying—requires training the ear to hear the literality of the utterance, its cadence and intonation, and play with polyphony or the equivocations of language. The literality of the signifier stands out from the signifying chain through the subject's peculiar use of expressions or words, but mostly because of what the signifier says literally. Listening to linguistic equivocations sustains analytic interventions that explore the polyvalence of signifiers, which, represent the subject, for another signifier whose values of truth can shift. Since the signifier structures the unconscious, the analyst can highlight an element in the analysand's speech that resembles other sounds (phonemes) or potential meanings, opening the possibility of unveiling a latent truth or shifting directions within the signifying chain to name or represent themselves in a different way. For example, an analysand dreams that she “can't live without a Rolex” and her associations bring about

the signifier “paper roll”; the “Rolex” then turns into a “role”: “I can’t live without a role.” This is the principle of *lalangue*, which shows the *senseless sensed* that can’t be mentalized or rationally articulated, but finds resonances in the subject’s *jouissance*, opening new directions of understanding desire and truth. A young analysand says “I want to be *heard*” and within the context of the utterance and the history of her amorous life, the analyst asks: “I want to be *hurt*?” and she could hear what she couldn’t say; or another analysand, who has identified themselves as “shit,” is asked if he perhaps was referring to “the shit;” yet another person expresses a sense of *inadequacy* with her body, and the analyst repeats it back as *in-adequacy*. These interventions were discovered early by Freud in his work *Interpretation of Dreams* (1900) and elaborated in a text known as *The Antithetical Meaning of Primal Words* (1910), in which he writes:

The way in which dreams treat the category of contraries and contradictories is highly remarkable ... there is no way of deciding at a first glance whether any element that admits of a contrary is present in the dream-thoughts as a positive or as a negative. (Freud, 1910/1973, p. 155)

He gives various examples, such as the signifiers “siccus” (which refers to dryness) and “succus” (which refers to juice). In those cases, Freud adds, the value gets decided in written language and Lacan retakes this very proposition to instantiate how a clinical intervention or interpretation should refer to the polyvalence *inscribed* in its very existence: “Is it true that is false, or it is false that it is true. It is not at all something linear, univocal and decided” (Lacan, 21.06.1967). So, the truth of the subject’s being—an absence for every speaking being—gets to be decided *by the subject*, not out of volition or planned will but by partially extracting or separating themselves from how sayings by the Other have represented them. Considering the equivocation of language aims at making new inscriptions and re-inscriptions possible, yet the effects of an analytic intervention, operating in language through the transference position in which they are received, is always unknown to any of the analytic *partenaires*, because language effects are decided *only* when a subject can occupy a signifier with a new signification, as in the above examples, heard or hurt? shit or the shit? Rolex or role? in or out of adequacy? Only the effects of the intervention will show if the decision—an act—was made.

By giving all the power to the sayings of the analysand and directing the inquiry toward the materiality of the signifier, without forcing meaning, the therapeutic

relationship builds trust without demanding the “being of the clinician,” albeit the style of the analyst is always at stake—personality, space, physique, etc. Clinical competence in psychoanalysis is derived from the art of asking the hard questions with the best strategy possible for examining the subject’s suffering beyond victimization and perpetration. That does not mean that this type of inquiry is for everyone or that every service user will be interested in it, but the ethical horizon should be there for planning TSS if the clinician truly wants to surpass what various participants perceive to be “putting a Band-Aid on the problem” (Ld2). Only in that way can the split of the subject be unveiled and heard by the subject, creating radical possibilities out of the repetition carried within the strictures of discourse, which colonizes meaning.

One more challenge of listening to the analysand’s suffering refers to the differential value of diagnosis between psychoanalysis and psychotherapies or the biomedical profession. Diagnosis in the MH institution, as it stands, articulates a demographically based category that facilitates an abstraction of the subject’s symptoms to plan the treatment. How could a diagnosis contain enough information to attend to the important questions of the cause, and more so, how could an individual seeking services in the mental health system connect it to the larger issue of the collectivity in which the suffering was generated? One participant said: “I’ve had so many diagnoses it’s not funny. It’s just ... what am I? What is this?” (A13).

7.5.2.2. *Diagnosing trauma?*

The challenge of diagnosis, from a psychoanalytic perspective, refers to the way in which the clinician can understand the subject’s logic to use probing questions that reveal their subjective split, so that the subject can reposition themselves to elucidate the cause of their suffering. This process can’t ever be forced or predesigned; it emerges at its own time during the treatment because it preserves the singularity of each speaking being. Diagnosing trauma requires challenging the mainstream idea that re-enactment—for example, exposure therapy—is the solution to trauma suffering:

I’ve seen over time that so many workers think that people have to relive the trauma in order to overcome it. Workers think it but clients do too, so they form their attachments based on terrible things. (C16)

Diagnosing trauma requires, as this same clinician stated, “focusing on the trauma by not focusing on the trauma” (C16); in other words, being able to listen to the

current cause of trauma (i.e., the occurrence of psychosis, any kind of abuse, any form of loss, etc.), while exploring how it over-imposes the transcendental traumas of being a mortal sexed being within a society. By elucidating the relationship with death, otherness, and sex, the subject's logical mode reveals its form as well as early significations of the current trauma (cf. 2.2.3; 6.3.1).

With respect to the trauma of death, the challenge is to encounter the right timing within the emergence of transference to inquire about what the history of death in the subject's tradition has been, not only of death *qua* end of life of loved ones, which explores experiences of grief and loss, but also regarding how the death drive has taken charge of their ancestry's mind and flesh within their historical context: the traumas they have suffered, the way their lineage has enjoyed, suffered, and destroyed. Listening to the trauma of death involves listening to instances of self-destructiveness or destructiveness to others with a curious inquiry about how that might connect to the unspeakable between generations, because those clarifications might open the possibilities for inscriptions and re-inscriptions of destiny.

With respect to the trauma of otherness, the analyst listens to how the person relates to the signifier *phallus* or ϕ , a signifier that allows signification and simultaneously signifies lack, which is deeply connected to narcissism because it relates to social valorization or what others have called social capital (Bourdieu, 1977, p. 184).⁴⁴ When exploring the trauma of otherness, the challenge is letting the analysand articulate their sense of worth when confronted with social others but also, maneuvering as carefully or as boldly as needed, punctuating the subject's speech to elucidate in what way such an imaginary phallus, an image that supports the ego, simultaneously constitutes a trap that can cause great suffering. The symbolic intervention regarding otherness in trauma involves the rehabilitation of the fundamental fantasy at the same time as the questioning of it because the supposed ontological sense of self is inconsistent, precarious, and ends in a broken image, not only for those who suffer the accident of trauma, but for all speaking humans. Another clinical aspect regarding otherness entails

⁴⁴ Bourdieu (1977) articulates social capital as "social universes in which relations of domination are made, unmade, and remade in and by the interactions between persons, and on the other hand, social formations in which, mediated by objective, institutionalized mechanisms, such as those producing and guaranteeing the distribution of 'titles' ... relations of domination have the opacity and permanence of things and escape the grasp of individual consciousness and power." (p. 184)

the challenge of how to interrogate, in a therapeutic way, the agitating dilemma of otherness that afflicts the human race, which refers to how one can deal with difference beyond the narcissistic trap.

With respect to the transcendental trauma of sex, diagnosis aims to investigate how the drive has structured neurocircuits of pain and pleasure that are revealed in language. The therapist needs to listen to the subject's position regarding jouissance to elucidate a possibility of the subject encountering their *response-ability* in suffering. "How is this sexual?" an analysand of mine asked about the term jouissance, "I do not get an erection when I suffer." Jouissance is sexual because sexuality, understood as the drive, is the force that takes hold of the body by the early experiences of exchange in the orifices of the body. It is sexual because it involves the sensuality of the body. As Freud explained via war neurosis, sexuality as causality does not ignore the *reality* of the horrors endured by those involved in war, and by extension does not ignore the reality of vexations or humiliations endured, but rather investigates how such intensities have taken charge of the body in a traumatized person, making the body repeat something that destroys and yet strangely satisfies, perhaps by the mere discharge of energy, always embodied, that comes to the analysand as a relief (Freud, (1919b/1973).

When exploring the constitutive trauma of sex, the challenge resides in how to listen to the subject's relation to their sexed body of jouissance in connection to the imperative ontologies or prescriptive ways that define what it is to be a woman, a man, queer, or trans within their social milieu. Sex constitutes a fundamental question, rather than an answer, as Lacan put it clearly: "In the psyche, there is nothing by which the subject may situate himself as a male or female being" (1964/1998, p. 204). Sexuation is a logical construction that conceptualizes two main modes of embodying enjoyment and desire—the feminine and the masculine—in addition to an emerging field that explores how this question is approached in transsexual and queer subjectivities.⁴⁵

The challenge of inquiring the relation of the subject to their sexuality goes beyond categories of gender normativity, expression, and identity because, at core, the

⁴⁵ Most interestingly, Patricia Gherovici (2017) proposes that the transexual subject constitutes an answer rather than a question with respect to the field of sexuality, and that crossing the frontier of the sex change is a matter of "finding a livable embodiment, which means a new way of being" (p. 145). Also, Sheila Cavanagh (2011) has considered transsexuality as a *sinthome*.

clinical investigation must question the field of the non-signified and the subject's position regarding the sexual nonrelation. For example, Bob (cf. 3.1), who expressed that the cause of his trauma was a masturbation problem, and the team reassured him it was not a problem, explains:

I started when I was 12 years old. I used to do it two or three, four times a day for eight years, every day. And afterwards, I was just completely, so much pain in the mind, and they don't treat that in the psychiatric team because it's healthy. (A12)

How can the mental health worker hear this singular truth about an experience of excess without choosing adaptation or commonsensical understanding, facilitating, instead, the subject's emergence? The beyond signified by the non-sexual relation exceeds the focus of my argument, yet it suffices to say that sexualization refers to how a subject relates to the phallus and to the impossibility of the sexual relation (cf. 4.2). The sexual nonrelation challenges spherical thinking and the totalizing intentions of "the thought of the One of the couple" (Lacan, 22.02.1967), which draws on the phantasmatic idea of being One with the mother, which accompanies the imaginary pleasures of love. The exploration of the field of sexuality is also important because, as Lacan mentions, "the true order of subjective satisfaction is to be sought in the sexual act, which is precisely the point in which it proves to be the most torn apart" (22.02.1967).

One final aspect within the diagnostic exploration of constitutive traumas involves the exploration of the subject's words to reveal whether they are alive or dead in respect to desire, to which I now turn to discuss.

7.5.3. The intangibles of the Symbolic horizon

A participant voiced his challenge with trauma in this way:

I have to talk about the trauma that I have caused myself. I have to, because I have to live with myself. I have to be able to forgive myself and understand why it was that I did some of the traumatic things I did to myself. (A17)

What is the horizon of the Symbolic register and how should the intervention be focused? The contingent effects of an intervention are only known after the acknowledgement of some truths, once the subject reaches a logical time which pushes

those truths into appearance. The consequences of the subject's appearance are the desirous act and the *sinthome*. I will explain these terms in what follows.

7.5.3.1. Desire

Lacan speaks of psychoanalysis as a “praxis that warrants a name, erotology. It is a question of desire” (Lacan, 1962/2014, p. 15). Desire, as the source of life, emerges as an effect of the said and heard, but also as an effect of having recognized subjective elision (Lacan, 07.01.59, p. 104). Desire is not a want or a wish—something you can have as tangible as a piece of bread—but rather is a subjective process in which the drive has been properly intervened with to allow for an erotic recuperation, losing its deadly force. Desire is a consequence of the subject's ethical assumption of that which, as Lacan says, is “in me more than me” (Lacan, 1964/1998, p. 267), loosely coinciding with the process of externalization:

once they start to externalize, they start to think about how did I end up here? A lot of people start to move beyond “I am the problem,” right? They start to see that they are doing this because of what happened to them, what happened to their family, etc. (FG Cl6)

While externalization is a first step toward signifying how perpetration became internalized, externalization is not enough to solve the issue of how the subject unconsciously participates in compulsive repetition. It is necessary to find a Symbolic law that contains the lethal and lawless *jouissance*, for “desire is law” (Lacan, 1962/2014, p. 150) because it sets a limit. Desire resists and is paradoxical in many accounts: 1) being different from want, it can't be fully satisfied or else the subject is complete, which is the state of death proper; 2) the desire of the speaking subject is always the desire of the Other (Lacan, 1964/1998, p. 235), hence it is always partially alienated; 3) desire is organized by anxiety and calls out for an act that engenders the pending task of the subject's becoming; 4) desire slides like the signifying chain, so it constitutes a horizon, never a goal, and its essence is lack, as Lacan explains: “[t]his lack is the lack of being properly speaking. It isn't the lack of this or that, but lack of being whereby the being exists” (1954/1991, p. 223); and 5) desire demands from the subject a renunciation of being the object for the Other (the support and vehicle of narcissism) and in that process, the subject risks being unloved.

7.5.3.2. ***From symptom to sinthome: Sublimating the drive***

Desire is possible when the effects of analytic treatment have created the possibility of *nomination*, which refers to the ability to count oneself as someone of worth and value among others. Nomination is also the pronouncement of a name that gives a person a sense of identity within their specific social context. This process is known as the *sinthome*, which is a Lacanian construction that explores the logic that actualizes a *know-how* relating to the unbearable impenetrability of truth (Lacan, 1975/2005, p. 14). In the various ways of naming oneself, some are more precarious than others, such as inhibition, anxiety, or even the symptom, which I discuss next.

Through the theory of the Borromean knot (BoKnot), another topology in writing the Real of the structure, Lacan renders several ways in which a subject can tie together the three registers of human experience. In addition to the three rings, Lacan adds an extra one in Seminar XXII (1974-75) to designate the signifier Name-of-the-Father, a concept akin to the phallus (cf. 7.4.2) which indicates the topological cut that separates the subject from the mother's body, and by extension from the bodies of others. The four-ring BoKnot corresponds to the Freudian psychical reality—the neurotic reality created by the triangulation of the Oedipus complex rather than a mere dyad (Lacan, 21.01.75)—because without the introduction of a third in the dyad “nothing holds together” (Lacan, 14.01.75). Following the Freudian triad of inhibition-symptom-anxiety, Lacan organizes the vicissitudes of the fourth nominative ring—the variable psychic reality—in the knotting to the other three rings. Since each of these rings are equivalent, only their spatial position establishes a distinction, whether the rings are crossing over or undercrossing, providing distinct clinical values. As depicted in Figure 7.1, and following Chapuis and Rosales (2015, np.), each Lacanian knot presents a differentiated way of *naming the subject* and thus presents a clinical organization that allows for a specific form of nomination in traumatic suffering.

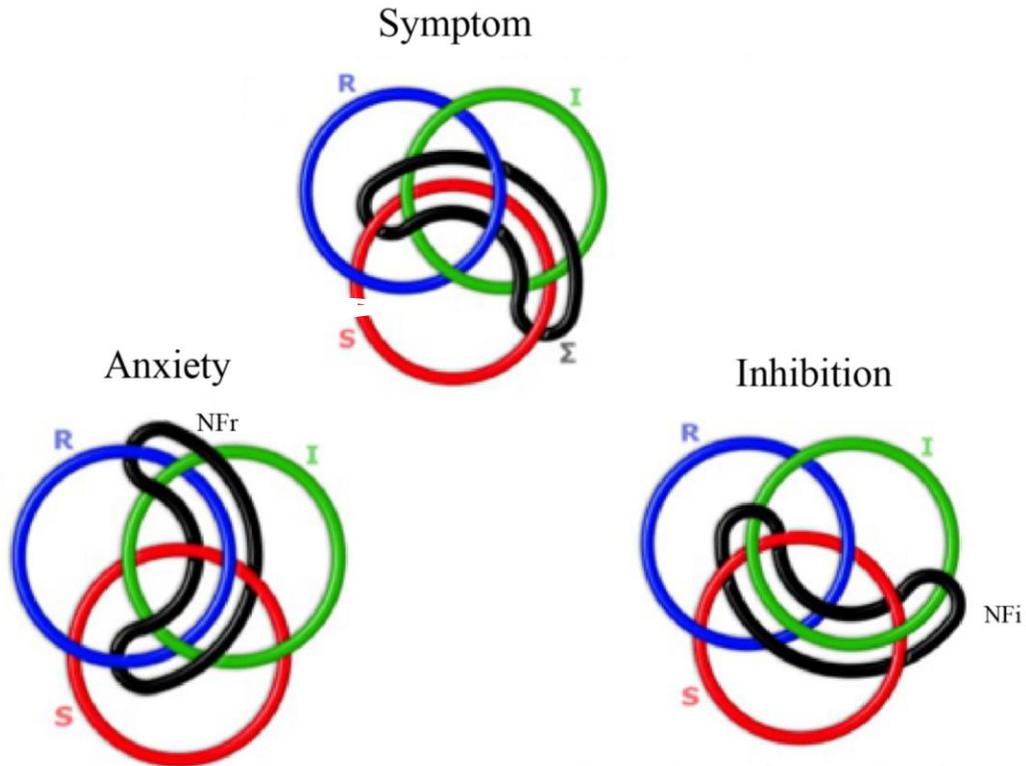


Figure 8. The knotting of the three RSI rings for symptom, anxiety, and inhibition (modified from Chapuis & Rosales, 2015)

In the symptom, the nominative fourth ring fastens the Symbolic under the Imaginary and the Real, allowing for access, albeit limited, to decoding the Real of the drive by means of deconstructing the symptomatic metaphor (cf. 7.3.3). The MH institution instantiates this nominative form in the increasingly common form of people identifying themselves through psychiatric diagnoses. Instead of their names, stories, or experiences, identification is with *a name* given by the DSMV: “my depression, my ADHD, my bipolar disorder, my trauma,” significantly limiting the possibility of overcoming pathologizing and victimizing positions. Sometimes those diagnoses hide the subject: for example, someone hoping to get a diagnosis of autism to justify their blunt, often read as aggressive communication and not be rejected, or the epidemic-like diagnosis of ADHD in adults and children, which covers more complex issues of alterity.

In inhibition, the signifier Name-of-the-Father ties over the Imaginary, allowing for a precarious nomination because it suppresses desirous functions, leaving the subject sutured in a phantasmatic idealization of self that avoids any challenge to such idealization and hence paralyzes them. This form of nomination locates the subject, with

respect to others, as inferior (I won't be able to do it) or superior (I can, if only by overcoming this perfectionism), maintaining their status quo. Finally, nominative knotting via anxiety does not prevent the Real from invading the Imaginary, and thus this nomination becomes precarious because it does not allow the subject to count themselves as one since the subject is dominated by an overwhelming paralysis, the result of occupying an object position for the Other.

Each form of nomination requires a different strategy to defuse the compulsive repetition caused by the traumatic rupture, and this constitutes what Lacanian psychoanalysis refers to as the analyst's direction of the treatment, which straddles strategy (the overall aim) and tactics (the means) (Lacan, 2006, p. 493). The nuanced discussion of the direction of treatment in each of these nominative modalities goes beyond the focus of this dissertation. Yet, as a mere illustration, suffice it to say that inhibition requires activating interventions that move some anxiety to stop something that continues *not happening*; in the symptom, the strategy is to look for the hidden cipher in what the subject says *in the said*; while in anxiety, the strategy is to facilitate the symbolization of unclaimed desires, ignorance of which agitates death and castration anxiety.

The nominative form known as the *sinthome* occurs when treatment reaches a logical conclusion, through the creation of a solution that sustains subjectivity via sublimation of the drive in the body, because, as Miller (2016), citing Lacan, has indicated, "the *sinthome* of a *parlêtre* is an 'event of the body'" (np). The subject does not get rid of jouissance—it will always live within—but it transforms it into life rather than death. Cavanagh states that "we create a *sinthome* when we identify with our symptom, that is, when we no longer believe in the truth of the symptoms but see it as a creative product of the self and hence take ownership of it" (2011, p. 2). Kingsbury (2021) states that the symptom's "knotting capacities are generated by the repetition of poetic, inventive, and artistic activities that give consistency to a person's ego and relations with other people" (p. 8). But it is perhaps Paul Verhaeghe and Frédéric Declercq (2002) who express more clearly the clinical challenge involved in the *sinthome*:

traditionally, analysis tackles the Symbolic component of the symptom, but it is the Real part that jeopardizes the effectiveness of therapy. All the well-known problems – the partial resistance of certain symptoms to analytic treatment, the symptom relapse after a certain period, the negative

therapeutic reaction – can be understood as expressions of the Real, that is the drive component of the symptom. That is why the overcoming of the repression – the Symbolic component of the symptom – does not lead automatically to the expected results. (p.3)

In other words, and paraphrasing Freud,⁴⁶ to find a nomination that reduces miserable suffering to common unhappiness, the treatment of trauma must intervene on the Imaginary register, rehabilitating fantasy and the pleasure principle, while the Symbolic elaboration of the meaning of transcendental traumas will reach the impasse of the Real, which demands, as a response, a *creation* that can access know-how relating to the symptom. That is why the *sinthome* is not an aim but an effect of what the subject has done through sublimation.

Sublimation, for Freud, is a cultural development that guards against suffering and constitutes “the most important vicissitude which an instinct can undergo,” where the sexual drive changes both object and aim and finds satisfaction in “a higher social or ethical valuation” (1923, p. 256). Lacan, for his part, defines sublimation by the logical mechanism that elevates an object “to the dignity of the Thing” (1959/1992, p. 112). Sublimation goes beyond the simple discharge or channeling of affect as its transformation demands a pairing thought, or as Lacan puts it:

an emotion or a traumatic experience may, as far as the subject is concerned, leave something unresolved, and this may continue as long as a resolution is not found ... The action must be discharged in the words that articulate it (1959/1992, p. 244).

To facilitate sublimation, a subject needs access to a social practice of an artistic nature. In my research, only one participant of the focus group advocated for this important aspect:

Art Studios is no longer part of VCH, and it was fully funded before. I think that was a huge mistake because it had the creative arts there ... It really is a good model ... I think we need more of that. (FG CI4)

There are abundant examples of mental health institutions in various parts of the world that create partnerships with artists-in-residence to contribute to people’s healing journeys. This is not the focus of my research, but during my research residency at

⁴⁶ Freud stated that “much will be gained if we succeed in transforming your hysterical misery into common unhappiness” (1893b/1973, p. 305).

Ghent (September 2018), I learned of the project known as *Beautiful Distress* (2014), which operates in Kings County in New York, and *Het Vijfde Seizoen* (The Fifth Season) in the psychiatric institution Willem Arntsz Hoeve in Utrecht. These projects consist of having “a more known or lesser known artist to live there [in the psychiatric hospital] for three months and create at least one piece” (Museum Dr. Guislain, 2018).

Other examples involve music as a way of trying to deal with trauma (Yake, 2022), or the work of poets in various mental health spaces such as the Pongo Poetry Project (2022), which engages youth in writing poetry to inspire healing and growth. There are also poets who work together or lend their voices to people to explore metaphors and words that can approach the inexpressible of trauma, to find opportunities for grief, humor, joy, or the remembrance of ancestral wounds (Bass, 2021; Der Vang, 2021; Herrera, 2021).

If desire and *sinthome* are horizontal to symbolic interventions that facilitate healing, in this last section, I will discuss the specific symbolic challenges, expressed by service providers, which involves pedagogies and supervision, as strategies that resist techniques of subjective emptiness.

7.5.4. Resisting techniques of subjective emptiness

I classified five themes that identify the main concerns expressed by service providers: 1) *trauma is ubiquitous* in the work done at MH and SU services as “a natural part of working with people who are suffering a lot” (Ld4); 2) a *diagnostic-based medical model with exclusive offerings of Evidence Based Treatments (EBT)*, such as psychiatry medications and CBT psychoeducational treatments that result in a “one size fits all” approach (cf. the whole of Chapter 4), is prevalent; 3) there are *budgetary time-space constraints*, as discussed above (cf. 7.2.1); 4) *decision-making* in therapeutic protocols is not critically or democratically driven, but is hierarchically imposed from the top down, hindering possibilities for safe ethical inquiry; and 5) *effective training and supervision* is required to support cultural competences, to effectively prevent burn out, and to create trust in discussing the more complex aspects of ethical and clinical challenges. To address these themes, I analyze the ways in which psychoeducation and supervision are conducted at VCH.

7.5.4.5. Psychoeducation

[the role of the clinician is] to educate the clients around trauma and talk about how it affects us as human beings *physiologically; how it effects our brains*, how it effects our mood, how it can intersect with substance use. (Ld4)

It reminds me of a client who was in one of the DBT groups ... they asked if all the groups are like school ... I told them that it is a type of therapy but then I realized that this is not what this person needed ... They just wanted to be able to share their narrative and feel like they are being heard. There is no room for that in our DBT groups because we are teaching skills, right? (FG Cl4)

Most of the group therapies at VCH teach emotional skills, such as distress tolerance, emotional regulation, or self-management of psychosis, anxiety, and depression. The focus is on these skills and on learning about the physiology of the human, rather than on learning about the subject's existence as a sexed, mortal, and social individual. There are hopeful exceptions, such as the START women's day treatment program (South MHT), suicide bereavement at SAFER-MHSU OS, PRISM at 3BSU, and the culturally-led groups at AWP. These programs, while keeping a few psychoeducational concepts, focus on collective ways of healing that create relational ways of fostering communities, because they engage in dialogical and personal storytelling. In my working experience at SAFER, some participants in the suicide bereavement group, coming from various walks of life and carrying intersectional differences—socioeconomics, education, race, age, or gender—shared their personal stories of traumatic grief, and it often happened that after the group therapy finished, they continued holding regular meetings on their own to care for each other in their healing journeys of suicide bereavement.

Nonetheless, most group therapies at VCH follow manualized versions of CBT and DBT, which are supported by the bulk of research, hence are given supremacy for being “evidence-based.” The reinforcement of these programmatic forms of group therapy, vastly employed not only at VCH but in global MH, poses significant concerns. In my experience as group therapist at VCH, I have observed that these skill-based groups require a pre-post measurement and thus are focused on outcomes rather than on experience. Groups are often led by two therapists, and they do most of the talking while advancing the CBT or DBT's workbooks. The manualized content focuses on promoting skills for managing various challenges posed by affect, thought, and

behaviour. The teaching-learning process follows constraining rules and to avoid potential conflicts within the group, participants cannot connect outside of therapy. To prevent the overflowing of emotion within the group, participants can only talk about lighter examples of their experiences, mostly focusing on what hurdle their skill practice. The premises behind these manualized therapy groups are seriously problematic on multiple accounts, the most important one being that they ignore the complexity of trauma and mental illness and silence the voice of the subject. By focusing reflection on skill efficiency, a radical example of instrumentalized reason, these manualized group therapies ignore meaning-making, prevent the establishment of social bonding, and self-discipline the individual, dismissing existential self-understanding or the gaining of critical, historical self-consciousness. These forms of group “therapy” also ignore advances made in the fields of health and education, where subjective creation of knowledge is crucial (Pillen et. al., 2019; Parker & Pavon-Cuellar, 2014; Murillo, 2018). We do not learn by having information fed to us; we learn by producing questions.

I consider the deployed pedagogies of most manualized therapies at VCH to be devoid of the *critical, ethical, and dialogical* articulation of their employed epistemologies, and consider their techniques to involve an emptying of subjectivity. By criticality, I refer not only to the Enlightenment notion that validates knowledge based on how well beliefs withstand criticism, but also to the self-reflexive articulation of subject and object positions inherent in the production of those theories. Criticality involves the awareness of social, cultural, and political contexts, but also the awareness of intrinsic impasses to every human thought, such as the impasse of trauma articulation, for which criticality reflects on both knowledge and the lack of knowledge. In addition, the delivery of manualized CBT and DBT group therapies lacks ethical stands, understood as the informed articulation of the rational behind treatment goals and in showing what is considered to be the common good, how it is defined, and why. Finally, this model lacks dialogical engagement because it is focused on efficient outcomes rather than on the human individual. The pedagogical technologies are centered on use-value or utility; as Fernando Murillo (2018) clearly states, there is “an expectation of efficient rate-of-return, disregarding [the] human condition” (p. 53).

There are many forms of engaging in group therapy where psychoeducation is not programmatic. For example, Adalberto de Paula Barreto (2021) created Integrative Community Therapy (ICT), a modality born in Brazil and now expanded to all parts of the

world, built to engender “solidarity bonds among the participants, improving resilience and self-esteem and educating future citizens within different populations” (p. 1082). In a video (2016), de Paula talks about *4 Varas*, a project that provides interventions in highly stressed communities that evidence collective suffering from the violence they endure in the slums or favelas. Their methodology is language-based and de-professionalized, incorporating traditional epistemologies—i.e., healers, community interventions—as well as traditional psychotherapeutic approaches that allow for the group to *guide* the process. ICT works in large groups that discuss rules first and meet weekly. Participants choose the theme of the day by group vote; words and silences are encouraged, as well as creative interventions such as calling out proverbs, singing, movement, or humour, that ease conflict or heavy affects. This example shows one of many group therapy methodologies in which the centre of attention is the human subject in a collective setting that encourages social bonding opportunities, rather than the achievement of efficient use-values.

Within the researched sites, perhaps AWP is the one that best honours the complexity of the human subject by “reclaiming and reconnecting to our cultural practices and knowledge-bases” (C17) which then converge in a collective perspective of trauma that is not about “individual pathology but about the impact of violence” (C17).

Let’s move to a discussion of two other concerns for practitioners: supervision and personal analysis.

7.5.4.6. Supervision and personal analysis

One thing that is needed at VCH is the official recognition of the centrality and importance of clinical supervision to the provision of trauma therapy ... having non-clinical managers makes it very difficult. (C17)

I felt that clinical supervision was often individual and one-on-one with the clinical supervisor. We had not figured out how to really create peer safety with one another to be able to share those vulnerable-making points of talking about this work and talking about doing trauma counseling, and feeling overwhelmed, unprepared or out of our depths. (Ld4)

Participants demanded quality supervision at VCH, work methodologies that allow for one-to-one supervision, as well as the collective creation of knowledge. A common rush to jump into solution-focused brainstorming, “to go into task or rescuing or

something” (FG C13), as well as weak transference—the inability to locate who is the subject supposed to know—appeared as concerns regarding supervision at VCH. The fact that managers often have a double function as clinical supervisors constitutes an obstacle because administrative agendas become the priority rather than understanding therapeutic needs. In my experiences at VCH, supervision has been uneven, sometimes provided by the clinical manager, sometimes peer-led, or a combination of both. The best experiences, however, were when an external, experienced supervisor, often working from a psychoanalytic perspective, conducted group supervision for a consecutive period of years. This is, of course, biased by my own interests, but the psychoanalytic perspective allowed for a deeper understanding of the clinical situation by conjuring up the subjectivity of the therapist without ignoring the temporo-spatial constraints of the agency; hence, it was well received by most of my clinical colleagues. If there is no subjective awareness in the therapist, the clinical practice perpetuates empty subjectivity.

Supervision should instead be called “super-audition,” or so Dulsster and Vanheule write (2019, p. 57), because rather than a superior *vision* that sees and understands the analysand’s story or the therapist’s reactions (so-called countertransference) with great precision, *super-audition* instead involves paying attention to the flowing of the signifier chain, as well as to the words used by the therapist to describe the analysand’s situation. Following Lacan, Dulsster and Vanheule claim two stages of supervision, the stage of the rhino and the stage of the pun. The rhino acts blindly, and this refers to the supervising stage where the supervisor lets the therapist intervene with “their own ‘movement’ or inspiration” (p. 60). This circumvents identifications and discourages false beliefs in the superior knowledge of the supervisor on where the intervention or the process is going, while assisting the therapist to listen to their own way of intervention in the hope of creating more refined forms. This view coincides with a participant voice: “the process of supervision results in the therapists finding their own creativity” (Ld1). The stage of the pun relates to training in polyphony or multitudes of meaning, in which listening occurs beyond the given meaning and breaks it down, playing “on the equivoque that might free up something of the *sinthome*” (p. 61, my emphasis). Finding a rigorous form of supervision that includes the subjectivity of the clinician as much as that of the analysand is a must at VCH in order to resist instrumentalizing therapeutic outcomes.

Another aspect of significant concern among service providers was the therapist's personal analysis and one participant expressed the purpose is "to minimize the degree of which my own struggles, life themes or trauma get in the way of the clients or therapists that I am working with" (Ld1). Another participant said, "I do think that we bring our personal experiences to the work" (Ld5) and someone else mentioned that the limits of service provision and supervision "have to do with my own limitations; what I do not know, what I do not hear well" (Ld1). The clinician's self-examination through rigorous inquiry is a fundamental part of the ethics involved in trauma service provision and is based on a true desire that can't be reinforced, or it loses its purpose. The clinician's own analysis or therapy allows a *savoir-faire* with their own personal triggers and conflicts so that they can refocus attention on the analysand's speech rather than the therapist's own fears and discomforts. In Lacanian psychoanalysis, this is known as *the desire of the analyst*, a fulcrum that sustains the analyst's act, whose horizon aims to listen to expected conflicts of a transference nature beyond the analyst's own discomforts, and beyond personal curiosity or gain, to stand for the radical elucidation of the subject's unconscious truth of their desires.

After discussing the challenges of a Real, Imaginary, and Symbolic nature from various perspectives, we now turn to the final section of this chapter. I propose the clinic of the social link as a practice engaging Real, Symbolic, and Imaginary challenges.

7.6. The clinic of the social link: The extimate intervention of subject and discourse

A participant provides a point of departure from which to illustrate what I propose as a general response to the violence of trauma:

the problem does not occur with the Indigenous individual but in the systems and structures of settler society and process of ongoing colonization. Therapy alone will not address oppression. (CI7)

Based on my research, I am proposing the clinic of the social link or the clinic of social bonding as a psychotherapeutic practice that connects the two scales of subject and society in the work with people with posttraumatic suffering. The clinic of the social bonding rejects pathologizing trauma and locates the cause beyond the person's mind, assuming trauma to be an extimate coproduction between the exterior—others, history,

the environment, society—and the interior—the Other, the body, the ego, the story, the subject. It is my claim that the trauma clinic is always a clinic of the social link because structurally, trauma involves a failing Other. The clinic of social bonding also assumes an inherent alienation of body, desire, and speech in the Other, for which MH trauma treatments demand built-in mechanisms that acknowledge the historical causes of traumatic experiences. In this research, it is not only the estate-sanctioned trauma caused to the Indigenous peoples of Canada that demands historical elucidation; every form of trauma can find its cause in social disturbances, such as sexual violence, war, heteropatriarchy, the exploitation of others, etc.

Social bonding does not necessarily refer to an enthused community, nor to a cohesive group with sustained identifications. Although these elements are part and parcel of the social link, the most essential aspect of the social link refers to the opportunities a society and its discourse provides in shielding the subject from the violence of the Real (See *discours-écran*, Soler, 2004, p. 18). The clinic of social bonding also provides possibilities for a subject *to knot* their various experiences, to *nominate* themselves as an *I* with a name worthy of being included in social solidarity, despite and because of their own singularity.

The clinic of social bonding demands a radical change with respect to the categories of normal (professionals) and abnormal (patients): we all are affected by the perils of being speaking mammals trapped by language, and thus all humans are affected by a form of mental and emotional disarrangement, although unevenly. This quote exemplifies that need:

We are just human beings trying to get by. Some folks have a little bit of an easier time because of privilege that we might have or circumstances that we were born into, but in the end we are all just trying to get by. (C11)

That does not mean that people are all affected equally or that there is a way to predict outcomes based on such differences. Rather, each subject makes their own way of suffering and desiring within the constructions of an inherited language. By departing from pathology, VCH and global mental health institutions can better serve the increasing demand for mental health services (depression, anxiety, paranoia, psychosomatic ailments, trauma sequelae) that has skyrocketed since the pandemic on a global scale (Moreno, et. al., 2020; Richter, et. al., 2021). Understanding suffering as a

fair reflection of the world in which we live now, instead of as a defect in the person's life, is vital. Mark Fisher (2011) describes this problem in terms of the systemic ailments of late capitalism:

The privatisation of stress is a perfect capture system, elegant in its brutal efficiency. Capital makes the worker ill, and then multinational pharmaceutical companies sell them drugs to make them better. The social and political causation of distress is neatly sidestepped at the same time that discontent is individualised and interiorised. (p. 130)

In what follows, I discuss how the clinic of social bonding operates, and, as I have been doing throughout this dissertation, I approach the analysis by alternating the focus between the scales of the subject and society.

7.6.1. Scale subject: Externalization of the Other (partial separation)

In each saying, a culture speaks; in each pronunciation or instance of full speech, the subject reveals an accumulation of preceding intergenerational experience, the precipitation of lineage and discursive traditions in which a subject was born and raised. Therein the possibilities arise of finding and rescuing something that insists in subject's speech: the letter, a sort of branding made by the Other on the subject's flesh that repeats the structure.

The clinic of social bonding externalizes the various ways in which an internalized Other—culture and tradition—speaks in each of the subject's symptoms and by doing so the subject finds a new way of knotting the registers of their experience. The internalization of the Other is actualized via the superego's oppressive and exploitative logic: a guilty and compulsory self-subordination to defend bigotry, moral fanaticism, classicism, heteronormative patriarchy, and so on. The clinic of social bonding encounters the perpetrators' meaning, repeated as if it is the subject's very own voice, but other vicissitudes are also encountered, such as an identification with the aggressor who threatens and exploits others. The clinic of the social link brings such linguistic contents into the context of the subject's suffering and traces their origins, always mythical, in the slip of the tongue, in dreams, or in the literality of the said. The subject's sayings require punctuation or a cut to externalize them, to locate them in the social source from which they have come. For example, a mulatto woman engages with a man who controls her in everything, for she finds it to be a way to fight against "the genetic

vices of my race,” and the analyst asks, “tell me about those vices, and who says so?” Another example is a young woman, a fierce feminist who hates all mothers for what she thinks constitutes female weakness. A father insists on finding the cause of his young daughter’s homosexuality; “and what is the cause of your heterosexuality?” the analyst asks. The oppressive Other speaks in the subject’s jouissance and it can’t be unknotted through psychoeducational or cheery moralistic explanations, but instead through the subject’s confrontation with their own sayings, something that *is not planned but found*, and that permits the unveiling of the linguistic mechanisms that cause the dominant, preordained, and naturalized discourses of oppression. This form of listening makes the subject of the unconscious emerge in their relation to discourse and allows the Symbolic *to eat* the Real (Lacan, 1975/2005, p. 32).

When externalizing the Other, the clinic of the social link rescues traumatic experiences sealed in past silences, only recorded in the body, to allow the subject to pronounce themselves regarding the value of truth about those internal significations, assuming a difference with the preceding traditions and generations, a desire that is paid with *response-ability*. At the scale subject, the clinic of social bonding requires intervention for a partial separation from the sources in which the subject’s own language emerged, as this condition keeps open the hole of trauma, generating a great deal of pathos or intense suffering. The subject requires partial *separation* from the Other of language, or else meaning continues to be hooked up to that pre-given by their lineage and culture of origin.

7.6.2. Scale social: Identification for belonging (partial alienation)

At the social scale, to find possibilities for nomination and actualize social bonding, the subject requires a minimal alienation from language and the Other because a subject, represented by a signifier for another signifier, cannot represent itself. A partial alienation allows the formation of identifications with something or someone within the social milieu, which provides a sense of belonging. This is not required to be an actual group because identification occurs in the field of the signifier; as someone mentioned to me in a session, “I identify myself as a hermit.”

The social scale is central to the clinic of social bonding because it grapples with the question of regaining trust in the Other after experiencing a structural rupture

(individual trauma) or after enduring a larger share of the traumatic void (collective trauma). Within my research, a participant voiced this social aspect through the opportunities brought about by peer support:

there's a lot of suffering on the Downtown Eastside. But there are people that have bounced back; there are people that have been in that condition and have recovered, and they can help others to recover. (A12)

A sense of belonging is important for those with traumatic suffering because it fosters collective solidarities and eases the horrific burden carried by individuals by themselves, as in the above case, in the experience of living with on addiction in Vancouver's Downtown Eastside. Another example was given by an Indigenous clinician, who stated that preserving Indigenous peoples' cultural sense of belonging is key because "part of healing from colonization is reclaiming and reconnecting to our cultural practices and knowledge-bases" (C17).

One example from my literature review illustrates well the importance and difficulties of collectivized traumas at the social level. Jenyu Peng (2017) discusses the case of "comfort women," about 200,000 abducted women and girls from various parts of Asia that served as sex slaves for the Japanese Imperial Army in World War II (p.115). Peng wonders whether the sharing of trauma, necessary for its historicization, is worth the stereotyping effect on the specific population, stating that the benefit of "the shareability" of narratives of collective trauma "resides in an inquiry into the narrator's singularity" (p. 117), as well as in allowing the victim to understand that the traumatic event is not a matter of their bad fortune, shifting self-blame towards identifying the traumatic cause.

Belonging and forming strong identifications is essential in creating opportunities for social bonding, yet the necessity of alienation always poses the risk of succumbing to a group mentality. Freud gives a clear picture of its perils when he states that the libidinal constitution of a mass consists of "*a number of individuals who have put one and the same object in the place of their ego ideal [ichideal] and have consequently identified themselves with one another in their egos*" (1921/1973, p. 116, original emphasis). When idealizing a leader or an unquestioned idea, antagonisms must be sacrificed to preserve a cohesive sense of the group. Also, Freud mentions that while cooperation is an actual phenomenon, we should be aware of the gregarious drive, manifested in a moral sense of justice, community spirit, and egalitarian aspirations, as a

reaction formation to the inherently forced renunciation of enjoyment in civilization and culture. Hence, the group mentality always poses a risk of denying the hostility and competition intrinsic to a group, which gets channeled, through intolerance and hate, against those who dissent, instead of accepting and acknowledging difference (Freud, 1921/1973, p.118-119). A well-known example is *call out culture*, the result of heightened polarization and the overall sense of public confusion in the present, which aggressively censors dissent. The group mentality is an extreme pole of spherical thinking and consequently becomes easily oppressive, mainly because “[o]pposition to the herd is as good as separation from it, and is therefore anxiously avoided. But the herd turns away from anything that is new or unusual” (Freud, 1921/1973, p.118). The group mentality installs a ferocious master signifier and demands uncritical docility, as instantiated by the extremism of what supposedly should be the progressive politics of identity. Identity politics affirms a particularity that is absolutely necessary to collectivize visibility. Yet when grasped by a herd mentality, discussions redirect towards a matter of rightful property that hurdles both discussion and solidarity, as Samir Gandesha (2019) states: “identity politics entails a proprietary relation to a reified form of experience – unchanging, fixed, substantive – that can be understood as the possession or property of a given group” (np). The group mentality is the most significant challenge on the social scale when establishing a needed bonding of solidarities.

Psychoanalysis refuses group thinking, which is why treatment cannot be the site of militant activism, or else the effectuation of a psychoanalytic act is eclipsed. Psychoanalysis is an emancipatory practice that starts with the liberation of the subject, a subject trapped in social discourse by the singular way in which the drive determines ways of enjoying and suffering (*jouissance*), surplus *jouissance*, and the traps of the image. A liberated subject cannot share the spherical thinking of the mass, fueled by the passions of love, hate, and ignorance (Lacan, 1953/1988) that imaginarily smooth the idea of being. Instead, analysis bids on for a subject that can love, hate, or ignore while remaining aware of difference.

Thus, the clinic of the social link focuses the transcendental trauma of alterity (cf. 2.2.3) to elucidate the sources of identity and insert them into a dialectic exchange that finds its cause and looks for an inscription of the residue. For such a purpose, the subject is required to partially separate and be partially alienated, overcoming the trap

that a group might constitute. Let's see what discourse supports social bonding in that way, and how it was manifested in this research.

7.7. Analyst discourse: Bending the structure to transform discourse

To actualize the clinic of social bonding in all its radicality, and to facilitate a certain form of non-spherical healing, a specific discourse is needed. Lacan (1954/1988) bluntly states that life does not want to be healed because the negative therapeutic reaction⁴⁷ is all too well known, yet he asks: "what is healing? The realisation of the subject through a speech which comes from elsewhere, traversing it" (p.233). In this section, I want to introduce a final discourse in my research, the analyst discourse, which I render as a discourse of transformation that bends the structure through linguistic means.

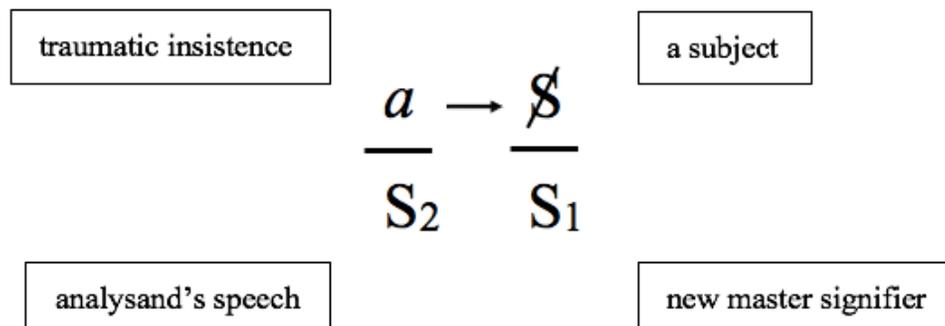


Figure 9 Lacan's discourse of the analyst

The logical mechanism that circles around the psychoanalytic discourse reads as follows: it departs from the analysand's own knowledge, revealed through their speech, activating the analyst's function which makes semblance out of traumatic insistence. The analyst's position, as a semblance of object *a*, or the residual aspect of trauma—what is not heard and thus remains unknown to consciousness—is directed toward the subject and conjures the subject up to appear and take a stand about the unconscious

⁴⁷ The negative therapeutic reaction refers to an intractable resistance to healing in some people. Freud (1923b/1973) writes: "the need for illness has got the upper hand in them over the desire for recovery" and adds that this powerful obstacle includes "narcissistic inaccessibility, a negative attitude towards the physician and clinging to the gain from illness" (p.49).

emergence. From that exchange, surplus jouissance appears as one subjectively produced master signifier.

The intervention of the analyst is vital in disrupting the reproduction of the same conditions of suffering. That is why auto-analysis is impossible, because analysis requires someone to bring difference into a dialectic; someone other than the subject is needed in psychoanalysis because “[o]ne does not see oneself as one is” (Lacan, 2006, p. 736). If it is true that “[t]he psychoanalyst’s position leaves no escape, excluding as it does the tenderness of the beautiful soul” (Lacan, 2006, p. 727), then the task within analytic discourse is precisely a radical inquiry that pushes the subject to emerge and articulate some knowledge—*savoir faire*—of the repeated truth of their suffering. It is common that the traumatized subject bears the blame for what happened to them, which indicates an object position in front of the perpetrating Other. The subject must step in because “one is always responsible for one’s position as a subject” (Lacan, 2006, p. 729). The latter does not imply any justification for the trauma endured, nor does it diminish the responsibility of the perpetrators, but rather questions the subject’s position with regards to the unthinkable or the negative avoided. To heal suffering, a subject must precisely summon their own *response-ability* in their suffering, to be able to occupy a position as *subject* rather than as *object*. Remaining an object for the Other maintains unbearable suffering, but also attempts to cover the lack in the Other to maintain an illusion of control and order.

At both scales, the analyst discourse demands the analytic position. The subject scale involves the creation of a trustworthy therapeutic relation that assumes certain knowledge, embodied by someone whose presence occupies the function of the analyst. On the social scale, the psychoanalytic function can be adopted by anyone who causes transference; that is to say, anyone can occupy the semblance of the subject supposed to know within a social relation, and from such a position, address an ethical question. I have claimed elsewhere that in “a civic society this is the function of the intellectual, who comes to occupy the function of the analyst in the processes of inscribing the residue of the Real” (Fernandez-Alvarez, 2020, p. 155), but this research allowed me to discover a new embodied finding thanks to my autoethnographic engagement. Instances of the analytic discourse are found in my research through engagement with the AWP’s community. In my consultation with VCH’s council of Elders, while I was having a puzzling emotional reaction (cf. 6.6.2), Elder Iggy George stated that “guilt and shame

are languages of the settler.” In such a pronouncement, Elder Iggy interpellated me as researcher, tracing the colonial oppressive mode *in language* and positioning himself and by extension the community outside of self-victimization, which constituted a *de facto* intervention in the body of jouissance that signified my apparent affect. Being confronted with the council of Elders’ solid presence—vital for the position of the analyst—I was able to face *knowledge I did not know I knew* regarding unacknowledged shame about the racist core of my culture of origin, as well as regarding the assumption of my partial Indigeneity.

We find yet another instance of the analytic discourse in the AWP’s refusal to let their service users participate in my research. The AWP’s response was a cultural intervention in the larger political body of the institution, to assert the conditions of the epistemic possession and transfer of their knowledge. This Indigenous intervention in my research reminds me of the forms of resistance against the politics of recognition and reconciliation that Glen Coulthard (2014) articulates. Coulthard advocates for a politics of resentment as a way of acquiring the cultural and political power of assertion against what he deems an ineffectual thirty-year global turn towards reconciliation. The refusal to engage in research and to assimilate the signifiers of shame and guilt, examples of analytic interventions in my research, would correspond to what Coulthard identifies as valuable signs of active forms of “self-affirmative praxis that generate rehabilitated Indigenous subjectivities and decolonized forms of life” (p. 109). These interventions “represent the externalization of that which was previously internalized: a purging, if you will, of the so-called ‘inferiority complex’ of the colonized subject” (p. 114). By doing so, it is my claim, the Indigenous community intervention in my research indeed occupied a psychoanalytic position that returned traumatic insistence back to their interlocutors, disrupting, stretching, and transforming a fixated discourse. The discourse of the analyst is a discourse of transformation because it bends the structure in which discourse has reproduced itself: “Analysis can have as its goal only the advent of true speech and the subject’s realisation of his history in its relation to a future” (Coulthard, 2014, p. 302).

The analytic discourse produces a new master signifier. On which signifier has emerged from this linguistic exchange in my research with the AWP is not transparent to me, yet certain effects traverse me and my research. Perhaps this signifier relates to me conducting an unapologetic and rigorous institutional critique while trying to maintain a *relationality of dignifying humbleness*. This signifier is what I found most striking in my

engagement with the Indigenous community at VCH, and it is perhaps identification with it that could indicate a production. Yet psychoanalytic discourse is incompatible with the uncritical tendencies of a group, as Lacan summarizes: “The psychoanalytic discourse ... is precisely the one that can establish a social bond cleansed of any group-necessity” (1972b, p. 6). In other words, the master signifier that I might derive from the AWP’s cultural intervention has no effect whatsoever if *imposed or forced* onto anyone, because social bonding—nomination and social responsibility in front of others—occurs already as an effect, and hence prescinds multiplying identifications. In what way does the Indigenous intervention in my research affect the research community at VCH? That is still to be seen, as it will depend on the reception of my research by the body politic or institutional constituency.

There is yet one more fundamental aspect of psychoanalytic discourse: that it “implies no other subject than that of science” (Lacan, 2006, p. 733). The subjectivities that emerge from psychoanalytic discourse entail the Cartesian subject that doubts and asserts itself through reason, yet the Freudian-Lacanian subject assigns a different role to thinking precisely because it poses that our being *is* where we do not think, because the *unconscious thinks us* via language. Lacan (1969/2007) says: “There where I am thinking I do not recognize myself, I am not, this is the unconscious” (p. 103), the reason why that which cannot be thought (the Real) is traumatic. The subject in psychoanalysis, although conceived of by the rationality of science, is the subject *thought by* language and experienced by *jouissance*, reason for which demands that the subject step in; “Where *it* was, there must *I* come to be a subject” (Lacan, 2006, p. 734). By focusing on the *I qua* subject, psychoanalytic discourse bypasses the ego, a site of misrecognition where contentious claims of “competency,” “capacity,” or “ego strength” are based. The focus on the *I* of the subject instead of their ego gives ample space for those with disarranged excesses, neurodiversity, or delusional claims to be heard regarding their levels of social proficiency.

As psychoanalysis involves the subject of science, it does not address the spirit because psychoanalysis is neither mystic nor mantic; it does not belong to the realms of divination and prophecy. Even when abundant impassés and impossibilities cannot be articulated, a subject in the final analysis can account for the act in which their subjectivity actualized, assuming an ethical accountability that can be articulated rationally. Yet, while psychoanalysis involves science in its praxis with the subject of the

unconscious, psychoanalysis is not a science because the latter “forgets a dimension of truth that psychoanalysis seriously puts to work” (Lacan, 2006, 738). Psychoanalysis faces the impossible truth of the Real *qua* impossibility, a negativity that resists articulation. In the next and final section, I will discuss how such an impossibility can be approached through analytic discourse, by proposing the politics of inscription and re-inscription that work with the subject of the unconscious in a different direction to that of science.

7.8. The politics of inscription and re-inscription: writing a loss, a new re-writing of repetition

When postulating that the subject of the unconscious is the subject of science, Lacan introduces the idea that “an inscription does not etch into the same side of the parchment when it comes from the printing-plate of *truth* and when it comes from that of *knowledge*” (Lacan, 2006, p. 734, my emphasis). Psychoanalysis assumes that there is a structural impossibility between knowledge and truth, and it is the subject in psychoanalysis that “join[s] knowledge and truth together” (Lacan, 2006, p. 737), in the articulation of their experience of the *senseless sensed*. The politics of inscription and re-inscription account for how a person *becomes* a subject, through a minimal symbolic grasp of the Real: a signifier to be repositioned in the signifying chain, a letter to be grasped, and a loss to be written. These politics are crucial because they recalibrate surplus jouissance, which is to say, they bend the structure and consequently the libidinal economy.

With regards to trauma, various forms of emancipatory politics have been proposed, and each addresses a portion of what a community might need at any given point in time. Some focus on the Imaginary and Symbolic registers, such as the politics of apology, testimony, and remembrance (Felman & Doub, 1992; Peng, 2017; Fassin & Rechtman, 2009; Caruth, 1996; Hamburger, 2018), or the politics of identity, such as the politics of gender, sex, or race (Haaken, 1996; Umaña, 2012; Abbot, 2012; Hartmann et al., 2019; Toner, & Akman, 2012). Other politics focus on the Symbolic register and the Real *qua* structure, such as the politics of reparation (Peng, 2017), the politics of proof and restitutive justice (Fassin & Rechtman, 2009; Valgiusti, 2021), the politics of working through the past (Adorno, 1973/1998), and decolonial politics against ongoing exclusion (Gone, 2013; Haig-Brown, 2010; Linklater, 2014; Coulthard, 2014; Dupuis-Rossi &

Reynolds, 2018; Sayigh, 2013; Sheehi & Sheehi, 2022). The politics of the inscription and re-inscription of traumatic residues align under those whose intervention focuses on the Symbolic and the Real, *qua* impossibility. The importance of the mechanisms of inscription has been implied by Davoine and Gaudilliere (2004), Žižek (2012), and Soler (2004), and is akin to other psychoanalytic proposals such as the politics of the event, the act, or the Real (Pavon-Cuellar & Parker 2014; Bistoën, 2016; Tomsic, 2019). It is my contention that these politics can indeed affect the Real *qua* structure, as discourse, which I develop in what follows.

The politics of inscription and re-inscription emerge directly from the clinic. I understood inscription and re-inscription in the findings of my analysis, and in analytic work with people experiencing trauma sequelae in my private practice, where time allowed for the actualization of negative aspects—the residual—within transference. I have instantiated inscription at the *subject scale* through a clinical case of a woman with a traumatic past of sexual abuse, who inscribed something of what happened to her within the emergence of a transference conflict involving my anxiety and her anger. This analysand found a way to *write* the unspeakable by expressing her anger about the violence she endured through the person of the analyst, by maintaining the inquiry of the affect, by analysing the signifying associations, and mostly by being accompanied toward the limits of signification. Multiple sessions after the anger event, the analysand partially unburdened herself from suffering and started expressing herself through poetry, rather than insisting on speaking of herself as a trauma case (Fernandez-Alvarez, 2018, unpublished). Elsewhere, I have instantiated the process of inscription at the *social scale* through the epidemiological research of Chandler and Lalonde (1998), which explores the disproportionately higher rates of youth suicide in Aboriginal groups in British Columbia; their results reveal that the Indigenous communities that have the highest degree of cultural continuity allow for a sense of temporal self-continuity in youth, significantly lowering the incidence of suicide. I claim that “Indigenous groups which successfully have preserved life among their youth, have inscribed, partially, the brutally devastating colonizing effects through a political achievement that preserves their own cultures” (Fernandez-Alvarez, 2020, p. 147).

7.8.1. Logical modalities

Inscription and re-inscription are logical mechanisms submitted to contingency, so they are not planned but encountered, and they create possibilities for redirecting language towards new questions that recalibrate surplus *jouissance*, the very excess of the life/death drive. To situate inscription and re-inscription, we need to contextualize the four categories of modal logic proposed by Lacan (1972/1999, p. 59; 1973/session 20.11.73), the necessary, the impossible, the possible, and the contingent:

- 1) The *necessary* is defined as that which “what does not cease of being written” (*ne cesse pas de s'écrire*) (Lacan, 1972/1999, p. 94). The necessary is linked to the *automaton* as the repetition of the phallic function, as a support of discourse, which also alludes to the master's signifier as a structural support of signification; hence, this is the field where re-inscription operates.
- 2) The *impossible*: refers to that which “does not stop being *not* written” (*ne cesse pas de ne pas s'écrire*) (Lacan, 1972/1999, p. 94). The impossible is the field of the Žižekian “unknown unknowns” (2009, p. 124), which Lacan locates in the impossibility of writing the human sexual non-relation due to the impossibility of being One with another. The impossible, in my research, designates *the trauma residue*, also known as object *a*, the unspeakable of the traumatic event at any scale.
- 3) The *possible* is a disruption, an event understood by Alain Badiou as “the creation of a possibility of a truth procedure” (2013, p. 14) that reveals “a possibility that was invisible or even unthinkable” (2013, p. 9). According to Shepherdson, the event as possibility poses questions such as: “‘Can we?’... ‘Should we?’” (2009, p. 65). The rupture of the event as a form of possibility opens up opportunities for a partial inscription of that which can't be written (the impossible) and/or a re-inscription, which is a new form of the already written (the necessary). This is where Lacan positions the effects of the analytic act, because psychoanalysis creates possibilities by disrupting preordained significations.

- a) The *contingent*: refers to the decidability of an event, rendered by Badiou as a “truth procedure” (2013, p. 10) underway which assigns a different value to truth, to either partially halt what “does not cease of being written” or to create a partial form of writing of that which until then has not “stop being *not* written”. Contingency is linked to *tuche* (the unpredictable and chance) and constitutes the outside of the structure that bends it to produce a new Real *qua* structure. Lacan positions love as contingency par excellence because it is “a sign that one is changing discourses” (1972-73/1999, p. 16).⁴⁸

7.8.2. The act and the event: Would VCH grasp contingencies?

How does someone make the magic of the inscription and re-inscription that operates on the body and the psyche of a person? These logical processes occur within the event, understood by Badiou as the emergence of a *truth procedure* that produces a universal truth that can’t be defined by positive “identificatory predicates” (Badiou, 2004, np), but rather “states a valence for something that was previously undecidable, uncertain or anonymous; by doing so, such an event reaches an inaugural subjectification” (Fernandez-Alvarez, 2020, p. 152). That is why the event cannot be explained, as Pavon-Cuellar and Parker (2014) assert, or “then the event would no longer be an event, but simply one more element of the structure” (p. 7). Pavon-Cuellar and Parker render the event as aligned to Foucault’s view of the “‘historic irruption of an enunciation’ *irreducible* to the ‘play of the linguistic structure’” (2014, p. 7, my emphasis); therefore, a linguistic event, though *always historical, exceeds structural discursivity, and*

⁴⁸ While Lacan recognizes the Imaginary nature of love, the love Lacan proposes is aimed at the *being in the Other*, not as object (sexual intercourse and the enjoyment of the Other), God (transcendence), or absolute being (ontology), but as love between subjects, which tries to inscribe something of the impossible traumatic sexual relationship by means of a certain “courage with respect to this fatal destiny [of its own impossibility]” (Lacan, 1972/1999, p. 144). Love in Lacan aspires to be Symbolic love, beyond *Veirleibheit* (the narcissistic trap), as it involves a radical recognition of the other through “knowledge and connivance” (Allouch, 2009, p. 342) and accepts the ambivalence between love and hate (*Hainamouration*) (Lacan, 1972/1999, p. 146), which permits a specific relation with unconscious knowledge. This quality of love not only indicates the renunciation of any impulse towards integral, totalitarian love (the persecution of the One as the confluence of two) or transcendental love, as we know through Freud can lead to catastrophic oppression, but it also contradicts the dominant maxim that conditions that one must love oneself in the first place in order to love others. One loves oneself when one opens to the Other as subject, not as object, which reconstitutes their relation to others.

yet is assimilated by language; that is to say, by structure. The inscription of the event does not fully crush the structure, but only bends it.

For the event to be inscribed it requires the condition of transference at both levels, the individual and the social. At the subject level, inscription mechanisms are potentially conflicting because negative appearance, at the time of the event that reveals it, is often but not always accompanied by affect and intense effects on the speaking body. Nothing can erase the intractable truth of trauma, impossible to signify, but transference sets about an inquiry that involves both the rational mind and the body to ethically account for excess and the need for limits to the somatic affect of *jouissance*. When the process of analysis touches on non-identity, an impasse is reached and analysis can go awry: because even though the analyst has always been on the side of the subject, their interventions go against the stubbornness of the structure and against the subject's ego. Equally, the social scale and the institution require transference to inscribe the event, since only among others deemed able to hold some knowledge can the dialectization of the negative or non-identity become possible. Inscription and re-inscription need to be heard by a community, a collectivity able to maintain fidelity to the event (Badiou, 2013, p. 13). When a political event undresses a negative truth, only a resolute body politic can choose to get organized around it. Would the various mental health teams at VCH step in to grasp contingencies, and turn them into truth procedures regarding that which needs to be dealt with to implement other forms of providing service?

When confronted with the negative, most people activate a *passion for ignorance* (Lacan, 1953/1988, p. 270)⁴⁹ because most of us prefer to go against the knowledge of trauma, and with very good reason, because trauma is the field of near-death

⁴⁹ While discussing transference in seminar I, Lacan states that "It is only in the dimension of being ... that the three fundamental passions can be inscribed" (1953/1991, p. 271), on the condition that they get through the Symbolic order. The three passions of being are a Lacanian adoption of the Buddhist *Kleshas*: *Avidya* (ignorance), *Raga* (attachment or love), and *Dvesha* (aversion or hate). Lacan says it very succinctly: "love aspires to the unfolding of the being of the other, hate wishes the opposite, namely its abasement, its deranging, its deviation, its delirium, its detailed denial" (1953/1991, p. 277). Ignorance is when one speaks without knowing what speaks in us. These passions stand in relation to the three registers. Ignorance is found at the convergence of the Symbolic and the Real, and as a passion asserts that no other knowledge is imaginable, thus refusing curiosity. Love as a passion, between the Imaginary and the Symbolic, endows the subject with worth, and hate is found at the junction of the Imaginary and the Real, as a passion that reassures the subject that the Other can be destroyed.

experiences, of evil, excess, or an unguaranteed Other of care. The passion for ignorance is, for the traumatized subject, an initial necessity in being able to rehabilitate the Imaginary register, but in the long run trauma demands certain inscriptions that alter its truth to find a peaceful silence, a forgetting of the awful memories of the violence endured. Contra Wittgenstein, “[w]hereof one cannot speak, thereof one must be silent” (Davoine & Gaudilliere, 2004; p. 3; Lacan, p. 60), psychoanalysis asserts that for that which cannot be spoken, an inscribing act must emerge for the subject to find some peace.

The effects of inscription and re-inscription are known only retroactively, in parallel to what has been defined as the subject’s act, and that is why there is nothing that can be prescribed for VCH. The act is where the subject, unbeknownst perhaps to themselves, appears and establishes a decision on the specific value of truth of an event that is always discursive, linguistic, and social. An act nominates the subject, and by extension a community, through an acquired certainty: “all human activity opens out onto certainty ... certainty’s reference point is essentially action” (Lacan, 1962/2014, 77). Regarding trauma and its treatment, what type of certainty can we assert? An act is different from other attempts of nomination (acting out or *passage à l’acte*)⁵⁰ because it produces a subject who discovers in the act something of the Real, the impossible universal truth of the drive: death and eros. Bistoën (2016) reminds us that “a true act ‘transforms’ the subject, in that the subject that arises from the act cannot be identified with the subjective forms prior to its occurrence” (p. 135). Elsewhere, I mention that “the paradox of an act resides in the transformation of a subject by erasing it: If the subject dies the subject is lost; if the subject is alive, it can’t fully transform itself or it would disappear” (Fernandez-Alvarez, 2021, p. 187). Therefore, the act is opaque to the subject, who emerges from it and only signifies retroactively in the future perfect tense, “it will have been.” Through a desirous act, the subject and their community retroactively signify a shift of the structure by means of the logical mechanism I will further describe next.

⁵⁰ Acting out, described by Lacan as a demonstration in “wild transference,” aims to show something to the Other and requires interpretation (Lacan, 1962/2014, p. 125). *Passage à l’acte* refers to the action in which the subject identifies absolutely with object *a*, and in great embarrassment lets themselves be dropped, outing their subjectivity (Lacan, 1962/2014, p. 115). A desirous act is the only way in which a subject appears and sustains themselves.

7.8.3. Re-inscription of MH treatments

Re-inscription and inscription are both contingencies but differ in how they are effectuated. Re-inscription is mostly of a Symbolic order but impacts the Real *qua* structure, while inscription refers to something of the Real, *qua* impossible, that lets the subject write a letter missed or lost so far. At the subject level, re-inscription is the individual's pronouncement of the truth of the language that inhabits them, whose signification up to now has caused oppression for themselves or others. In re-inscription, the subject decides on the direction of the signification that has represented them and retroactively loses something: the phallic image that sustains the signification of lack and excess. In re-inscription, the analyst has perhaps called out the signifier's polyphony, disturbing the signifier enciphered in the subject's body through their lineage and their social milieu that has so far represented them. Yet it is not the analyst who makes any pronouncements on behalf of the subject; the subject must respond with an assumption of the truth of that which *does not cease being written* to reposition themselves in the social by an ethical authorization of themselves.

The clinic renders abundant instances of re-inscription: for example, someone shifts the meaning of the signifier of a "wasted" man toward a desire to no longer want to *waste* his time. At the social scale, re-inscription appears as an effect of political struggles; for instance, in the achieved redefinition of linguistic categories, unquestioned until recently, that has hitherto pervasively constructed gender, race, sexuality, or ability in society. Regarding the mechanism of re-inscription for VCH, I wonder whether the body politic would be willing to rewrite the unquestionable necessity of treatment anew, shaping services that strengthen communities. In re-inscription, master signifiers get rewritten. And the risk is always in how the constituency fights the reestablishment of a new form of discourse that believes it knows-it-all.

7.8.4. Inscription of the impossible in trauma treatment

In contrast to re-inscription, inscription emerges from the Real when the letter is grasped by the subject, who was able to make a signifier or an act from it. The letter (cf. 5.2) needs to be written because it stands alone, meaninglessly, is merely littoral between the seashore of knowledge, on one side, and the sea of the truth of jouissance, on the other. Inscription, in my research, constitutes the possibility of grasping traumatic

residue: for example, in somatic memories that find no words for a subject, or events of global knowledge we cannot hear in the social, and partially *write them* because they cannot be said. What aspects of trauma residues can be written? We must first admit that the process of inscription is impossible, it occurs only partially. Its full attainment would correspond to an epistemic account of every truth of social violence inhabiting our bodies; or it could mean solving the impossibility of the lost object, cause of desire; or even writing all the letters involved in thinking and writing trauma. We must understand inscription as a process that “carries in itself its own limit” (Lacan, 20.11.73).

An example of inscription at the social level is found in the film awarded the Grand Prix of Cannes in 2015 and the Oscar for Best Foreign Film in 2016, *Son of Saul* (Nemes, 2015). This film, set in the death camp of Auschwitz during World War II, without being excessively graphic, shows Saul’s desperate efforts to inscribe something of the death drive. Saul is a Hungarian member of the *Sonderkommando*, a special unit of prisoners forced to dispose of the corpses of those killed in the gas chambers in World War II. Facing grave danger, Saul frantically looks for a rabbi who could facilitate a Jewish burial of the body of a young boy he has managed to hide from the medical guard. The film shows a desperate need for inscription, in this case of death, to regain a precarious sense of human dignity, considering the unspeakable horror of thousands of human bodies disposed of as nameless “units,” (in)human residues. Saul’s act—spoiler alert—successfully writes a loss, not only for himself, but for his precarious collectivity. To write the insistent letter of death, Saul partially writes a loss because the letter is only the “furling of a signified” (Lacan, session 12.05.1971). When grasped, the letter marks an event and quiets the insistence of the non-signified. By writing death with the rite of a burial, Saul partially stops that which *does not cease of being not written* and thus signals an end, even if the act is precarious or deemed useless.

At the subject scale, inscription indicates that something has reached the end of analysis. A libidinal shift is but an effect of a letter that found its destiny. The subject has encountered a circumvention of morbid *jouissance* by accessing another dimension of knowledge—the partial writing of *jouissance*—even if *jouissance* won’t ever cease to exist because the body is marked by the musicality of *lalangue*. “I know my sore is incurable,” says Bataille (1962/2000, p. 29, my translation), and at the end of analysis, the subjective structure stretches in such a way that the trauma of the Other’s castration—the structural rupture of the traumatic event—does not leave the subject

adrift. At the end of analysis, the subject's specific modes of satisfaction achieve acceptance and are redirected so that the subject's ego identifies with their own singularity of satisfaction. As Miller writes: "the identification with the symptom signifies that I am exactly as I enjoy" (1998, p. 73, my translation). The / traps the letter, the jouissance that has insisted in the subject, and assumes a loss, the traumatic residue that buries a certain enjoyment. At the end of analysis, an indestructible desire appears, beyond the superego or the will to enjoy, whose condition recognizes the universality of castration, not only for others but for the subject themselves and the Other that supports them, reconstituting the phantasmatic narcissistic trap. At the end of analysis, singularity applies to everyone, in which the logic of exceptionality is overcome. Then, in inscription, the subject trades narcissistic horror for desire: the act versus the death drive.

With my research, I wonder if VCH could take on the impossible task it faces, starting from impossibility rather than impotence, and if it could allow contingencies to be encountered, which is the only way to arrive at inscription. What letter of trauma, the non-symbolized, the unfathomable, could be trapped if the institutional unconscious was heard?

Let's conclude this long chapter.

7.9. Conclusions: Breaking the institutional fantasy that supports the instrumental reason of surplus jouissance

What is the mental health practice that my research proposes? What do I envision as best practices given the vast complexity of trauma and its healing? A participant expressed the following desire:

I have always dreamed if I ever won a million dollars it would be wonderful to set up a holistic clinic ... where there was an opportunity, staffing and time to go gather traditional medicines plus perhaps some naturopathic, homeopathic work, and some body workers like osteopaths, massage therapists, you know, like a holistic clinic along with a therapist and possibly a medical doctor at times. (Ld1)

The participants in my research had plenty of ideas, and in my Team Grant report I made some recommendations, such as the clear opportunity for VCH to mobilize

existing resources and infrastructure to develop an innovative, trauma-specific program of care that goes beyond what is currently provided. These voices summarized it:

What people need is more than just a psychiatric assessment, medication and 6 sessions of CBT. (Ld1)

We cannot just lump everyone together in a generalized program; we need to have specific programs. (FG Cl2)

VCH could implement a core curriculum of education in cultural competency and critical pedagogies for service delivery, promoting self-reflective practices in relation to the clinician's positionality regarding knowledge and power. Also, I suggested a more comprehensive approach to the service delivery of TSS that emphasizes relations among people—service users and providers—rather than relations with outcomes and measurements. This involves the cultivation of true interdisciplinarity, as a participant expressed:

Ideally that team needs to be multidisciplinary. It was so much more helpful when we had multiple disciplines from different places bringing their expertise to that population. (Cl2)

Yet, rather than prescribing a specific program for VCH in these conclusions, I propose that the active underway design of MH services at VCH should count feedback from service users and providers through a different methodology, one that includes the subject of science, as conceived of by psychoanalysis, and incorporates the consideration of the oppressive sources as proposed by critical intersectionality.

I think it is really important for there to be long-term trauma therapy that is widely accessible and culturally informed and aware of the impacts of intergenerational trauma and trauma that specific members of specific communities experience at higher frequency than other communities do. (Ld4)

I participated in one of the consultation sessions (Research notes, 13 February, 2019), and I observed that the explored premises—what services are provided and how they are delivered—redresses the basic neoliberal approach I have questioned in this research, whose objective is increasing *effectiveness* rather than targeting structural issues that continue emptying the institution of subjectivity.

A critical and democratic consultation that explores how to bring subject-based, collective, and critical approaches to VCH entails the body politic unmooring dogmas

and detaching from sacredly preconceived ideas, which means letting go of the institutional fantasy that sees mental health as an exclusive matter of biomedical concern and as education of the emotionally illiterate. A critical and democratic consultation that involves the subject also demands the active search for libidinal transformations of the body politic, which is the challenge posed by surplus jouissance.

7.9.1. Traversing the institutional fantasy

Trauma—that which is rejected and impossible to articulate—is covered by fantasy. In the case of service provision, the master signifier MHEBP (mental health evidence-based practice, cf. 4.3) functions as a fetishistic mechanism. Fantasy is inherent to every subjective attempt to protect oneself against the Real. The institutional fantasy protects from within a narcissistic pact based on an ideal representation, because the institution “preserves law and order, and by itself constitutes a protection against the negative, both for the subjects and for itself” (Kaës, 1989, p. 53, my translation). Other forces within the institution, however, antagonize “in favour of differentiation and integration of the distinct elements” (Kaës, 1989, p. 32). The dominant logic that the institutional body politic can engage—sameness or differentiation—will “work in benefit, damage or alienation of the subject and the group” (Kaës, 1989, p. 12). Therefore, bringing methodologies that sustain differentiation—the non-identity principle—within the institution is crucial to excelling in service provision. This of course implicates to consider the inherent antagonism within and among service providers and users.

7.9.2. Surplus jouissance or deciding on the common good

The excessive excitations caused by the spectral negativity of trauma, agitations of both the subject and society, body and mind, nature and culture, cause surplus jouissance within discourse. Transforming the libido of a subject or a community, from suffering (death) to desire (life), constitutes the ultimate frontier one can wish for within a psychoanalytic perspective, because it creates a new linguistic and structural path—it bends the structure—in which libidinal energy circulates.

At the subject level, such a transformation is reached in the clinic through the process, described above, of inscription and re-inscription, only reached after the

necessary meaning of the symptom has been exhausted, a limit has appeared, and a threshold has been crossed. If at the clinical level a loss needs to be inscribed and assumed for a subject to let go excess of suffering by trauma, the social scale might necessitate a redistribution of loss to alleviate the leak of surplus *jouissance*. For the body politic to recalibrate surplus *jouissance* it requires to decide on the value assign by the institution to the various residues and expenditure of libidinal and economic nature.

Changing the libidinal economy at the social level—and consequently the craze for surplus value—falls in the realm of impossibility, not because it is impossible for it to occur, but because it is impossible to imagine, track, or plan. The impossible is what does not exist. How could the drive be redirected at the social scale? This question has Bataillan echoes: “It is not necessity but its contrary, ‘luxury’ that presents living matter and mankind with their fundamental problems” (Bataille, 1967/1988, p. 8). What heuristics are needed to deal with the leaking and relaunching of surplus *jouissance* at the social scale? Subverting libidinal economies and disrupting instrumental reason, my core questions regarding surplus *jouissance*, entails articulating community values for the negotiation for the common good. The economy of the good is mostly problematic, not only because of finicky human jealousies, petit narcissisms, and violence, but also because we do not know how to ethically locate the place of residual traumatic surplus, which involves a conscious decision as to what we are willing to sacrifice, and under what *conditions*, for the community we desire. Lacan, secretly influenced by Bataille’s general economy but not losing his focus on what allows for desire’s assertion, states that there is “a practice conceived to have a salutary function in the maintenance of intersubjective relations” (Lacan 1959/1992, p. 234) and which consists of the possibility of a “[d]estruction that is carried out consciously and in a controlled way” (Lacan 1959/1992, p. 235). What do we decide to sacrifice?

It is impossible to articulate knowledge of the excess, loss and residues of a body of *jouissance*, let aside of the body politic, as those conditions ex-sist beyond language: for example, how do you account for an overburdened workforce, whose labour demands from them to bear high embodied intensity by dealing with a large caseload and abundant administrative demands? How does an institution deal with the expenditure of psychic and bodily energies, labour indeed, when the psychological models employed fail to issue ethical articulations on how to truly listen to people who request mental health services? The valorization of the institution requires to shift the

model, bending the structure to create a social link that disengages from the rigidity, short sight and alienating forms of clinical inquiry based on cognitive-behavioural psychology, which thrives, as Pluth mentions “as a sort of the science of the human by becoming a service branch of the technocracy” (2019, p. 277).

Instead of supporting the senseless reproduction of the same mental health practices, and instead of a conservative budget and practices, the institutional constituency can create a *revalorization* of self and others that assumes an ethical guidance for treatment design and provision of the mental health services. Such shift requires that the body politic become an explorer of the unconscious, that is to say to become an analysand, knowledgeable of subjective split, beyond ego trips and articulating somehow the loss (castration) of not being able to provide the *ideal* treatment for trauma recovery. Such assumption, perhaps complicated by the intrinsic antagonisms within any given body politic, could become publicly committed to find creative ways of listening differently to alternative ways to respond to the increasing demand of mental health services.

Chapter 8. Conclusion

In seeking to escape from the university discourse one implacably re-enters it.

Lacan, 1969/2007, p.64

8.1. It is time to conclude

One concludes a saying after a sentence has reached a full stop, giving sense to what was just said. One concludes a project after cumulated impasses have reached a point of halt, overcoming doubt, to complete a periphrasis, for the time being. But then again, what conclusions are suitable regarding trauma? What truth can be heard in the mental health institution about trauma and healing?

The following conclusions, obtained from my fieldwork research at the various participant sites in Vancouver Coastal Health (VCH), have been extrapolated to include the historical context of the present as well as the global neoliberal mental health institution, based on my structural analysis of predominant discourses on trauma and healing at the mental health institution alongside an extensive literature review of various discourses focused on the clinical aspects of trauma. As explained in Chapter 1, my analysis of the discursive spaces and the socio-spatial structure at VCH is embedded in three paradigms: psychoanalytic geography, clinical psychoanalysis, and mental health, which have allowed me to provide a scalar analysis of the entwinement between the private experience of an individual and the public aspects of society.

8.2. Trauma shows an *extimate* topology

Today, trauma is ubiquitous. Every field is saturated and fueled with questions about the perplexing intricacies of trauma. Trauma is studied at every scale and from every angle, individual or collective, scientific or aesthetic, environmental or cultural, technological or philosophical. The signifier of trauma performs a voidness because not many commonalities ground the discussion of trauma within the various fields that study it, except perhaps the assumption of trauma's topology: trauma is a hole, a non-space, a spectral negativity that cannot be represented or fully communicated yet brings burdensome effects on those who experience it.

The interdisciplinary focus on the field of trauma at present is a result of the imperious need to articulate something of the unprecedented historical acceleration of social processes, and the intensification of capitalism and technology that humanity confronts at a global scale. This acceleration directly impacts the increasing mental health demands in public and private settings. Since the pandemic struck, the demand for mental health services has significantly risen, and it is calculated that about 40% of people in Canada have experienced a decline in their mental health, affecting the most vulnerable groups more intensely: a report states that “two-thirds, or 61% of those with a pre-existing mental health conditions and 61% of those who are unemployed tell us their mental health has worsened” (CMHA, 2021). According to the World Economic Forum, “mental illness will, using 3 different forms of analysis, be the major contributor to the erosion of gross domestic product over the next 20 years” (McGorry, 2012, p. 221). Such an economic decline will perhaps be paralleled by damage to social bonding opportunities and human subjectivities, de facto challenges that necessitate rethinking the responses to trauma within mental health institutions.

Trauma is caused by a violent event of a physical, emotional, sexual, or environmental nature that *ex-sists* outside of speech, and always appears through spectral forms of the negative—the inextricable, the unspeakable or that which we are unable to symbolize, even the sublime—that engender intensities and excesses experienced in the body and the mind. In my research, contra mainstream ideas that conceive of trauma as an exclusive matter of the mind, usually imagined inside one’s head, I render trauma as evolving via live topologies that entwine the subject and society in *extimacy*—the interior and exterior immixed. Therefore, trauma strikes two bodies: the subject’s body of *jouissance* and the body politic. These topologies compulsively reproduce discourse and appear as impervious to change because they are Real structures.

At the individual scale of the subject, the hole opened by trauma blurs spatial borders and dilutes time, creating non-spaces where the subject as an individual and the Other as society appear broken and lacking. I rendered this topology, in Chapters 2 and 6, as a symbolic and embodied fracture, as a *structural rupture* that is often both constitutive and contingent in nature, and which brings about helplessness and hopelessness, Freud’s *Hilflosigkeit* (1926/1973, p. 138). The reality of a broken and unreliable Other, whose absence or actions permitted the unspeakable in the first place,

breaks something within the subject that hurdles possibilities for social bonding. The open sore that is trauma necessitates healing at every level, the individual's soul and flesh as well as the social tissue, understood as the one plus one plus one of humans in society, whose repair requires viable forms of establishing social links. To think the socio-spatial dimensions of trauma I proposed another topology, the protruding void based on topological surface of the crosscap and that I described below as a form of the Real.

8.3. Trauma requires scalar differentiation

In principle, each subject has traumatic experiences constitutive of their subjectivity because the human being is built around the voids of transcendental traumas, such as the finitude of death, the perplexity of sex, and the narcissistic wound of otherness. These constitutive traumatic experiences, which I discussed as negative universals in Chapter 2, inhere in every ontology and constitute an impasse of knowledge, yet those structural traumas are experienced in the particular socio-spatial, political, and economic context in which the singularity of a subject embodies discourse, and consequently not everyone is hit by transcendental traumas with the same intensity or difficulty.

Added to the structural and ontological impasses of sexuality, finitude, and other's difference, every subject can face forms of traumatic experience, of a personal or social character, of a single or repeated nature, such as the various forms of trauma I detailed in Chapter 6—contingent, developmental, transgenerational, or state-sanctioned violence. However, the psychosomatic experience of something impossible to say and write after the experience of traumatic event is not comparable in the individual level, hence scalar differentiation of such a phenomenon is required. When focused on the *subject scale*, there is no possible way of constructing a standard understanding of how traumatic events affect people; no category, no diagnostic or identity marker, such as gender, class, sexuality, and so on, can provide a satisfactory explanation for how a subject experiences suffering, because this depends on the subject's sensibilities and libidinal constitution, it depends on their *lalangue*. That is why the clinical act exists: to elucidate the unconscious knowledge of the subject. When focused on the *social scale*, however, there is a way of seeing how the residues of trauma affect a community or particular group unequally, because the collective condition of trauma demonstrates that

some communities hold larger shares of trauma than others. That is why there are collectivized political actions.

8.4. Traumatic holes of the present

What contingencies and structures, predetermined by language, do we face now? How does the story of an individual traumatic experience connect to the larger picture of historical traumas? Have we opened new traumatic holes in our present history?

We are slowly starting to recover from two years of a global Covid19 pandemic that has paralyzed the world and transformed living conditions in every aspect of life in still incalculable ways; for instance, economic hyperinflation, the hybridity of job spaces, increased use of dating apps, the polarization of political views, lingering social isolation, or the increased demand for mental health services. The Covid19 pandemic is only one instance of a higher incidence of zoonotic diseases, illnesses transmitted to humans by sick animals, whose susceptibility emerges from their transgressed and weakened habitats. Researchers indicate that 75% of the infectious diseases that affect humans today are zoonotic, and that two-thirds of those are caused by contact with wild animals due to human invasion of their habitats, especially in tropical regions. These diseases have quadrupled in the last 50 years (Robbins, 2012).

Freud indicates that one of the sources of unrest in civilization refers to the furies of the outside world (1930/1973, p. 76), whose wrath manifests now in the ominous repetition of natural disasters. In the same province in which I conducted this research, environmental refugees already exist, albeit they are not designated as such in the media. Last summer, 619 people died in the province as a result of the heat dome that hit the region of British Columbia, mostly people who were living alone, elderly, or disabled. The small village of Lytton was burnt to the ground, a calamity that occurred on the hottest day ever recorded in Canada; such was the heat that it cooked apples right on the trees (Lindsay, 2021, n.p.). The province was later affected by atmospheric rivers that flooded hundreds of homes and farms in Abbotsford in November 2021, in the region known as the Sumas Prairie, a location where the former Sumas Lake drained about 10,000 years ago, and now returned to its geographical origin to retake its

ancestral space, a true geographic unconscious, albeit thousands of people lost their livelihoods, homes, and animals (CBC Communications, 2022).

Alongside the most impressive scientific and technological advances of the Anthropocene era, the geological era characterized by the greatest influence of human endeavors on the planet, the convergence of climate change and social collapse, which shows how late capitalism has been welded to the death drive, as Pavón-Cuellar puts it, by forcing a “transmutation of living labor into dead wealth” (2021, p. 97-98). The social processes and various technologies have accelerated drastically in the past fifty years: not only has the human population increased by more than double (Population matters, 2021), but socioeconomic and geopolitical conditions have created a great deal of refugees and stateless persons; according to the United Nations High Commission on Refugees, right now “humanity is witnessing the highest levels of displacement on record” because in 2021 “100 million people were forcibly displaced worldwide as a result of conflict, persecution, human rights violations and violence” (UNHCR, 2022). When I was finishing writing this dissertation, Russia invaded Ukraine and the geopolitical tensions brought about talks on nukes and nuclear armament, agitating apocalyptic anxieties that were reflected in the clinic.

So-called progress, Walter Benjamin wrote, is a voracious fascination with the future that obliges one to treat the past as a “historical norm” (1968, p. 257), leaving piles of unaccounted residues and a radical avoidance to thinking about material and moral debris, which has already affected the social tissues of culture as much as the environment at large. The last fifty years have been key to the catastrophe of the present. The end of the Cold War and the collapse of the Soviet Union saw the birth of a post-Fordist economic model known as “neoliberalism,” which broke with the closed economies that stabilized growth, and opened itself to deregulation and market domination, relying on the old false promise that there would be an “invisible hand” that would benefit everyone (Harvey, 2005, p. 2). Neoliberalism is based on deregulating entrepreneurial freedoms as much as personal freedoms to enjoy whatever products we can afford regardless of their origins and residues. The corporations and governments who support neoliberal policies take care of macroeconomic interests much more than the needs of their governed constituencies, with the sole purpose of solidifying a system of financial accumulation. Surplus value is nowadays accumulated mostly by financialization, obtained through the speculation of financial instruments—such as

loans, credit, or shares—instead of the exclusive exchange of labour power and its products. This system has led to the incremental indebtedness of governments and individuals for the benefit of speculative capital, which has paradoxically accelerated overflowing consumption and increasing inequality.

The unprecedented consumption that the regime of free markets has implemented in the past fifty years has led to brutal overexploitation in every order of life. The compulsion toward overproduction and the overexploitation of the earth's fertility has also increased waste, including emissions from fossil fuels, as well as pollution from plastics and microplastics, creating a rapid and dangerous environmental imbalance that compromises not only the climate, but the possibility of life itself by risking the collapse of the planetary biosphere. Furthermore, humanity faces the unthinkable: we have entered a sixth mass extinction of biodiversity on the planet; we have wiped out 68% of the global population of wild animals, and when compared with previous mass extinctions, have done so in the shortest degree of geological time, as indicated by a prestigious group of scientific researchers: “It took us 50 years—and let's be clear, the ‘us’ here refers to the richest people in the richest countries—to push the earth beyond 10,000 years of extraordinary stability” (Gaffney & Rockström, 2021, p. 17).

8.5. Trauma is negated

How and why did all the above occur? If our history as a species is traumatic, as the effects on the planet evidence, we ought to remember that trauma inhibits thought. When confronted with the negative space opened by trauma, we cannot think because we are unable to articulate how the Real has hit the body, the mind, or the community. If one voices a critique against the devastation caused by late capitalism, outside of academic or activist spaces, one often encounters a deep negation borne out of ingrained fears that hurdle thought. People imagine that criticizing capitalism threatens their enjoyment. The primal fear of losing enjoyment triggers a passion for ignorance, and people might decide not to understand the history that informs the dire situation we live in at present for various reasons: people might despise identifying themselves as exploited, preferring to embrace their wealth, imaginary or real. They might think that there are no better alternatives to surplus value and exploitation than to accelerate excess without limits, to consume all that can be consumed in a tautological pursuit of surplus value. Some others might refuse the critique of capitalism because they confuse

capital with everyday money, essential for subsistence. Someone else might present a phantasmatic and uninformed related to loaded signifiers such as socialism or communism, which are conflated with the horrors of the Gulag, the Khmer Rouge, or forced labour camps. What is paradoxical is the fact that very few owners of technological, financial, military, agricultural, pharmacological, medical, ecological, or even humanitarian industries practice *radical solidarity* amongst themselves, to protect *their* astronomic gains of trillions of dollars, obtained at the expense of the ruthless exploitation of the many. Moreover, what is more important is the fact that regardless of the de facto enjoyment of the anti-capitalistic system, we cannot escape capitalism, for we care about our future security, because we need to make a living within the conditions in which capital is the master.

Is it then *all* about the socio-economic system that has been adopted globally? Because the system is a structure of the Real, we all are active accomplices by the positions we occupy in discourse. Because individual and society are entwined structurally, through our perpetual will to enjoy *qua* jouissance, which is not only pleasure but the morbid derivation into pain and entropy, psychoanalysis reaches its radical impossibility in the social, for it cannot replicate the radical transformation obtained in the clinic *en masse*.

8.6. The structure of the Real

The Real structure, with its traumatic residues, might be deemed as impossible to change because destruction, hunger, greed, exploitation, and violence have always accompanied human history and can be perceived as naturalized. People might think that fires, flooding, and mass graves have always existed and always will. Why should that be discussed when talking about trauma, healing, and mental health? My thesis is ultimately concerned with discourse *qua* social bonding, and to instantiate how trauma entwines the individual and social aspects of trauma, I proposed in Chapters 2 and 6 a second live topology, the *protruding void*, which shows that the excess of traumatic residues is repeatedly distributed unequally among the global populations, because that which cannot be placed in preordained discursive spaces, given by the dominating social link, is excluded and dumped on the most vulnerable.

The linguistic structure of the Real is then “connected to politics, *strictu sensu*” (Lafont, 204, p. 10) because it repeats the infinite line of self-intersecting of language that preserves its same form. In Chapter 5, the topological surface known as crosscap guided me to think about the spatial entwinement in social bonding, placing in the back enunciating truths of aspects that are denied in the front. By veiling what is not palatable and by designing predetermined spatial positionings for those who participate in a particular kind of social bonding—the body of jouissance and the body politic—the structure consequently forces those with the most intersected differences or vulnerabilities, such as class, gender, race, ability, geography, or any other imaginary or real difference outside and under the discursive consensus. This linguistic knot -Real, Symbolic and Imaginary, forces the most traumatic losses, traumatic excesses, and traumatic residues on those more vulnerable within their sociopolitical contexts.

8.7. Trauma is responded to with inhibition, anxiety and symptoms. But also, with fantasy and the *sinthome*.

Grappling with the current historical moment, the subject finds themselves in a condition of deep “ontological insecurity” (Gandeha, 2003, p. 3) that causes helplessness, and loneliness. The difficulties in creating social bonding and forming limits and borders around the traumatic hole of history have engendered profound anxieties that equally paralyzes thought and action, and leaves people increasingly isolated.

People with posttraumatic suffering are captured by what the traumatic event left behind, a residue of an inarticulable truth that agitates the drive with compulsive repetition. Against the drive, a force of life and death that links body and mind, the subject responds with anxiety, inhibition, or the symptom. *Anxiety* is the most associated sign of posttraumatic stress disorder: hyperarousal, flashbacks, obsessional thoughts, night terrors, panic attacks, or fear. Anxiety is an *extimate* affect that signals the grave danger of the proximity of the Other, for one risk being trapped by the Other as object of their enjoyment, -incarnating object a- rather than a subject of their own desire. Hence, this proximity to the Real triggers anxiety and confronts the subject with the imperative to act. But the subject also can respond to trauma with *inhibitions*, which can be understood as renunciation and restrictions of desire; through the *symptom*, which is a form of knotting something of the trauma via the metaphorization, however precarious, of

the event in the body, fertile soil to the analytic work. These are responses to the trauma of the drive, or the drive of trauma, but they are also forms of nominating (the knotting of the three registers Real Symbolic and Imaginary) as one subject among others. Other forms of knotting, nominating or respond to trauma are the *fantasy*, which is an apodictic subjective logic that connects and disconnects the subject with the object a cause of desire, or the *sinthome*, which is a nominating act via sublimation, all discussed in Chapter 7.

If the above landscape is what the clinic demonstrates of the subject of the unconscious, how do we consider such psychic mechanism in the body politic? Psychoanalysis is not meant to extrapolate the principles of the clinic in an identical way to the social, yet there are clear social symptoms, result of the *zeitgeist*, that as any given symptom knots something of the Real to the Imaginary and Symbolic in a veiled way, to make up for that which cannot be said. Social symptoms speak of the type of damaged subjectivities that in principle constitute a *response* without *ability*, for their deficiencies reside in a lack of historical consciousness, as they are too the return of the repressed, a metaphorization of history. The nuanced articulation of social symptoms of present exceeds the scope of my research, however, elsewhere I identified three symptoms, result of the historical time in which we live (Fernandez-Alvarez, forthcoming b): 1) the *decline of symbolic Law* as the social weakening of that which prohibits the excess of violent and evil jouissance (which is commanded by the subject's will to enjoy). Even if the symbolic Law is castrated, as the Other is condemned to partially fail and each libidinal prohibition poses a granted transgression, the weakened symbolic law hinders language as support of the exchanges and instead produces the *imagarisation* of master signifiers (Braunstein, 2012, p.164), which increasingly relies on imaginary omnipotence to cover the gapping void of trauma, manifested now in the depletion of the Enlightenment values of democracy, science, and reason as well as the increasing spreading of anti-science activism and conspiracy theories, known as "post truth," a critical concept of recent emergence. The effort to appear interested in a shared reality has been disinvested, replaced with reliance on authoritarian opinions instead. The use of affect and emotion that resembles verisimilitude disregards public dialogue, leading to polarizing and vitriolic antagonisms of difference. How can symbolic Law be established? 2) Digital enjoyment of present brings about what I call *cyborgic narcicapitalism*, which captures the libidinal force via the passionate attachment to the

lathouse object (Lacan, 1969/2007, p.162) —smartphones, computers, video games or social networks. Algorithmically programmed by artificial intelligence, our affects and emotions feed neoliberal markets by assuming the commodification of the self, and so, our libidinal energy is channeled toward the idle reproducibility of sameness, of a private ideology based on the adoration of the self-image, reflected back to the ego by followers. How can the image, as the most capturing element of digital bonding, be reinvented so that people have access to connections less emptied of subjectivity? 3) A *cancerous growth of surplus jouissance* is a symptom of the body politic and its libidinal investment with regards to the devastation we confront at present. In Chapter 7, I focused on the concept of surplus jouissance as a site of discursive production, a notion that bounds the global mental health system to the political economy in vogue. I rendered surplus jouissance as a notion inherently homotopic and homologous to surplus value; in other words, both surpluses, jouissance and value, are the logical and spatial continuations of each other and feed on an excess of a lack—of enjoyment, on the one hand, and of surplus gain obtained from labour power, on the other. In this way, excess and lack inhere in and connect the economic structure with the psychosocial structure. Surplus jouissance is paradoxical because our very enjoyment—of consumption, narcissisms, etc. —is what forces the subject into voluntary servitude (Marcuse, 1955/1992, p. xxi; Agamben, 1998, p. 11) to the same socioeconomic system that wreaks havoc on the world. That is why surplus jouissance constitutes the site where the socioeconomic and political traumatic residue actualizes, where the libidinal economy can be recalibrated, and discourses redirected. How could the satisfying and expansive function of desire be achieved?

The body politic confronts their own antagonisms and symptomatic formations, how could deadly jouissance, paralysis of the image and weakening of the symbolic could be approach to shift discourses and create *sinthomic* formations? In chapter 7, I proposed the politics of inscription and re-inscription, as effects of an event and as a horizon.

8.8. The institutional response to trauma

Aware of the fact that trauma and social symptoms are interconnected, in Chapters 3 and 4, I articulated my central critique of the mental health institution. I approached Vancouver Coastal Health (VCH) and its neoliberal corporative structure as

an institution that organizes an erroneous way of responding to trauma from an individual focus exclusively, where consequent social bonding is based on suturing the brutal challenges from the Real with Imaginary signifiers. Institutions serve the purpose of preserving stability, law, and order to protect people from the negative (Kaës, 1989, p. 53). The particularity of VCH, at core, shares the same limitations of the neoliberal managerial institution in that it instrumentalizes reason for the sake of achieving an efficiency that follows economic markets, with the cost of offering treatments that impoverish social connection and dismiss differentiation, practices that fall within the logic of the university discourse described by Lacan (1969/2007, p. 21). At VCH, I found that the master signifier that dominates social bonding is that of “mental health evidence-based practices,” which extrapolates methodologies that are crucial for the science of medicine, but when applied to mental and emotional suffering, appears impotent in its spherical ambition of responding to the subject’s needs with a semblance of knowing-it-all, preventing analysands from being heard. In the institution, positivistic forms of thinking explain, systematize, and measure human disarrangement through biomedical reason and pharmaceutical solutions (psychiatry), and with acritical psychoeducational responses (the umbrella of cognitive-behavioral therapies). These forms dominate linguistic exchanges at VCH, and consequently dismiss conceptual notions of the subject and society at the core of program design. In Chapter 4, I also demonstrated that these modalities dominate the global mental health scene (Summerfield, 1999; Mills, 2014), so those who suffer through social or environmental catastrophes, land displacement, refugee status, etc. are given the same forms of psychotherapeutic treatments.

In Chapter 5, I located the institutional unconscious at VCH in the fetishistic attachment to the master signifier “evidence-based,” which constitutes a protection, based on fantasy, against understanding the complexity of the psychical and intersubjective entwinement of this phenomenon. This choice of treatments also appears to reduce costs within the institution, but does it? What cost is valued, the economic or the social? Instead of materially and historically informed treatments that generate subjects, the mental health institution provides treatments, including trauma-specific treatments, that focus on the brain and on the idealizations of the ego and its identifications, and that preserve the reproducibility of alienation and the pauperism of discourses. I understand the brain as an organ of the body, it is flesh that can carry a

specific disease manifested in thought, mood, perception, attention, or cognitive alterations of a neurological nature, but such an organ is hosted by a subject already immersed in language even before *she/he* is born. Thus, even when the human being carries the Real of the biological organism, concerning trauma, the object of study is not the brain, nor the sole traumatic event or the technique that tries to cover it, but the *human speaking subject*. That is why the treatment of trauma that focuses on the human subject necessitates not only biomedical and psychoeducational skills, but the inclusion of traditions better equipped with methods that study the logic of language to treat the alienation caused by language and society.

In Chapters 5 and 7, I proposed strengthening institutions democratically, culturally, and intellectually as a must to repair damaged tissue in the body politic, whose wounds are sustained by the individualization of the subject's suffering. The institution is in urgent need of immanent criticality and the democratization of program design, as well as the wider inclusion of alternative epistemologies that respond to the vast challenges posed by trauma. To revitalize the institution intellectually, it is necessary that the body politic makes conscious the institutional unconscious and decides to act.

8.9. Healing trauma?

Like architectural structures, traumatic knowledge is built around a hole, a structural fracture whose truth is felt yet simultaneously inarticulable. That is why traumatic truth appears veiled and is shared only in mediated forms, such as art—photographs, novels, or films; communal acts such as testimony, remembrance, myth, or ritual (Caruth, 1996; Felman & Laub, 1992); or the exercising of apology, restitutive justice, or resistance (Peng, 2017; Fassin & Rechtman, 2009; Coulthard, 2014; Dupuis-Rossi & Reynolds, 2018; Sheehi & Sheehi, 2022). Cultural institutions have traditionally been implicitly in charge of responding to social symptoms, because culture writes memory and reinvents the past. But could the health institution maintain its core services while enacting larger collaborations with alternative, cultural, and artistic discourses of healing?

In Chapter 4, I examined how post-traumatic suffering and the structure that repeats cannot be overcome exclusively with knowledge (representation); an intervention is necessary at the level of the materiality of the body of jouissance

(production) to upset circuitous compulsive repetition. A project like that, I explained in Chapter 7, necessitates realignment of the value given to services and people, and of other epistemologies, relevant to specific populations, which might facilitate regaining a sense of pleasure, such as alternative somatic practices that calm the brutal brunt of the drive on the body (massage, yoga, acupuncture, Reiki, dance, etc.); the inclusion of practices that channel creativity and foster sublimation through any aesthetic practice (painting, writing, or singing); as well as activities that provide a connection to community and nature (such as hiking, sports, etc.). Those services cannot be provided by one sole institution, nor can a clinician be trained in every therapeutic modality. Diversifying treatments, rather, requires building sustained partnerships that include alternative forms of treatment from professional and non-professional perspectives, as well as supporting ongoing cultural and artistic endeavors.

If the mental health system must find ways of diversifying its response to traumatic suffering in dialogue with alternative forms of healing, it, however, must include “the mother tongue of our modernity” (Copjec, 2002, p. 10), because psychoanalysis is the most articulated theory and method to dialectically deal with the impasse of trauma and the emergence of conflict that conjures up automatic negation. The treatment of trauma requires psychoanalysis to actualize in praxis a viable structural response to the three forms of negation that Lacan works with throughout his oeuvre: denial (neurotic symptoms), disavowal (perverse symptoms), and foreclosure (psychotic symptoms); and to correlate with the increasing demands of mental health complaints, such as anxiety and depression, addiction, and/or psychosis, respectively, which I did not detail in my research but which I will further articulate in forthcoming projects.

Psychoanalysis can also help the mental health institution prevent the burning out of clinicians serving those who need assistance by understanding, through their own personal work, how to *not* intervene with their beings, but to create the logical functions of the analyst and analysand. The latter, as I explained in Chapter 7, requires from the subject a self-awareness of their own logical split, and from the collective, overcoming techniques of subjective emptiness, disinvesting from the cult of mass consensus, and relinquishing a superficial rosy humanism. For hope and transformation, the mental health system that is needed today is one that takes seriously not only the challenges of the work in trauma from an Imaginary order, such as the restitution of the pleasure principle out of morbid jouissance and the rehabilitation of the fundamental fantasy, but

also Real and Symbolic challenges. As detailed in Chapter 7, the specificity of trauma treatment also involves know-how in intervening with the challenges of the Real *qua* unsymbolizable (object *a*, anxiety, symptoms, and inhibition), the Real *qua* structure (residue, surplus jouissance), as well as in promoting the temporo-spatial emergence of the subject.

Many would think this is utopic, and it is. Utopias are nothing but impulses to materially concretize better worlds (Beauchesne & Santos, 2011, p 4-5). Also, dreaming of a better mental health response is already inscribed in the *letter* of trauma, for its meaning is not exhausted as a wound or a hole. Trauma can also be a dream (*Traum* in German means dream). If the cause of posttraumatic suffering is found in social discourse, situated in social, environmental, economic, political, affective, and psychic space, the body politic must think of how to dream of a different structure, perhaps outside of ideologies of liberal individualism or moral relativism (Woolfolks, 2015, p. 143), or outside of bureaucratic organizations that reduce “self-discovery to efficient and transparent outcomes” (Parker, 2011, p. 65). Sheehi and Sheehi, in the particular context of their struggle, call for the decolonization and reappropriation of the “psychotherapeutic commons” (2022, p. 162).

8.10. Trauma and discourses, the need for a clinic of social bonding

In Chapters 4, 6, and 7, I explored various discourses around mental health services to examine specific responses to posttraumatic human suffering and how the institution approaches the rewriting of memory and the past. Following Lacan’s theory of discourse, I explained that discourses are structures that designate linguistic places, even if speech is absent, embodied by subjects in certain socio-spatial exchanges; by doing so people are gathered in a specific form of a social link. I elucidated that the master discourse perpetrates, the trauma discourse victimizes, the university discourse sutures truth and knowledge by pretending to know-it-all, the hysteric discourse denounces the master’s perpetrations, and the analyst discourse plays the impossible card of inscribing and re-inscribing, as well as venturing for a form of social bonding outside of a group mentality. Those discourses are in constant movement; they turn incessantly while always preserving a new master signifier and a fantasy to enjoy. Yet, in Chapter 7, I also elucidated that the social link breaks right at the temporal moment in

which the Real proper emerges as residue—surplus jouissance—which reshapes the discourse into a new form that, by necessity, imposes a new master signifier. As the epigraph to this chapter reads: “in seeking to escape from the university discourse one implacably re-enters it” (Lacan, 1969/2007, p.64).

What discourse could allow social links that bypass the coagulation of a master signifier, which is necessary to speech and discourse, beyond the Imaginary capture of spherical or totalizing thinking? To preserve a trauma discourse that allows the recognition of conflict, antagonism, and differentiation, a new type of clinical response needs to be created. Giving medications, strategies for coping, and psychoeducation is an impotent modality; we need to move to a modality of intervention that reaches for the impossible, understood as not yet existent, hence not possible to imagine, track, or plan. Subsequently, in Chapter 7, I proposed the clinic of social bonding or the social link with a twofold proposal: on the one hand, to provide possibilities for a subject to knot their various experiences, to *nominate* themselves as an *I* with a name worthy of being included in social solidarity, despite and because of their own singularity. And on the other, the clinic of the social link permits clinicians to hear how such a singularity connects to a traumatic social cause in the analysand’s speech, whose elucidation will favour inscription and re-inscription as much as libidinal recalibration, aiming to shield individuals against the violence of the Real.

8.11. Trauma and community

I have mentioned that subverting libidinal economies and disrupting instrumental reason, two of my interrogations of surplus jouissance, entails articulating community values and the negotiation of the common good. Community as a signifier appears as the common good, but is it? This depends on what is understood as community, because according to Van Den Abbeele, community in the West has two main connotations: *com-munis*, which gives “the sense of being bound, obligated, or indebted together,” and is on the side of the Enlightenment project; and the second meaning *com-munus*, “what is together as one” (1991, p. xi), which would correspond to a Hobbesian ideal of the multitude of a mass following a leader. Could we afford not to organize a community that is ethically obliged, at present? Even better, could we incorporate other epistemologies, such as Indigenous or Eastern thought, to encourage different communities while sharing a collective desire?

I discussed in Chapter 7 how the economy of the good is problematic and at the core of a community, due to human jealousies, petit narcissisms, and violence, but also because we do not know how to ethically locate the place of residual traumatic excess, which involves a conscious decision as to what we are willing to sacrifice, understood as that which “servile use has degraded, rendered profane” (Bataille, 1967/1988, p. 55), and under what *conditions*, for the community we desire. Depending on how we answer such a question, the past could be reinvented and the future of communities would change.

8.12. Trauma and collective destiny

There are many discourses that respond to the suffering of trauma, and each of them represents a form of understanding healing. Each has helped someone at some point, in one way or another. Throughout my dissertation, I advocate for the incorporation of various interventions—somatic, cultural, and artistic—to facilitate healing from posttraumatic suffering. However, I have detailed the psychoanalytic perspective as the only modality that can account for the subject of the unconscious, and thus it is a vital field that provides a lynchpin to understanding the link between the subject who suffers those traumatic experiences and the socio-spatial aspect where they emerge.

Yet, given the fact that trauma is a gapping void, my research rejects totalitarian aspirations as much as spherical thinking. I examined critically the immense challenge that trauma involves, not with the hope of solving or healing it all, but to lay bare the impossibility of its challenge. To aim at the impossible, VCH, as much as the global mental health institution, requires modalities that create social bonding with collective knowledge pertaining to theory and practice, intellectual inquiry, and political action. The historical present requires modalities that create democracy in the workplace, recognizing the vital interdependence of thought with action, as well as action with thought, because, as Lacan says, “we cannot confine ourselves to giving a new truth its rightful place, for the point is to take up our place in it” (2006, p. 433).

Would VCH’s political body want to hear the voices that here speak? Could it hear them? Is it insane to dream of a possible mental health program that immanently maintains a parallel focus on social aspects—discourse—and the subject, and on top that be publicly available? Ethical communities of solidarity and support exist all over the

world, but the biggest challenge resides in the difficulty for a community to emerge outside of the structure, bypassing the group mentality—which so often reinaugurates another oppressive or vitriolic master signifier. Bold thought and audacious desire are needed. VCH has great assets: there are compassionate, accountable and experienced, critical thinkers among mental health clinicians and managers; also, people who seek services are capable of articulating truthful questions about their suffering if heard properly. My experience of more than a decade as a clinician at VCH has demonstrated to me that the vast majority of those who seek services are intelligently curious about doing something different with their suffering, with their bodies and minds.

If the institution chooses to ignore the complexity of the phenomenon of trauma, and instead insists on serving its population with psychopharmacological management and predigested psychological formulas of behavioural focus as first options, it will infringe on the ability to build more resilient communities. Assumed uncritical thought— institutional fantasy— can only think its own thoughts, for which personal and collective ethical inquiry about what causes the assumption of such thoughts could be a good start in launching new institutional discourses. To build resilient communities, the subject and the society must emerge and ethically decide on their desires in life. At the subject scale, one encounters desire after elucidating the insistent truth that speak on one's body and this truth is not sought, nor forced through will. In contrast, the body politic must will itself to encounter opportunities of making libidinal calibrations and to launch an act of desire. Collective desire, the field of life and love, is moving beyond the trauma of our own narcissism, our own enjoying bodies, and from the denial of death and conflict. May potential resignifications and the bending of discourse occur, for both individuals and societies, so that we can now write a desired destiny.

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Appendix A.

Questions for Semi-Structured Interviews with Clients

We will frame the questions according to the participant's specific language. For example, if they refer to trauma as a "challenge" or "the event", or if they refer to recovery as "healing journey", "overcoming", etc., we will replace that word in the formulation of the following questions.

- 1) Knowledge location: The ongoing practices of defining, speaking, listening, writing, and reading about trauma and recovery.
 - What type of services/treatment for trauma have you received within VCH?
 - Who do you think knows best about recovering from trauma?
 - Do you remember reading any written material on trauma recovery/healing while receiving services at VCH?
 - What has been your experience when talking about trauma in the services you receive at VCH?
 - In your own words, what does it mean to you that someone has overcome trauma?
 - What do you believe is the most important aspect of healing from trauma?

Agency: The factors conceived as empowering the individual recovering from traumatic experiences.

- What makes you feel better when you are feeling unwell mentally due to a traumatic experience?
- What makes you feel validated / recognized when receiving treatment?
- In your experience what makes people feel stronger, courageous or committed to getting better?
- Do you recall an important moment in your recovery that you would like to share?
- Who have been important to you in working on your trauma?
- Have you ever wished there would be complementary services for trauma within VCH?

Truth: The considerations hold as accurate, certain, and realistic in the recovery of trauma.

What has worked well in the time that you have been receiving trauma recovery services at this site?

What has been the least helpful while you have been receiving trauma recovery services at this site?

Trauma recovery is known to be a difficult journey, what would you say is difficult about it?

What has helped you to move through this process?

In one phrase, what is true about trauma recovery?

Otherness: The suppositions participants hold about the individuals they work with in the practice of attending to trauma and its recovery.

In your opinion, who or what can help someone to heal from a traumatic experience?

What do you think is the role of the mental health worker in helping you to recover from a traumatic experience?

Have you experienced any difficulty with service providers at this site? Is this difficulty expected or can it be avoided?

What and/or who has been helpful to you in recovering from trauma?

In your view, what are the most effective ways to connect with service providers to approach trauma recovery?

Appendix B.

Questions for Individual Semi-Structured Interviews with Clinicians

We will frame the questions according to the participant's specific language. For example, if they refer to trauma as a "challenge" or "the event", or if they refer to recovery as "healing journey" or "overcoming", etc., we will replace that word in the formulation of the following questions.

I. Knowledge location: The ongoing practices of defining, speaking, listening, writing, and reading about trauma and recovery.

- a. For how long have you been working in VCH and in what capacity?
- b. Have you provided
- c. trauma-specific services within VCH?
- d. How do you define trauma?
- e. What do you consider of utmost importance to recover from trauma?
- f. Who do you think knows best about recovering from trauma?
- g. In your experience, what are the stages of trauma recovery? Where would you locate your intervention?
- h. Have you suggested any reading material on trauma recovery/healing while providing services at VCH?
- i. Have you suggested any activity/practice to the population you serve for trauma-specific services?
- j. Have you ever wished there would be complementary services for trauma within VCH? If so, would you consider these options to be easily implemented?

II. Agency: The factors conceived as empowering the individual recovering from traumatic experiences.

- a. What makes a person feel better when feeling unwell mentally due to a traumatic experience?
- b. What makes people feel validated/recognized when receiving treatment?
- c. In your experience what makes people feel stronger, courageous or committed to getting better?
- d. Do you recall an important moment of recovery while working at this site that you would like to share?
- e. Who have been important to you while working on the provision of trauma services?

III. Truth: The considerations hold as accurate, certain, and realistic in the recovery of trauma.

- a. In the time that you have been providing trauma recovery services at this site, what has worked well?
- b. In the time that you have been providing trauma recovery services at this site, what has worked successfully?

IV. Otherness: The suppositions participants hold about the individuals they work with in the practice of attending to trauma and its recovery.

- a. In your opinion, who/what can help people to heal from a traumatic experience?
- b. What do you think is the role of the mental health worker in helping people to recover from a traumatic experience?
- c. What and/or who has been helpful for you in supporting your work with these populations?
- d. In your view, what are the most effective ways to connect with clients when approaching trauma recovery?
- e. What do you think are the limits of a clinician in assisting individuals recovering from a traumatic experience?
- f. In your own one phrase, what is true about trauma recovery?

Appendix C.

Questions for Semi-Structured Interviews with Managers

We will frame the questions according to the participant's specific language. For example, if they refer to trauma as a "challenge" or "the event", or if they refer to recovery as "healing journey" or "overcoming", etc., we will replace that word in the formulation of the following questions.

- I. **Knowledge location:** The ongoing practices of defining, speaking, listening, writing, and reading about trauma and recovery.
 - a) Does this site provide trauma-informed care, and/or trauma-specific services?
 - b) How do you define trauma? Does your knowledge include objective and/or personal experience?
 - c) What do you consider of utmost importance to recover from trauma?
 - d) Who do you think knows best about recovering from trauma?
 - e) What has been your experience overseeing trauma informed services at your site?
 - f) What educational materials about trauma services are used in your site?
 - g) What initiatives to encourage trauma-informed or trauma-specific services do you have at your site?
 - h) In your experience, what are the stages of trauma recovery? Where would you locate the intervention provided within your team?
 - i) Have you ever wished there would be complementary services for trauma within VCH? If so, would you consider these options to be easily implemented?

- III. **Agency:** The factors conceived as empowering the individual recovering from traumatic experiences.
 - a) Who do you think knows best about recovering from trauma?
 - b) What and/or who has been helpful to implement trauma services in this site?
 - c) In your view, what are the most effective ways to approach trauma recovery?
 - d) What makes a person feel better when feeling unwell mentally due to a traumatic experience?
 - e) What makes people feel validated/recognized when receiving treatment?

- IV. **Truth:** The considerations hold as accurate, certain, and realistic in the recovery of trauma
 - a) In the time that you have been managing trauma recovery services at this site, what has worked well?
 - b) In the time that you have been managing trauma recovery services at this site, what has not worked successfully?
 - c) Have the services that you provide in this site helped people to deal more effectively to recover from trauma? If so, in what way?
 - d) In your own one-phrase, what is true about trauma recovery?

- V. Otherness:** The suppositions participants hold about individuals they work with in the practice of attending trauma focused services.
- a) In your opinion, who/what can help people to heal from a traumatic experience?
 - b) What do you think is the role of a manager to help recovering from a traumatic experience?
 - c) What do you think are the limits of a manager and team in assisting individuals recovering from a traumatic experience?

Appendix D.

Questions for focus group with clinicians.

1. Please introduce yourself and tell us briefly about your experience of working with populations touched by trauma.
2. What are some of the principles that guide your own clinical practice?
3. Name 2-3 elements that you consider the most important challenges of treating trauma.
4. Name 2-3 initiatives to inspire safety with clients and among clinicians working with them.
5. How do you deal therapeutically with the manifestations of compulsion repetition (when people continue experiencing/seeking the repetition of what brings them suffering)
6. Skills training/education to clients seems to be a recurrent theme in the provision of mental health therapies at VCH. What is the role of teaching in therapy? What principles, if any, we should observe when using education? (please name 2-3)
7. Do you think that bodily or alternatives therapies shall be addressed as part of core services at VCH for the treatment of trauma? Why?
8. Name 2 things that work well in the work being done at your site to address healing processes for people suffering traumatic experiences. Name 2 things that does not work and 2 opportunities to improve those services.
9. If you could have a magic wand, what sort of services do you imagine VCH could ideally provide to help our populations advance their healing?

Appendix E. Recruitment poster Vancouver Coastal Health Research Institute (VCHRI)

How do clients and service providers of mental health and substance use services understand trauma and recovery services?

PURPOSE OF THIS STUDY:

A research is being conducted on how the understandings of trauma recovery among clients and care providers affect the way trauma-informed services are provided. This research aims to enhance the quality of the existent services.

WHO CAN PARTICIPATE?

- Clients who self-identified as having experienced some trauma in their lives.
- Receiving services, for more than 3 months, in a Mental Health Team; Mental Health and Substance Use Outpatient Services; Aboriginal Wellness or Addiction Services'.

WHAT IS INVOLVED?

- You will attend an hour of a semi-structured interview with the principal investigator, who will ask questions about your understanding of trauma and recovery and your experiences with our services.
- The interview is not intended as a psychotherapeutic session.

CONTACT INFORMATION:

Hilda Fernández Alvarez



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Vancouver
CoastalHealth
Research Institute

PRINCIPAL INVESTIGATOR

Hilda Fernández Alvarez
PhD candidate, Department of Geography
Simon Fraser University
VCH Research Institute Affiliated
Investigator

STUDY TIME / DURATION

October 2018 to March 2019

STUDY LOCATION

A room in one of the sites where you are currently receiving services.

To learn more about research opportunities, visit vchri.ca/participate

Version date: October 24, 2018