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Re-stor(y)ing Trauma

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Abstract

Individualistic and disembodied trauma narratives that emerge effortlessly from dominant discourses like biochemistry and diagnostic nomenclature fail to address the effects of trauma in people's lives. Trauma could also be understood as a challenge to personal narratives of living in the face of exceptional experiences that stand far outside what is known and familiar. This invites personal accounts of values, purposes, skills, and acts of resistance which offer more possibilities for addressing the negative effects of trauma than descriptions from the cultural canon.

Keywords: Diagnoses, narrative, neuroscience, story, trauma

If you label it this, then it can't be that.

Tom Wolfe (paraphrasing Ken Kesey), *The Electric Kool-Aid Acid Test*

I crashed my car when I moved to the West Coast right after finishing up my MSW. I shouldn't have been focused on getting out to Oregon so urgently because there was a heavy snow and the roads were icing over. I was pulling a trailer behind my little Ford Escort with everything I owned tetrised inside. Just short of my final destination—50 miles to go in a 1,750 mile journey

(only 3% left!)—at the peak of a fold in the freeway along the Columbia River Gorge I looked down the highway and quietly mutter-swore as the clutter of cars all crumpled together in the depression below presented an image to my eyes and my pre-frontal cortex of a pool of metal and plastic settled into a trench. I pressed on the brake pedal with enough force to slow my descent down the frozen slope confident that I wouldn't sustain any major injuries in the imminent crash but fast enough to know with certainty that my car wasn't going to make out as well. At least two additional vehicles joined me in the basin confluence, ensuring I got it from all sides. The U-Haul trailer's feeble walls shredded, and my stuff scattered about the snowy road and blizzard wind like a sculptural Pollock interpretation.

My computer, one of the early internal hard drive consumer models, now had an external hard drive that wasn't supposed to be external. The turntable for my record player laid in the median like one of the assortments of hubcaps also present. My ten-speed street bicycle was now recumbent. I could see the cathode ray tubes from my first small color television, a high school graduation present from my parents. Both my acoustic and my electric guitars looked like Pete Townshend had taken to them. And the bright green pillow that comforted my head through six years of collegiate reading rested near the general location of where road stripes would have been if they were visible through the opacity. My car was wrecked too.

I started my professional social work career as a freshly minted 23-year-old MSW with few intact possessions. My clothes were fine. My books readable, if a bit damp. Despite their shattered cases, my stellar collection of Grateful Dead bootlegs survived. Pretty much all the rest of my things were in pieces. In my journal I wrote,

A storm raged through Ronnie's life yesterday, leaving his treasured possessions ravaged on the surface of the freeway. This unusual event had far-reaching effects.

The snow has melted away, rain and sun eroding the atmospheric residue. And I have grasped the intrinsic value of life and the impermanence from whence it comes. Not without a price, mind you. There is more to an acoustic guitar than all the screws and transistors and microchips that

make up a computer, a stereo, or a television. I'll start my work as an MSW knowing I have a clean slate.

Seventeen years later I'm sitting at the dinner table with my nine-year-old daughter and she looks worried. She thinks I'm going to die.

I haven't been well for several weeks now. I've been having a lot of difficulty chewing my food into small enough bits to swallow comfortably; fearing that I am going to choke when I swallow because it's not only my mouth that gets tired but muscles needed to swallow, prevent choking, and make sure food goes into the right part of my body and not somewhere that could lead to pneumonia or other infections.

Exhausted bulbar muscles aren't just affecting my eating. My ability to speak has been compromised. I can't form a bunch of the sounds in the English language that require strong lips: B, F, M, P, V, W. Plus my voice has been going out on me because the larynx, the so-called "voice box," is also weakened by the disorder that recently emerged in my life. When my voice starts to go out I begin sounding nasally and constricted. If I don't stop talking very soon and rest those muscles, I won't be able to speak coherently at all. My family has come to call the nasally cadence "The Nutty Professor Voice" because I sound like Jerry Lewis as Professor Julius Kelp (and clearly not Buddy Love). I now carry around a card in my wallet in case I get pulled over to let law enforcement officers know that "sometimes these symptoms are mistaken for intoxication."

So we're at the dinner table together and my daughter has buried her gaze in her food and she looks worried. I had asked a question that pushed and strained and tore through stitches in our individual and collective narratives. I knew I wasn't going to die. I read all the peer-reviewed journal articles and book chapters written about this muscle disorder (which happens to be one of the 91 muscle disorders included in the research portfolio of the Muscular Dystrophy Association, whose Labor Day telethon host for 45 years was, of course, Jerry Lewis). Yes, some people do die from this, but most don't. Probabilities that have been calculated with strong statistical significance were in my favor. *Myasthenia gravis* wasn't going to kill me.

There had been moments when I imagined this, particularly when things first started to go downhill, but I didn't think much of it when the question catapulted from my mouth. Ignited by the lightning fast internal probe of *I know I'm not going to die from this, but I wonder if she does?* and without critical reflection, pause, or insight surged the query, "Honey, are you afraid that I'm going to die?" She looked down at her food. She looked worried. And she said "Yes."

This was my first time having a death-related conversation with my kid that was clearly more immediate and experience-near than the generic discussion about organisms, entropy, death and cycles of life. This was about me. Her father. This was a chasm between the world of the everyday and the numinous or perhaps spiritual; a crevasse in the seamless story I had generated about my very self, the world in which I go on, and the relationship betwixt and between. This was a trauma to the narratives of my life, my daughter's life, my partner's life, and our collective lives together.

Trauma discourse does not have to be based on a medical, biological, pathology-oriented way of thinking about illness, disease, and disorder. It can emerge from an understanding that problems like trauma effectively operate by limiting people's authority in their own lives; that is, being the primary source for narrative authorship in one's life. People's capacities, their intentions, their hopes and dreams, how they express what they give value to, and their ability for significant achievements given difficult circumstances are occluded by dominant trauma discourse.

These days trauma is frequently conceptualized materialistically and deterministically (Supin, 2016, Nov.). I understand that trauma can be described in relation to neurological effects. This perspective can be of tremendous help in liberating people, particularly young people and parents, from the sort of blame, shame, and guilt that comes along with failed attempts at navigating life's difficulties. Defining trauma in the context of neuropathways may provide helpful interventions for people who have directly experienced trauma as well as those that care for and support them professionally and personally. Yet there is risk in totalizing trauma as electrochemical. When trauma is localized in people's brains, real social and

cultural contexts related to trauma are rendered invisible, such as patriarchy, racism, homophobia, cisgender privilege, colonialism, ableism, and classism, to name a few. These are contributing elements of power structures that lead to disproportionate incidences of trauma that involve women, people of color, people who identify as gay, lesbian, bisexual, trans, and other gender identities, Indigenous Peoples, people living with disabilities, and people without enough money to get by (e.g., Harrell, 2017; Mani, Mullainathan, Shafir, & Zhao, 2013; McIntyre, Harris, Baxter, Leske, Diminic, Gone, Hunter, & Whiteford, 2017; Roberts, Austin, Corliss, Vander-morris, & Koenen, 2010; Sacco, 2018; Williams, Metzger, Leins, & DeLapp, 2018). Trauma can certainly be understood in terms of the formation, deterioration, and reinforcement of neuropathways and the ways in which different sets of neurons fire simultaneously. But there are other options.

How do we make sense of events, whether intense and brief, or insidious and lengthy, that are located far from the everyday? The late Australian social worker Michael White (2004) described trauma as an experience or set of experiences that disconnects a person from what is known and familiar. Trauma is a subjective experience where the severity of a single event or the duration of multiple events has an individual effect. Though there are common, shared effects of trauma, the totality of effects are specific to a person. Trauma is an *exceptional* event or series of events that stand(s) outside our dominant narratives of the world, our selves, and our relationships with the world.

As language-using social beings we are constantly making meaning of the information, communication, and exchanges within which we swim. In general, it's fairly easy to make sense of so-called "everyday" events because their stories are everywhere to be found. They are embedded in historical, social, and cultural discourses (Foucault, 1982). (From a biology-based perspective, I'd say that the neuropathways for everyday experiences are well formed and firing quite regularly.) Descriptions, understandings, explanations, and sense effortlessly emerge from dominant discourse to render these experiences meaningful.

However, *everything* we experience has to be storied, including exceptional events such as trauma. Storying trauma events in ways that are consistent with existing personal narratives is extremely difficult because they are, well, *exceptional*. Jerome Bruner (1990) explained that we pull from the canonical stories of culture to make meaning when it's hard to story an experience or set of experiences. This approach to meaning-making limits other possible stories for living through trauma. People may make sense of trauma through easily accessible and readily available explanations such as, "I am not worthy," "I brought this on," "I deserve this," "I am crazy," and/or "I have PTSD."

These thin conclusions are obvious when we appreciate that the dominant, Western-European culture is filled with canons of individualism; personal responsibility; measurement, diagnosis, and scaling of normality; insurance codes; and institutional concerns of productivity, perfection, pulling yourself up, and just moving on. These narratives may offer help with making sense of traumatic experience but they overwrite stories that strengthen and protect us. People's preferences, their achievements, their values, what they stand for, and their demonstrations of resistance and resilience are subjugated despite often existing before the experience of trauma and exceptional distress. Canonical tenders of meaning for troubling events are generalized and universalized, rarely speaking to a person's particular trajectory of life and their unique experiences (Gergen, 2000). They promise to explain what's going on, sure, but not grounded in locally relevant, personal narratives (Geertz, 1973).

This understanding of trauma as a rift in the storyline of one's life and our discursive attempts to make sense of experience can explain why, though I was certainly shaken, I was not oppressed by the chattel-destroying car accident when I moved out West. I was able to story it with resilience (along with youthful pretentiousness): *I have grasped the intrinsic value of life and the impermanence from whence it comes*. The benefits I am granted via intersectional privileges helped as well (e.g., white privilege, cisgender privilege, male privilege). But when my daughter's potent and entirely reasonable fear that I would die landed on me while I was still reckoning with the

narrative turn myself, I struggled to story this exceptional set of events free from the canon of options for making sense of medical crises.

Nine years later now, when I lie down on the tray that inserts me into the CT machine to make sure the tumor that likely instigated the whole thing hasn't started to grow back, I can be flooded with intense thoughts, feelings, and memories. The canon might call this an "intrusion." I know I couldn't have prevented the muscle disorder's development...but maybe if I had only done *this*? (Eaten more kale?) Or not done *that*? (Tried pot in college?) These could be considered "distorted cognitions about the cause" of the disorder. I had problems with my concentration when there was a norovirus outbreak in local schools a few years ago and I didn't want to stay in crowds for very long because I don't want to get sick and have my immune system kick into high gear and target my neuromuscular junction while it neutralizes antigens. I am willing to go to great lengths to avoid getting sick because the last time I had a bad virus I couldn't swallow liquid without a good bit of it streaming out my nose and I sounded like Professor Julius Kelp much of the time. COVID? Oy vey. This could be understood as "avoidance." Intrusion symptoms, avoidance of stimuli, negative alterations in cognitions and mood, and marked alterations in arousal and reactivity are important criteria for a PTSD diagnosis (American Psychiatric Association, 2013). However, I don't want to make sense of my experiences using clinical criteria from the *Diagnostic and Statistical Manual of Mental Disorders*, even if it is the newest, most accurate, most evidence-based fifth edition. This canonical narrative doesn't seem to yield opportunities for me to persist in the face of adversity that are consistent with what I hold precious and my personal commitments.

Contesting essentialist understandings of trauma is in no way dismissing or minimizing the very real effects of trauma. People diagnosed with PTSD frequently experience significant distress, which can be understood in physical, emotional, psychiatric, and spiritual contexts. Many people who meet the diagnostic criteria for PTSD deal with legal and economic challenges as well (Substance Abuse and Mental Health Services

Administration, 2014). Interrogating dominant ideas about trauma is not the same as doubting people's suffering.

What I am suggesting here is that there are narratives of people's lives—ways to make meaning—that emerge from people's lived experience before, during, and after trauma. Canonical narratives can help people make meaning but usually, maybe not always, these meanings render other powerful narratives invisible. Narratives that could be helpful in overcoming the troubling effects of trauma are pushed to the margins. Simply put, the diagnosis of 309.81 does not tell me very much about a person's lived experience, their personal commitments, what is dear to them, what they stand for, and what they have achieved. I don't think it does very much to assist people in addressing the difficulties they face either.

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