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ARTIGO ORIGINAL

A INDUSTRIALIZAÇÃO DO TRAUMA PSICOLÓGICO: MEDICALIZAÇÃO, PSIQUIATRIA E COMERCIALIZAÇÃO DO SOFRIMENTO HUMANO

THE INDUSTRIALIZATION OF PSYCHOLOGICAL TRAUMA: MEDICALIZATION, PSYCHIATRIZATION, AND THE COMMODIFICATION OF HUMAN SUFFERING

LA INDUSTRIALIZACIÓN DEL TRAUMA PSICOLÓGICO: LA MEDICALIZACIÓN, LA PSIQUIATRIZACIÓN Y LA MERCANTILIZACIÓN DEL SUFRIMIENTO HUMANO

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ABSTRACT: Undoubtedly, the trauma narrative occupies a particularly prominent position within the fields of psychology and psychiatry. Dozens of specialized mental health professionals seek to relieve individuals of their traumatic past, aiming toward inner harmony and self-actualization. The therapeutic narrative surrounding the consequences of psychological trauma appears across various social domains (individual or group therapy sessions, self-actualization groups, television programs) where human suffering is presented as a structural component of the subject's very identity. Within this framework, psychological trauma is reduced to a personal experience, becomes an object of consumption, and is depoliticized. Insofar as the social causes that may give rise to it are not addressed, it is transformed into a form of spectacle, while treatment itself becomes a consumer product. This article aims to highlight the ways in which psychological trauma and human suffering are instrumentalized and commodified within the context of a neoliberal ideology.

Keywords: psychological trauma, post-traumatic stress disorder (PTSD), commodification, psychotherapy, resilience, vulnerability

RESUMO: Sem dúvida, a narrativa do trauma ocupa uma posição de destaque nos campos da Psicologia e da Psiquiatria. Profissionais de saúde mental buscam aliviar os indivíduos de seu passado traumático, promovendo harmonia interior e autorrealização. A narrativa terapêutica sobre o trauma psicológico manifesta-se em diferentes contextos sociais, como sessões de terapia, grupos de desenvolvimento pessoal e programas de televisão, nos quais o sofrimento humano é apresentado como parte constitutiva da identidade do sujeito. Nesse contexto, o trauma psicológico é reduzido a uma experiência individual, transforma-se em objeto de consumo e é despolitizado. Ao desconsiderar suas causas sociais, converte-se em espetáculo, enquanto o tratamento passa a ser comercializado como um produto. Este artigo analisa como o trauma psicológico e o sofrimento humano são instrumentalizados e mercantilizados no contexto da ideologia neoliberal.

Palavras chave: trauma psicológico, transtorno de estresse pós-traumático (TEPT), mercantilização, psicoterapia, resiliência, vulnerabilidade.

RESUMEN: Sin duda, la narrativa del trauma ocupa un lugar destacado en los campos de la Psicología y la Psiquiatría. Los profesionales de la salud mental buscan aliviar a las personas de su pasado traumático para favorecer la armonía interior y la autorrealización. La narrativa terapéutica sobre el trauma psicológico aparece en distintos ámbitos sociales, como sesiones de terapia, grupos de desarrollo personal y programas de televisión, donde el sufrimiento humano se presenta como un componente de la identidad del sujeto. En este contexto, el trauma psicológico se reduce a una experiencia individual, se convierte en un objeto de consumo y se despolitiza. Al ignorarse sus causas sociales, se transforma en un espectáculo, mientras que el tratamiento pasa a comercializarse como un producto. Este artículo analiza cómo el trauma psicológico y el sufrimiento humano son instrumentalizados y mercantilizados en el contexto de la ideología neoliberal.

Palabras clave: trauma psicológico, trastorno de estrés postraumático (TEPT), mercantilización, psicoterapia, resiliencia, vulnerabilidad.

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Introduction

Over approximately the past three decades, we have been experiencing what has been described as an epidemic of psychological trauma. Increasingly, adversities affecting not only individuals but also communities and entire populations are characterized as traumatic events, without, however, a clear definition of what truly constitutes a traumatic experience. While in the past the concept of psychological trauma referred to a limited set of events, such as rape, war, and natural disasters, since the early 1990s there has been a steadily growing tendency by mental health professionals for various everyday experiences—such as bereavement, marital difficulties, work-related stress, and sexual harassment— to be increasingly framed as traumatic. This development may, to some extent, be justified given that such events do not only negatively affect the individual but also have repercussions across multiple domains of life, potentially leading to significant dysfunctions.

As noted by Summerfield (2004, p. 65), during the 1990s references to trauma increased by nearly 20%, reaching a peak within the medical and social sciences between the 1980s and 1990s, when more than 10,000 academic articles on the subject were published (Bedard et al., 2005). Within this context, a growing industry centered on psychological suffering gradually took shape, with various branches of psychology playing a central role in its development alongside a broader shift toward increasingly individualized interpretations of human distress. In the United Kingdom, for example, the number of clinical psychologists increased by 50% from the early 2000s, while the number of registered counselling psychologists tripled (Appleby, 2003). During the same period, specialized therapists appeared focusing on individual and collective trauma and grief, along with organizations dedicated to the treatment of traumatic experience, aiming at the wisdom derived from engaging with trauma.

The American Psychological Association (2018a) defines trauma as *"any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive emotions intense enough to have a long-lasting negative effect on a person's attitudes, behavior, and other aspects of functioning."* Such a broad definition appears to expand the range of experiences that may be classified as traumatic, thereby contributing to the identification of many potential dysfunctions. Within this framework, the ideal of health and the capacity for harmonious adaptation to one's environment function as normative standards, delineating an expanding field of dysfunctions.

From this perspective, as Michel Foucault (1976, p. 22) notably argued, contemporary practices of self-care—closely linked to forms of self-observation and self-regulation—serve to reinforce the image of a sick self in need of assistance and improvement. This stands in contrast to psychological discourse itself, which, while emphasizing individuality and equating health with personal development and well-being, is simultaneously accompanied by social institutions that promote values such as health, self-help, and self-actualization, thereby contributing to the expansion of the domain of mental health problems (Illouz & Sicron, 2023, p. 77).

In summary, the above considerations point to the necessity of a critical re-examination of psychological trauma, not only as a psychological phenomenon but also as a sociocultural construct shaped by specific historical and ideological contexts. In this theoretical paper, we aim to highlight the mechanisms through which trauma is transformed into an object of consumption and therapeutic management, while also examining the role of psychologization; that is, the interpretation of social phenomena as individual psychological states and medicalization in the depoliticization of human suffering, whereby social causes are deliberately downplayed or obscured. More specifically, we explore the processes involved in the conceptual expansion of trauma, the consolidation of a mental health industry, and the implications of these

developments to understand subjectivity and the vulnerable condition of the individual in contemporary societies.

This article constitutes a theoretical and critical review of contemporary trauma discourse, drawing on interdisciplinary literature from psychology, psychiatry, sociology, and critical theory. Rather than denying the reality of traumatic suffering, the article critically examines the sociopolitical and institutional conditions through which trauma is currently conceptualized, classified, and managed.

Medicalization and Psychiatrization of Psychological Trauma

The Concept of Medicalization and Psychiatrization

The term medicalization was introduced by Illich (1976, p. 34) in Medical Nemesis, where he defined it as the incorporation of human problems into the domain of medical authority, defined exclusively in medical terms and placed under the supervision of health professionals.

Closely related to medicalization is the concept of psychiatrization, which refers to a range of sociocultural processes through which psychiatric knowledge, classifications, and interventions increasingly shape the interpretation and management of human experiences and behaviors. As noted by Beeker et al. (2021, p. 45), the psychiatrization of everyday behaviors does not only concern the rising global rates of mental disorders, but also the increasing prevalence of overdiagnosis, the overprescription of psychiatric medications, and the expansion of mental health professionals who emerge to address each identified disorder.

The Conceptual Expansion (Concept Creep) of Psychological Constructs

A particularly illuminating concept in relation to psychiatrization, first introduced by Haslam (2016), is that of concept creep. It refers to the expansion of concepts associated with harm-related states such as abuse, trauma, addiction, mental disorders, and prejudice, thereby pathologizing human experiences and reinforcing processes of victimization. Over the past decades, these psychological concepts have undergone significant semantic shifts, often coming to encompass an increasingly broad range of psychological phenomena.

This expansion occurs in two dimensions. On the one hand, there is a horizontal expansion, whereby qualitatively new behaviors are incorporated. On the other hand, there is a vertical expansion, whereby less extreme, quantitatively milder phenomena are included.

For example, over time, the concept of bullying has expanded horizontally to include adult behaviors within workplace settings. It has also expanded vertically to encompass less severe forms of conduct that do not necessarily involve repeated occurrences or clear intentionality and may occur between individuals occupying similar positions within social hierarchies. At the same time, the notion of abuse has been broadened to include emotional components alongside physical harm, extending even to acts of omission and neglect.

Similarly, the concept of addiction has expanded beyond substance dependence to include so-called behavioral addictions, such as compulsive shopping, gambling, and sexual behavior. Notably, a study by Vylomova et al. (2019) analyzing 800,000 articles across 875 psychology journals between 1970 and 2019, identified not only an increase in the use of such concepts but also significant semantic shifts. These findings are further reflected in contemporary social media discourse where trauma-related content has become increasingly prevalent (O'Connor et al., 2025).

The Expansion of the Concept of Trauma

The expansion of trauma from physical to psychological conditions emerged in the late 19th century and constitutes an example of horizontal expansion, whereby the meaning of a concept extends outward to encompass qualitatively new domains. By contrast, certain developments in the concept of trauma represent instances of vertical expansion, in which the semantic broadening is primarily quantitative (Haslam & McGrath, 2020, p. 513). Two such semantic shifts in the psychiatric definition of trauma illustrate this vertical form of conceptual change, particularly in relation to post-traumatic stress disorder (PTSD), as defined across successive editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). First, the range of events classified as traumatic was expanded; second, the requirement that such events be exceptional or outside ordinary human experience was removed.

The medicalization of human suffering finds one of its most complete expressions within the trauma narrative. In Western societies, trauma has become a generalized reference point, as the term is now ubiquitous and increasingly framed as a disorder; that is, as a pathological condition requiring professional intervention. This reflects a form of medical expansionism, whereby everyday human problems are medicalized, and new disorders are constructed and promoted in order to justify corresponding pharmaceutical treatments.

As Hacking (1995) notably argues, through the concept of social looping which describes a feedback mechanism the scientific classification of a mental disorder (e.g., trauma, schizophrenia, Attention-Deficit/Hyperactivity Disorder/ADHD) not only sustains a sense of deficit in individuals but also exerts a powerful influence on their behavior, leading them to adopt corresponding patterns of conduct and expectations in their everyday lives.

It is widely acknowledged that the more frequently a term is used, the more meanings it tends to acquire. As a result, intensified usage contributes to the ongoing reproduction and expansion of concepts. Studies employing computational linguistics confirm both the increasing frequency of the term trauma in textual corpora and the expansion of its semantic range (Hamilton et al., 2016). According to Hacking (1995, p. 376), theoretical concepts are not fixed but evolve in response to social and scientific developments.

Indeed, contemporary understandings of trauma have expanded even further to include experiences such as infidelity, sarcastic remarks, academic difficulties, and distressing childbirth experiences, among others. Similarly, Vylomova et al. (2019) found that from the 1980s to 2010, trauma became increasingly associated with psychological and sexual stress rather than physical injury, reflecting its growing semantic expansion within psychiatry and psychology.

Historical Formation of Psychological Trauma

Early Theoretical Approaches (Charcot, Freud, Janet)

Scientific interest in understanding and analyzing trauma began to take shape in the late 19th century, primarily through the work of Jean-Martin Charcot, Pierre Janet, and Sigmund Freud (Jones & Cureton, 2014). Charcot was the first to describe what was then an incomprehensible disorder, which he termed hysteria, and he employed hypnosis, a pioneering technique. One of his patients, a former soldier, suffered from recurrent nightmares related to his wartime experiences, despite many years having passed. Charcot introduced new diagnostic terms, such as traumatic neurosis and hysterical trauma, concluding that accidents or war could trigger symptoms in individuals with a hereditary predisposition.

Freud linked psychological trauma, particularly sexual trauma, to the etiology of hysteria and defined trauma as a disruption of psychic equilibrium, resulting from a psychological rupture following intense emotional excitation (Herman, 1992, p. 45). Later, within the framework of ego psychology, he described

the ego as helpless and overwhelmed when unable to cope effectively with internal and external pressures. In Freudian theory, trauma thus incorporates both real and imagined elements (e.g., loss of the object). Psychoanalytic perspectives dominated the study of trauma from the late 19th to the early 20th century.

From War Trauma (Shell Shock, Combat Neurosis) to Society (Feminist Movement, etc.)

In the 19th century in Great Britain, a form of traumatic neurosis was described among factory workers and railway passengers following accidents. Although their physical injuries had healed, they continued to report headaches, spinal pain, and psychological distress. Around 1900, physicians attributed these symptoms to physical causes—specifically, spinal disorders and nerve damage (railway spine)—while often dismissing survivors' complaints as motivated by financial compensation claims against factories and railway companies (Lerner, 2003, p. 18).

During World War I, systematic research on traumatic stress began, primarily with the aim of rehabilitating soldiers so that they could return to the battlefield (van der Kolk, 2007, p. 21). Although interest declined during peacetime, it resurfaced during the Vietnam War (Jones & Cureton, 2014). At the time, physicians initially paid little attention to traumatic neurosis as participation in war was considered a military duty. However, shortly thereafter, the concept of "shell shock" emerged, introduced by the British psychologist Charles Samuel Myers (1919). He described a syndrome observed in soldiers exposed to prolonged bombardment, characterized by hysterical symptoms such as impaired reasoning, difficulty walking, sleep disturbances, and inability to flee; symptoms similar to those previously documented by Freud and Charcot.

Several decades later, Abram Kardiner and Herbert Spiegel (1947) examined what was termed "combat neurosis" from a psychoanalytic perspective, laying the groundwork for the concept of traumatic syndrome. At that time, it was widely believed that this condition occurred primarily among frontline soldiers, and rarely among those with limited exposure to combat (Lerner, 2003, p. 165). Accordingly, soldiers who survived such distressing experiences without physical injury were thought to be unable to assimilate these terrifying events.

During World War II, although it was acknowledged that extreme stress could disrupt even the healthiest personality, the prevailing view during wartime was that those who collapsed in battle were psychopathic, defective, or constitutionally unstable (Sargant & Slater, 1944, p. 43). Within this context, the Vietnam War drew the attention of psychiatrists who introduced therapeutic group settings, allowing soldiers to share their experiences in a safe environment. By the 1970s, these groups had expanded across the United States attracting significant research interest.

At the same time, alongside the rise of the feminist movement, activism and protests emerged against domestic violence. Women reported experiencing emotions like those of soldiers in war, thereby expanding the discourse on trauma beyond the battlefield (Herman, 1992, p. 59).

Contemporary Theoretical Approaches to Trauma

Caruth (1996, p. 27), in Unclaimed Experience, argues that trauma is difficult to fully comprehend at the moment of its occurrence, but gradually becomes intelligible through its repetitive manifestation. She suggests that trauma negatively affects an individual's capacity to process experiences in real time, leading to fragmented and disjointed narratives. She further emphasizes that trauma is characterized by delayed awareness, noting that individuals may not fully grasp the impact of their experiences for an extended period.

From a different perspective, Jenny Edkins (2006, p. 107) conceptualizes trauma as "a response to a shocking encounter with brutality and/or death" arguing that traumatic events belong to a category of experiences that resist meaning-making.

From the field of neuroscience, Bessel van der Kolk maintains that trauma is not merely a past memory, but an experience inscribed in the body altering brain structure and shaping how individuals perceive themselves and others. He advocates individual coping strategies such as neurofeedback, yoga, mindfulness, and the use of psychedelics. He also introduced the concept of Developmental Trauma Disorder (van der Kolk, 2007).

Similarly, Gabor Maté argues that society itself is traumatogenic and responsible for the emergence and increase of mental disorders, as trauma generates a pervasive sense of alienation (Maté & Maté, 2022).

Trauma, Violence, and Sociopolitical Dimensions

The Individualization of Trauma and the Depoliticization of Violence

Psychological and psychiatric discourse is grounded in an individualistic framework, emphasizing the traumatic event while shifting attention away from perpetrators and toward victims. In this way, trauma is approached unilaterally, detached from its structural determinants, and reduced to an individual dimension with particular emphasis on vulnerability. Such approaches ultimately lead to the depoliticization and medicalization of neoliberal policies addressing trauma (Johnstone, 2017; Tseris, 2019).

However, the root of the problem does not lie within the individual but within the structural, social, cultural, and economic conditions that generate traumatic experiences. In contrast to the dominant biomedical model which obscures the underlying causes of trauma by focusing exclusively on the individual and its consequences, it is necessary to foreground the social context in which violence is produced.

Moreover, the term trauma tends to neutralize human experiences insofar as it is not explicitly linked to social inequality, poverty, racial discrimination, or power relations, but rather focuses on isolated abusive events. Within this framework, it may be more appropriate to shift from the abstract notion of psychological trauma to concepts such as adversities and hardships, which more accurately reflect the lived realities of individuals affected by structural inequalities and discrimination.

In this regard, the contribution of Frantz Fanon is particularly significant, as he examined the relationship between power structures and psychopathology, including trauma. Mental health, trauma, and power are deeply interconnected; without understanding these dimensions, it is impossible to adequately address psychological distress. Fanon strongly opposed the imposition of Western psychiatric frameworks onto diverse sociopolitical and cultural contexts, arguing that modern psychiatry is a product of specific historical, economic, and epistemological developments in Europe and North America. A defining feature of Western psychiatry, according to Fanon, is its neglect of sociocultural factors and its tendency to pathologize normal responses to oppression and violence (Fanon, 1952, p. 9).

The Commodification of Psychological Trauma

The Concept of Resilience

By labeling individuals as vulnerable or psychologically fragile in response to traumatic events, conditions are created for the commodification and expansion of psychological suffering across various domains, including parenting, childhood, and mood. Human trauma, often rooted in social inequality and violence, is reduced to an individual condition, while therapeutic approaches offer individualized, technical interpretations of traumatic experiences (e.g., vulnerability frameworks).

The culture of resilience is actively promoted through media, self-help literature, and wellness applications, constructing an ideal personality that is expected to remain resilient under all circumstances. From a Foucauldian perspective, concepts such as vulnerability and resilience function as mechanisms of self-surveillance, regulating individual behavior within contemporary society. The mental health system through its dichotomies of healthy/unhealthy and vulnerable/resilient operates as a key institution of social control. Within neoliberalism, it reinforces individualization, competitiveness, and consumerism at the expense of social bonds, solidarity, and collective well-being. Moreover, it functions as an ideological apparatus that normalizes ongoing forms of oppression through a dominant or hegemonic psychiatric discourse (Cohen, 2016, p. 50).

At the same time, clinical psychology and psychiatry establish norms for acceptable behavior, defining what counts as psychopathological or vulnerable. Psychological resilience and recovery from adversity are often linked to so-called protective factors, such as positive emotions (Tugade & Fredrickson, 2004), extraversion (Campbell-Sills et al., 2006), self-efficacy (Gu & Day, 2007), spirituality (Bogar & Hulse-Killacky, 2006), self-esteem (Kidd & Shahar, 2008), and positive affect (Zautra et al., 2005). Within this framework, diagnostic classifications decontextualize individuals' problems and subsequently reframe them as disorders.

Traumatic experiences are thus evaluated primarily in terms of an individual's inability to function adequately at psychological, physical, and social levels. Following the introduction of PTSD in the DSM-III by the American Psychiatric Association, the concept of vulnerability came to dominate psychological research and practice (Bonanno et al., 2010).

Individuals typically encounter a wide range of challenges throughout their lives, ranging from everyday difficulties to severe life events. Responses to trauma vary significantly and depend on factors such as age, pre-existing resilience, prior experiences, ongoing stressors, available social support networks, and family history of trauma. There is considerable heterogeneity in longitudinal stress responses (Norris et al., 2009) and severe manifestations are observed only in a minority of exposed individuals (Bonanno et al., 2010).

Under normal conditions, traumatic life events do not necessarily lead to psychological or social breakdown. Rather, they often result in a range of responses, most of which are adaptive. Most researchers agree that resilience is demonstrated when both adversity and positive adaptation are present (Fletcher & Sarkar, 2013). For example, the resilience shown by New York citizens following the events of September 11 attacks surprised many contemporary trauma researchers, who had predicted widespread PTSD among the population (Marshall, 2006).

Resilience as a Neoliberal Ideal

Within contemporary social conditions, public health increasingly focuses on how individuals can develop and sustain resilience. Commodification refers to the process through which goods and ideas acquire exchange value and become marketable. In this context, resilience and mental health can be understood as commodities as their acquisition promises a better life.

Commodification reinforces hierarchical relationships between patients and psychiatrists. Sami Timimi (2025, p. 88) argues that perceived failure is attributed to internal, personal deficits, thereby necessitating professional intervention to correct these internal dysfunctions. Psychiatric practice continues to prioritize this pathogenic perspective rather than adopting a holistic approach, disconnecting individuals from their inherent capacities to cope with adversity.

By categorizing emotional and behavioral responses and attributing labels such as vulnerability and dysfunction, these classifications become commodified within the free market (Timimi, 2014). This

commodification encompasses a wide array of products and services, including specialized professionals, therapeutic techniques (e.g., medication, psychotherapy), books, and training programs. Within this logic, commodities offer only temporary satisfaction, necessitating continuous consumption. Consequently, concepts such as resilience create demand by persuading consumers that appropriate solutions exist and that failure to address personal trauma may result in deterioration. Consumer culture thus generates psychological distress which in turn becomes a growing market for exploitation and profit (Timimi, 2025, p. 102).

When resilience is framed narrowly within individual boundaries, broader sociopolitical contexts are overlooked. Access to and availability of health-related resources such as education and employment are frequently neglected, reinforcing the dominance of individual-level intervention strategies. For example, the American Psychological Association (2020) recommends strategies such as reframing crises, accepting change, pursuing goals, taking decisive action, fostering self-awareness, and maintaining a positive self-image.

These recommendations reflect a neoliberal ideology that places responsibility on individuals to modify their attitudes and behaviors in order to achieve success. In Western societies, the autonomous, self-directed individual striving for personal improvement is highly valued, and individuals are held accountable for their life trajectories (Carver & Connor-Smith, 2010; Morling & Fiske, 1999). This dynamic contributes to the proliferation of diagnostic categories, thereby creating profitable markets for pharmaceutical companies and psychotherapeutic services.

The Industrialization of Mental Health

Mental well-being and resilience are closely linked to social and economic determinants. Empirical evidence indicates that greater inequality in economic and social resources is associated with poorer mental health outcomes at the societal level (Pickett et al., 2006; Wilkinson & Pickett, 2010). In a comprehensive review, Hatch and Dohrenwend (2007) found that individuals from lower socioeconomic backgrounds, ethnic minorities, and younger populations are disproportionately exposed to stressful and traumatic events with significant health consequences.

Social inequality negatively affects individuals' capacity to mobilize social, economic, and psychological resources, as well as their ability to influence their environment over the life course (Ferraro & Shippee, 2009). Hobfoll (2011, p. 141-142) emphasizes that access to social support is contingent upon power and status. Those lacking privilege are subject to discrimination and exclusion regardless of their behavior with social status ultimately determining inclusion.

Accordingly, resilience should be understood as a product of cultural, social, economic, political, and psychological factors, as well as social inequalities related to gender, socioeconomic status, ethnicity, and other variables (Schwarz, 2013, p. 312). It should also be linked to participation in public and private life, labor markets, income distribution, and overall well-being. Conceptions of resilience must therefore be grounded in human rights, policy frameworks, and socioeconomic realities, moving beyond individual responsibility toward the structural integration of individuals within society.

Post-Traumatic Stress Disorder as a Social Construct

The Emergence and Development of Post-Traumatic Stress Disorder (Vietnam)

The 1960s was marked as a period of political unrest and growing dissatisfaction with American military involvement in Vietnam. During this time, a group of psychiatrists and Vietnam War veterans collaborated to propose a new framework for understanding the psychological consequences of war and

trauma. Many veterans experienced chronic distress, depression, alcoholism, and social instability upon returning home, leading them to conclude that they were suffering from a distinct mental condition associated with their wartime experiences.

They formed self-help groups to promote the concept of the post-Vietnam syndrome and disseminate it among other veterans. This term functioned as an umbrella concept encompassing a wide range of psychological distress manifestations.

Inclusion in DSM and Subsequent Transformations

At the same time, a major revision of the DSM was underway by the American Psychiatric Association. Contributors to the manual actively sought testimonies from veterans to substantiate the psychological characteristics of this proposed disorder.

Veterans advocated for the inclusion of PTSD in the DSM not because they were eager to have their experiences medicalized, but because they sought formal recognition of the suffering they had endured during the war. The cost of this recognition, however, was the classification of their experiences as a mental disorder (Kutchins & Kirk, 1997, p. 125).

PTSD was officially introduced in the DSM-III (American Psychiatric Association, 1980). Earlier editions had conceptualized stress reactions as transient conditions implying that symptoms would subside once the stressor was removed (Yehuda & Bierer, 2009). In contrast, DSM-III defined trauma as an event outside the range of usual human experience (American Psychiatric Association, 1980, p. 236).

Although Vietnam veterans pushed for a clear etiological link between trauma and the disorder, DSM-III ultimately detached PTSD from any specific cause. As a result, PTSD became an individualized and depoliticized diagnosis. As Neale (2001, p. 287) notes, veterans' experiences were never connected to the political motivations of the war but were instead attributed to the individuals themselves. Moreover, treatment centers were largely government-run, making it politically expedient to assign responsibility to individuals rather than to state policies.

Subsequent revisions in DSM-IV and DSM-IV-TR expanded the scope of PTSD to include victims of various forms of violence, such as road accidents, natural disasters, and even life stressors like divorce (American Psychiatric Association, 1994, 2000). This shift was not driven by purely scientific developments but by pressures from influential institutional groups resulting in a 59% increase in trauma-related diagnoses (Breslau & Kessler, 2001).

DSM-5 defines a traumatic event as exposure to threatened death, serious injury, or sexual violence (Benjet et al., 2015), either directly or indirectly, including through learning about such events affecting close others (American Psychiatric Association, 2013). According to Galatzer-Levy (2013), more than 600,000 symptom combinations could meet DSM-5 criteria for PTSD, highlighting its heterogeneity. Similarly, Bryant et al. (2023) concluded that PTSD does not constitute a single, unified disorder. Nonetheless, the categorical models used in diagnostic manuals fail to capture the complexity and variability of human responses (Clark et al., 2017).

Depoliticization Through Diagnosis

PTSD is not necessarily associated with functional impairment. Individuals may experience distress while still fulfilling their roles as parents, partners, workers, and citizens (Hobfoll, 2011, p. 128).

Dissociation, often labeled a symptom of PTSD, has been described as the essence of trauma (van der Kolk, 2014, p. 66). Dillon et al. (2012) emphasize its protective function enabling psychological distancing from traumatic experiences. In this sense, such responses are not merely pathological symptoms but adaptive survival strategies.

Research by De Vries and Olff (2009) found that 80% of the general population in the Netherlands reported at least one traumatic event (e.g., bereavement, chronic illness, miscarriage, job loss), yet the majority did not develop PTSD.

Summerfield (2001) argued that PTSD emerged not from a purely medical framework but from a political context in which returning Vietnam veterans sought to position themselves as victims rather than perpetrators of violence imposed by military structures. He further noted that in Western societies, PTSD became a widely adopted diagnosis emphasizing individual victimhood, medicalized pathology, and compensation claims, thus reflecting specific cultural and ideological assumptions.

Critique of the Validity and Universality of PTSD

The relationship between culture and trauma is crucial, as responses to traumatic events are shaped by culturally specific systems of meaning. Contemporary PTSD symptomatology differs significantly from earlier constructs such as shell shock.

Empirical research has identified diverse trauma typologies including natural disasters, domestic violence, child abuse, and sexual assault (Agaibi & Wilson, 2005; Wilson & Lindy, 1994). Hinton and Good (2016) highlight cultural variations in trauma responses and the limitations of applying Western diagnostic criteria to non-Western populations.

Cross-cultural studies (Mbiti, 1990; Mugumbate et al., 2024) show that in collectivist societies, community dynamics significantly shape individuals' responses to trauma in contrast to more individualistic contexts.

For example, in many African contexts, perceptions of fate and mental health are deeply embedded in communal relationships (Ubuntu philosophy). In North Korea, trauma severity is more strongly correlated to witnessing harm to family members than to personal victimization (Jeon et al., 2005). Following Hurricane Andrew in Florida, Latino populations were more affected than non-Latino groups due to prior experiences of displacement (Perilla et al., 2002). In Buddhist frameworks, post-traumatic distress may be interpreted as an opportunity for enlightenment and detachment from ego-centered perspectives (Timimi, 2025). Survivors of the Rwandan genocide identified the inability to bury relatives as a profoundly traumatic experience due to spiritual beliefs (Hagengimana & Hinton, 2020).

Similarly, Tibetan refugees reported religious persecution as more traumatic than imprisonment or torture (Sachs et al., 2008). Mollica et al. (1998) found that 90% of Vietnamese refugees with torture histories met PTSD criteria. However, notably, 79% of the control group without such histories also met the said criteria, raising questions about diagnostic specificity.

Summerfield (2004) studied 800 Nicaraguan refugees in the UK and found that although many met PTSD criteria, they were functionally active, emotionally stable, and capable of adapting to new environments suggesting that distress does not necessarily equate to pathology.

These findings illustrate that the medicalization of war-related experiences represents a reductionist approach that isolates the individual while ignoring broader sociopolitical contexts. Despite its global diffusion, PTSD remains rooted in Western, individualistic conceptualizations of trauma.

Loughrey (1997) noted the limited role of psychiatric services during the Northern Ireland conflict, while Rose et al. (1998) found insufficient evidence that counseling improves outcomes compared to no intervention. More recent research (Leichsenring et al., 2022) reports minimal therapeutic effects with other estimates placing effectiveness at 15–25% (Drury, 2014).

Moynihan and Henry (2002) argue that humanitarian interventions often reframe war trauma as a technical issue of individual psychological regulation, rather than addressing its structural causes.

Controversies and Empirical Challenges

In 1983, the U.S. Congress commissioned the *National Vietnam Veterans Readjustment Study*, which reported that in 1988, 479,000 out of 3.14 million Vietnam veterans still had PTSD diagnoses approximately 15 years after the war (Kulka et al., 1990). It is also estimated that 30.9% experienced PTSD at some point. These figures were widely contested as implausibly high given that only around 300,000 soldiers had served in combat roles (Shephard, 2000).

Southwick et al. (1977) found that veterans' recollections of combat experiences changed over time with later accounts often amplifying perceived severity. These evolving memories were associated with increased reporting of PTSD symptoms.

Further controversy arose with *Stolen Valor* (Burkett & Whitley, 1998), which suggested that many individuals claiming Vietnam-related PTSD had neither served in combat nor in the military at all. Frueh et al. (2005) similarly found discrepancies between reported trauma exposure and military records.

Finally, a study at the National Center for PTSD in West Haven, Connecticut (Fontana & Rosenheck, 1997) found that intensive inpatient treatment for chronic PTSD in Vietnam veterans did not produce lasting benefits. Although patients reported short-term improvements, follow-up data after 18 months indicated worsening psychiatric symptoms, increased substance abuse, and higher rates of suicide attempts.

Psychotherapy and the Neoliberal Management of Trauma

The Proliferation of Psychotherapies

Over the past several decades, there has been a marked proliferation of psychotherapeutic approaches and techniques emerging in response to the steadily increasing burden of mental health problems. Online psychotherapy, in particular, expanded significantly during and after the COVID-19 pandemic; a trend also documented in recent research (Sjöblom et al., 2025). The underlying driver of this expansion can be traced to the core tenets of neoliberal ideology, which emphasize the optimization and commodification of human capacities, individual initiative, and a focus on the individual as the primary unit of well-being, success, and happiness.

Within this framework, contemporary socioeconomic conditions may contribute significantly to psychological distress and subsequently construct mechanisms for its resolution. Any deficit or shortcoming is thus attributed to the individual, who is held responsible for a perceived lack of self-care, while deviations from normative functioning are pathologized. Accordingly, the growing emphasis on the concept of the self and, by extension, on notions such as self-efficacy, self-care, and self-awareness has emerged gradually yet persistently within the field of psychology.

The Hegemony of Cognitive Behavioral Therapy

It is widely acknowledged that more than 500 forms of psychotherapy exist, with Cognitive Behavioral Therapy (CBT) occupying a dominant position within the field. CBT effectively appropriates the full spectrum of human difficulties and is frequently promoted, often in conjunction with positive psychology, as a pathway to happiness. It is commonly recommended as the treatment of choice across a wide range of conditions, also recommended by official governmental bodies (National Institute for Health and Care Excellence, 2018).

CBT emerged in the 1970s; a period marked by increasing individualism and consumerism. Prior to this, psychoanalysis largely monopolized the psychotherapeutic domain with most psychiatrists in the United States during the 1960s and 1970s adhering to psychoanalytic orientations. However, the high cost, long duration, and inward focus of psychoanalytic treatment, often excluding broader socio-environmental factors, gradually paved the way for the rise of cognitive approaches. As Dalal (2018, p. 34) notes,

"according to this mythology, the field of psychological research was barren of scientific grounding—in other words, it was psychologica nullius." CBT emerged to fill this perceived void.

Critique of Effectiveness

The American psychological community has developed registries of empirically supported treatments within which CBT occupies a leading position. Nevertheless, many therapeutic approaches are excluded from these lists not due to ineffectiveness, but because they do not participate in what has been described as a game of power (Foucault, 1980, p. 298). Grounded in a positivist epistemology, CBT focuses primarily on aspects of human behavior that are observable, measurable, and quantifiable resulting in a reductionist and one-dimensional framework.

The widespread dissemination and acceptance of CBT is less attributable to its superior outcomes and more to its adaptability across diverse institutional contexts (e.g., healthcare systems, schools, correctional facilities). Its appeal has also been linked to its relatively low cost and its capacity to produce rapid, observable changes. However, claims regarding its superior effectiveness have been challenged with evidence suggesting that its apparent advantage may stem largely from its stronger capacity for outcome measurement compared to other therapeutic modalities (Cuijpers et al., 2010).

Psychotherapy as a Mechanism of Adaptation

CBT employs a range of techniques, including emotional regulation, gradual exposure, desensitization, Eye Movement Desensitization and Reprocessing (EMDR), relaxation strategies, and cognitive restructuring across a broad spectrum of psychological difficulties, often irrespective of their nature. These techniques are applied in a "one-size-fits-all" manner, extending even to domains such as trauma, autism, ADHD, and social attitudes (e.g., homophobia). From a critical perspective, contemporary CBT has been described as increasingly expanding its explanatory framework across a broad range of human difficulties, often reframing them within medicalized and diagnostic categories.

While CBT incorporates valuable elements such as the critical examination of negative cognitions, it largely reinforces the biomedical model, often minimizing the role of social determinants in the development of psychological distress. It does not primarily address why individuals have been exposed to adverse experiences (e.g., rape, war, poverty, unemployment, eviction) but rather focuses on modifying maladaptive cognitive schemas in order to facilitate adaptation to existing social conditions.

In this framework, difficulties in coping with traumatic experiences are interpreted as deficits in internal cognitive regulation. CBT thus aims to teach individuals how to alter their beliefs about traumatic events, even when external conditions remain unchanged.

Combined with EMDR, one of the most widely used trauma-focused techniques, CBT seeks to process traumatic memories and reduce emotional distress. However, such approaches often fail to adequately address the relational and emotional dimensions of trauma (Cuijpers et al., 2019) as well as its developmental trajectory (Athanasiadou-Lewis, 2019; Fonagy, 2018, p. 158). They also tend to overlook the fact that thoughts, emotions, and behaviors are not merely products of the individual mind but emerge through relational processes within dyads, groups, and communities. Moreover, the distinction between cognition and emotion is not universally applicable across cultural contexts (Cromby, 2015, p. 73).

Trauma-focused CBT emphasizes psychoeducation, the modification of dysfunctional schemas, reduction of avoidance, exposure to traumatic stimuli, cognitive restructuring, and emotional regulation skills. A recent systematic review and meta-analysis (Rowe-Johnson et al., 2025) found only a moderate statistically significant effect in reducing PTSD symptoms. Other studies reporting positive outcomes (Kelly et al., 2022; Loftus et al., 2024) are limited by small sample sizes, lack of long-term follow-up, and high dropout rates in general populations.

In a meta-analysis comparing CBT with other therapies, Wampold et al. (2017) identified methodological shortcomings in earlier studies and reported non-significant differences in effectiveness. Similarly, Shedler (2011, p. 54) found no evidence of CBT's superiority, while Holmes (2002, p. 228) argued that its perceived advantage is superficial rather than substantive.

Current evidence does not consistently demonstrate the superiority of CBT over other psychotherapeutic approaches. Research consistently indicates that therapeutic outcomes are less influenced by specific techniques and more influenced by common factors such as therapist characteristics, the therapeutic relationship, alliance, and empathy (Timimi, 2025, p. 223; Wampold, 2015, p. 39). The National Institute for Health and Care Excellence (2009) has also noted that brief psychotherapies may, in some cases, elicit intense and potentially harmful emotional responses.

Castonguay and Beutler (2005, p. 358) emphasize that "factors external to the therapy itself exert the greatest impact on outcomes"; particularly, the therapeutic alliance as perceived by the patient, while the specific treatment model plays a comparatively minor role. This relationship between alliance and outcome appears robust across therapeutic approaches and clinical conditions.

Longmore and Worrell (2007) report limited evidence supporting CBT's effectiveness, while Strauss et al. (2021) document significant adverse effects, including distressing memories (57.8%), negative emotions (30.3%), and a perceived lack of understanding by the therapist or of the treatment (19.3% / 18.4%). Additional studies indicate minimal improvement among young individuals (aged 12–25) with trauma, depression, and anxiety (Peters et al., 2022).

In the United Kingdom, the Improving Access to Psychological Therapies (IAPT) program was introduced in 2007 to expand access to psychological treatments for anxiety, depression, and trauma-related difficulties associated with long-term unemployment. CBT was central to this initiative with plans to train over 10,000 new therapists (Layard & Centre for Economic Performance Mental Health Policy Group, 2006, p. 13). The program aimed to facilitate individuals' return to work, thereby reducing welfare expenditures and improving economic productivity.

However, this approach reflects a mechanistic understanding of mental health, prioritizing adaptation to existing labor conditions rather than addressing the structural causes of distress. A ten-year meta-analysis of the program found that only approximately 50% of the 900,000 service users derived any benefit despite a total cost of £4 billion (Scott, 2021). Furthermore, other research indicates that only 15% experienced short-term benefits with no evidence of sustained long-term improvement (Callan & Fry, 2012).

Conclusions

By focusing exclusively on individuals' subjective interpretations of traumatic experiences, the broader social, cultural, and political determinants of those experiences are systematically overlooked. Human beings are not abstract, decontextualized entities but inherently social actors; therefore, patterns of thought, emotion, and behavior cannot be adequately understood through Westernized biomedical models alone but must instead be grounded in values and sociocultural contexts. The meanings attributed to traumatic experiences are constructed through social relations within specific cultural environments. Consequently, their analysis should not be confined to the individual level but must extend to encompass wider structures of power, inequality, and injustice.

Traumatic experiences may be more effectively addressed through interpersonal and social relationships, as well as through engagement with the broader community, fostering collective awareness

and action. Social responses to trauma can provide survivors with alternative sources of empowerment. Human reactions to traumatic events should not be reduced to standardized symptoms but should rather be understood as adaptive efforts aimed at survival and protection in the face of adversity. Moreover, traumatic events are not the sole determinants of psychological distress; structural conditions such as poverty, unemployment, gender inequality, and racial discrimination are equally significant contributors.

The expansion of therapeutic techniques that target trauma at the individual level risks obscuring the underlying causes of psychological suffering, particularly within the context of increasingly fragmented subjectivities in contemporary societies. As a result, attempting to address the individual may occur at the expense of addressing the broader structural and socioeconomic conditions that contribute to psychological distress, including increasingly precarious contemporary living conditions.

Mental health professionals should remain vigilant against reproducing and reinforcing the dynamics of a self-perpetuating neoliberal system. This entails critically reflecting on professional roles that may position mental health practitioners within increasingly commodified and market-oriented systems of care.

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