Screen Trauma: Visual Media and Posttraumatic Stress Disorder

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Shortly after the 1989 Hillsborough Stadium disaster in Sheffield, England, sixteen people brought actions claiming to suffer a ‘nervous shock’ as a result of learning about the disaster from the media. The plaintiffs, most of whom were relatives of the victims, demanded compensations as secondary victims, arguing that their injury was within the ‘immediate aftermath’—a category recognized by the British law as having been involved in the consequences of a tragic event. The court rejected the claim, but not before speculating on the hypothetical possibility of a traumatic live broadcast (Pugh and Trimble, 1993: 427-8). Numerous claims for psychiatric injury had been filed prior to this case, yet this is probably one of the first to consider whether media could cause trauma to viewers, and consequently be compensable by law. Were such a case to be heard today, it might find support from recent developments in psychiatric research. For there is now a growing acceptance among mental health experts that trauma could transfer, under certain conditions, through visual media. Referring to notions such as ‘distant trauma’, ‘traumatic media exposure’ and ‘vicarious traumatization’, many clinicians and researchers are now willing to acknowledge that witnessing disastrous events through the media could cause a reaction that complies with existing Posttraumatic Stress Disorder (PTSD) clinical criteria. How did this development come about? What are its legal, social and moral consequences? How does mediated trauma manifest itself? And what are the implications for contemporary understanding of both media and trauma? These are the questions this essay sets out to explore.
Psychiatry has long been in the business of understanding how external violence affects mental processes. While operating under various nomenclatures, modern conceptions of trauma have dovetailed with modern developments in technology and warfare. As such, trauma is a central theme in the grand narrative of the shock of modernity (Benjamin, 1968; Kracauer, 1960; Simmel, 1950). In the latter half of the 19th century, conditions such as ‘railway spine’ (British surgeon John Erichsen’s term) and ‘male hysteria’ (French neurologist Jean-Martin Charcot’s term) were associated with inflictions of mechanized modernity, typically industrial and train accidents; syndromes such as ‘war neurosis’, ‘shell shock’, and ‘traumatic neurosis’ (Sigmund Freud’s term) followed directly from World War I; and more recently ‘gross stress reaction’ and ‘posttraumatic stress disorder’ were the corresponding postwar psychopathologies of World War II and Vietnam, respectively (see Hacking, 1995; Leys, 2000; Micale and Lerner, 2001; Young, 1995). From the very beginning, the science of psychic injury corresponded with tort law jurisprudence and health insurance provisos; then, like today, causation is what determines compensation. Early conceptions of trauma restricted the affliction only to direct and immediate experience: there was no reason, and indeed no sense, in speculating about distant traumatic effects. In the last few decades psychiatry and psychology began to consider the possibility that traumatic behavior and symptoms could transfer across time from one generation to the next, a paradigmatic case being second generation of Holocaust survivors (see Herzog, 1982: 103-19). The possibility of trauma through media, which is now beginning to gain purchase, further shifts the location of violence from direct to indirect, and from the immediate to the mediated.

Media have long been accused of exposing the audience to violence. The 1930s Payne Fund Studies are notorious for having incriminated movies as
propagating sex and violence among the young (Sklar, 1994: 122-40); one of the first mass media effects studies was on an alleged media-induced panic: the 1938 *The Invasion from Mars* radio broadcast (Cantril et al., 1940). Violence on television has been a favorite topic for cultivation theory (Gerbner and Gross, 1976), and studies on the impact of violence in the media on children are too many to count (see Anderson et al., 2003; Paik and Comstock, 1994; Villani, 2001). Despite the divergence, these and many other studies understand the deleterious effects of media as impinging on viewers’ moral framework: how media violence affects people’s attitudes, beliefs, and consequently social behavior. As I argue in the following, the psychiatric recognition of a technologically mediated trauma marks a qualitative change in the understanding of media effects: the impact is no longer symbolic but literal, and the damage suffered is not only emotional but clinical. The status of mediated violence shifts from obnoxious to noxious, making media influence a question for psychiatric epidemiology as much as for social psychology. As Ruth Leys (2000) explains in her genealogical study of trauma, the prevalent PTSD theory today is of a literal, often visual, imprint of the traumatic event, which is registered in a special traumatic brain memory system (cf. Van der Kolk, 1984; Caruth, 1996). That mediated images might be traumatic to the viewer complements this theoretical trend, rendering the screen itself a potential locus of trauma.

While people may have suffered from trauma throughout history, it was only in the late 19th century that the term, traditionally associated with physical injury, acquired the meaning of a psychological wound (Hacking, 1995: 4). As Allan Young (1995: 5) argues, PTSD is neither timeless nor intrinsically coherent, but rather ‘glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented’. This does not mean the condition is not real but
rather that it is something that has to be made real through various material and discursive mechanisms. Another way to approach the idea is through what German media studies term ‘cultural technique’: ‘the operations or sequences of operations that historically and logically precede the media concepts generated by them’ (Siegert, 2011: 15). Thus counting precedes the concept of the number, writing precedes the concept of the sign, and painting precedes the concept of the image (see Macho, 2003). The concept of trauma might then be regarded against the cultural techniques of its making: the alignment and interrelation of bodies, knowledge, technologies, and practices—from the clinic to the lab, from the ‘talking cure’ to the MRI scan—that have given rise to and sustained the traumatized condition. The main argument this study advances is of the link between visual media and contemporary conceptions of trauma, a link that informs recent speculations about the possibility of trauma through media. Mediated trauma has a visual media a priori.

The relation between media and trauma is not only historical but also conceptual, as trauma itself can be considered as a ‘media concept’, as per Siegert’s definition above. To begin with, trauma literature is replete with media metaphors: traumatic imprint, unprocessed memory, unconscious registration, flashbacks, intrusive images, and transmission of trauma. Media are sometimes employed in PTSD treatment: in one method the patient is recorded recounting the traumatic story, and is then asked to listen repeatedly to the recording so as to desensitize herself (Foa and Rothbaum, 2001); another method employs video recording to capture the traumatic story, which is then analyzed together with the patient (Greenwald et al., 2006); and virtual reality exposure therapy (VRET) simulates the traumatic experience using visual immersion technology as part of repeated exposure treatment program (Väliahho, 2012). What these methods invoke, and indeed draw on, is the
structural similarity between the repetition compulsion of trauma and the technological reproduction of media (see Pinchevski, 2012). But more fundamentally, trauma, being a violent clash between outside and inside, can be viewed as the result of failed mediation, a pathology of intermediacy. This is essentially Freud’s view in Beyond the Pleasure Principle, where he deems trauma as ‘excitations from outside, which are powerful enough to break through the protective shield…a breach in an otherwise efficacious barrier against stimuli [Reizschutz]’ (Freud, 1961: 23). Trauma is what happens when the medium does not hold. Seen in this light, the traumatic potential of media is not just another example of an external stressor with which the ‘psychic apparatus’ has to contend, but rather a situation where technological mediation begets failure of psychological mediation.

This essay explores three key cases in the development of trauma through media. The first is an experimental research program developed in the early 1960s under the name ‘trauma film paradigm’, which employed stressful films (often the same one) to simulate traumatic effects. The work of psychiatrists working within this paradigm came to inform some of the most basic tenets of contemporary understanding of stress and trauma. The second case traces the emergence of ‘distant trauma’: the psychiatric study into the clinical effects of watching catastrophic events on television. A watershed event in that respect was the September 11 attacks in New York in 2001, after which ‘distant trauma’ became an extensively researched—and increasingly accepted—condition. The third case focuses on a current debate: according to U.S. Air Force reports, operators of remotely piloted aircrafts (also known as drones) exhibit PTSD symptoms at rates closer to those of ground troops than to pilots. Flying missions by remote, some drone operators claim to be traumatized by images of surveillance and killing as received thousands of miles
away from war zone, thereby adding a new dimension to the vexing designation known as perpetrator trauma. While these three cases involve three different media (film, television, digital), from a psychiatric standpoint—which is the focus of this study—they are all equipollent instances of screen-based traumatic effects. As such, these three cases constitute defining moments in the progressive distanitation of trauma by technical means. Preceding the main discussion is a short interpretative reading of the recently amended PTSD diagnostic criteria, which for the first time include a direct reference to media. The media caveat introduced therein marks the culmination of a process traced by the three cases to follow, each representing a different phase in the psychiatrization of media effects.

**DSM Prelude**

The 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), published by the American Psychiatric Association, presents the revised criteria for Posttraumatic Stress Disorder (PTSD). The first criterion stipulates the originating factors:

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing of the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent of accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeated exposed to details of child abuse).

**Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or picture, unless this exposure is work related (2013: 271).

Consider the note that follows Criterion A4: while barring media exposure as a possible cause of trauma, the note nevertheless admits, by way of exception, that under certain conditions media may in fact have a traumatic effect. As the DSM supplies no further explanation, let us venture a short interpretative reading of this peculiar addendum.

First, it is instructive that of all things media are singled out to be excluded, as though the DSM is compelled to correct a supposedly existing misconception about the traumatic potential of media. Note also that the media specified (television, movies, picture) are all visual media, a detail with particular significance to the current understanding of trauma, as the following sections show. The exclusion comes with an exception: media exposure in general is denied only to allow a special case—work-related media exposure. This is presumably because it would take a special kind of exposure, the kind that, unlike ordinary media exposure, is integral to the job and is most likely recurring and involuntary. Which line of work might that be? Conceivably one that involves working daily before a visual medium emitting potentially distressing images: jobs such as CCTV security guard, surveillance camera operator, drone operator, news reporter, film editor, perhaps even television critic. Media exposure may now be narrowly declared as an occupational hazard with posttraumatic consequences.
The DSM is obviously much more than a diagnostic manual. As Ian Hacking (2013) notes, the primary readers of the DSM are not mental health professionals but bureaucrats of various governmental and cooperate branches, who rely on its categories to process mental health claims. As a key tool in legislation, insurance, and policy, the DSM has been in the fray of a number of public campaigns that sought recognition for yet unacknowledged conditions. PTSD is an exemplary case in this regard. DSM-I (published 1952) included a broad entry of ‘gross stress reaction’, which was later dropped from DSM-II (published 1968). PTSD was first introduced in 1980 with the publication of DSM-III, following a politically motivated effort to amend the psychiatric nomenclature of stress in the wake of the Vietnam War (Scott, 1990). As Leys claims, it took Vietnam to learn the psychiatric lessons of World War II, and it took WW II to learn the psychiatric lessons of WW I (2000: 15). Belated awareness of a traumatic past is not limited to victims but might also extend to experts. The recent reference to media in DSM-V can be seen as a belated response to events that redefined the scope of trauma over the last two decades.

A short comparative reading of PTSD entries in DSM editions reveals an expansion in the description of trauma impact. DSM III speaks of symptoms following a ‘psychologically distressing event that is generally outside the range of usual human experience’ (1980: 236). DSM III-R largely reiterates the above but adds ‘serious threat or harm to one’s children, spouse, or other close relatives and friends; sudden destruction of one’s home or community; or seeing another person who has recently been, or is being, seriously injured or killed as a result of accident or physical violence’ (1987: 247-8). DSM IV presents a more extensive revision: ‘The person has been exposed to a traumatic event’ in which one ‘experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or
serious injury, or a threat to the physical integrity of self or others’ (1994: 426). The impact of trauma seems to expand from one edition to the next: from personal to secondary, and from direct to indirect. It is instructive that the term ‘exposure’ appears only in recent editions, and as in the latest DSM-V definition above, assumes the general category from which the subsequent criteria ensue. Significantly, ‘exposure’ is applied to both immediate and mediated traumatization, suggesting a common mechanism in both cases. The inclusive exclusion of media exposure in DSM-V marks perhaps the farthest extent of traumatic impact yet to be officially recognized.

**Trauma Films**

In the early 1960s the understanding of stress and trauma became entangled with experimental psychology, and more specifically, with a research program that employed film as stress stimulus. This program, known as ‘trauma film’ or ‘stressful film’ paradigm, provided a ‘prospective experimental tool’ for investigating the mechanism of traumatic reactions in laboratory setting (Holmes and Bourne, 2008: 553). In retrospect, what it also provided is a technical apparatus from which a transformed conception of trauma was to emerge. Experiments typically involved having subjects watch a film featuring stressful images while recording their physical reactions, using electrodes for measuring heart rate and a galvanometer for skin conductance (precipitation is an indication of parasympathetic arousal). This was supplemented with interviews and self reports immediately after screening and over time. ‘Properly selected motion picture films’, claims the pioneer of this paradigm, psychiatrist Richard Lazarus, ‘could have tremendous emotional impact upon subjects and, therefore, could serve as stressor stimuli’ (Lazarus et al., 1962: 3). Film, as
Lazarus dubs it, is a ‘laboratory analogue’ to real life conditions: it closely simulates processes at work in an actual event, sans the danger (Lazarus, 1963).

Early experiments employed one film as stress stimulus: the 17-minute silent documentary *Subincision Rites of the Arunta*, filmed in 1937 by the Hungarian anthropologist and psychoanalyst Géza Róheim while studying aboriginal tribes in Australia. The film depicted scenes from puberty rites of crude surgical operations on male genitals. As control, experiments used *Corn Farming in Iowa*, a documentary chosen specifically for its lack of distressful content. An initial experiment was designed to determine whether the *Subincision* film could actually produce viable stress indicators in viewers. It concluded that, despite some mitigating variables, the film ‘yielded consistent and marked evidence of psychological stress’ (Lazarus et al., 1962: 27). Stress effects were further ascertained from retroactive personal accounts; reportedly, a few were so distraught that they asked that screening be terminated.

Subsequent experiments developed the schema to include the manipulation of soundtrack as a way to modulate cognitive orientations toward the film. Three different soundtracks were produced: ‘intellectualization track’ evoked a detached anthropological viewpoint; ‘denial tack’ downplayed the harmful aspects of the ritual and emphasized the possible positive aspects; and ‘trauma track’ accentuated the major sources of pain, danger and sadism in the film. The original silent version was retained as a fourth soundtrack. Results showed that the ‘trauma track’ produced the highest degree of stress among viewers, with the ‘silent track’ ranking second in effect. The two other tracks, ‘denial’ and ‘intellectualization’, produced a remarkable decrease in stress response (each ranking lowest with different groups). Thus if the visual track of the film acts as the source of stress—i.e. the ‘laboratory analogue of stress processes’—the sound track acts as the corresponding evaluative process, ‘an
analogue of the process of cognitive appraisal’ (Lazarus, 1963: 211-2). If images constitute the traumatic content, vocal narration constitutes the evaluative response, which, according to Lazarus, regulates the degree of stress felt by viewers. Or as one psychiatry textbook summarizes the experiment: ‘What we tell ourselves about external situations (cognitive appraisal) influences our level of arousal’ (Puri and Treasaden, 2009: 175).

It is worth lingering on the term ‘analogue’. As Lazarus explains, ‘analogue refers to the manipulations in the experiment which parallel, or are similar to, the processes that are postulated to take place in nature,’ and adds, ‘we assume that these conditions represent those in real life, and that the findings can be generalized to conditions like in nature’ (1963: 194). Analogy implies an inference based on similarity. Logically speaking, the analogy Lazarus describes is proportional (Greek analogon: up to ratio): A is to B as C is to D; hence: stressful film is to subjects as stressful event is to victims. Film is an effective analogue since its impact ‘is natural and appears to take advantage of the human tendency to identify with characters and their experiences in a dramatic portrayal’ (Lazarus et al., 1962: 3). Here psychiatry treads into film theory: the identification process enacted by cinematic depictions is not only assumed to be effective but is actively elicited for the purpose of objective recording and analysis. The effects of identification are not simply a matter of psychological association but are factual and literal—and hence, comparable to the point of generalization with respect to a real event.

Yet analogue could also be interpreted with reference to media. The underlying assumption, without which trauma film paradigm would be pointless, is that the visual medium of film can reproduce reality to the extent of producing discernible and tangible effects in viewers—and do so better than any other media
(otherwise a different one would have been used). Film is the analog medium upon which the analogue experiment is performed. For the psychological processes to be analogous there must first be a medium analog to reality. Yet at the same time film is cast as a deeply split medium: the moving image gives it its gripping, ‘natural’ impact, whereas the soundtrack serves a secondary, reflective function. The mental imagery arising from this analog(ue) apparatus is of a receptive visual sensory (‘stress stimulus’) and a cognitive voiceover (appraisal, ‘what we tell ourselves’). Trauma film constitutes a prime example of what Friedrich Kittler calls (following Hugo Münsterberg) ‘psychotechnology’ as that which ‘relays psychology and media technology under the pretext that each psychic apparatus is also a technological one, and vice versa’ (Kittler, 1999: 160). And just as in Kittler’s analysis of film, psychotechnology does not simply spells similarity between mind and media (‘dreams are like movies’) but deep correlation: the mental is bounded up and co-extensive with the technical.

Trauma film paradigm has achieved wide recognition with the work of psychiatrist Mardi J. Horowitz, whose focus has been on the role of imagery in trauma and stress disorders. Horowitz builds on Freud’s idea of the repetition compulsion but takes it to the computer age: ‘A traumatic perceptual experience remains in some special form of memory storage until it is mastered. Before mastery, vivid sensory images of the experience tend to intrude into consciousness and may evoked unpleasant emotions’ (Horowitz, 1969: 552). To study visual repetition, Horowitz repeated the method used by Lazarus, and even employed the same Subincision film as stress stimulus (the control this time was The Runner, depicting a long-distance race). Films, according to Horowitz, can produce stress ‘minor to moderate in intensity’ and ‘afford a well-studied and replicable laboratory device for
providing visual stress events’ (Horowitz, 1976: 62-3). Unlike Lazarus, Horowitz was mostly interested in visual impact and its recurrence in the mind, and so had no use for soundtrack manipulation (in fact, both films were shown silent). His conclusion was that ‘a traumatic film is more likely to be followed by intrusive or unbidden visual images than a neutral film’ (Horowitz, 1969: 558).

Horowitz went on to develop a most influential theory of image formation and cognition, classifying a range of images, from hallucinations to unconscious images. With respect to trauma, his theory was of a conflict between two processes: ‘one favors completion of unfinished business, i.e. translation, codification, and permanent storage, while the second favors continued inhibition to avoid emotional pain’ (Horowitz, 1978: 199). This mechanism explains the posttraumatic repetition of ‘unbidden image’ as a byproduct of the second process undermining the first. Because hindered from being integrated into permanent memory, the traumatic experience remains stuck in ‘a kind of active memory storage that has an intrinsic tendency toward repeated representation of its contents until those contents are actively terminated’ (1978: 215). Imagery became increasingly important in understating posttraumatic processes in the late 1970s and early 80s (see Brett and Ostroff, 1985). Horowitz’s work on stress response had earned him an invitation to join the working group whose recommendations ended up as the first PTSD nomenclature (Scott, 1990: 306; Young, 1995: 110). At the background of the introduction of PTSD in DSM-III lies a distinctive visual understanding of the condition and its mechanism.

In her recent study on trauma, Leys (2007: 15) highlights the centrality of imagery to the conceptualization of PTSD, particularly of what she calls the ‘traumatic image, defined as an externally caused mental content or “icon”’. She also
notes the role of stressful films as used by both Lazarus and Horowitz (associating the latter with what she calls the antimimetic strand of trauma theory [115-7]). Yet her analysis downplays the media a priori from which the imagistic conception of trauma arises. That imagery has become central to the understanding of trauma must owe something to the film apparatus employed to approach trauma, both technically and conceptually. Resorting to film as an analogue presupposes the technical ability both to record stressful events and to replay those events so as to reproduces stressful effects. The psychiatric use of films assumes, in other words, the technical iterability of the ‘Real’. Indeed, there is an obvious affinity between repetition and reproduction as two parallel mechanisms that converge on the centrality of the image with respect to trauma. For what makes film such an apt a device for the study of posttraumatic image repetition is the fact that it is itself a technology for reproducing images. Film emerges as a proleptic device, producing the motion pictures later to become recurring flashbacks.

Trauma film paradigm stands out as an important step in naturalizing the idea that visual exposure to violence could have clinically observable consequences. At its core is a double move of separation and integration: separation between perception and presence, between witnessing violence and being subjected to violence; and integration between direct and mediated effects, between posttraumatic processes occurring in harm’s way and those occurring at a remove. Indeed, it is the mediated that acts as a stand-in for the direct, despite declared differences in scope and severity. With trauma film paradigm, the precedent is set for far-off images to cause a scientifically corroborated injury to the beholder’s mind.
Distant Trauma

Is it possible to be traumatized by watching a catastrophic event on television? Can media exposure count as a legitimate cause of PTSD? While having little bearing in the past, these questions have recently become a focus of much debate and research. If there is a defining moment in this story it is the September 11 2001 terrorist attacks, whose live television broadcasts have since been the subject of numerous of studies. Although causality is still under dispute, there seems to be an agreement that watching disturbing images on TV, like those memorable pictures of airplanes crashing into the Twin Towers, might indeed cause posttraumatic symptoms in some viewers. Who might be most vulnerable? Under which circumstances? What might be the explanatory personal, social and cultural backgrounds? Psychiatric epidemiologists are now rehearsing hypotheses on media effects much like those that have traditionally preoccupied the work of communication scholars. Yet unlike communication research, what psychiatry deems as effects is likely to carry far-reaching implications.

Precursory studies began appearing in the early 1990s, and virtually all were concerned with traumatic effects of media on young children. One study on PTSD symptoms among Kuwaiti children during the 1990-1 Gulf Crisis found that ‘the viewing of explicit graphic images of mutilation on television had measurable influence on severity of reaction’ (Nader et al., 1993: 407). Another focused on the impact of the televised explosion of the Challenger space shuttle in 1986 on American schoolchildren. The authors found lingering trauma-related fears, dreams and plays, including cases which could qualify for PTSD diagnosis ‘if not for their failure to meet the first criterion for PTSD—having endured a traumatic event’ (Terr et al., 1999: 1542). Attempting to find adequate terminology, the authors suggest:
If we call what happened to the Challenger subjects ‘distant trauma’, if we define their responses as ‘the reaction (memory, thinking, symptoms) to a disastrous event, experienced at the time of the event, but from a remote and realistically safe distance’, we might also propose that distant trauma be considered part of a broad range of trauma-related conditions, or the ‘trauma spectrum’.

They proceed to distinguish between different types of conditions on this ‘trauma spectrum’, most of which are media-enabled. Their conclusion is that ‘for children raised from birth with television, the immediacy of the medium seems almost as real as pure, untouched reality’ (1999: 1543).

Still before 9/11, psychiatrist Betty Pfefferbaum and her colleagues held a series of studies of posttraumatic media effects on children following the 1995 Oklahoma City bombing. A clinical assessment conducted seven weeks after the bombing showed that for those with little personal connection to the disaster ‘the media appear to play a role in sustaining posttraumatic stress symptoms’ (Pfefferbaum et al., 1999: 1073). One of several follow-ups found evidence of impact as long as two years later: ‘The potential for media coverage to serve as a traumatic reminder and the potential for symptoms to endure cannot be overemphasized’ (Pfefferbaum et al., 2000: 367). Another study suggests that television viewing itself may be a sign of an existing distress and so could become ‘a sources of secondary exposure’. Since this kind of exposure is largely in parents’ hands, it may ‘constitute an important aspect of prevention’ (Pfefferbaum et al., 2001: 209).

As noted, the September 11 attacks were a formative event in the study of distant trauma. Just two months later, a group of 10 psychiatrists published a special report in the prestigious New England Journal of Medicine, featuring the results of a
national survey on stress reactions immediately after the attacks:

People who are not present at a traumatic event may experience stress reaction … After the September 11 terrorist attacks, Americans across the country, including children, had substantial symptoms of stress. Even clinicians who practice in regions that are far from the recent attacks should be prepared to assist people with trauma-related symptoms of stress (Schuster et al., 2001: 1507).

The survey showed that 44% of adults and 35% of children reported at least one of five substantial stress symptoms. Levels of stress were found to be associated with the extent of television viewing, especially with ‘repeated viewing of terrifying images’. The conclusion is unambiguous: ‘the September 11 attacks, the shocking televised images, and the profound ramifications are unprecedented’—and so is the warning: ‘Ongoing media coverage may serve as traumatic reminder, resulting in persistent symptoms’ (2001: 1511). Significantly, the special report goes beyond the previously studied impact on children and extends the impact to the entire population.

A wealth of studies ensued with a great many reaffirming the connection between television exposure and PTSD symptoms. Here is a small selection:

‘intensive exposure to the news coverage of such an intense disaster situation is associated with psychopathology’ (Ahern et al., 2002: 299); people who watched television the most were 66% more likely of having ‘probable PTSD’ than those who watched least (Ahern et al., 2004: 224); stress in parents who watched the disaster on television was associated with stress in children (Fairbrother et al., 2003); television related PTSD symptoms were found significant even when controlling for directly experiencing the attack, the kind of coverage seen, and sociodemographic characteristics (Schlenger et al., 2002); each hour increase of television viewing
resulted in 5-6% increase in dreams containing references to the disaster, which ‘strengthen the hypothesis that there was a causal path from television viewing of these events, to increased stress and trauma’ (Propper et al., 2007: 340); in addition to television exposure, changes in viewing habits (like avoidance or seeking out more coverage) were also associated with PTSD symptoms (Otto et al., 2007).

And yet, whether television exposure fully merits trauma nomenclature remains a rather contentious issue. A pioneer on traumatic media effects, Betty Pfefferbaum, presents a qualified view: ‘it is doubtful that media exposure alone, absent other forms of exposure such as physical or interpersonal relationship to direct victims, would qualify as witnessing’ (Pfefferbaum et al., 2002: 306-7). Another commentator presents the opposite view, arguing that for numerous spectators, the collapse of the Twin Towers ‘was a trauma—without direct stress’. What they witnessed, he claims, was ‘the unthinkable’, which did ‘not stem from a threat to life but rather from a threat to one’s image of the world’. Trauma should therefore be conceptualized as the experience of ‘shocking novelty’ and may include ‘exposure to extreme brutality, disfigured dead bodies, people jumping out of windows, or major loss’ (Shalev, 2004: 175). For this commentator, distant trauma has bearing on rethinking trauma in general.

Nevertheless this debate should not obscure the underlying framework from which the question of media posttraumatic effects is approached. The operative term here is exposure—a term that subsumes an entire catalogue of orientations enfolded in the act of viewing and converts it into a largely passive stance. Such a stance persists regardless if posttraumatic effects are ascertained or not. Furthermore, on one point virtually all studies—including those that deem media’s influence minimal—readily concur: that mental health professionals should be involved in future media coverage
of disasters, both on the broadcaster’s side and on the audience’s. As one psychiatrist sums it up: ‘we have sufficient research in hand to develop guideline and practices that limit the potential negative effects of excessive viewing of traumatic imagery. All parties—viewers, networks, and the scientific community—have critical roles to play in this prevention effort’ (Putnam, 2002: 312).

This preventative intervention conforms to a development identified by Fassin and Rechtman (2009) of the rise of proactive involvement by mental health professionals in situations of crisis and disaster. Such intervention, which would have been unthinkable three decades ago, relocates psychiatrists and psychologists from the clinic to the site of impact to supply on-scene preemptive therapy. From a mental health standpoint, the media presents the risk of amplifying the site of impact, sending aftershocks far beyond the area of direct danger. In this sense, media coverage of disastrous events is a disaster site in its own sake, requiring an appropriate emergency protocol. A recent study conducted following the Boston marathon bombing in 2013 calls media outlets to ‘recognize that repeatedly showing gruesome, distressing images is not in the public interest’. While ‘it is important to stay informed’, the authors urge local health care providers to advise the public, especially those prone to stress, ‘to limit the time spent watching news coverage of events in the immediate aftermath of a highly publicized local or national trauma’ (Holman et al., 2014: 97). Taking a break from the news when disaster strikes is now the official advice of the American Psychological Association (as well as Dr. Phil’s!).

If media do indeed present a risk of trauma, those working in the media are most likely to be affected. As Carrie Rentschler (2009) argues, the language of trauma has penetrated journalistic labor, making journalists whose reporting touch death a species of ‘first responders’, and hence prone to the same psychological
afflictions that await those arriving first on the scene. Psychiatric studies confirm that war correspondents are as likely as combat soldier to develop PTSD (Feinstein et al., 2002). Yet it now seems that journalists working in the studio are also at risk—the risk of excessive exposure to traumatizing images. A recent study on newsroom employees found high rates of intrusive memories among those who have been exposed to ‘violent video clips’ during their work. These ‘intrusive memories were similar to those occurring in PTSD patients’ (Weidmann and Papsdorf, 2010: 269).

The risk that newsroom workers face is more akin to that of the television audience than to on-scene reporters. The newsroom occupies a hybrid position on the ‘trauma spectrum’: witnessing tragedy from afar but in proportions amounting to work hazard.

As per DSM-V media caveat, it all comes down to whether exposure is work-related or not. Thus a newsroom reporter’s claim might be valid but not one by a member of the audience. However, the growing acceptance of distant trauma among mental health professionals might portend otherwise. For neither risk of experiencing ‘shocking novelty’ nor risk of overexposure are exclusive to the workplace. Indeed, warnings to limit television viewing during and after tragic events further confirm the plausibility of both risks at home. The point here is not whether the risk is real or not, but rather the rationale behind recognizing only one type of media exposure.

Children are a case in point: although virtually everybody in the psychiatric establishment agrees that young children are most likely to be affected, DSM-V unequivocally rejects media exposure as cause in children posttrauma. As the note following clause A.2 stipulates: ‘Witnessing does not include events that are witnessed only in electronic media, television, movies pictures’ (2013: 273). The risk narrowly accepted for adults is completely rejected for children. Ironically, children watching TV at home were the first research subjects of ‘distant trauma’, but adults at
work are the first to benefit from its clinical diagnosis. The rationale might be found elsewhere: the inclusive exclusion of media in DSM-V comes in a time when the possibility of distant trauma is increasingly gaining recognition. In the post 9/11 context, the prospect of formally admitting traumatic media exposure into the home might carry momentous economic, legislative and social consequences. What the selection of work-related exposure indirectly achieves is the preclusion of audience PTSD claim from the outset.

**Drone Stress**

According to recent studies conducted by the US Air Force, remotely-piloted aircrafts operators flying missions over Iraq, Afghanistan or Pakistan from ground stations in the American Southwest, show stress symptoms typical more to ground troops than to pilots (Bumiller, 2011; Lindlaw, 2008; Zucchino, 2012). One operator describes the distinctive nature of his work: ‘You are going to war for twelve hours, shooting weapons at targets, directing kills on enemy combatants, and then you get in the car, drive home, and within twenty minutes you are sitting at the dinner table talking to your kids about their homework’ (quoted in Singer, 2009: 347). Remote-controlled warfare gives rise to a new constellation of psychology and technology, one that fuses extreme visibility with extreme distance. In terms of the cases discussed here, if trauma films paradigm is about seeing distressing things happening to far-off strangers but not to me, and if distant trauma is about seeing distressing things happening to far-off strangers that could also happen to me, the situation of drone operators is about seeing distressing things happening to far-off strangers because of me.
Drone operators’ occupation has recently been described as ‘the labor of surveillance and killing’ (Asaro, 2013: 197). This combination is said to contribute to the combat-related stress some of them experience. Flying a drone can be an exceedingly monotonous task, sometimes involving surveilling a single target around the clock for days and weeks. In the process, operators become acquainted with local routine and terrain, as well as with ground troops deployed in the area, with whom they feel camaraderie despite the distance (Gregory, 2011: 200-1). As one Air Force Colonel puts it, ‘These guys actually telecommute to the war zone…the band of brothers is built online’ (quoted in Zucchino 2012). But then there are those high-adrenalin moments when operators zoom in to eliminate the target. Unlike fighter pilots, who fly thousands of feet away from target, drone operators have real-time high-resolution view of the strike—and its aftermath. Those who are farthest from combat can see more of it than those physically there, particularly when it comes to close-up details of civilian casualties (Holmqvist, 2013: 542). Their vision is ‘eighteen inches of the battlefield’: the distance between the eye and the screen’ (Gregory, 2011: 197). Balancing war on remote and life in suburbia, on the one hand, and maneuvering between mind-numbing observing and spasmodic killing, on the other—such are the makings of a new type of combat-related stress.

Air Force officials prefer to describe operators’ condition in terms such as ‘burnout’, ‘existential crisis’ and ‘operational stress’, distinguishing it from PTSD symptoms (Martin, 2011; Sifton, 2012). The cause, according to the official explanation, does not stem from visual exposure to combat (Ouma et al., 2011: 1). However, when drone operators speak publically, they tell a different story. Former sensor operator Brandon Bryant describes the following scene:
And there’s this guy over here, and he’s missing his right leg above his knee. He’s holding it, and he’s rolling around, and the blood is squirting out of his leg, and it’s hitting the ground, and it’s hot. His blood is hot. But when it hits the ground, it starts to cool off; the pool cools fast. It took him a long time to die. I just watched him. I watched him become the same color as the ground he was lying on.

Upon discharge, he was given a scorecard of his missions sporting a total number of kills: 1626. He was later diagnosed with PTSD resulting from ‘a soul-crushing experience. An experience that I thought I’d never have. I was never prepared to take a life’ (quoted in Power, 2013).

Heather Linebaugh (2013), a former imagery analyst for the drone program, offers another account:

I may not have been on the ground in Afghanistan, but I watched parts of the conflict in great detail on a screen for days on end. I know the feeling you experience when you see someone die. Horrifying barely covers it. And when you are exposed to it over and over again it becomes like a small video, embedded in your head, forever on repeat, causing psychological pain and suffering that many people will hopefully never experience.

Still another account is brought by video artist Omer Fast (2011) in his film 5000 Thousand Feet is the Best, which features, among other depictions, an interview with a blurred-face drone operator:

You see a lot of death. You know, you see it all. As I said, I can tell you what kind of shoes you are wearing from that far away. It’s pretty clear about everything else that’s happening. I mean there came a point after five years of doing this that I just had to think about, ‘wow so much loss of life that was a
direct result of me’… A lot of people look at me like, ‘how can you have PTSD if you weren’t actively in a war zone?’ Well, technically speaking every single day I was active in a war zone. I mean, I may not have been personally harmed but I was directly affecting people’s lives over there every single day. There’s stress that comes with that, with having to fire, having to see some of the death, to see what’s going on, having anxiety, looking back at a certain situation or incident over and over and over, you know, bad dreams, loss of sleep. You know, it’s not like a videogame. I can’t switch it off. It’s always there.

What these accounts reveal is something other than burnout or operational fatigue: the story they tell is of witnessing in full detail the death of distant strangers whose killing was of their own doing. Their posttraumatic symptoms all point to a moral conflict prompted by the increased visibility of the airstrike and its aftermath. The technological ability to act from a distance, so argues Zygmunt Bauman (1990: 31), serves to eliminate ‘contact between the actors and the objects of their actions, and with that naturalized its morally constraining impact’. Bauman refers to Stanley Milgram’s (1974) experiments on obedience to authority, where the technological mediation of action (administering electrical shocks) accounted for the rate of obedience, which ranked highest when actors were kept separate from and blind to the effects of their actions. Clearly this is not the case with drone operators, who embody a situation Milgram (and Bauman) did not anticipate: great distance combined with great visibility. Their actions are technologically mediated across great expanses but likewise are images of the carnage wrought.

Clinically speaking, drone operators’ stress is arguably closest to what has recently been termed ‘perpetration-induced traumatic stress’ (PITS): a form of PTSD
caused not by being a victim to trauma but by being an active participant in producing trauma (MacNair, 2002). Although the psychiatric establishment is yet to recognize PITS classification, DSM-V parenthetically acknowledges the condition under ‘peritraumatic factors’, which include ‘for military personnel, being a perpetrator, witnessing atrocities, or killing the enemy’ (2013: 278). That one can be traumatized by the violence one inflicts on others is a possibility already entertained by Freud—traumatic guilt alongside traumatic fear (Young 1995: 80). Such is the trauma of killing: ‘Looking another human being in the eye, making an independent decision to kill him, and watching as he dies due to your action combine to form the single most basic, important, primal, and potentially traumatic occurrence of war’ (Grossman, 1996: 31). For this reason, combatants killing at a distance, such as pilots, mariners and artillerymen are consistently reported to be less encumbered by the psychological agonies of war (1996: 108-9).

Following the Gulf War conflict, Jean Baudrillard (2001: 243) famously commented: ‘The isolation of the enemy by all kinds of electronic interference creates a sort of barricade behind which he becomes invisible… it becomes impossible to discern whether or not he is dead’. The cutting-edge war technology at the time was the ‘smart bomb’ with its onboard television camera transmitting images, later widely broadcast, of a continuous zoom-in descent, culminating with a blank screen: the destruction of both bomb and target. Drone technology presents a reversed relation between strike and image: visual surveillance not only precedes the strike but lingers long after to ascertain the kill. As opposed to the sterilized killing of the ‘smart bomb’—a prime example of Bauman’s ‘distant technology’—high-resolution drone cameras supply the enemy in plain view before, during and after the strike. In this version of panoptic power, images of the surveilled return to haunt the observer.
One of the remedies offered likewise focuses on the visual basis of the condition, seeking to minimize image definition:

To reduce RPA operators’ exposure to the stress-inducing traumatic imagery associated with conducting airstrikes against human targets, the USAF should integrate graphical overlays into the visual sensor displays in the operators’ virtual cockpits. These overlays would, in real-time, mask the on-screen human victims of RPA airstrikes from the operators who carry them out with sprites or other simple graphics designed to dehumanize the victims’ appearance and, therefore, prevent the operators from seeing and developing haunting visual memories of the effects of their weapons (Fitzsimmons and Sangha, 2010: 11). Operators, on their part, resort to other coping methods, which equally rely on visual technology. A favorite pastime, as the operator in Fast’s film reports, is video gaming: ‘A lot of guys over there, believe it or not, play videogames in their free time. I guess that’s their way of unwinding… I guess Predator is similar to playing a videogame, but playing the same videogame four years straight every single day on the same level’ (Fast, 2011). If the mediated battleground is the origin of trauma, the pretend battleground is the outlet for its acting out. The screen is the primal scene of both the enactment and reenactment of the mediated traumatic experience. The videogame repeats, both in content and form, elements form a drone mission, albeit with the relief of ‘game over’ with no casualties. In this, operators intuitively exercise principles of exposure therapy, the most advanced techniques of which employ virtual reality technology to recreate the traumatic scene (see Valiaho, 2012).

Drone operator’s plight captures most distinctively the stakes involved in trauma through media. However controversial, their claim to PTSD fits squarely with
recent DSM-V criteria, being a traumatic media exposure suffered in the line of duty. Theirs is the continuation of perpetration trauma by technological means. Yet perpetrator trauma, to the extent that such exists, is a condition that traffics on a problematic premise: it casts both aggressor and victim of aggression under the same category of psychic suffering. Here, moreover, the perpetrator is situated in an air-conditioned booth thousands of miles away from action while claiming to be affected as if being there. Being exposed to warzone imageries but not to warzone risks makes the perpetrator suffer from a ‘moral injury’ (Maguen and Litz, 2012). Yet in pleading for recognition of their own plights, operators obscure the suffering of those targeted by them. Media-enabled violence leads to media-enabled guilt, which in turn leads to media-enabled posttrauma—the perpetrator ends up as a victim of his or her own mediated violence.

**Conclusion: Trauma and Morality at a Remove**

Witnessing the pain of others from afar is a modern condition drastically intensified by modern media. At its core is a moral predicament: the ability to witness distant suffering far exceeds the ability to intervene in the misfortune. If there is a sense in which media can be said to implicate morality, it is in aggravating the disparity between seeing and doing. Whether it is Luc Boltanski’s (1999) account of distant suffering in terms of ‘the politics of pity’, or Susan Sontag’s (2004) plea that atrocious images continue to haunt the observers, or John Ellis’s (2000) admonition to worldwide audiences: ‘you cannot say you did not know’—what these formulations presuppose is a clear distinction between those who suffer and those who observe suffering, between the unfortunate and the fortunate. Only as long as this disparity persists can the situation be regarded as presenting a moral predicament. The
growing acceptance of trauma at a remove marks a decisive shift: the observer becomes the sufferer. And with this shift, the moral problem in observing distant suffering is occluded.

As the psychiatric approach to media gains professional and popular traction, issues of public health become conflated with issues of public sphere. Consider a recent controversy in the academia: a number of US colleges are now compelled to issue ‘trigger warnings’ altering students that the material they are about to see in class might be upsetting, or even cause posttraumatic symptoms in victims of rape or war veterans (Medina, 2014). That some expressions might be offensive is an old freedom of speech theme, and as many debates demonstrate, the very threat of legal sanction is often enough to bring about inhibition of expression. Under a mindset deeming the individual as needing protection from the media for therapeutic reasons, the traumatic effect might become the new chilling effect. Broadcasters’ statements informing the audience before showing distressing images, or government agencies warning susceptible populace against excessive media exposure, can be seen as first signs of acquiescence to the mental health mindset. While the clinical status of distant trauma is still under debate, the popular discourse surrounding it is already afoot.

The foregoing discussion interlinks with the critique of the literalization of trauma. As Leys (2000; 2007) affirms, the literalist view—the prevailing view of trauma nowadays—suggests an external violent event that befalls a passive subject, leaving a direct and indelible imprint in the mind. The problem with this view, according to Leys, is that it sidetracks other, more complex, psychic processes, including those that imply the subject’s collusion in the event or in what makes it traumatic. A similar problem can be identified, on a social scale, with respect to
trauma through media: at issue is not the psyche per se but those elements in reality deemed detrimental to the psyche. Once psychiatry declares, however restrictively, media effects as potentially traumatic, it appropriates a complex social, cultural and technical process and converts it into an individual mental problem multiplied to mass proportions. Engaging with distressing images is channeled through private psychic experience under pathological framing. The result is a mass scale literalist view of trauma, where the focus on the observer obscures the conditions under which images come to assume traumatic impact in the first place. From a psychiatric perspective, both television viewer and drone operator are observers who suffer from watching others suffer. From a moral perspective, the two are worlds apart. Whether observers can be wounded by what they see is a question for critical rather than clinical history.

It is therefore important to develop a critical evaluation of traumatic processes at a remove, for what is at stake is recovering the moral position of witnessing distant suffering. This does not mean renouncing the consideration of trauma—which would leave it in the hands of psychiatry and psychology—but rather exploring alternative conceptions of trauma. An example is the concept of ‘cultural trauma’ which refers to the social construction of certain events as traumatic for a society (Alexander, 2004). Such metaphorical employment of trauma favorably contrasts with the literalist view of direct impact. What this study contributes to the critical evaluation is an understanding of the media a priori of the psychiatric conceptualization of traumatic experience: that is, the visual mediation of psychological trauma. Foregrounding the media logic of trauma serves to denaturalize the literalist view, emphasizing instead the threshold operations connecting and separating inside and outside, sameness and otherness. These threshold operations are also the starting point for a renewed discussion of media and morality.
Acknowledgments

For comments and suggestions I would like to thank Wolfgang Ernst, Paul Frosh, Bernard Dionysius Geoghagen, Sharrona Pearl, John Durham Peters, Jan Claas van Treeck, and the five anonymous reviewers.

References


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Notes

1 See APA advice on ‘Building resilience to manage indirect exposure to terror’ at http://www.apa.org/helpcenter/terror-exposure.aspx. See advice Dr. Phil’s webpage on life strategies in a time of war at http://drphil.com/articles/article/1