

PSYCHOANALYSIS AND TRAUMA
Monash Parkville Psychoanalytic Forum
1st June 2002

I will try to tell you a story of psychoanalysis and trauma. It will include a number of subplots, including Freud and his encounter with trauma, my encounter with psychoanalysis and my traumas, and my emergent view of a life-trauma paradigm. Such a paradigm assumes that our basic dialectic is life vs. trauma (not life vs. death, as had been thought). In the process, I will indicate some clinical applications of this approach, which applies traumatology in psychotherapy.

I am giving my talk in story form, because stories engage us and stick in our memories, and because rebuilding a life story is central to trauma therapy. Trauma disrupts life stories and patients come to us to have them repaired and reconstructed. From trauma and meaninglessness being a dominant even if unconscious pulse of a disrupted life, they become part of a purposeful (hi)story of a meaningful life.

So let me start with Freud, the first and most influential figure in the psychoanalysis and the trauma story.

Freud

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

Freud came to state unequivocally in *The Etiology of Hysteria* (1896) 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 was sceptical of theories that masturbation was psychopathological; rather, he believed that pathological masturbation was a result of abuse. *The Etiology of Hysteria* is still a classic, and supersedes much of rediscovered traumatology.

Freud may have been motivated in his explorations by his own unusual family history and childhood traumas. Reder (1989) noted that Shlomo/Sigismund (later 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 Philip.

During Amelia's pregnancy with Sigmund and soon after, the family suffered multiple bereavements. Jacob's father died during the pregnancy. Soon after birth, Amelia'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 Krull (1987). At this time too, Sigmund might have

witnessed his mother commit “incest” with her step-son and Sigmund’s half 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.

Jumping a few decades, in 1895, at the age of forty, Freud suffered a major trauma. He allowed Fliess, his quasi-analyst, to operate on his patient Emma Eckstein’s nose. He deferred to Fliess’s crazy belief that Fliess would cut out Emma’s masturbatory fantasies, and thereby her hysteria. Freud relied on Fliess as his not only quasi-analyst, but also sole support of Freud’s sexual trauma theory; but even more so, he depended on Fliess for his life, believing that Fliess could cure his hysterical but firmly believed and feared cardiac symptoms. Such dependencies can shape compliant behaviour, distort morality, and at times, clinical paradigms.

Fliess failed to unpack half a metre of gauze inside Emma Eckstein’s nose, and she nearly died. Schur (1972), Freud’s doctor and a psychoanalyst, described how Freud was psychically and physically traumatised, but how within ten minutes had dissociated, and eventually repressed, and displaced Fliess’s negligence on to the surgeon who saved Emma’s life. He could not afford to be aware of the truth.

The second trauma was the death of Freud’s father in 1896, at a time according to Rush (1977), when Freud was troubled by his suspiciousness of his father in regard to his hysterical sisters, and his own incestuous wishes toward his daughter. So within a year, 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 intensified. From this time this time, he started to exonerate fathers, and to abandon his seduction theory.

By the following year, September 1897, Freud 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...” Ironically, in years to come, Fliess’s son Robert wrote that around this very time his father was molesting him. He rued the fact that Freud abandoned his seduction theory.

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 it was the child that desired the parent sexually. 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.

Finally, Freud suppressed recognition of the importance of trauma in the non-sexual traumatic neuroses, after suffering another string of bereavements, culminating in the death of his favourite daughter Sophie. Three weeks after Sophie’s death, Freud used the term “death instinct” for the first time (Reder, 1989; Schur, 1972) (Freud, 1920). Again unable to face the truth and to mourn traumatic losses (perhaps a heritage from Freud’s early life), Freud blamed the child again, this time as the source of death, destruction, sadism and masochism.

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, recognition that trauma radiates into symptoms. Of course, his brilliant mind continued to explore unconscious matters. However, his theory was honed to re-enact the original trauma, re-wounding the victims.

Personal Observations

After finishing psychiatry, while in Israel in 1967, I did a study on the effects of the Six-Day War. More than a decade before the arrival of PTSD, I was aware of earlier trauma diagnoses and descriptions. In the 1983 Ash Wednesday bushfires, I led a team to the Mt Macedon area. These experiences and twenty years as consultant in emergency departments, expanded and deepened my experience of people's traumas. In the wider world trauma was becoming recognized again after the Vietnam War. As well, another wave of recognition of the effects of sexual abuse was occurring.

During this time, when in my experience my own and others' traumas were gaining credibility, I started to change my psychoanalytically derived stance. A paradigm, a philosophy, influences one unwittingly. But slowly, as I opened my mind, patients seemed to volunteer traumas which I had ignored for years, and which were ignored by previous therapists for years too. I had done to patients what was done to me. In the outside world some analysts realised that many patients had never "mentioned" the Holocaust to their analysts. My patients had not "mentioned" to me their personal holocausts.

As my blind spots lifted, I slowly integrated my different fields of work. For instance, I saw immediately traumatised patients in the morning in emergency departments, and consequences of similar traumas 20-40 years later in the afternoon in my psychotherapy patients.

I became a firm believer in biopsychosocial medicine, for I saw physical manifestations, often misdiagnosed, of a variety of specific stress and trauma emotions. In the emergency department, I evolved a pragmatic approach to diagnosing symptoms according to a variety of classes of biopsychosocial interactions.

I was lucky to discover a couple of original traumatology concepts. One was a complement of eight survival strategies (fight, flight, attachment, caretaking, goal achievement, goal surrender, competition, and cooperation). You see none of them is original but I brought their adaptive and maladaptive biological, psychological, and social aspects together for the first time.

The second new concept was the triaxial framework, a three dimensional view of traumatology and fulfilment, a map of where and how survival strategies manifest their adaptive and maladaptive biological, psychological and social characteristics. The combined wholist perspective, may help to map the right brain, which is being discovered as the site of unselfaware nonverbal traumatic and fulfilling fragments and gestalts.

What I would like to concentrate on in the remaining time, are some practical ways I have learned to apply a new combined view of trauma and psychoanalysis.

Combination of trauma and psychoanalytic views in psychotherapy

Let us return to the concept of a story. The ingredients, which make up a life story, are also the ingredients of trauma therapy.

1. Recognition

Recognition involves four aspects – that there is a story of trauma having befallen a normal innocent victim, with certain consequences which therapy will elucidate and help overcome.

So First, there must be *recognition* that there is a story. We saw that this is a big first step. All traumas, were initially denied, whether physical or sexual abuse of children, rape, Holocaust, combat trauma, domestic violence, etc. To not recognize, and worse, to disbelieve and blame victims as manipulative, weak, inadequate, perverse, mad and bad, is to inflict what is called the second wound. This may be as painful as the original one.

Recognition has a **second** aspect, often forgotten. That is, that the story occurs in a person, otherwise healthy, normal, good, lovable, with a potentially purposeful meaningful life story. This says more than that the person has resilience, strengths, or good defences. It says that a normal person has been victimized and distorted by trauma, and can be undistorted. Without such hope, there is no point in starting to dig out the story. Luckily, the hope is justified, because alongside traumatic consequences the normal part of the person has developed apart from the distorting effects of trauma. The trauma is only an imprint, a boil, a shadow, no matter how early it has been inflicted.

A **third** aspect of recognition is the specifics of the trauma and its effects and ramifications. Here knowledge of specific survival strategies and their triaxial manifestations is helpful.

The **fourth** and last aspect of recognition is what therapy is about. I have found more and more, that gradual explaining to clients the nature of traumatic disruptions and how they can be integrated into a (hi)story, including the use of transference and countertransference, is useful, and can be referred to when enactments do occur in the transference.

2. Becoming aware

This is often called remembering, and not very helpfully, recovering repressed memories. But to have a story, rather than blindly reliving traumas, one has to be consciously and verbally aware of the traumas.

Trauma is always remembered, but may only be represented in the nonverbal right brain, the site of (un)consciousness in the first three years of life, and the site to which dissociated trauma is removed. When trauma is 'remembered' the sense is that it has always been there, but now it is revealed, it can be thought about, talked about, as against before when it just 'was'.

Conscious memory and awareness, unconscious memory and unawareness are subject to vital survival and fulfillment interests, for instance, as we saw with Freud. Essence of psychotherapy is to untangle the madness of maintaining balances of awareness and unawareness which are no longer adaptive.

Defences, the primary one being dissociation, followed closely by splitting and fragmentation, are called in if unawareness is vital. This occurs as a last resort when one appraises that life has no longer any possible meaning. This happens either when one feels that one is going to die, or when one may as well be dead, such as when one becomes convinced that one is irretrievably bad and unlovable, or that one's caretakers hate, and abuse one for no good reason.

Perpetrators also induce unawareness by threatening death, and making victims feel worthless. Threat of death if they expose the secret may induce unawareness at the point of disclosure.

A patient at point of disclosure said vaguely, "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." She remembered her father pressing her skipping rope against her throat as he said that.

Another patient grappling with exposure of her father, automatically entered a quasi-hypnotic paralysed state in which she was variably aware of her father threatening that if she told, he would sexually torture her mother and sister the way he did her.

Children's dissociations, splitting, fragmentations, and displacements are coloured by interpretations according to childhood developmental phases and atavistic fantasies. Frequently as memory is beginning to be expressed victims feel persecuted by monsters, and may even have delusions and hallucinations, often confused with schizophrenia. The onset of such illnesses may come on at times of sexual and reproductive awakening.

One common defensive means of maintaining a tenuous hope of fulfillment is to take on the guilt and shame for parental abuse. Including a childhood imperative to see their parents as good, children may interpret the bad things happening to them as punishment for being bad. This is reinforced by parents, who denigrate and blame children as sluts and whores. The desire to please adults, and the physiological arousal accompanying abuse is often seen as incontrovertible proof of inner badness.

When masturbation and sex trigger early abuse responses, victims may feel that they are mad or perverse, or they may sink into illnesses.

To take on badness or madness gives hope that through one's behaviour one may change an otherwise punishing world. Without such a defensive hope, life is meaningless, and one may as well die.

It is not so much that patients want to kill truth, but they believe that truth (their defended against memories) will kill them.

Countertransference responses

Therapists may themselves feel threatened by the frequency, enormity, and extent of the consequences of traumas. This may evoke similar defences in them as those in their patients. For instance, patients' dissociation may be mirrored in therapists' not knowing what is happening in their patients. I became aware over time that quite concretely, many silences in which I had thought patients were deep in thought or resisting, as well as forgettings of previous sessions, were actually dissociations. Once aware of this, I was able to work cooperatively with patients on their blankings out, which became distressing to them as they became aware of them. To overcome such blankings out, I have asked patients to write one sentence reminders during sessions, to write summaries of sessions immediately after the sessions, for review in the next session.

Another countertransference response is fear of the perpetrator. This may be rationalized as an 'open mind', or making sure therapists are not 'implanting false memories'. Blame of the patient means both are safe from perpetrators. Therapists may concur with perpetrators' and victims' own judgements of their badness and perversity in order to avoid danger from perpetrators. Alternately, therapists may identify with the idealized part of the split where the child fantasises a rescuer parent. They may fancy themselves to be the all-good rescuer parent/therapist.

We can see that it is a major achievement to include trauma as the central factor in pathogenesis, especially if one's own therapist did not in their own repertoire, and could not clear our own traumatic blind spots, and countertransference responses to others' traumas. If one can adopt a trauma paradigm, emotional outbursts, aggression, perversity, masochism, madness, and badness, can be seen as facets of relived traumas. Patients act them out in transference and countertransference because of their inability or because of their fear to tell their stories in words and awareness.

Ultimately awareness by patient and therapist must include specific verbal memory of all facets of trauma, its judgements (who was bad, needs to be ashamed, etc), and basic meanings, e.g., "My uncle was bad to molest me when I was an innocent small child".

3. Dual focus of attention

At some stage, and this occurs in all trauma therapies, there must be a dual focus of attention on the traumatic episode and its current benign opposite.

Because the essence of traumatic illness, neurosis and madness is the conviction that past trauma has current life (which from outside is called being relived), such a dual focus on the past and actual present results in a Zen like koan, an insoluble paradox. To help its resolution, the original dissociation is traversed backward, right and left

brain can reconnect, and experiences can be thought and told. This occurs in an altered state of consciousness, akin to the hypnoid state in which trauma occurs. It takes skill to facilitate the reconnection sufficiently for emotional awareness to occur, but for the person to not enter total other consciousness and reliving, which will not be remembered on reawakening. Many trauma therapists including myself facilitate clients as soon as practicable to picture both past and present together and to be prepared to not lapse into a hypnotic-like state.

In the resolution of the paradox words and time are introduced. Remember, the unconscious right brain has no words and knows no time. The left brain adds words and time to the traumatic experience. This allows creation of a narrative history. Trauma resolution does not occur by outweighing bad internal objects through good therapist introjections. It occurs by obtaining a clear perspective on a bad past in contrast with a good present.

Because it may take a long time to obtain clear awareness of traumatic events, and because resolution of past and present paradoxes has to occur for many ramifications of traumatic events, therapy may take a long time.

Fulfillment Therapy

I used to think that once forgotten traumas were verbalized (abreacted), the person's self-awareness and common sense would take over and make them normal. However, it takes time to absorb the new perspective of past and present, and then to appose the new template to the multitude of mental nodes which had been distorted by past traumatic views. Correcting distortions of shame, guilt, justice, love, relationships, values, principles, dignity, ideology, religion, the sacred, and existential meanings, and learning to enjoy and develop new views, can take a long time too.

Psychoanalysis and Trauma Therapy

Some aspects of psychoanalysis are actually non-specific counter-trauma experiences. Regularity, routine, reliability, trustworthiness, non-judgemental attitudes, boundaries, kindness, goodwill, giving oneself for the sake of clients, are direct opposites to features of trauma, and provide corrective emotional experiences. These may be explained as replacing bad objects with good. This is useful, but insufficient.

Psychoanalysis has provided free association, which is a potent means of right brain revelation to the left brain. Transference and countertransference are two further potent techniques. So is the reading of a kind of somatic Braille.

However, with Freud's abuse of his child, psychoanalysis forgot to use these powerful tools to reveal the original reasons for the mind's distortions.

In a sense, psychoanalysis has had a neurotic relationship with trauma, which it could never totally repress. At times, analysts trivialise it, as in, "Life is a trauma." Or, "I have an open mind about trauma and what happened to you." Or, "Yes, but it is the

way you perceive it internally, that matters.” To patients this is either non-belief or therapist madness, like saying, “I have an open mind about the Holocaust”. And, “It is really doesn’t matter what happened to you in it, it is the way you perceive it that is important.”

Some analysts like Brenner, Quinidos, and Gartland have attempted to marry the old and the new theories, but succeed only partially. This is reflected in quaint terminology such as Brenner’s oedipal victory for incest.

Nevertheless, some non-mainstream psychoanalysts have contributed to the current surge in traumatology. Horowitz formed a direct bridge from early Freud, which influenced PTSD recognition of reliving and defending against trauma. Bowlby has been confirmed in his work on attachment trauma. Kestenberg described effects of Holocaust on adults, children, and transgenerationally. Schore has helped to paint a neurological substrate for the unconscious in the right brain.

But overall, psychoanalysis has forgotten the rock (trauma) which caused the ripples in the pond. It has concentrated only on the ripples. It must combine the various facets of the rock, the pond, and the ripples in its conceptualization.

Conclusion

I was lucky to live during a time of traumatology’s rebirth, and many discoveries, which could take it to a new level. I was lucky to have a psychoanalytic background, which enabled me to recombine the two splintered disciplines in for me creative and efficacious ways, some of which I have tried to convey to you today.

It only remains to thank you for the privilege of allowing me to talk to you.