CHAPTER 13

Afterword: Human Rights and the Science of Suffering

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The twentieth century has become known as the Century of Megadeath. Human beings destroyed other human beings in numbers too astonishing to absorb in the name of many different ideas and ideals and in defiance of the multitude of injunctions from many different wisdom traditions of "Thou Shalt Not Kill." But the last century was not just about the wanton destructiveness pushing humankind to the brink of annihilation.

The human rights movement emerged out of the profound suffering of that century, although as several creative interpreters have pointed out, the discourse about human rights is deeply rooted in earlier conversations in many cultures (Donnelly, 2013; Hunt, 2007; !shay, 2008; Van Cleef, 2008). The opening words of the *Universal Declaration of Human Rights* ring out today as a clarion call for forever preventing another man-made global catastrophe through the clear assertion that "recognition of the inherent dignity and of the equal and inalienable

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L. D. Butler et al. (eds.), *Tmuma and Human Rights*,
https://doi.org/10.1007/978-3-030-16395-2_13

rights of all members of the human family is the foundation of freedom, justice and peace in the world" (United Nations, 1948).

Trauma theory and all the researches associated with it about the effects of stress, toxic stress, and traumatic stress on body, mind, and soul across the life span also emerged as a product of war, the Holocaust, and other disasters, and it has become what I think of as the science of suffering. This science is accompanied by an anthropology, a sociology, a history, an economics, a religion, and an art of suffering. Trauma is and has been a central organizing principle of all human experience and behavior that has been largely ignored in the full understanding of what it means to be human in part because all of these aspects of suffering are not yet fully integrated as components of an overall paradigm shift in our understanding of human nature. The Declaration of Human Rights and the Convention on the Rights of the Child have encoded this recognition in a set of universal values and principles, making the willful infliction or tolerance of suffering the only true universal-although frequently ignored-taboo.

Something else emerged out of the twentieth century-a new paradigm beginning in quantum physics about the nature of reality, the world, and us. It seems we are all interconnected in a vast networked fabric of existence (Capra, **2002;** Laszlo, **2008).** The version of this new paradigm in psychiau·y was social psychiatry, and it too arose out of the tumult of the twentieth century. As in quantum theory and the emergent field of systems theory, the focus of social psychiatry was a deliberate attempt to move away from ideas about the individual isolated from others and move toward an understanding and practice that connects the individual to others and all people to large-scale events. The emphasis in social psychiatry was not just on treatment but also on *prevention.* It represented the emergence of interdisciplinary studies in which all of the humanities had a voice in informing our understanding of how to prevent the destruction of the century from happening again.

The scientific study of the effects of stress, adversity, and violence on human development similarly emerged in that same era. Beginning '"th the research of John Bowlby and others after World War **II,** we began evolving a new perspective on the importance of early childhood relationships. By the end of the century, the Adverse Childhood Experiences Study and all the science about the continuous unfolding aspects of child development had revealed the delicate, complex, and interactional nature of the child and the adult that child becomes. The genome project then revealed

to us that all human beings are members of the same family, regardless of the color of our skin, and that the racial divides that have served to justify eons of misery constitute mythological beliefs (Sussman, 2014).

Taken together, these shifts in the scientific paradigm that underlies all that we think, feel, and do have the possibility of rapidly changing our worldview. Changing our worldview is vital if we are to save ourselves and the planet. We have an array of tools for self-destruction surrounding us, drivers of extinction that most of us would rather deny as we deal with our own harried lives. Certainly, civilizations have collapsed before, but life has continued. Never before has our sentient species been confronted with the possibility-and with every passing second, the probability-of extinguishing all life on earth. When we focus on human rights, we are being too restrictive. What we can see now is that the human rights movement is directly connected to the right of life to exist at all. Humanity has become the steward of these rights, a truly terrifying responsibility for which we are largely unprepared.

The authors in this book have taken on the challenge of uncovering ways to integrate two powerful late twentieth-century discourses: human rights and trauma theory, and I feel honored to be asked to write the Afterword for their prodigious work. That these two discourses have even been running down separate tracks is an example of a well-known problem that has emerged in the last several centuries: We have accumulated an enormous amount of data about just about everything but there has been little attempt to integrate all of it into a manageable and meaningful whole. This book makes a step forward in that direction. The editors set out the context of the book by making it clear that in the human rights discourse, humanity is being set a moral standard that explains and explores the paradigm shift that we are immersed within. As we learn about the evolution of human rights standards we can begin to see the still vague outline of what health in human cultures could actually look like.

The other authors variously point us toward other key concepts: that women's rights and children's rights are human rights; that monitoring human rights violations at every level of our service delivery system is vital; that many populations have experienced-and continue to experience-multiple, multigenerational trauma that does not just disappear and therefore an overemphasis on resiliency may be doing a disservice to many; that moving from identification and treatment to policy and advocacy is vitally important but also requires different skills and therefore expanded collaborative efforts; that incorporating activism as an important component of

trauma treatment and transformation may be a vital component of restoring hope, meaning, and purpose to people's lives.

Without stating it, the editors and all of the authors are setting out frameworks that will be the only form of social immunity available to us as humanity goes through the overwhelming trauma that is coming as a result of climate change. My contribution to this rich collection of powerful and passionate discourses is a historical and philosophical musing triggered by absorbing the wisdom of the chapters of this book and being myself a sentient being traversing through the tumult of this century. The chapter begins with a brief explanation of my own journey of awakening and explores some of my efforts to make sense of what I have learned. Through a brief review of some of the roots of social psychiatric thought that were dominant in the first six decades of the twentieth century, I hope to show the interconnected nature of prior psychiatric thought and the overlap with human rights, explain something about how this knowledge was lost, and then explore how those intertwined discourses have arisen again as a result of traumatic stress studies.

REMINISCENCES

I am a child of the 1960s, a postwar baby boomer, growing up in a lower middle-class, safe suburban family of working parents. From adolescence on I was immersed in the feminist slogan that the "personal is political," that all oppression begins within a social context, and that there is therefore no way to avoid the economic and political origins of adversity. I attended college during an era when it was usual to participate in student protest against the conflict in Vietnam, American apartheid, and discrimination against women. Before college, during college, and upon entering medical school I worked summers and holidays at an urban hospital where the results of poverty, community violence, sexism, and racism were abundantly obvious and fundamental components of our approach to medical and psychiatric care.

Once I decided to embark on a career in psychiatry, my mentors were themselves political activists who did not hesitate to connect American politics and economics to the mental health problems we encountered daily. I began my psychiatric studies during an era of community mental health, democratic therapeutic communities, and social psychiatry when it looked like the humanities as disciplines were beginning to converge. Studying sociology, anthropology, history, and philosophy was simply a

part of what we did as students to try to grapple with the complexity of human suffering. We were well aware that we existed within an only partially conscious world, that most of what happened within and between people was unconscious and influenced by a multiplicity of factors. As physicians we worked collaboratively with social workers, psychologists, and creative therapists. Each specialty had a different lens for viewing each patient, and being able to view the complexity of a person through multiple lenses lent strength to our shared ability to promote healing and recovery. I learned the value of true collaborative teamwork and of a leveled hierarchy based on mutual respect.

Social psychiatry was embedded in the post-World War II human rights framework that was eagerly extended to those suffering from emotional disorders of all kinds, and before that in the cataclysm of World War I. One prominent spokesperson of the day wrote, "the mentally ill person is seen as a member of an oppressed group, a group deprived of adequate social solutions to the problem of individual growth and development" (Ullman, 1969, p. 263). The goals of social psychiatry-the mainstream and dominant discourse at the time-were extensive and unequivocally political: "To include all social, biological, educational, and philosophical considerations which may come to empower psychiatry in its striving towards a society which functions with greater equilibrium and with fewer psychological casualties" (Jones, 1968b, p. 30).

As a result of this experience, the human rights framework seemed both obvious and necessary. I saw no contradictions between social psychiatry and human rights-they were different levels of analysis and action but dealt with similar issues-what it means to be a suffering human and what it takes to minimize or eliminate human suffering. Human rights workers were acting to change the political contexts within which trauma occurred, while mental health workers including psychiatrists were acting on the results of human rights violations within individuals and families, and sometimes communities.

THE DEEPER ROOTS OF SOCIAL PSYCHIATRY, EMPOWERMENT, AND HUMAN RIGHTS

These ideas of the mid-twentieth century were the natural evolution of earlier connections made between mental disorder and the social context extending back to the moral treatment movement in the eighteenth century and to social philosophers like Emil Durkheim, George Mead,

Charles Cooley, William McDougall, and John Dewey in the nineteenth and early twentieth centuries (Bloom, 2013). During that period discoveries in physics were beginning to explore the relational nature of the universe. Similarly, psychiatry in America began to shift to a deepening understanding of reciprocal processes and extend the previous work of the social philosophers (Witenberg, 1974).

According to a number of authmities, the origins of the first usage of the words "social psychiatry" are to be found in the work of E. E. Southard, the Director of the Boston Psychopathic Hospital from 1912 to 1920, and in his usage became the practice of applied sociology, an interdisciplinary body of knowledge and practice (Bell & Spiegel, 1969). In an early textbook, he described social psychiatry as a new and promising specialty, "an art now in the course of development by which the psychiatrist deals with social problems" (Southard & Jarrett, 1922, p. 523).

In what was then the new field of psychiatry, Adolf Meyer is considered by many to have been the most influential psychiatrist of the early twentieth century, and his ideas of "psychobiology" and "common sense psychiatry" were still profoundly important during the period of my early training and experience. Interestingly, he had grown up in Switzerland, a democratic republic since the 1200s, and Swiss values of democracy, broadmindedness, practicality, and respect for both individual and collective judgment were said to have a continuous and powerful influence on his understanding of human nature (Lamb, 2014).

Meyer's ideas were supported by progressive reform movements in the United States at the end of the nineteenth century and the start of the twentieth century that expressed an abiding confidence in the interconnectedness and malleability of the individual and society, and, importantly, a belief that deliberate action guided by qualified experts would lead to progress. Along with many peers, he had faith in the ability of humans to ameliorate social problems by means of collective action, economic and political efficiency, and science (Lamb, 2014). For Meyer, mind and body were united and influenced by biology and by culture. Emotional disorders were largely problems of failed adaptation. In 1925, he wrote that "This gives us a science which would mean the acceptance of man as the product of physicochemical, biological, and finally psychobiological interpretation, an intrinsically social type of individual, the heir, structurally and culturally, of a succession of civilizations" (p. 538). The practical application of psychobiology was a systematized study of the working of the various determining factors in mental illness, resulting

from disharmony with environment, and a search for factors of adaptation (Lief & Meyer, 1948).

Trigant Burrow, with an MD and a PhD in psychology, and a student of Meyer's, was one of the founders of the American Psychoanalytic Association in 1911 and its president in 1926. After being analyzed by Carl Jung and practicing psychoanalysis for years in Baltimore, he became disillusioned with psychoanalysis as a useful approach to psychopathology that he was conceptualizing in an entirely different way, and in doing so took a radical diversion from his psychoanalytic colleagues. This disillusionment with individual approaches led him to create an alternative community where he and his colleagues practiced what would become group therapy but which they termed *phyloanalysis* because they believed that they were uncovering the deep, inherited, and destructive flaws of the species. In 1927, he wrote,

> the question is often asked whether insanity will ever become curable. The answer can only be that the insanity of the individual cannot be curable as long as there exists the insanity of the social mind about him. It is not humanly possible for the psychiatrist to remedy conditions of mental disorganization as long as he himself is part of the disorganized social mind. (p. 24)

Dr. Burrow spent his long life, from 1875 to 1950, wrestling with the reality he saw that "Individual discord is but the symptom of a social discord" (Burrow, 1926, p. 87). From his studies of individuals and groups, he believed that social insanity was, like smallpox and measles, a communicable process, "We do not recognize that of all communicable diseases the most communicable are mental diseases, that in the sphere of mental disharmonies communicableness is itself the essential disease" (Burrow, 1926, p. 87).

Another giant of American psychiatry characterized as "America's most original modern psychiatrist" (Witenberg, 1974, p. 844), Harry Stack Sullivan sounded a similar theme, articulating a split that continues to haunt American mental health services of all kinds,

> Either you believe that mental disorders are acts of God, predestined, inexorably fixed, arising from a constitutional or some other irremediable substratum, the victims of which are to be helped through an innocuous life to a more or less euthanistic exit.... Or you believe that mental disorder is

> largely preventable and somewhat remediable by control of psychosociological factors. (Albee, 1981; Witenberg, 1974, p. 9)

For Sullivan, a person was constituted by a complex interplay of physiological, psychobiological, and situational factors. These included all the conditions that inhibit or facilitate the development of the person. As one of his biographers explained, "From the first mysterious contagion between child and mother to the last personal interchange of the old man at the moment of death, the human person is a being in process-not a fact but an act" (Witenberg, 1974, p. 844).

Yet another important voice came from Karen Horney, lending a powerful female voice to the evolution of social psychiatric thought in the twentieth century. Horney, trained in Freudian psychoanalysis as well, viewed man as a social being who could only become fully human in a cultural milieu. She felt that the development of psychopathology was significantly determined by the cultural conditions of development and she focused on three fundamental conditions that foster feelings of helplessness, insecurity, hostile tension, and emotional isolation as well as competitiveness that brings "the germs of destructive rivalry, disparagement, suspicion, and begrudging envy into every human relationship" (Horney, 1966, p. 173). She believed that economic exploitation, inequality of rights and opportunities, and an overemphasis on success bred destructive feelings in those affected. She saw a second set of factors related to cultural contradictions, such as the emphasis on winning and competition, in conflict with the equal emphasis on love and humility, as well as the cultural emphasis on freedom combined with ever-increasing restrictions and constraints. A third set of factors related to conflicts in the individual over what the culture rewards or punishes. She understood the neurotic individual as someone who had experienced injurious influences in childhood and who had essentially become "a stepchild of our culture" (p. 863).

PREVENTING ANOTHER WORLD DEVASTATION

After World War II, it became universally obvious that what psychiatrists of an earlier era had been pointing out was true. Ideas connecting social stress, the social determinants of psychopathology, and the influence of society permeated psychiatric knowledge and research (Albee, Joffe, & Dusenbury, 1988; Caplan, 1961, 1964; Joffe & Albee, 1981b). As one analyst wrote in 1949,

> Our jails and prisons are filled with criminals. Our institutions are filled with insane. Our hospitals are filled with cripples-cripples mangled by war. Wars are made by bullies. Bullies are made by tear. And this kind of fear is made by injury to the child, physical or emotional injury when the child is too young, too helpless, to be able to protect himself: This culture criminally ignores the fact that the question of peace or war tomorrow is in the wombs of the mothers of today. (Moloney, 1949, p. 337)

In the first two and a half decades after World War II, spurred on and made obvious by the devastation of two global wars, the Holocaust, the dropping of the nuclear bombs, and the constant threat of nucle r warfare as well as the growing problems related to totalitarianism and the Cold War efforts to articulate prevention moved to center stage. The Korean conflict, as well as the repeated assassinations of key leaders, accentuated political and philosophical divisions that remain with us today.

By mid-century, George Albee, one of the founders of community psychology, was stating that "the principal noxious agent for emotional disorders is stress. The principle source of stress worldwide is poverty. Poverty is at the root of many of the stresses that have been identified as causing emotional distress" (Albee, 2006, p. 451). The problems that emerged out of the devastating events of the twentieth century made it quite clear that if psychiatry was to find a way not just to treat, but also to prevent mental health problems, we could not ignore the multiple social problems that give rise to war, poverty, discrimination, and inequality. One of the seminal thought leaders of mid-century psychiatry, William Menninger, made the cover of *Time* magazine and wrote that "Every institution in American society has to evaluate its program "in terms of the contribution to individual and group mental health" and that it was vital to determine "the more serious community-caused sources of emotional stress" (Grob, 1991, p. 20).

The movement toward community-based inpatient treatment was aligned with a growing push for deinstitutionalization of the enormous state hospitals that, due to their size alone, were hugely expensive and depersonalized and sometimes abusive. In 1945, the average daily resident population of mental institutions was about 430,000; approximately 85,000 were first-time admissions. Nearly 88% of all patient care episodes occurred in mental hospitals; the remainder were located in general hospital psychiatric units. In 1951, total state expenditures for all

current operations were $5 billion. Of this sum, 8% was for mental hospitals (Grob, 2005).

Part of the discourse for closing state hospitals derived from Erving Goffman's (1961) analysis of the impact of "total institutions" like asylums on mentally ill patients in the United States. Beginning in the 1960s and gathering momentum throughout the 1970s, clearing patients out of state hospitals and back into the community was frequently articulated as a human rights issue, and various movements to protect the rights of the mentally ill began to grow in the United States and in Europe (Sheth, 2009). At the same time, others focused on human rights abuses of those termed mentally ill in the Soviet Union and in China and in other countries using torture as a political tool ("Abuse of Psychiatry in the Soviet Union," 1983; .American Psychiatric Association, 1985; Nightingale & Stover, 1985). The first committee to oppose political abuse of psychiatry was founded in 1974 and ·eventually became the Netherlands-based Geneva Initiative on Psychiatry. From then on, pressure on the Soviets and bloc countries mounted with condemnations by the British Royal College of Psychiatrists (BRCP), the American Psychiatric Association, and the World Psychiatric Association (WPA), among others ("Psychiatry and Human Rights Abuses," 2004).

In an important book published in 1955, noted psychologist Erich Fromm echoed earlier social c1itics when he wrote:

> many psychiatrists and psychologists refuse to entertain the idea that society as a whole may be lacking in sanity. They hold that the problem of mental health in a society is only that of the number of 'unadjusted' individuals, and not of a possible unadjustment of the culture itself. (p. 15)

He then went on to define what he meant:

> An unhealthy society is one which creates mutual hostility [and] distrust, which transforms man into an instrument of use and exploitation for others, which deprives him of a sense of self, except inasmuch as he submits to others or becomes an automaton. (pp. 71-72)

Fromm recognized that disconnecting the utilization of scientific concepts from ethical principles could have devastating results. It meant that a man could kill a hundred or a thousand people by pushing a button and not react emotionally to his act, though that same man might

experience overwhelming feelings of guilt and shame were he to injure one helpless person (Witenberg, 1974).

As the connections between social conditions and the development of emotional problems were becoming abundantly more obvious, many other psychiatric workers began to address prevention, particularly those at the "coalface" of community mental health. Like Albee and associates, they sought to define and discuss *preventative psychiatry* (Albee et al., 1988; Caplan, 1961, 1964; Joffe & Albee, 1981b). The purpose of this expansion of knowledge was to (1) find ways to reduce the incidence of mental disorder of all types in a community (primary prevention); (2) · reduce the duration of a significant number of those disorders which do occur (secondary prevention); and (3) reduce the impairment which may result from those disorders {tertiary prevention) (Caplan, 1964). The role of psychiatrists was to expand because they needed to acquire knowledge of a much wider range of issues-social, economic, political, administrative, and so forth-anything that would enable them to plan and implement programs that focused not only on individual patients but beyond them on the community problems of which they were a part.

CREATING DEMOCRATIC THERAPEUTIC ENVIRONMENTS

As the influence of deinstitutionalization was growing and was perceived as not just a medical issue, but also a human rights issue, many people still needed extensive services which then had to be delivered within the community. One of the key sites for secondary as well as tertiary prevention was the acute care inpatient psychiatric setting usually called *therapeutic milieu settings.* The 1960s saw the rise of both democratic therapeutic communities and therapeutic milieus across the United States.

These programs, often in community hospitals, were based on principles that grounded an understanding of psychopathology of all kinds in terms of power dynamics and rights: "The fundamental premise of any therapeutic milieu is the sharing of power between all members of the community" (Kennard, 1998, p. 60). A primary assumption was that people had become mentally ill within the context of a social environment and that a psychiatric inpatient program was a microcosm of society which could be seen as a kind of laboratory for social change (Tucker & Maxmen, 1973). As was pointed out at the time, "In the United States, in the United Kingdom, and in other parts of the world, the therapeutic community impulse furthered the idea that a community created in the

'reverse image' of a society at large can be therapeutic for the casualties of that society" (Kennard, 1983, p. 34). By this time, there was a widespread understanding about the dangers of authoritarianism and the totalitarianism that follows in its wake that had been so evident in the events of the previous decades. At the same time, social movements including the feminist movement, the anti-war movement, and the civil rights movement were demonstrating clearly that "the personal is political" and the growing discourse around human rights served the purpose of bringing a value-based philosophical conversation into all of these activist movements.

From the beginning of its development, therapeutic milieu ideas were meant to be applied to a wide variety of settings and populations including schools and prisons (Bloom, Bennington-Davis, Farragher, McCorkle, Nice-Martini, & Wellbank, 2003; Jones, 1962; Kennard, 2004). One of the key founders of the therapeutic community, Maxwell Jones (1968a; see also 1968b), wrote:

> **What distinguishes a therapeutic community from other comparable treatment centers is the way in which the institution's total resources, scan: patients, and dlcil· relatives, arc self-consciously pooled in furthering treatment. That implies, above alJ, a change in the usual status of patients. (pp.** 85-86)

The therapeutic community was designed to be a living-learning situation where everyone had the opportunity to learn from everyone else. To make that possible, power had to be distributed in a very different way, a way that was defined as both permissive, tolerant, respectfi.tl, and democratic. In such an environment there needed to be an emphasis on creating a culture of inquiry where basic assumptions about oneself and the other could be re-examined and potentially changed within the context of real life expe1iences within the therapeutic community. Although largely unshared beyond the world of mental health treatment, therapeutic communities were actually uncovering the necessary substructure of participatory, democratic processes.

The therapeutic community (TC) approach was found to be particularly essential for the post-World War II treatment of returning and troubled veterans and former prisoners of war, and then for the chronically unemployed who had serious personality problems (Jones, 1953; Wilmer, 1958). These were all people-initially men-who had been exposed to traumatic and often very abusive childhood, adolescent, and/ or adult experiences with the abusive use of power and the violation of human rights, so the ways in which the issue of power was addressed in any therapeutic milieu became an essential focus.

> The TC model represents an attempt to erode the traditional hierarchy existing between clients and staff replacing this with a more collaborative and power-sharing relationship. When successful, the effect is to produce a more "equal" and symmetrical state of affairs. Each of the parties knows where it stands in relation to the other, in terms of role expectations and, importantly, also the limits of these. Achieving this reciprocity comes via the delegation to the clients of much of the authority conventionally invested in the professional role. (Norton & Bloom, 2004, p. 251)

The foundational ideas around therapeutic environments, patient empowerment, democratic processes, and social responsibility were derived from the experiences of war and survival on the psychiatric community in Europe and in the United States. There was little question in minds of these innovators by the end of World War II that

> It seems eminencJy reasonable to view the concept of the trauma itself as a potential opportunity for growth; we must seek to determine appropriate procedures as a function of the interaction between the subject, significant others in his social world, and sociall)' skilled professional workers during the period of stress,

wrote Maxwell Jones (1968a, p. 86).

The 1960s also saw the rise of "anti-psychiatry" largely coming from clinicians who were mobilizing powerful critiques to psychoanalysis, Kraepelinian diagnostic ideology, coercive forms of treatment, racial and social injustice, and social stigma. In some ways, they picked up the baton of Trigant Burrow and carried it forward but with even more strident critiques. There were many voices of radical psychiatry, representing different ideas including David Cooper, Thomas Szasz, R. D. Laing, and Claude Steiner. Consistent with the questioning and challenging environment of young people in this era, young psychiatrists were also asking some fundamental questions through this discourse:

> In this field most particularly, in the midst of people in extreme situations, one experiences the Zen 'doubt sensation' - why am I here, who put me here, or why have I put myself here (and what is the difference between these questions), who is paying me for what, what shall I do, why do anything, why do nothing, what is anything and what is nothing, what is life and death, sanity and madness? (Cooper, 2007, Preface)

For R. D. Laing and David Cooper, both practicing psychiat1ists in the UK, the hallmark characteristic of psychiatry was a misunderstanding of "madness," a decontextualization from the social and political context of psychosis and its relationship to disordered family functioning. Laing described the diagnosis of schizophrenia as a theory, not a fact, and Cooper (2007) noted that "Over the last century psychiatry, in the view of an increasing number of present-day psychiatrists, has aligned itself far too closely with the alienated needs of the society within which it functions" (Preface). Thomas Szasz (1974), on the other hand, declared that the very idea of mental illness was a myth, that problems in living were an entirely different category than illnesses of the body, and that he particularly opposed coercive measures used in psychiatry. He perceived much of the problem with psychiatry as centering on the abuse ofindividual rights.

THE PERSONAL Is POLITICAL, RIGHTS AND SCIENCE

By the 1970s, it was clear to those of us who were young practitioners that we were engaged not only in medical treatment but also in working to further human rights. The second wave feminist slogan asserting the close connection between our personal lives and the social and political context was evident in the work we were engaged in. Each of us had to figure out how to balance respect for fundamental rights of our patients with protection of ourselves and others in the environment when violence was threatened, but at a deeper philosophical level, there was no contradiction in the discourses. The postwar therapeutic community experiences had shown that paying attention to the social norms of the environment, practicing democratic values, and becoming constantly aware of the interplay of power dynamics within and among every member of a community were all vital if we were to create nonviolent environments (Wilmer, 1958, 1964). We could see in our own lives at home and at work that the personal was indeed political.

For those workers involved in community mental health and preventive psychiatry, it was impossible to ignore the deep and clear connections between emotional disturbance, power inequities, and income inequality. As the political context for psychiatry became increasingly obvious, workers in mental health were increasingly vocal about the undermining of equality that was damaging individuals and our society as a whole. Albee and colleague (Joffe & Albee, 1981a), ever vigilant, summarized their findings pointing out the political, economic, and social conditions promoting mental health problems:

> There is a strong tendency in our society to separate and isolate social problems. We have a social problem labeled violence against children in the family, and others labeled battered wives, sexism, racism, abuse of elderly persons, family disruption, poverty and unemployment, the incarceration and decarccration of persons we call mentally ill, the neglect of the mentally retarded, and the isolation of the physically handicapped, to name just a few. What do all these problems involving different groups have in common? We have suggested, for your consideration, the best answer we can come up with. It is their powerlessness. People without power are commonly exploited by powerful economic groups who explain the resulting psychopathology by pointing to the defectiveness of the victims. The rest of us do not rush to the defense of the victims because we are caught up in the ideology that puts 'justice' in the hands of those with power. We join the groups "blaming the victims.".... If we see all these groups as powerless because of socioeconomic conditions, then a logical approach is to determine whether there might be an equitable redistribu.tion of power.... Without meaning to be simplistic, *we* would like to suggest that we examine the arguments in the papers for a redistribution of power through a redistribution of wealth in our society. (p. 322)

This blatant criticism of the existing social structure came at a time when typical American values were being challenged on every front-in the family, the workplace, communities, schools, and in society as a whole. Could materialistic values give way to increasing concerns about the results of economic inequity and ecological destruction? Could women and African-Americans be given equal protection and equal rights? Could warfare finally be prevented through increasing democratization at home and aroqnd the globe? Could technology be the key to creating a global civilization, and in doing all this, could human rights finally come onto center stage as humanity's fi.mdamental priority? General systems theory of the late 1960s and early 1970s began to provide a way of thinking about complex adaptive systems consistent with these emerging values but further research on complex systems was going to have to wait for the development of computer technology that could meet the needs of complexity (Marrnor, 1983; Von Bertalanffy, 1974).

At this point most of us were unaware of Thomas Kuhn's seminal work, ***The Strttctm·e of Scientific Revolutions,*** that was originally published in 1962 (Kuhn, 1970). In it, Kuhn had recognized the role of values in science, that there is no such thing as a values-free application of theory. Scientists have often pretended that values can be completely independent from the human beings performing the science and endorsed a concept

that without the burden of moral decision-making, progress in science occurs smoothly, while theories and models are continually being refined and replaced by newer and more accurate versions (Capra & Luisi, 2014). Kuhn exposed this notion as invalid, recognizing that underlying all theory choices are deeper assumptions of belief and of value.

Developing these ideas further, Capra and Luisi (2014) asserted that there is a recurrent historical tension in science: "the basic tension is one between the parts and the whole. The emphasis on the parts has been called mechanistic, reductionist, or atomistic; the emphasis on the whole, holistic, organismic, or ecological" (p. 4). They pointed out that these are two very different lines of inquiry that have been in competition with one another throughout our scientific and philosophical tradition. For most of the time, the study of matter-of quantities and constituents-has dominated. But every now and then the study of form-of patterns and relationships-came to the fore (Capra & Luisi, 2014). During the Scientific Revolution of the seventeenth century, values had been separated from fact and here, values were being drawn back into the discussion about the etiology of mental disorders. It was being asserted that if we changed our values to those being described by feminists, civil rights workers, ecologists, and human rights workers, then we could prevent most of the problems plaguing humanity.

But mainstream psychiatry was uncomfortable and largely unprepared to address these enormous political, economic, and social dilemmas, and the need for revolutionary change if mental illness, as being articulated, was to be prevented. The wheel was turning. As causal explanations were becoming ever more complex by the mid-1970s, psychiatry was turning away from a systemic way of viewing fundamental problems as patterns and back toward the ages-old focus on mechanism and number via a biological explanation for mental illness and in doing so, taking up the cudgel of diagnosis.

THE WHEEL TUilNS

Beginning in the 1970s, psychiatry began to radically change with mounting opposition to preventive psychiatry, the community mental health movement, and all aspects of social psychiatry. Vehement criticism arose in the pages of influential journals. In 1979 came one attack on efforts at primary prevention with a criticism of the "fuzziness of the concepts" and the "assumption - which is yet unproved - that difficult

life circumstances lead to mental illness"....while going on to state that the "cause and effect relationship between social conditions and mental illness is extremely questionable" (Lamb & Zusman, 1979, p. 13}. In another article, the same authors state that

> **recent research.... in particular, the adoption studies of Kety and others (1976)....indicates that major mental illness is in large part genetically determined; therefore, it is probably not preventable and at best only modifiable. Even that it can be modified is questioned by many, and there is little hard evidence one way or the other. (Lamb & Zusman,** 1982, **p.** 22) .

By the end of the 1980s, biological psychiatry had achieved dominance and had successfully displaced psychoanalysis, psychodynamic, and systems theory as the driving forces within the discipline, completely overshadowing the biopsychosocial model derived from Meyerian psychiatry of the earlier decades. This abrupt turning away from previous experience and the failure to integrate the knowledge gained over the prior century was influenced by many factors. The development of psychiatric drugs, the economic power of the psychopharmaceutical industry, the urgent pressure for rapid deinstitutionalization, .frustration with psychoanalytic and psychodynamic approaches, and a repressive reaction to widespread social unrest led to a dramatic upswing in the medicalization of what had been previously understood as complex and interactive individual and social problems (Hari, 2018).

A new generation of psychiatrists were being selected and trained, often by psychiatric residency directors who were eager to bring about change as well as garner economic support for their programs from research grants coming from pharmaceutical companies. As an anthropologist who studied these changes wrote,

> **These psychiatrists saw themselves as scientists, and to them that word set them apart from psychoanalysis, to which many of them were openly hostile and which few of them regarded as scientific.... The psychiatric scientists were committed to what they called strict standards of evidence, and they tended to view psychoanalytic theories of causation as neither provable** nor disprovable **by those standards. They were determined to create a psychiatry that looked more like the rest of medicine, in which patients were understood to have diseases and in which doctors identified the diseases and then targeted them** by **treating the body, just as medicine identified and treated cardiac illness, th)'roiditis, and diabetes. (Luhrmann, 2000, p.** 225)

With increasing fervor and the power of advertising, the public began being given repeated messages. One was that psychiatric diagnosis was as firm and definitive as medical diagnoses. The subsequent diagnostic categorization schemes of the DSM-III, III-R, IV, IV-R, and 5[1] each introduced ever-widening definitions of mental illness (Frances, 2014; Greenberg, 2013). This diagnostic fervor was said to be so important because discoveries had been made showing clearly that mental illnesses are biochemically induced and often genetically determined and although not preventable by known means, could be treated effectively with pharmaceutical preparations (Whitaker & Cosgrove, 2015).

By the 1980s, George Albee, along with Justin Jaffee, edited a seminal text about preventing psychopathology titled ***Prevention Throitgh Political Action and Social Change*** (Joffe & Albee, 1981b), a book that can almost be viewed as a "cri de coeur" for what was by then the disappearing idea of prevention in mental health discourse. In the opening chapter, Albee (1981) wrote:

> Back in the days when the world was a much simpler place, a great many of us held firmly to the belief that scientific judgments were based on facts and that social policy changed with accumulating scientific findings, and that theories were held only so long as they were supported by objective evidence. Those who thought of themselves as politically liberal held to the conviction that the world was slowly and steadily changing for the better, and that with improved education, more scientific research, new evidence, and practice society would eventually reach a condition of universal justice and fairness. I am a slow learner. I no longer believe these things to be true. I now believe that the thirst for power is an addiction, far more dangerous than any other addiction... Power needs override the tempering consequences of human empad1y and blind the addict to considerations of justice and fairness. (p. 5)

Since that time, psychiatry has consistently been powerfully influenced by a restrictive and reductionist medical model. Although there is an abundance of sound data showing that psychotherapy plus medication gives a significant benefit over either approach alone, many insurance plans refuse to cover psychotherapy or cover only a minimum of sessions. And new psychiatric residents do not receive the intensive psychotherapy training that was characteristic of earlier training experiences (Luhrmann, 2000). The concerns of human rights activists pointed out in this book, that political, social, and economic injustice and oppression is in danger

of being medicalized and individualized, should not be overlooked, since that is exactly what has occurred in psychiatry during the last few decades. Psychiatric thought leaders became those who were focused on the molecular level of brain disorders and largely away from the social situations that may have been creating those molecular-level problems.

More disturbing yet are the multiple critiques that expose the enormity of corrupt influence that raise consistent questions about whether or not the medications now prescribed in epic quantity are actually effective, confirming Albee's prescient comments about the addictive nature of power—and the money that trails along with it (Barber, 2008; Bentall, 2009; Hari, 2018; Healy, 2012; Whitaker, 2010; Whitaker & Cosgrove, 2015).

TRAUMATIC STRESS AND ADVERSITY: RETURN OF THE REPRESSED

The war in Vietnam stretched from 1955 to 1975. It was a devastating time in American culture as the older generation and the younger generation polarized not unlike the polarization we see today between liberal and conservative, except then the dividing line was age and experience. But it was also in the 1970s that the human rights movement, as it is currently understood, gained credibility around the globe after the failure of the multiple totalitarian utopias of the twentieth century became apparent (Moyn, 2012). Veterans from the Vietnam war, their families, psychiatrists, and other activists campaigned to get a diagnosis of post-traumatic stress disorder because the previous diagnostic category that had been applied to sufferers of combat-related psychiatric disorders had been removed from the diagnostic manual in 1968, and as a consequence these men and some women could not get treatment or benefits from the VA. The diagnosis of PTSD arrived in 1980, and that can be seen as a marker for the beginning of the traumatic stress field. The International Society for Traumatic Stress Studies (ISTSS) had its first formative meeting in 1985, while what is now the International Society for the Study of Trauma and Dissociation (ISSTD) formed around the same time. From the beginning of trauma studies, it was clear that values could not be omitted from traumatic stress science when it was perfectly obvious that most trauma occurred in the context of the abusive use of power and that exposure to adversity was largely determined by the political, social, and economic context of individuals' life experience.

The original stated purpose of the ISTSS was "to advance knowledge about the immediate and long-term human consequences of

extraordinarily stressful events and to promote effective methods of preventing or ameliorating the unwanted consequences" (Figley, 1986, p. xxvi). In 1998, I served a term as the President of the ISTSS. In service of the honor of being elected, I interviewed as many of the founding members of the organization as I could access and subsequently wrote a history of the organization's first years. As had already been pointed out by others, one remarkable aspect of the organizational history was the extent to which the founding mothers and fathers had personal experience with trauma (van der Kolk, Weisaeth, & van der Hart, 1996). As I discovered,

> War crimes, war protests and war babies; child abuse, incest and women's liberation; burning monks, burning draft cards and burning crosses; murdered college kids and show trials of accused radicals; kidnappings, terrorism and bombings; a citizenry betrayed by its government and mass protests in front of the Capitol in Washington-all play a role in the backgrounds of the people who founded the organization and in the evolution of the organization itself (Bloom, 2000, p. 28)

Among those who were pioneering this field of study there was no question that understanding and responding to the political and social context was vitally important, nor that struggle for human rights was at the core of the scientific field that was being developed. To be part of the solution instead of a part of the problem it was necessary to speak truth to power. Charles Figley, the original organizer and first ISTSS President, had served in Vietnam (Figley, 1985, 1986). Robert Lifton, psychiatrist in postwar Japan and in Korea and longtime human rights advocate, researcher, and activist, was one of the participants at the original organizing meeting, and his understanding of the sociological context for the traumas of combat, of totalitarianism, of the threat of nuclear annihilation, and of thought reform was embedded in traumatic stress studies from its inception (Lifton, 1961, 1963, 1967, 1973, 1986, 1987, 1993). The third President, Yael Danieli, served in the Israeli military before immigrating to the United States and was herself the child of Holocaust survivors (Danieli, 1997). She became very involved with the United Nations (UN) and was instrumental in bringing knowledge about traumatic stress studies to an international audience.

As the first person to call extensive attention to the plight of adult survivors of sexual abuse, Dr. Judith Herman (1992) wrote in her seminal book *Trauma and Recovery* that

> **To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins victim and witness in a common alliance. For the individual victim, the social context is created by relationships with friends, lovers and family. For the larger society, the social context is created by political movements that give voice to the disempowercd. The systematic study of psychological trauma therefore depends on the support of a political movement. (p. 9)**

In the 1980s and 1990s, I had the opportunity of learning about the impact of trauma from Dr. Judith Herman, Dr. Bessel van der Kolk, and several thousand adult survivors of child abuse and other forms of interpersonaJ trauma. I had the good fortune to be learning in an interdisciplinary environment where all of my colleagues were learning about these experiences at the same time (Bloom, 1997). As we saw the enormity of what we were uncovering in a psychiatric inpatient setting and in the relatively small community within which we were embedded, we recognized how little we had truly understood about the development of mental health problems in spite of good training. We also began to grasp the parallel impacts on us, our families, our workplaces, and our society. I began to conclude that traumatic experience has been so much a part of human evolution that it had been largely ignored as a central organizing principle of human thought, feeling, and behavior until there were sufficient numbers of the population to have ***not*** experienced the magnitude of trauma experienced by their predecessors. By 1991, we recognized that as an entire team, we had been experiencing a "paradigm shift," a fundamental change in the way we understood and responded to our patients and each other. At the time, we spoke of *this* shift as a change from asking the primary question of "What's wrong with you?" to "What's happened to you?" (Bloom, 1994).

I too went through a paradigm shift for myself when my prevailing and finaJly life-determining question became, "Why should those events have to happen to people in tlle first place?" The context of my patients' abusive and traumatic life experiences was ctitically important in understanding the impact those experiences had had on development of body, brain, and mind.

We were discovering what I have begun calling the science of suffering. The psychobiology of trauma, the emerging body of research and clinical wisdom about the multigenerational impact of traumatic experience and its impact on attachment behavior was offering us an underpinning for the practice of the therapeutic community. But it was also providing an integrative framework for multigenerationaJ family therapy

and the wide variety of therapeutic approaches that had evolved over the previous century to address widespread human suffering. I began thinking that the extreme fragmentation that had plagued the mental health world for so many years could be overcome through this scientifically grounded, integrative framework that would help all of us to come to grips with the complex biological, psychological, social, economic, political, and existential impacts of trauma (Bloom & Reichart, 1998).

Radical changes occurred in the patients when they were offered a different and coherent cognitive framework to understand their lives and their problems-a trauma-focused approach. This shift in our perspective that has now become known as ***trauma-informed*** (Harris & Fallot, 2001) allowed us to see our patients as survivors of life's torments who had adapted as best they could, as will any living creature, but who had in the process become derailed in a wide variety of ways. We came to see ourselves less as healers or fixers and more as educators, coaches, and mentors.

Throughout this period, the 1980s and 1990s were in full swing with all of the extreme emphases on materialism and denial of more fundamental social problems that characterized that era. Despite my previous political activism, little had prepared me for embracing the devastating magnitude of traumatic experience in my culture that we were learning about every day. As I wrote in another chapter,

> **My job as an individual therapist, as the medical director for a psychiatric unit, and as the supervisor for several dozen other clinicians meant that over the course of two decades, I was compelled to bear witness to thousands - not hundreds, but thousands - of terrible stories. When it all began, we could not conceive that there could be so much evil in the world. Within a few years, we could not conceive of ever having not known there was so much evil in the world. (Bloom, 2017, p. 39)**

By this time, the research arm of traumatic stress studies was launched and actively making the field of study more credible and academically acceptable. As research kept flooding in, supported by our own experience and observation, it also became evident that the vast majority of psychological and social pathology is related to a past history of trauma, that a substantial proportion of physical illness is likewise related, and that most of the clients in virtually every other social service system have a similar history. We began recognizing the mark of trauma everywhere,

in ourselves, our systems, and the world around us, what we spoke of as the *parallel process* nature of reality, what in systems theory is known as *isomorphism.*

This was a wake-up call. At the time I was comfortably ensconced in suburbia with a lucrative and successful practice and a healthy management contract to operate our program designed to compassionately respond to the needs of the "mentally ill." My colleagues and I had never completely forgotten our roots in social psychiatry, but the mores of the 1980's did not lend themselves to philosophical speculation about the sources of oppression that constituted our psychiatric care. So when I began to grasp that the evolution of the psychiatric problems in the majority of our patients-and at the time these mostly middle-class Caucasians-had begun with exposure to violence in childhood, frequently exacerbated by exposure to more violence as adults, it was no longer possible to ignore the social and political forces around me.

This distress was paired with anger and righteous indignation as I grappled with a sense of betrayal by my profession (Freyd, 1996). I had been trained to believe that the illnesses of my patients were largely of indeterminate cause and recovery was not even discussed as a meaningful possibility. Our job, my job, was to reduce symptoms, and in doing so, alleviate suffering. As a physician, I was assigned the responsibility for diagnosis, for treatment planning, for medication management. For the most prob,lematic symptoms, medications were both necessary and inevitable, despite the many side effects that accompanied them. Neurotic symptoms were to be addressed with psychotherapy and sometimes medication. Personality disorders were said to *be* largely untreatable without intensive, long-term forms of treatment that were becoming increasingly unavailable, so it was advised that we not even try to treat them. That I never had entirely swallowed all this I had attributed to my own quirkiness and relative ignorance, not to bad information.

But now the research in traumatic stress and later the Adverse Childhood Experiences work was demonstrating that the number of people exposed to overwhelmingly traumatic experiences either and/or as children represents a majority of the population. It became clear that people who have survived traumatic experiences are not just in psychiatric hospitals, prisons, or homeless shelters. *They* are doctors and lawyers, judges and teachers, mechanics and truck drivers. They campaign

for human rights, and they resist the oppression of dictators. They are also the dictators. They serve in the military, and they serve in the Peace Corps. They run businesses and lead governments. As a consequence, it became obvious that one-to-one psychotherapy would never be able to reverse this situation and that most of the pathology we all have to address was at some point in time preventable.

That recognition produced a fault line in my psyche that is still unhealed, and it is a fault line in traumatic stress studies. As the field matured, and increasing numbers of clinicians and researchers became interested in what was being uncovered, and as traumatic incidents like the Oklahoma City bombing and 9/11 continued to unfold, most of the attention has gone to what those of us trained in the health care, mental health care, and social services fields know how to do-treatment. And that does make it appear that the field is being medicalized; meanwhile, the ability to rapidly and thoroughly bring about change even in the population of individuals who can be more effectively treated with trauma-specific methods has been severely limited and often curtailed by destructive changes in the funding of mental health services. Now reductionism, in the guise of a demand for "evidence-based practice," has come to dominate not only psychiatry but the other professions as well. Increasing numbers of clinicians are prohibited from providing services that are not manualized and evidence-based, meaning that they have been subjected to the rigors of randomized, controlled-and very expensive-studies. On its surface, developing conclusive evidence that a strategy is effective makes sense and should have been standard operating practice all along. Unfortunately, the standard for defining an intervention as "evidence-based" is so high that very few interventions can meet the criteria. Experienced clinicians who are confronted with the complexity of the problems related to prolonged suffering recognize that the evidence-based practices that exist are often "necessary but not sufficient."

In the early years, many of us thought that scientific discovery alone would be enough to change our systems. All of the progress has made a significant difference for individuals and their families, but little has happened to change the sources of the problems. We are still on the edges of the river, pulling babies threatened by drowning out of the water, but few are upstream figuring out how to keep the babies from being thrown in. That is where advocacy for human rights comes in. We must depend upon other people, with different available skills, who

can change policy and change minds at every level and in every government, since we are now a global society. The trauma field has provided the scientific underpinning for the human rights movement, and somehow we have to bridge *the* gap between science and activism and offer our knowledge as an invaluable weapon in the war of ideas to those who can effectively use it. I have come to firmly believe that we live in a global culture that is organized around-and routinely reenacting-the unresolved traumatic experiences of the past. There is no more important goal than trying to figure out how everything we have learned from trauma survivors since that last World War can influence the current of events that is driving all of us toward a future that is unsustainable-to species suicide-and instead move us collectively toward a future worth surviving.

As a trauma specialist, I am certainly not alone in the frustration that affects everyone who works in helping trauma survivors. As a former President of the European Society for Traumatic Stress Studies (ESTSS) has put it,

> **The ESTSS track record must involve raising awareness of trauma, its sequelae, and effective interventions. Yet, I still struggle with a question of what the core matter or crucial ingredient of psycho-traumatology really is. Two answers come to mind. The first is that all considerations of trauma interfaces with human rights as they pertain to individuals right through to global matters. It is this practical and legal perspective, not theories or models, that should furnish the foundation for our field. I would welcome a shift in ESTSS, so human rights becomes its explicit focus. (Orner, 2013, p. 4)**

And from the conclusion of two weighty tomes devoted to trauma psychology, the editors (Gold, Cook, & Dahlenberg, 2017) write,

> **And yet with the waning connection of trauma studies to the consideration of the political structures that allow or actively promote the violent victimization of the powerless and disenfranchised - women, children, ethnic minorities, the poor, sexual minorities, the elderly, the disabled - trauma studies and trauma practice have been diminished by a certain level of detachment from the reality of human suffering and the political conditions that actively foster it. There is a limit to how much trauma psychology specialists can do to reduce trauma-related suffering if our work does not encompass the sociopolitical conditions that perpetuate**

> victimization through marginalization, disenfranchisement and disempowerment. (p. 573)

THE CHALLENGE GOING FORWARD: INTEGRATION OR COLLAPSE

Humanity brings into the world of the twenty-first-century adaptations that belong to our ancestors and that helped us to survive but that now can be viewed as the major public health problem confronting us as an entire species. The overarching question that the authors of the chapters in this book ask is, "How can we integrate all of the advances in understanding and treating trauma-related dysfunction with an emphasis on monitoring, responding to, and ultimately preventing abuses of human rights?" If you watch current events, you may have noticed the strong human tendency to avoid or ignore highly complex problems such as this question asks while posing overly simplistic solutions to other complex problems such as climate change, worldwide shifts in populations, and nuclear disarmament.

In her book, *The Watchman's Rattle,* sociobiologist Rebecca Costa (2012) pulls headlines from today's news to demonstrate how accelerating complexity quickly outpaces the rate at which the human brain can develop new capabilities. She calls this the *cognitive threshold,* the point at which a society can no longer think its way out of its problems and instead passes the unresolved issues on to the next generation. With compelling evidence based on research in the rise and fall of Mayan, Khmer, and Roman empires, Costa shows how the tendency to find a quick solution to complex problems leads to frightening long-term consequence: a society's ability to solve its most challenging, intractable problems becomes gtidlocked, progress slows, and collapse ensues. She raises the question about whether our knowledge of previous civilizations can help us avoid the same problems for our own. As the renowned sociobiologist, E. 0. Wilson ("An Intellectual Entente," 2009, n.p.) has put it: "we have paleolithic emotions, medieval institutions, and god-like technology."

Visionary utopian ideas have always been criticized, but we need now not a vision of perfection but a vision of *survival* which can only happen through collective thought, feeling, action, and not just the survival of me, or my group or your group, or my country or your country, but the literal survival of life on Earth. We have never been here before. Behavior change is a result of changes in attitudes, while attitudes change as a result of changes in our systems that depend entirely on our deeply held

mental models that only change when the scientific paradigm changes, and that can only change when the deepest systemic assumptions-our worldview-change. This level of change-a change in worldview-is the real power behind the integrated function of trauma studies and human rights advocacy.

Long ago, Adlai Stevenson, mid-twentieth century US Presidential candidate and Ambassador to the UN, observed:·

> **We travel together, passengers on a little space ship, dependent on its vuJnerable reserves of air and soil; all committed for our safety to its security and peace; preserved from annihilation only b}' the care, the work, and, I will say, the love we give our fragile craft. We cannot maintain it half fortunate, half miserable, half confident, half despairing, half slave-to the ancient enemies of man-half free in a liberation of resources undreamed of until this day. No craft, no crew can travel safely with such vast contradictions. On their resolution depends the survival of us all... (quoted in Grinspoon, 2016, p. 405)**

Until we collectively decide to stop promoting the conditions that allow children to be abused, neglected, and otherwise violated, and adults to be repeatedly exposed to interpersonal violence, we will continue to be confronted with the refugees of our own domestic warfare. Where does the study and treatment of trauma survivors and human rights advocacy come together? In a new global political principle and practice which is really our own hope of survival in this threatened world, Hannah Arendt (1979) summed it up:

> **Antisemitism (not merely the hatred of Jews), imperialism (not merely conquest), totalitarianism (not merely dictatorship)-one after the other, one more brutally than the other, have demonstrated that human dignity needs a new guarantee which can be found only in a new political principle, in a new law on earth, whose validity this time must comprehend the whole of humanity while its power must remain stricdy limited, rooted in and controlled by newly defined territorial entities. We can no longer afford to take that which was good in the past and simply call it our heritage, to discard the bad and simply think of it as a dead load which by itself time will bury in oblivion. The subterranean stream of Western history has finally come to the surface and usurped the dignity of our tradition. This is the reality in which we live. And this is why all efforts to escape from the grimness of the present into nostalgia for a still intact past, or into the anticipated oblivion of a better future, are vain. (p. ix)**

We-meaning humanity-have taken a new evolutionary leap, and it is up for grabs whether we are going to fall into the chaos of destruction or leap into a new kind of species. We began as weak and vulnerable hunter-gatherers living in small groups only to become the dominant species now numbering in the billions. Our technological expertise gives us the capacity to destroy all life on the planet. We are now planetary stewards, and can we make that leap into the unknown, or will we create our own black hole of trauma? David Grinspoon (2016), an astrobiologist and senior scientist at the PJanetary Science Institute and adjunct professor of Astrophysical and Planetary Science at the University of Colorado, has written that

> The scientific community is now converging on the idea that we have entered a new phase, or epoch, of Earth history-one in which the net activity of humans has become a powerful agent of geological change, equal to the other great forces of nature that build mowuains arid shape continents and species. The proposed name for this new epoch *is* the "Anthropocene" or the age of humanity. This concept challenges us to look at ourselves in the mirror of deep time, measured not just in decades or centuries or even in millennia, but over hundreds of millions and billions of years.... We are witnessing, and manifesting, something unprecedented and still completely unpredictable: the advent of self-aware geological change... Many species have changed the planet, to the benefit or detriment of others, but there has never before been a geological force aware of its own influence.... In seeing ourselves as a geological process, we also see the planet entering a phase where cognitive processes are becoming a major agent of global change.... We have, unconsciously, been making a new planet. Our challenge now is to awaken to this role and grow into it, becoming conscious shapers of our world. (pp. x-xiv)

NOTE

1. American Psychiatric .Association, *Diagnostic and Statistical Manual of Mental Disorders,* 1980, 1987, 1994, 2000, 2013, Washington, DC.

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