INTRODUCTION

A New Language of the Event

IN THE DAYS FOLLOWING the attacks on the World Trade Center in New York on September 11, 2001, an estimated nine thousand mental health specialists, including seven hundred psychiatrists, intervened to offer psychological support to survivors, witnesses, and local residents.[1] One month later, a New York Academy of Medicine survey of one thousand people living in southern Manhattan revealed 7.5% of respondents suffering from post-traumatic stress and 9.7% from depression, an increase in the consumption of psychotropic drugs and alcohol, and an unusually high level of recourse to mental health services. But these phenomena were observed mainly in the white university-educated population.[2] Soon afterward another survey, of a larger sample representative of the US population as a whole, showed 4% of Americans suffering from post-traumatic stress—which, it emerged, was the same percentage as would be statistically predicted in the general US population, regardless of the events in New York. In other words, there appeared to be a sort of background level of trauma that was not greatly altered by the attacks. However, the proportion was higher among those who had had prolonged exposure to television coverage of the attacks on the Twin Towers.[3] During this period a number of professional Web sites were set up or modified to respond to the demand for psychological support. Some three years after the attacks, an electronic search using the keywords "September 11" and "trauma" produced nearly 1.5 million results on the Web.[4] The US

[1] See the article by Richard Gist and Grant Devilly in *The Lancet* (2002) and that by Matthew Dougherty on the Columbia University Health Sciences' Web site (http://www.cumc.columbia.edu/news/in-vivo, accessed April 25, 2005).

[2] Sandro Galea et al. (2002) and Joseph Boscarino et al. (2004). In the *New England Journal of Medicine,* Galea et al. note, "Posttraumatic stress disorder and depression are the two most commonly studied mental health problems after trauma and disasters." In *Psychiatric Services,* Boscarino et al. remark that "the racial and ethnic disparities in post-disaster mental health service use that we found were surprising, because free counselling services were available in New York City after the attack." They note that African-American and Hispanic respondents to their survey had consulted mental health services only half as often as white respondents, even when they exhibited signs of post-traumatic stress.

[3] W. E. Schlenger et al. (2002). While the figures for the population of New York were higher than the national average, paradoxically those for Washington DC were lower.

[4] A Google search using keywords "trauma" and "September 11" made on April 25, 2005, yielded 1,470,000 results. The results included http://www.traumaresponse.org (with

political establishment was also quick to seize on the attacks—not only, as has been widely noted, to reinforce its international authority through a security structure set up by George W. Bush and Secretary of State Donald Rumsfeld, but also for the less widely remarked purpose of establishing its legitimacy within the United States, founded on its expression of empathy and reassurance. When, in December 2002, the Foundation for Psychocultural Research organized a major conference on post-traumatic stress disorder (PTSD) in Los Angeles, it naturally turned to Rudolph Giuliani, the former mayor of New York who was acclaimed for his management of the crisis, to give the opening address.[5] Thus, psychologists treating victims of the tragedy and epidemiologists gathering statistics on its psychological consequences, Web designers and politicians were all coming to a similar conclusion: both survivors and witnesses, but also television viewers and residents of the United States in general were suffering from exposure to a traumatic event, the effects of which were to be dealt with mainly by psychiatric care.

Of all the possible consequences of the attacks on individuals—aside, of course, from the thousands who died—it is thus the psychological impact that emerges as the clearest, most lasting, and most incontrovertible: after the mourning, the trauma remains. The term "trauma" should, moreover, be understood here both in the restricted sense in which it is used in the mental health field (the traces left in the psyche) and in its more widespread, popular usage (an open wound in the collective memory), for the trauma affects both New Yorkers and the United States as a whole, both individuals and a nation. From the literal sense in which the term is used by psychiatrists (a psychological shock) to its metaphorical extension disseminated by the media (a tragic event)—and it is worth noting that discourse often shifts from one meaning to the other within the same passage, without particularly marking the distinction—the idea of trauma is thus becoming established as a commonplace of the contemporary world, a shared truth. No one thinks to question whether residents of Manhattan, or even a large proportion of US citizens, are psychologically affected and thus in need of specialist care. No one expresses surprise at the huge number of psychologists and psychiatrists present at the scene

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"The 9/11 Trauma Response Database") and http://www.psychologistshelp.org (which gave advice on its "Coping with 9/11" page).

[5] The Post-Traumatic Stress Disorder Conference, UCLA, December 12–15, 2002. In the conference program the organizers write, "This conference addresses the profound effects of traumatic experiences, which persist long after the horrifying events themselves. The tragedy of September 11, 2001, testifies to this and underscores the importance of understanding the ways in which trauma shapes and is shaped by our culture and biology." Justifying the presence of their guest of honor, they add, "On September 11, 2001, Mayor Giuliani brought strength and stability to the citizens of New York at a time of great trauma."

of tragedy. This reading of the events is universally accepted. Faced with the violence of the facts, or even that of the television images of them, it seems so natural to invoke the notion of trauma that society's response of providing therapy appears to signal progress, both in our knowledge of the reality lived by those directly or indirectly exposed to the events and in the care offered by society and its representatives.

The reaction to the attacks on the World Trade Center was unique in its level of confidence in the reality of trauma, but it illustrates a generalized social phenomenon. In France, after the plane crash at Sharm el-Sheikh on December 3, 2004, during the hurried return of French citizens from the Ivory Coast on November 8, 2004, following the collapse of the Roissy air terminal on May 23, 2004, and upon the return of survivors of the South Asian tsunami on December 26, 2004,[6] emergency aid and psychological support facilities were put in place. In specially installed cubicles, psychiatrists and psychologists offered "debriefing" or emergency preventive counseling to those directly affected and to their families waiting at the airport.[7] Similarly, when the Somme River flooded in the spring of 2001 and in the Gard region in the fall of 2002, during hostage-takings in a shopping center in Cergy in 2001 and at a primary school in Clichy in 2005, following the suicide of a classmate or even the appearance of graffiti insulting teachers in Seine-Saint-Denis, medical and psychological emergency units responded, with experts in psychotraumatology working alongside their resuscitation-specialist and paramedic colleagues in the ambulance service. These are mental health professionals, trained in crisis management, who carry out on-the-spot "defusing" procedures for victims and witnesses, pupils and teachers.[8] Similarly, in other countries, teams of psychiatrists and psychologists belonging to Médecins du monde (Doctors of the World, MDM) and Médecins sans frontières (Doctors without Borders, MSF) go to the aid of distant peoples ravaged by natural disasters, wars, or other calamities—survivors of earthquakes in Armenia and Iran, people who have lived through conflict in Bosnia and Chechnya, street children in China, and Romanian orphans.[9] Psychological disturbance on the battlefield has become a serious

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[6] After a long delay, the French Department of Victims' Rights published a booklet for survivors of the tsunami, the introduction to which includes a note warning of the possible psychological effects of the event and gives a list of contacts for specialist services.

[7] For an account of the "debriefing" technique, see the articles by François Lebigot (1998) and Lionel Bailly (2003).

[8] For an account of the "defusing" procedure, see articles by Louis Crocq et al. (1998) and François Ducrocq et al. (1999).

[9] The two organizations' humanitarian psychiatry programs are covered in their respective journals: *Médecins sans frontières. Medical News* (Psychiatry special) 7, no. 2 (1998), and *Médecins du monde. Journal destiné aux donateurs,* "The Wounds of the Soul," 56 (1999).

issue for military commands, initially as it affects the troops themselves (witness the "Gulf syndrome" affecting soldiers involved in the 1991 conflict in Iraq) and then also in relation to civilian populations (for example during the second conflict in 2003). Following the first Gulf War, US$250 million was spent on hundreds of programs aimed at identifying the causes of mysterious symptoms presented by US veterans; however, in the absence of any satisfactory explanation of the origins of the condition, the treatment given consisted largely of behavioral psychotherapy. As the bombing of Baghdad began at the start of the second Gulf War, US authorities published estimates that 570,000 Iraqi children were at risk of post-traumatic stress and would need psychological care.[10] In this wide range of situations, which looks more like "a certain Chinese encyclopedia" described by Borges than a systematic list drawn up by the American Psychiatric Association, the lowest common denominator is trauma—in other words, the tragic event and its psychological traces.

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Contemporary society now accepts without question the notion that psychologists and psychiatrists intervene in situations of war and disaster, in cases of exceptional or even everyday violence. No one seems astonished when mental health professionals leave their care centers and consulting rooms to attend to the "psychically wounded" in debriefing spaces. The idea that tragic and painful events, whether individually or collectively experienced, leave marks in the mind which are then seen as "scars" by analogy to those left on the body, is just as easily accepted.[11] The idea that someone damaged by an accident or an attack can, under the victim compensation laws of his or her country, claim financial compensation for psychic trauma is judged entirely legitimate, even if, as is often the case, the person simply witnessed the event deemed traumatic. If a victim of torture or persecution provides a medical certificate testifying to post-traumatic distress in order to gain refugee status, this is generally accepted as relevant evidence, precisely because a line of imputability and inevitability has gradually been established between abuse and its consequences.

Twenty-five years ago the issues were not so clear-cut. Trauma was rarely evoked outside of the closed circles of psychiatry and psychology.

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[10] On the Gulf War syndrome, see the article by Enserink in *Science* (2003); the figures relating to the potential child victims of trauma during the second war in Iraq are cited in a *Newsweek* special report (April 7, 2003).

[11] In the dedication of his book, Claude Barrois (1998) states, "Almost all injuries leave scars. A person who has almost passed through the looking-glass never returns unscathed.

Psychiatrists and psychologists were unlikely to appear at the scene of individual or collective misfortune, except in the rare cases where courts sought their clinical expert opinion. And when they did become involved in situations of conflict or occupational injury, they questioned the reality of the symptoms presented by the wounded and survivors, always suspecting that the soldier's "neurosis" after a shock was simulated in order to avoid returning to the front,[12] and that the worker's "sinistrosis" after an accident concealed a more or less conscious desire for reparation.[13] The victim—who in fact was rarely thought of as a "victim"—was tarred as illegitimate; trauma was a suspect condition. Thus, within a few years the course of history has changed: now the victim is recognized as such and trauma is a legitimate status. It is this new condition of victimhood, established through the concept of trauma, that we address in this book.

"My problem," Michel Foucault said toward the end of his life, "is to know how men govern (themselves and others) by means of the production of truth." He added: "By 'the production of truth,' I do not mean the production of true statements, but the arrangement of domains where the practices of the true and the false can be at once regulated and relevant."[14] This is in effect our premise in this book. The question is not whether or not an individual who has experienced or been exposed to a dramatic event is suffering from post-traumatic stress, and hence whether he or she merits psychological care and financial compensation. Our goal is rather to understand how we have moved from a realm in which the symptoms of the wounded soldier or the injured worker were deemed of doubtful legitimacy to one in which their suffering, no longer contested, testifies to an experience that excites sympathy and merits compensation. The point is to grasp the shift that has resulted in what used to excite suspicion now having the value of proof—the shift whereby what was false has become what is true. We seek to grasp the historic moment when suspicion ended.

Even if his or her scar is well healed, it is indelible." Here we are in the realm of metonymy rather than metaphor.

[12] José Brunner's article (2000) on the First World War offers a glimpse into the intense discussion among neurologists and psychiatrists about this "neurosis," which effectively amounted to stigmatizing soldiers as calculating cowards, thus justifying particularly brutal treatment.

[13] On this subject it is worth returning to Sayad's article (1999) on "sinistrosis." The author points out that by the 1960s and 1970s this label was used only to describe psychological distress observed in immigrant workers following accidents at work, which was explained purely in terms of their tendency to claim indemnities.

[14] This extract, where Foucault (1994, pp. 20–34) also uses the expression "regimes of truth" (*régimes de véridiction,* which means literally "regimes of truth-telling"), comes from a little-known text derived from a roundtable discussion with a group of historians on May 20, 1978.

This turnaround is played out simultaneously on two stages. On the one hand we have the professional circles of psychiatry and psychology, which as we shall see have been substantially influenced by social movements demanding rights, particularly for veterans and women who have suffered violence. It was the convergence of these disciplines and movements, as well as alliances between them, that gave rise to the diagnostic category of post-traumatic stress disorder, which was to become the keystone in the construction of the new truth. And it is in this context that further developments in psychiatric victimology and humanitarian psychiatry emerge. On the other hand, the more generalized and global idea of trauma, designating an irrefutable reality linked to a feeling of empathy, has spread throughout the moral space of contemporary societies. This trend is independent of opinions as to the validity of the diagnostic category as a way of accounting for the painful experience of tragic events in other cultural contexts. In fact, although there has been much criticism of what some see as a form of psychological ethnocentrism, the critics do not question the moral importance of trauma. Thus there are two orders of facts, one relating to the history of science and medicine, and one linked to an anthropology of sensibilities and values. Most of the writing on psychic trauma, particularly in the North American literature, looks at trauma from the first perspective, focusing on the research and debates that have resulted in the production of this new classification of mental illness.[15] It seems to us essential, however, to consider these two orders of facts together, bearing in mind both the genealogy of the medical category and of the moral norms, both the invention of post-traumatic stress and the recognition of its victims, both what psychiatrists and psychologists say about trauma and how this issue is handled by journalists and support organizations. Trauma is not confined to the psychiatric vocabulary; it is embedded in everyday usage. It has, in fact, created a new language of the event.

The reading we propose in this book might be described as constructionist, in the sense that it explores the ways in which trauma is produced

[15] The principal contribution in social science is Allan Young's book (1995), which traces the history of the category while analyzing the sociology of its use in a psychiatric treatment unit. In parallel, Ian Hacking's writings (1995) explore more broadly the reclassification of psychological disorders affecting memory, particularly around the emergence of multiple personalities. In the United States, literary studies have also played an important role in the investigation of the theoretical and practical issues raised around trauma, particularly in the field of psychoanalysis: Cathy Caruth (1996) and Ruth Leys (2000). All of these works effectively relate to an analysis internal to the field of psychiatry and psychology. This is even more true of mental health specialists themselves, whether they promote the concept of trauma, like Bessel van der Kolk et al. (1996), or challenge assumptions of its universality, as do Patrick Bracken et al. (1998).

through mobilizations of mental health professionals and defenders of victims' rights, and more broadly by a restructuring of the cognitive and moral foundations of our societies that define our relationship to misfortune, memory, and subjectivity. In this our approach differs from essentialist perspectives, which either (in the case of psychoanalysis) view trauma as a psychic given inscribed in the unconscious, or (as in the organicist paradigm) seek the material traces of trauma in the human brain.[16] This is not to question the validity of psychoanalytic interpretations and neurophysiological observations; rather, our approach derives from a different epistemological choice. We are interested in the development of a category of thought and the emergence of a realm of truth. We do not dispute the universality of trauma or its variation in different cultures: we affirm that it is almost universally accepted and that the concept has been adopted in multiple cultural contexts. We are not asking whether, either in general or in specific cases, trauma is a relevant concept from the medical or social viewpoint: we are aware that it is considered as such in medical circles and in the social sphere. In other words, our viewpoint derives neither from a relativism that would implicitly or explicitly raise doubts about the concept of trauma by asking if it really exists, nor from a moral standpoint prompting us to contest the unrestrained use of the term, nor from a cynicism that might lead us to comment ironically on its tendency towards exaggeration.[17] These viewpoints have their logic, but they are not ours. We are attempting instead to understand what we see as a major social shift in terms of its anthropological significance, to understand how a system of knowledge and values was shaken and how one truth was overturned and another produced. In short, we seek to understand how the contemporary moral economy has been reshaped.

If social sciences are of use to society—and we are convinced they are—it is by virtue of the critique they offer. This critique primarily addresses the concepts and tools with which the men and women of today think and transform the world—concepts and tools that are often invisible, and therefore unrecognized, by those who use them. Thus a critical reading of trauma rejects the naturalization of the concept.[18] The simple fact that within the last two decades it has become standard practice to send psychiatrists and psychologists to places where people have been involved in

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[16] These two approaches can of course be reconciled, as van der Kolk and van der Hart (1995) show in bringing Freudian theories and neurophysiological observations together in a single analysis.

[17] This perspective is what one of us has conceptualized as a "well-tempered constructionism" (Fassin 2004a) that involves a certain degree of "realism."

[18] Notably by showing how the "trauma narrative" (Rechtman 2002) creates a resonance between the "human condition" of victim and the "clinical condition" of PTSD.

or have witnessed dramatic events should invite reflection. From our clinical experience and our ethnographic work with people who have been through terrible ordeals, we know that a painful past can resurface in veiled or violent form in the body or the mind.[19] However, since this reality has only recently been recognized (that is to say, identified and legitimized), our question is: what does this social recognition change, for the men and women of today (whether victims or not), in their vision of the world and its history, and in their relationships with others and with themselves? When we consider the soldier suffering from nightmares and flashbacks as psychologically wounded rather than as a malingerer or a hero, what does this view of war and those who participate in it tell us? When the concept of trauma allows the survivors of an industrial accident to speak of their a priori right to compensation, regardless of any evaluation a posteriori of the facts in their individual cases, how are the management of damage and the administration of evidence altered? When witnesses testify publicly to the plight of the Palestinian people on the basis of cases reported by psychologists, how are the representation of their situation and the defense of their cause affected? When more credence is given to a medical certificate attesting to post-traumatic stress than to the word of an asylum seeker, what conception of the law and of the subject is operating? These are some of the questions we will be asking throughout this book. The answers we suggest sketch out what we will call a politics of trauma.

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The history of the invention of post-traumatic stress in the late nineteenth century and of its rediscovery in the late twentieth century, thus allows us to trace a dual genealogy (part 1). The first strand, which belongs in the domain of psychiatry, psychology, and psychoanalysis, conceives trauma both at the level of theoretical debate (which has been analyzed many times) and in actual practice (particularly in the fields of forensic medical expert opinion and colonial medicine, which have not hitherto been the object of much attention). The second strand, which relates to social conceptions, traces changes in attitudes to misfortune and to those who suffer it, whether soldiers or workers, accident victims or survivors of the concentration camps. More specifically, it marks changes in attitudes towards the authenticity of such suffering. Although most research on trauma has focused on the first area, it seems to us that the second is an equally important factor in the emergence of the concept of trauma. What

[19] For an account of our clinical work and ethnographic studies, see our work on disease patients in South Africa (Fassin 2007) and Cambodian refugees (Rechtman 2000).

is most revealing is the way in which these two histories have interacted. We can identify key moments in twentieth-century history at which trauma was able, with surprising ease, to lock into values and expectations embodied, in each case, in a very specific historical configuration. How did this acceptance of trauma come about? How did it travel from the First to the Second World War, from North American feminists to Vietnam veterans? How did clinical theory and everyday practice adapt to these changes in pathological categories and social norms? How and why has trauma been able to embody, equally powerfully, entirely opposing values? Examination of this dual—scientific and moral—genealogy of trauma gives us a key to understanding each of these turning points. We end this first phase of our study at the point where post-traumatic stress disorder has achieved universal acceptance, but our aim is not simply to emphasize the discontinuity marked by the end of the era of suspicion that hung over victims of violence. We also try to demonstrate a continuity, perhaps more fundamental, by means of which psychic trauma affirms the ultimate truth of humanity and negates other possible schemes of description and action.

From within the social context of constant change that has prevailed since the late 1980s, we have chosen three cases emblematic of the contemporary politics of trauma. Our first case study concerns the development of psychiatric victimology and intervention on the scene of assaults and accidents, hostage-taking incidents, and natural disasters; it focuses primarily on the so-called emergency medical and psychological units that have been established throughout France. We will examine an incident that had, and continues to have, major local and national resonance: the explosion at the AZF chemical factory in Toulouse on September 21, 2001 (part 2). Our second case study looks at the boom in humanitarian psychiatry and its work in the aftermath of earthquakes and war, in refugee camps and rehabilitation centers, through the missions of Médecins sans frontières and Médecins du monde. We will focus on one specific case where humanitarian psychiatry has been applied, probably the arena that has received the highest investment of both human resources and political stakes—the Israeli-Palestinian conflict, in the context of the second Initifada, which began in September of 2000 (part 3). Our third case study focuses on nongovernmental organizations operating in the field of the psychotraumatology of exile, particularly among asylum seekers and victims of torture. We focus on the activity of the main organization providing health care to immigrants in France, the Comité médical pour les exilés (Medical Committee for Exiles, Comede) (part 4).

So we have three scenes: the first is local, the second far distant, and the third lies between the two since it deals with foreigners hoping to gain official status. These three scenes delineate three spaces—national,

international, and transnational. Their diversity illustrates the ubiquity of the contemporary politics of trauma—from the local to the global, from the mental health system to the social management of major disasters—within which three new fields are opening up: psychiatric victimology, humanitarian psychiatry, and the psychotraumatology of exile. Together these three define the boundaries of a diffuse global concept of trauma which, we stress, has formed within less than a decade, and which bears witness to an important shift in mental health care. It is important both in terms of the growing number of actors involved (particularly psychologists, who have always been by far the most numerous in the field of social suffering and whose domain of intervention is much wider than trauma alone), and in terms of the implicit significance of their activity, which is directed at a radically new public (psychiatrists, for example, now deal with people who are not sick, but who are suddenly affected by the impact of abnormal events). Thus we wish to highlight a dual social innovation: the invention of new areas of knowledge and practices, and the discovery of new patients and subjects.

In each of these three arenas, offering care to people deemed to be victims of trauma demarcates a field of common problems (the relevance of diagnostic categories, the provision of appropriate psychological care), but the particular logic of each case raises specific political questions in the context of the social issues particular to disasters, war, and persecution. After the AZF accident the central concern of victimology was to repair the damage suffered, and the concept of trauma was important as a means of validating the status of accident victim. In humanitarian psychiatry, bearing witness to the suffering of the Palestinians and the Israelis during the second Intifada brought to light tensions within organizations, among their donors, and in the broader public. Trauma has created a new vocabulary for explaining causes and prejudices. In the psychotraumatology of exile, the growing suspicion weighing on asylum seekers means that demonstrating trauma becomes an additional way of testifying to the reality of persecution. Politics of reparation, politics of testimony, politics of proof—in all three cases, trauma is not simply the cause of the suffering that is being treated, it is also a resource that can be used to support a right. These different uses of trauma thus reveal a partly utilitarian dimension of the concept, which emerges when this notion is actively mobilized. In noting this our aim is not cynical (suggesting that the classification is being manipulated for aims stated or unstated), but is rather to avoid reifying the concept by suggesting that the social significance of trauma is the same everywhere and for everyone; we seek to show its relative autonomy in relation to psychology and psychiatry in general (those who adopt the term to some extent move beyond these

structures). Seeing trauma as a resource is, however, not simply a theoretical issue. It is also an ethical one: in asserting the tactical dimension of trauma we are recognizing the social intelligence of the actors involved.

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This book is born of research that we began separately fifteen years ago, one of us around the politics of suffering, and the other around the invention of trauma,[20] and then developed together. Our encounter happened on this common subject, which we propose to call the politics of trauma, and which we want to test through an empirical investigation. This study was conducted between 2000 and 2005.[21] It involved consulting a wide range of medical archives, reading hundreds of pages of paper and electronic documents produced by the institutions concerned, interviewing individuals we met in the three arenas mentioned above, and observant participation in the activity of the actors involved and in the life of these institutions.[22] We are grateful to the PhD students who collaborated in this study: Estelle d'Halluin, who was studying sociology at the École des hautes études en sciences sociales, and Stéphane Latté, who was preparing his diploma in social sciences at the École normale supérieure.[23] We are

[20] Seminars by Didier Fassin ("The Politics of Suffering") and Richard Rechtman ("The Ethnicization of Psychiatry"), at the École des hautes études en sciences sociales in the early 1990s.

[21] Within the framework of two study programs launched firstly by MiRe (Mission de recherche expérimentation [Mission for Research Experimentation]) of the Ministry of Social Affairs, and subsequently jointly with the CNRS (Centre national de la recherche scientifique [National Center for Scientific Research]) and INSERM (Institut national de la santé et de la recherche médicale [National Institute for Health and Medical Research]).

[22] In using the term "observant participation" our aim is to invert the canonical term "participant observer" by indicating that our primary role was as actors in the arenas in which we, in a secondary capacity, analyzed the issues. For one of us (Didier Fassin) this involved a position on the Board of Directors of two of the nongovernmental organizations studied (Médecins sans frontières, of which he became vice president, and the Comité médical pour les exilés, of which he later became president); and for the other (Richard Rechtman) membership in several official study groups in the Ministry of Social Affairs (on psychological emergency, on the treatment of victims of torture, on psychiatric expert reports, and on mental health and violence). This was admittedly a difficult position for both of us, but one in which the two dimensions (political and scientific) were clearly stated at the outset.

[23] Estelle d'Halluin conducted some of the interviews with humanitarian organizations and associations working with asylum seekers, and undertook one month's research in the Gaza Strip; her work was reported in a master report, *Guerre et Psychiatrie. L'intervention humanitaire en Palestine* [War and psychiatry: Humanitarian intervention in Palestine], EHESS, Paris, 2001. Stéphane Latté conducted some of the interviews at the Toulouse site; he had previously undertaken a study of victimology, which provided some of the material

also grateful to Sylvie Fenczak for her enthusiastic acceptance of the French version of the book, to Fred Appel for his unfailing support of its English publication, to Rachel Gomme for her remarkable work in translating our *L'Empire du traumatisme,* and to Eva Jaunzems for her subtle suggestions while turning it into *The Empire of Trauma.*

In the pages that follow we show how social agents—psychiatrists and psychologists, of course, but also accident victims, refugees, lawyers, and activists—make use of the category of trauma and the notion of post-traumatic stress disorder, appropriating, reformulating, or even twisting them. This is a testimony to how much we owe to all the actors who permitted our critical examination of their practice, and to our hope that this study will prove useful to those among whom they work. However, it goes without saying that the analyses we propose of these practices are entirely the responsibility of the authors.

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for the master report *La naissance de la victimologie. Institutionnalisation d'une discipline et ébauche de construction d'un group improbable: les victimes* [The origins of victimology: The institutionalization of a discipline and outline of the construction of the unlikely category of victims], ENS-EHESS, Paris 2001. Both took part in the two studies we led.