THE PLACE OF TRAUMA IN PSYCHOTHERAPY THEORY AND PRACTICE

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INTRODUCTION

First, I would like to thank the professional development committee for allowing me to share with you a central thread in my professional lifetime journey. This journey has returned for me the place of trauma as the progenitor of psychoanalytic thinking, and at the centre of the ripples of psychopathology.

In the coming hour I want to place that journey in the context of the history of psychoanalysis and trauma. I want to demonstrate how fertile it is to enter the world of trauma. Like with physical black holes and chaos, through new looking glasses what is sensed as overwhelming can be seen to contain highly logical elements, whose consequences develop and are arranged in highly logical and sensible ways. The alternative is to filter our vision from afar, and be fascinated by the ironies and self-destructiveness of human nature.

I will try to indicate a more common sense, even if less secure, view of human nature and its distortions, with trauma at the centre of distortions. I will refer to clinical advantages of such an approach. I will conclude with the necessity for psychoanalysis and trauma fields to reintegrate on the matrix of new knowledge in neurophysiology and developmental psychology.

History of Psychoanalysis

Freud was introduced to traumatic neuroses by Charcot, in a context where in France the widespread sexual abuse of children was well publicised at the time.

Freud added that with careful listening hysterics revealed that their trauma was childhood sexual abuse. Based on eighteen cases (12 women and 6 men), Freud (1896) stated unequivocally in *The Etiology of Hysteria* that the "determining factors..of hysteria are *one or more occurrences of premature sexual experience*..in the earliest years of childhood." (p. 203) (Freud's italics). These sexual experiences were "stimulation of the genitals, and coitus-like acts". In two cases, Freud had outside corroboration of the events. Two cases involved father-daughter incest (Freud, 1893 pp. 164, 170 footnotes). In arguing for the truthfulness of his patients' stories, Freud noted that they derived only pain and no pleasure from the telling. They came to remember the events during treatment with reluctance and shame. Further, in the process they suffered both the original distress and their later symptoms.

Freud himself may have been motivated in his explorations by his family's and his own childhood traumas and precocious sexual experiences, in the context of an unusual family background. As described by Reder (1989), Shlomo/Sigismund (henceforth we will call him Sigmund) was son to his father's third wife. His mother

Amelia was twenty years younger than his father Jacob. She was the age of Jacob's second son Philipp.

During her pregnancy with Sigmund, Jacob's father died. Soon after his birth, his mother's favourite brother died, and when Sigmund was 17/12, his younger brother died. During his infancy, Sigmund's mother was unavailable to him. During this time, Sigmund was cared for by a nursemaid, who might well have sexually abused him by masturbation according to some, e.g., Krull (1987). At this time too, Sigmund might have witnessed his mother commit adultery with his brother Phillip, the one who was his mother's age. This may have contributed or been the cause of Sigmund's parents separating when Sigmund was three.

In 1895, Freud suffered a major trauma. Emma Eckstein was one of the patients on whom Freud based his sexual abuse theory. By now Freud was sceptical of the current theories of masturbation being psychopathological; rather that pathological masturbation was a result of abuse. He did not believe that masturbation led to hysteria, as Fliess maintained. Nevertheless, he allowed Fliess to operate on Emma Eckstein's nose, deferring to Fliess's belief that he would cut out her masturbatory fantasies, and her hysteria. In a book by Fliess's son Robert, the son believed that his father was molesting him at this very time. He rued the fact that Freud abandoned his seduction theory.

During the operation on Emma Eckstein's nose, Fliess left half a metre of gauze inside her nose, and she very nearly died. Schur (1972), Freud's doctor and a psychoanalyst, described how Freud was traumatised, but within ten minutes had denied and displaced Fliess's negligence. He could not afford to blame Fliess, for Fliess was his quasi-analyst and support. He relied on Fliess for his life, believing that Fliess could cure his hysterical but firmly believed in cardiac symptoms.

The second trauma was the death of Freud's father in 1896, at a time when Freud was troubled by his suspiciousness of his father, and his own incestuous wishes toward his daughter (Rush, 1977). Freud was threatened with the loss of two fathers and extreme disillusionment in fathers including himself. His anxieties, depression, psychosomatic symptoms, and morbid fear of death heightened. By September 1897, he wrote to Fliess in reference to hysteria in his sisters, that he could no longer hold that in "every case the father, not excluding my own, had to be blamed as the pervert..."

Freud shifted blame from adult sexual perversity to child sexual perversity. Children's constitution was polymorphously perverse (Freud, 1905). Hysterical symptoms came to be products of patients' early masturbatory fantasies after all (1906). The Oedipal conflict became central, and here the child desired the parent sexually. For instance, in the case of Schreber, Freud (1911) deliberately did not look at the historical father who had published a book in which he advocated what could only be seen as instruments of torture to treat children's behaviour problems; rather, he analysed the son's delusions of his father's persecution on the basis of the son's Oedipal complex.

As a codicil, Freud suppressed recognition of the importance of trauma in the non-sexual traumatic neuroses after suffering a string of bereavements, culminating in the death of his favourite daughter Sophie. Three weeks after this death Freud used the term "death instinct" for the first time (Reder, 1989; Schur, 1972) (Freud, 1920).

Rather than adults mourning the traumas of loss (perhaps compounded with those in early life as with Freud), once again the child's constitution was blamed, this time as the carrier of death.

It may be said that having repressed his traumas, Freud re-enacted them. He abused his own child, psychoanalysis, by repressing its central creative life force. Of course, his brilliant mind continued to spur analysis of unconscious matters. However, his theories were also restrictive. In such cases, theories can be thought of as symptoms, which allude to and obfuscate the untenable centre. A non-traumatic theory can re-enact the suppression of trauma in both client and analyst, in fact re-enacting its secrecy and even abuse.

Examples of child and patient blame are seeing them as basically polymorphously perverse, subject to innate perverse masturbatory fantasies and desires, emphasis on the oedipal complex, on inner aggression manifesting as supposed attacks on the truth and goodness of analysts and analysis, fuelled by gratuitous sadism and masochism. Treatment involves absorption of the analyst's goodness, not on patients' victimization.

Freud and psychoanalysis have never quite rejected trauma, but it was like an encapsulated theory out of sight of the mainstream.

Nevertheless, psychoanalysis has contributed to the current resurgence of trauma in traumatology. Bowlby has been confirmed in his work on attachment trauma. Horowitz formed a direct bridge from early Freud, which influenced PTSD recognition of reliving and defending against trauma. Kestenberg described effects of Holocaust on adults, children, and transgenerationally. Brenner, Quinidos, and Gartland have attempted to marry the old and the new theories, but succeed only partially. This may be reflected in quaint terminology such as Brenner's oedipal victory for incest.

At times lip service is given to trauma, such as "Yes, but it is the way it is perceived internally that matters." Or, "Life is a trauma."

Whatever the theoretical mix, my experience has been that clinical sense is ultimately usually made through revelation of earlier traumatic facts.

Difficulties and Defences in recognition of trauma

The waves of recognition and forgetting of trauma resemble the features of trauma itself.

It is hard to appreciate the ***massive incidence*** of trauma. Just taking early sexual abuse as an example, its incidence is around 15%, and full father-daughter incest 1%. That is the prevalence of schizophrenia in the community. These percentages must be much higher in deep psychotherapy practices. The proportion of psychotherapists sexually abused is also likely to be higher than in the general community.

It is hard to conceive of the ***enormity of traumatic experience***. As well as a threat of death, it reaches into existential meanings, which make survival worse than death. For a child, it is not only the pain, but also the betrayal of childhood, and life trajectory. If

we look at only two of Freud's traumas, we see his analyst and friend nearly kill his patient through a mad theory coupled with extreme incompetence, and his favourite daughter die. Traumas of patients are not minor.

It is hard to conceive the ***massive consequences*** of trauma. They include intensely painful terrors, depressions and despair, judgements of self, distortions of meanings of self and world, mental splittings and fragmentation, lack of control.

It can be hard (though this is often exaggerated) to navigate ***massive defences*** which obfuscate traumas. It is not only lack of clear memories, mistrust by many of repressed memory, and fear of accusation of supposed therapist enthusiasm for childhood sexual abuse and implantation of memories.

It is also that abuse is not remembered according to normal adult memory models. At the time of abuse, there is often severe dissociation and fragmentation, which is relived with the recall of the abuse. This means that abuse may be represented by vaguenesses, out of body experiences, blanks and changes of consciousness; or a variety of sensations, or re-enactments.

The mind of the child which is thus fragmented may be a somatic and atavistic based mind which experiences sexual assault as a tearing apart or being intruded and occupied by monsters or devils. Involuntary sexual arousal may be misinterpreted as internal desires, easily judged as witch-like promiscuity, possession by the devil and whorishness.

Children naturally see their pain as punishment by authority figures for being bad, and they invent sources for guilt. Abused children are often told that they are bad, female seductresses, bitches on heat, sluts, and whores it is all their fault. Involuntary sexual feelings are the most potent apparent confirmation of this guilt, and shame of innate worthlessness and unlovableness.

Victims are also prone to take the onus for their abuse, as it preserves for them a sense of control, that is, if only they change, things will be OK. Guilt preserves a sense of cause and effect in a meaningful universe. Seeing themselves as powerless innocent victims of evil in their caretakers, makes the world and their worlds untenable.

Children are constrained by their attachment needs and craving for approval and affection to comply physically, mentally and morally with adult desires. Their attachment needs conspire to imagine the very caretaking perpetrator as their saviours. In a hypnotic like split mind, children may approach searching for an approving saviour, yet do what the perpetrator desires them to do.

Lastly, children are not infrequently physically threatened with death if they do not comply or do not keep the abuse secret.

Just last week a patient repeated vaguely at the point of disclosure, "Oh, it did not happen, it is all fantasy." At a second approach, she grabbed herself violently around the neck to the extent that she went blue, and said she felt faint. Eventually with great difficulty she wrote in the tiniest script, "He said he would kill me." In addition, she remembered her father pressing her skipping rope against her throat as he said that.

Another patient is grappling with exposure of her father, as she automatically enters a quasi-hypnotic state in which her father threatened that if she told, he would sexually torture her mother and sister the way he did her.

Frequently as memory is beginning to be expressed victims feel persecuted and may even have delusions and hallucinations, often confused with schizophrenia.

In adult life, intrusion into masturbatory fantasies and sexual life of dissociated abuse fragments continues to make victims feel that they are mad, perverse and to blame.

Careful examination of the relivings of arousal shows the concomitant disgust, nausea, terror of death, and physical freezing. Similarly, the perverse moralities can be carefully dissected from the life-giving innate moralities of children toward caretakers. This is done in the context of hope trust and understanding in a new meaningful world.

Views from trauma perspective

The basic traumatology view of humans is that under ideal conditions they grow toward their potentials according to their life cycles. Stress diverts or distorts their paths temporarily, but trauma is potentially life extinguishing. If it does not kill, its consequences are major disruptions, which may settle into compromise equilibria called symptoms and illnesses.

Trauma and trauma responses can be observed, made sense of, and ripples from traumatic events and trauma responses can be understood logically both prospectively and retrospectively.

The basic trauma package which ripples and later resonates in symptoms consists of cognitions of the traumatic event (Emma may die because Fliess left bandages in her nose), biological, psychological and social survival responses (flight into another room, vomiting out the information, taking cognac for distancing), judgements such as anger, shame guilt, right and wrong of the traumatic event in order to mitigate it (Fliess should be brought to justice and disqualified) and primitive meanings (Fliess is bad and cannot be trusted). This basic node of information is quickly shaped by splittings of consciousness for further survival needs (This did not happen – dissociation. Fliess is innocent, the surgeon is guilty for not taking her to hospital).

I will repeat the basic post-traumatic package, or nodes of information. They are cognitions of the traumatic event, biological, psychological and social survival strategy responses, judgements of them experienced as anger, guilt, shame and fairness), and primitive meanings (such as My father cannot be bad; I was abandoned because I was not worth saving). These packages ramify like ripples in a pond from the site of trauma.

Patients then present with basic packages and holes within them at different points, lines, or chunks along the ripples. Psychoanalysis lost sight of the central commotion, and why defences were used. It said that symptoms bubbled up from internal currents in the pond and defences protected against innate badness.

Centrality of trauma provides a fresh look at the oedipal complex. It is not so much the child's polymorphous perversity, which may draw in the adult, but vice versa, as with the priest and the fourteen year old child. The adult also threatens, apportions blame, distributes attachment and love, and arouses an unwilling child. Perversity lies in using the child's craving for love and attachment against its own ends. Evil, if we are to use such a word, lies in the child being induced to take the blame for its own victimization.

Personal Observations

I became ever more aware of traumas and their consequences. Sometimes I would see fresh traumas in the emergency department in the morning, and their ramifications years later in my rooms in the afternoon.

For me the deciding factor was seeing traumatic events and the formation of the basic packages for the sake of survival. For instance, three days after the 1983 bushfires, I saw that much of the population of Mt Macedon was consumed by intense, naked survivor guilt, for having their houses stand while their neighbours' had burnt down. It quickly became obvious to me that the guilt was instrumental in providing shelters to needy neighbours.

Greed and envy were similarly useful. A woman who lost everything greedily grabbed three frying pans from a welfare store. She was able to trade this excess for other necessities. Envy, such as that some received more than others, led to equalization of distributions.

Judgements such as anger and guilt, shame and esteem, led to a vector total of actions in which most people in a community survived as well as they could.

Splitting of consciousness, dissociation, dual consciousness, and more sophisticated defences helped navigations of survival. Splitting of good and bad meant that people in traumatic situations could hope for something better, and provided motivation to endure. Balances of awareness and unawareness served survival in untenable situations.

I found similar packages for similar reasons in different situations. For instance, child survivors of the Holocaust had also dissociated as children, and were unaware in similar ways to sex abuse victims. For instance, one child survivor thought she was perverse to have images of a shoe in a sea of shit, until she revisited Teresienstadt latrines.

I came to meet other children in my situation who had not recognized themselves as victims. I compiled a book of ten child survivors, indicating their experiences, consequences memories, and transmissions.

The most challenging intellectual project of my life was the putting together my knowledge and experience in two books – one offering a theoretical framework of trauma, fulfilment, and really of life, the other a therapy book using the frame work.

[Distribute Table]Adding to current traumatology theories, I observed that apart from fight and flight, there were six other survival strategies – caretaking, attachment (the one psychoanalysis is most concerned with when considering trauma), goal achievement, goal surrender (including grief), competition and cooperation. Manifestations of the adaptive and maladaptive biological, psychological, and social aspects of these survival strategies ramify in three dimensions, which I call the triaxial framework.

One dimension is the rippling process, arriving at symptoms, or alternately at fulfilment. The parameters axis defines manifestations according to developmental phases, times after trauma, and across generations. The depth axis defines manifestations from instinctive, through moral, identity, and spiritual dimensions.

This three dimensional survival strategy perspective I call the wholist perspective. Its language I call the wholist language. Through the works of Schore and others, we may see that the wholist perspective and its language belong to the right brain, the site of early life, traumatic unconscious and nonverbal encoding. The language can be decoded into ordinary language by various means, including the tracing back to its origins of typical survival strategy fragments, and using transference and countertransference. The wholist language and perps are then the functional anatomy of the right brain.

An example of how a right brain non-verbal dictionary can be translated into a left brain one is to list different types of trauma. You will note that each belongs to one of the eight survival strategies.

So the traumas are – [Table] - allowing or causing another to die, especially one's child; abandonment helplessness or cast out to die; lack of control and powerlessness; despair given in and succumbing; killing someone in fury; engulfment, annihilation; humiliation, defeat, and elimination; betrayal, alienation, decay.

Each survival strategy has its own anger, guilt, shame, and opposites, and rungs on the ladder of spirituality. The wholist dictionary can categorize them all in ordinary language.

Implications for treatment

Many non-specific aspects of psychoanalysis are counter-trauma, corrective experiences. They include safety; a reliable, trustworthy, well-meaning therapeutic relationship; compassion and empathy; a holding environment; regularity; privacy; respect for boundaries; reciprocity; distance, observation, thinking and use of words to describe and contrast past and present situations and their meanings; and non-judgemental attitude.

However, no matter how empathic, with a trauma blind spot therapy can only examine more or less peripheral ripples. It may be interesting, patient and therapist may wonder at existential problems and human nature and its paradoxes, but they will miss the core problems of why life is distorted.

Without a trauma framework, transference phenomena will be misinterpreted. Dissociation may be taken as silent thought. Lateness, absences, defences will indicate patient malevolence, rather than ways of avoiding traumatic terrors.

Specific trauma therapy requires recognition that a person has been traumatised, and a clinical model, which recognizes and makes sense of the consequences. Not recognising a person's traumatic experiences can reinforce earlier dissociations, defences, and secrecy. It reinforces the implications of guilt, shame, worthlessness, and unlovability, further reinforced if the therapist insinuates that the patient is oedipal, perverse, and destructive. The abuse is then re-enacted, rather than understood. At its extreme, re-enactment includes sexual contact.

After recognition that trauma had occurred, sense is made of the consequences. For this, the wholist non-verbal language speaking in typical biological, psychological and social fragments is retraced to its origins, understood, decoded, and translated into left brain verbal language. This will require a retraversing in the opposite direction of traumatic encoding. It requires some re-entry into the original hypnoid altered state of consciousness and some emotional reliving of the trauma. The danger is retraumatization, so it has to be done sensitively. One does not want catharsis, like in films, only an emotional reconnection.

In the healing reconnection, therapist and patient observe a simultaneous view from outside of the past and the present e.g., you were abandoned and in danger then, but you are cared for and safe here and now. The two together form a paradox of sensations, judgements and meanings out of which comes a new creative nodal package. A new historical narrative in the person's conscious control evolves.

Importantly, it is not enough to put trauma into a currently non-toxic perspective. Concurrently, and together with corrective emotional experiences in therapy, traumatic manifestations and their opposite idealizations, are replaced with realistic real time fulfilment alternatives. This is done over the whole triaxial framework.

Reintegration of psychoanalysis and traumatology

Since Freud, we have learned much in child development, neurology, psychology, and traumatic consequences. Traumatology and psychoanalysis need to reintegrate in a new way.

In the reintegration, psychoanalysis will need to take traumatic disturbances seriously and see the ripples as derivative from them. Traumatology needs to benefit from psychoanalytic awareness of a wide variety of feelings, insights into defences, psychosomatic links, and interest in evolution of morality and existential meanings. Its knowledge of transference and countertransference phenomena is important in understanding of reliving of trauma in the transference and countertransference, as well as in the evolution of fulfilment alternatives.

Freud's abused child can be revived, to help the traumatised children and adults around the world.