Psychoanalysis and Trauma

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Introduction

Trauma or better, traumatisation, places the relation between external reality and psychic reality in focus. This has been a conflictual theme for psychoanalysis throughout its history, e.g. which role to assign to external events and early environment in the causation and maintenance of psychic distress and illness. How is experience represented in the psyche, how is it "personalised", and what role does fantasy derived from drive conflicts play in the shaping of the perception of personal experience? How is the internal world of wishes, conflicts and deficits (resulting from trauma) negotiated in human interaction?

Furthermore, what is a trauma or a traumatising experience? Is it everything that impinges on the psyche and causes developmental problems or arrests, or is it possible to distinguish between developmental disturbance and traumatisation proper? Do specific characteristics of an event make it traumatic, and do specific psychic qualities (or quantities) exist that characterise an experience and make it traumatic? Is there a specific interaction between the environment and the psyche in specific developmental phases that makes an experience traumatic?

The loose and imprecise use of the trauma concept in clinical dialogues has obviously obscured theoretical discourse. One may also argue that the phenomenon of traumatisation itself is so difficult to grasp and is an experience so inherently impossible to empathise with, that our

countertransference as well our theorising suffers from the anxiety and wordlessness of the traumatic experience. This aspect is demonstrated in the phenomenon "conspiracy of silence" observed in populations where massive traumatisation has occurred. The victim or survivor has few words and feel too much shame making it impossible to relate what happened, and others, including professional health workers, turn a blind eye to the traumatised person, who then become isolated with his/hers suffering.

The victim, or survivor, of extreme experiences suffers, however, and there is convincing clinical and empirical evidence that changes and adaptations after such overwhelming experiences are of long duration, complex and far-reaching involving effects in biological, psychological and relational dimensions (Krystal, 1978).

In medicine and psychiatry controversies have focused on the relative influence of biology/heredity and external influences in causing mental illness. This was a central question when Charcot, Janet, Breuer and Freud revolutionised the concept of mental illness. The dominant view at that time was that mental illness was grounded in heredity and degeneration (connected with theories of race and degeneration in medicine). It was in this context that Freud and Breuer developed their theories of the social cause of hysteria (Breuer and Freud, 1895).

Discussions have revolved not only around aetiology, but perhaps more importantly around the mediating forces or processes between the “inner” (the internal world or the genes) and the “outer” reality: e.g. what is an outer reality for a child or an adult? When does this reality become associated with clinical trauma? What is mediating between inner and outer reality? What is the relation between conflict and trauma?

Understanding trauma involves thus basic questions related to psychoanalysis as a theory and science at the same time as the traumatised patient poses clinical challenges with no easy answers.

The early debate and controversies between Freud and Janet, are reflected in today's controversies in the trauma field. Janet held that the traumatised mind

suffered a "feebleness" (la feblesse de l'ame) of hereditary origin (Janet, 1907), while Freud argued that defence against the traumatising influence was motivated, that is, that the dynamics of the mind were at work even when the core-helplessness of traumatisation was present, reflecting a cognitive and psychoanalytic perspective respectively.

The historical and intellectual development of the understanding of trauma and traumatisation

In the following I will present a genealogical approach where concepts and theories on trauma are seen in the light of historical, social and cultural contexts rather than seeing them as a linear development of a growing knowledge base. The understanding and acknowledgement of trauma during the last century is an eloquent example on how theories and concepts are influenced by social forces and represents in itself a critique of the belief in a progressive development in science.

Ambivalence towards the victim

Psychic trauma and the consequences of traumatisation have been problematic and characterised by ambivalence both within psychiatry and psychoanalysis, as well as in society at large. After the pioneering confrontation with the effects of trauma of Freud and Janet, the tide has come and gone with periods of denial and ignorance followed by periods of confrontation, often with accompanying feelings of helplessness and horror. “Blame the victim” and the “Conspiracy of silence” has been two "rejecting" strategies throughout the last century. The first was notably seen during and after the First World War. In the aftermath of the insane fighting with casualties in the hundreds of thousands on both sides, those who reacted with “hysterical symptoms” were often executed for cowardice or treated as malingerers and subjected to inhuman and torture-like treatments which often scared them back to the battle fields. The same accusation of malingering was met with when they afterwards sought compensations for the damages done to them by the war. The term "Renten Neurose" (pension neurosis) was coined by psychiatry as derogatory claim about the "real" motivation for being sick after

being in the trenches. On the other hand dynamic approaches seeking to understand "shell-shock" as a complex dynamic reaction was presented by psychoanalysts.

Wars and crises regularly brought trauma into focus in psychiatry in the last century but subsequently the interest diminished. Kardiner's seminal book on the traumatic neurosis of war, published in 1941 and based on his work with war-veterans from First World War, explained clearly the connection between war-traumas and illnesses and basically described all symptoms of PTSD. The immediate effects of his work after Second World War was, however, poorly reflected in the diagnostic systems. The diagnosis “Gross Stress Reaction”, seen as a psychoneurotic disorder and a transitory reaction to an experience of intolerable stress, with vague descriptions of symptomatology, was soon left out. The veterans of Second World-War was for a long time largely neglected in most countries by psychiatry, psychoanalysis and also by politicians and the general public. In Norway many traumatised war-sailors led a miserable alcoholic life on the streets, in Israel the survivors of the Holocaust, were not acknowledged as suffering from their terrible experiences in the concentration camps, in Germany it took a long time before their own traumatised after World-War II were recognised to mention a few examples.

The ambivalence towards and the neglect of traumatised persons is still a major problem and it is not only in the consulting room that the encounter with traumatisation is filled with gross countertransference problems - the societal neglect impedes the necessary support and assignment of meaning to traumatising experiences so crucial for rehabilitation of the traumatised person.

The tension between recognition and rejection reflects on a theoretical level the understanding of the traumatised as either victim or participant survivor. The first implies seeing the traumatised as subjected to an external event which causes effects for which the victim has no responsibility. The latter implies a relational view stressing the involvement of the subject in a scenario where motives and wishes causing reaction patterns are central.

The apparent contradiction between these points of view may have to do with different stress laid on the traumatic moment or the later reactions to this respectively or with a confusion of these two moments in the traumatising process. While the definition of trauma as the state of helplessness certainly expresses a moment where the victim is laid bare to external forces, the involvement with the traumatic *situation or the perpetrators* and the later reaction to the trauma expresses secondary work with the experience. The subject is either involved in the situation expressing what Breuer called a "hypnoid state" (Breuer & Freud1895) *or* attributes "Nachträglich" personal agency to the event. The last may be clarified by the differentiation between primary and secondary intentionality. Primary intentionality implies self-representations that have been constituted as a responsible centre for the person's own impulses, feelings and actions while secondary intentionality refers to the situation where the subject initially had no intentional participation in the trauma, but as an act of later organization transferred for example bad intentions from other conflictual relationships to the trauma in order to supply an otherwise confusing or terrifying experience with meaning. This distinction refers to conflict pathology and deficit pathology respectively and posttraumatic conditions may be seen as a combination of both.

The development of the trauma concept in psychoanalysis and related fields

When Freud in 1896 coined the idea of sexual seduction as *the* cause of hysteria, he related primarily to the two current conceptions of aetiology in the medical community: the degeneration theory, which he rejected (he was also quite worried about its use in anti-Semitic propaganda), and the "germ theory" derived from Koch's postulates for isolating specific infectious agents. The latter he endorsed during the short period he entertained the specific seduction theory (the affect-trauma model).

The popular history has been that Freud in 1887 supposedly dismissed the conception of an outer force or external incident causing the illness in favour of a purely intrapsychic conception of the neurosis based on unconscious fantasy and conflicting sexual wishes. Behind this reasoning lies a

misconception that Freud first believed in this outer event as causative and that he later stressed instinctual conflict as the causative factor(s) in neurosis. His position, as it developed, was, however, in accordance with later research on how memory is distorted and reworked by fantasy and later experiences, assuring the relative influence of external and internal dynamics as I will show later.

It was thus a case of demonstrating that the effect of an event was dependent on inner psychic experiences and how the child or the adult dealt with them when the peculiarity of time and cause in psychic life are taken into account. The discovery of infant sexuality, and the agency or activity of the child, was of significance in that it could demonstrate that precisely because of the immature sexual drives and wishes of the child, a real seduction could have a serious effect on the mind's functioning.

Both the traumatic origin of neurosis and the traumatic neuroses proper continued to occupy Freud in the following years, and the question in these years became how to reconcile the two apparently distinct, if not contradictory, perspectives: trauma and conflict. In 1919, Freud stated that in the traumatic war neuroses the ego defended itself against outer dangers, while in the transference neuroses the ego had its own libido as its enemy. The theoretical difficulty this implied could, however, be resolved when one could see repression as a reaction to a trauma, that is, all neuroses could be seen as elementary traumatic neuroses.

Freud was thus through his work concerned with time and causation in the psyche and in the relation between experience and mental processes. Already in the nineteen eighties the concepts Nachträglichkeit and (the adjective) nachträglich were introduced to explain a causative chain of events. A process with a bi-phasic causation of trauma was conceptualised where the meaning of for example sexual abuse was first understood in a second event reminding of the first then causing the traumatic reaction.

This points to a complex interaction between outer reality and psychic processes and was taken up by several authors later to explain the late effect

of certain traumas and the accentuating effect of new traumas on earlier traumatic or potentially traumatic events (Varvin, S., 2003).

A summary of Freud's contribution to the understanding of the traumatic neuroses and to their causation could be the following:

1. Freud and Breuer were pioneers in the establishment of the external causation of hysteria and mental illness in general.
2. Freud always distinguished between the event and the psychic trauma.
3. He never denied the existence of incest or child abuse. He denounced the theory that all neuroses had a single cause, sexual abuse. Neurosis had a complex aetiology.
4. He established that there is no one-to-one relationship between the event and memory. Retrieval of memory is looked upon as reconstruction and is motivated, that is, dependent on the context, both internal and external.
5. The conceptions of transference and repetition compulsion implied that experiences could be stored and repeated non-verbally (foreshadowing modern theories on procedural memory).
6. His distinction between anxiety, fear (of something) and fright and showed that trauma is a state of fright in response to a danger, that the experience produces a primitive anxiety state, automatic anxiety, and that experiences that are endured without the appropriate affect cannot be processed and will return in intrusions and traumatic dreams, etc.
7. He perceived the mind as inherently symbolising. First, this was expressed mostly in economic terms as binding (Bindung) of energy. Later this was understood in a symbolisation context as the mind's attempt to bind, connect, on a symbolic level thus giving meaning to the traumatising experience.
8. Freud developed several aetiological. One was the bi-phasic model of trauma in which the second event, where the experience was understood (symbolised), brought about the traumatic reaction. Another not contradictory conceptualisation was the theory of

complementary series: an inverse relationship between the ego's strength and the strength and seriousness of the event underlining a complex dynamics between external and internal forces.

9. Freud's concept of trauma and traumatisation was mainly economic. An important precursor to an object-relational view was, however, present. The concept of stimulus barrier (Reizschutz) was formulated on a quasi-biological level, but can be seen as contained in later relational concepts such as holding.

Even though it is fair to say that traumatising experiences occupied psychoanalysts continuously, the ground was laid for the study of the inner psychic world, the drives and the dreams. The focus on actual incest lost its grounding both in psychoanalysis and psychiatry. A notable exceptions was Sandor Ferenczi.

Sandor Ferenczi's contribution

Ferenczi felt that traumatised patients needed a more direct and intimate approach and this made him aware of the interpersonal aspect of traumatisation and how the child represented the traumatising *relationship* in the psyche. He developed an object-relational perspective of trauma in addition to the psycho-economical model.

Harold Blum summarises Ferenczi's position in the following way:

> *"Ferenczi, though naive about the evidence of actual seduction, noted the hypocrisy, pathological lies, evasions, and silent collusion of the traumatising adults. He was concerned with the revival of trauma and its repetition, though not simply in the transference. The analyst might traumatise the patient because of countertransference impediments and enactments of the analyst. Ferenczi stressed the object-relations aspects of trauma and the child's relationship to the traumatising caregivers, which continues after the traumatic experience. He explicitly recorded sequelae of identification with the aggressor: dissociation, fragmentation, and the split in the child's personality between the observing and*

> *comforting self and the dissociated, traumatised self. The child is relatively helpless, desperate for the love and approval of the parent, or surrogates who are abusive. The child cannot protest, and silently submits to authority. 'Tongue-tied', during and after the trauma, the child also introjects or identifies with the parents' unspoken shame and guilt. He recognised the parents' tendency to project blame and guilt on to the child, and that the child is often punished for the parents' misdeeds. He noted the conspiracy of silence, the censorship, blame of the child, and child's self-blame which so often surrounds and follows child abuse. Ferenczi's work anticipated later concepts of strain and cumulative trauma and contemporary concepts of child abuse".(Blum, 1994) p 874-875).*

The guilt feelings and shame that Ferenczi describes as both the result of identification with the parent's misdeeds and a result of the blaming of the child and projection of guilt are features easily observable in other victims of interpersonal trauma. Ferenczi introduced the concept "identification with the aggressor", which has become an indispensable tool for understanding certain aggressive and self-destructive behaviour of victims. Ferenczi was concerned with the parent's empathic failures, the real traumas and the social and psychological context of traumatisation. He described with genuine clarity the experience of being traumatised from the victim's perspective. From the child's perspective, the words of the adult (the language of passion) became part of the trauma. His paper "Confusion of Tongues Between Adults and the Child—The Language of Tenderness and of Passion" (Ferenczi, 1933) anticipates several of the major themes of modern trauma research.

Ferenczi thus strengthened and laid ground for the development of the object relation perspective on traumatisation in that he developed an interactional perspective on traumatisation.

The war-neuroses

Several leading psychoanalysts had served as army doctors during the First World War. At the international psychoanalytic congress in Budapest in 1918, a symposium was held where Freud developed the conception of an ego conflict (Ich-konflikt) between the peace ego and the new war ego. Ernst

Simmel developed this perspective, in the frame of the new ego-psychological approach and underlined the importance of the *type* of traumatic situation and distinguished between traumatic neurosis in peacetime and in wartime (Simmel, 1944). The significant difference was bound to the fact that the soldier developed a “military ego” as a consequence of functioning in a military unit. This demanded a change in his civilian super-ego and the development of a kind of child-parent relationship to his superiors. This implied regression. His superiors would guarantee him protection and guidance in a situation that was both unknown and dangerous. If this was accompanied by disappointment, the soldier would feel abandoned in the same way as a child when abandoned by his parents. This then became a precipitating cause for a traumatic reaction due to loss of an inner protective agent. The outer, dangerous situation became overwhelming. Simmel placed thus significance to the other in the traumatising process and foreshadowed modern object-relational perspectives on traumatisation (Laub and Podell, 1995). It should be noted that even though the war neuroses were understood in a frame of an ego conflict between the civilian and military ego taking drive conflicts into consideration, this theory was nevertheless social-psychological in its perspective.

Abraham Kardiner's 1941 book, “The Traumatic Neurosis of War” (Kardiner, 1941) describes the chronic vigilance and sensitivity to environmental stress that characterised the posttraumatic state. There seemed to be a lowering of the threshold for stimulation and, on the psychological side, a “readiness for fright reactions”. He described a fixation to the trauma, ego inhibitions and altered relation of the self to the world, chronic irritability and a tendency towards aggressive reactions. The nucleus of the war neurosis was viewed as a “Physioneurosis”, a condition involving both the body and the mind. Not only did traumatic experiences repeat themselves in dreams and thoughts/images, but the survivor also acted as though the original traumatic situation were still in existence, and behaved accordingly, and also suffered a multitude of bodily reactions foreshadowing the symptoms described in the PTSD diagnosis.

Trauma after World War II; mourning and exile

A remarkable ignorance of the consequences of traumatisation set in after World War II, and research and reflection on trauma and the traumatising process did not occur to any noticeable extent in psychiatry until the eighties.

Psychoanalysts had, although apparently with some reluctance, begun to treat Holocaust victims in the fifties and sixties, and several important works appeared at the 1967 International Psychoanalytical Congress in Copenhagen. Jaffe described dissociative phenomena and also discussed the psychotic-like phenomena in these conditions (Jaffe, 1968). Simenauer remarked, "…the disorganization of the personality structure may be a very rapid process. Restitutional processes are also remarkably independent of duration and kind of injury", (Simenauer, 1968) p. 306), in line with Freud's reasoning on complementary series. What was perhaps most important was establishing how later influences (war, extreme conditions in concentration camps, flight, etc), had a decisive influence on personality development. These reflections had, however, relatively little influence on mainstream observation of psychical trauma in the following years.

By then, in the sixties and early seventies, important epidemiological research had demonstrated the relation between the traumas of war (concentration camps, wartime sailing) and later mental and physical disability. This research also demonstrated the latency between trauma and the development of symptoms and increased psychic and somatic morbidity, in addition to increased mortality among the survivors (Eitinger, 1965).

Martin Bergman, one of the pioneers in the treatment of Holocaust survivors, summarized the psychoanalytic work with these patients in the first decades after the war as following the model of the war neurosis. The psychoanalyst tried to get in contact with the pre-traumatic personality of the patient in the hope that then the effects of the Holocaust would be diminished (Bergmann, 1998). This turned out to be inadequate as most of the survivors came to the conclusion that it was too difficult for the psychoanalyst to deal with their

Holocaust experience, became silent, withdrew and discontinued their treatment. He noted further that they came to the conclusion that to survive, one must keep silent and that this coincided with their experiences and survival strategies from the camps. When his group (with Jucovy and Kestenberg) started their work, they decided to make it possible for the survivors to live through their traumatic experiences anew:

"We did not aim at a cathartic release, but instead to help a process of mourning to enfold which had not been possible in the camps" (Bergman, 1998. p. 124, my translation)[1].

Grief had two aspects, the grief over lost family members and the grief over the loss of one's own developmental possibilities, which the patients had suffered in their years of imprisonment. For this purpose, Freud's "Mourning and Melancholia" (Freud, S., 1917) served as a model.

This represented a significant development in the understanding of trauma and its context and in the understanding of the treatment of post-traumatic disorders. Although it is now mostly acknowledged that loss and mourning are important aspects of the lives of many traumatised people, they are often set up as additional factors to be considered (e.g. in the form of taking care of mourning rituals) or, when the mourning process is halted, in the form of an additional diagnosis of depression.

The importance of working with loss, grief and mourning in psychotherapy with survivors became central. According to Laub and Podell (1995), trauma basically implies a loss of trust in an external empathic dyad. This results in a loss of communication with "the other" in the internal world, and this loss leads to a loss of representations and self-observing reflective capacity.

They claim that:

> *"The feelings of absence, of rupture, and of the loss of representation that essentially constitute the traumatic experience all emerge from the real failure of the empathic dyad at the time of*

[1] "Wir zielten auf keine kathartische Abfuhr, sondern darauf, zu helfen, eine Trauerprozess in Gang zu setzen, der im Lager oder später nicht hatte stattfinden können",

> *traumatisation and the resulting failure to preserve an empathic tie even with oneself" (Laub & Podell 1995, p.992).*

Representation and capacity for reflection are, in their view, dependent on the link to an internal empathic other, and therapy must accordingly aim at re-establishing this link.

The work with Holocaust survivors resulted thus in strengthening of the relational perspective and brought loss and mourning to the centre stage of the treatment of survivors. This represented a major advancement and laid ground for what today distinguishes psychoanalytic treatment of traumatised patients from many so-called exposure therapies.

Another major contribution came, however, also from Niederland and his conceptualisation of the survivors syndrome (Niederland, 1981), which foreshadows what is now called complex trauma.

a. Chronic or recurrent states of depression. These depressions are mixed and carry a somatic "mask" which includes, "..neuralgic rheumatic pains, headaches, backache, gastrointestinal disturbances, muscular weakness, and 'general asthenia'", (Niederland, 1981, p. 414). He also noticed a tendency to isolation, withdrawal, and a wordless sadness with occasional outbursts of rage.

b. Anhedonia was closely related to unresolved grief, and manifested itself in an incapacity for feeling any pleasure, including sexual pleasure.

c. Anxiety, a dominating symptom associated with the fear of renewed persecution and transparent phobic fears, anxiety dreams and what he calls "re-run" nightmares, which reflect the persecution experiences.

d. Hypermnesia concerning the persecution events. This is described as one of the most tormenting manifestations. It concerns the "..the survivors' overly sharp, distinct, and virtually indelible memories as far as persecution events are concerned" (ibid p. 416). It concerns both the events and the atmosphere in the concentration camps.

e. Alterations in the sense of identity. This affects the body image and self-image as well as the sense of space and time, and is subjectively felt as a lasting impairment of the self. He noted that many survivors expressed a feeling of being a different person, and in severe cases the feeling of not being a person any more (ibid p. 417).

These features may take on psychosis-like proportions with blunt delusions, which now can be understood as having roots in dissociated states of mind.

f. Psychosomatic conditions. The increased frequency of psychosomatic conditions such as peptic ulcers, vascular diseases and asthma among survivors.

g. Survivor guilt and unresolved grief. Niederland found survivor guilt and unresolved grief in almost all survivors of the Holocaust (he studied about 2000). He did not accept the explanation that the guilt was based on early hostility towards parents or siblings. The survival itself was at the core of the inner conflict, and living meant betrayal of the lost loved ones.

h. Psychic vulnerability in Holocaust survivors. He described the propensity for having negative emotional reactions to reminders of the traumatic experience and, interestingly, also pointed to possible positive effects in that the alerting impact of such events may counteract the lameness and numbing of emotion.

Hoppe's work on the relation between affect, regression and sublimation is important in relation to Niederland's work. His empirical psychoanalytic study on Holocaust survivors showed the ubiquitous presence of psychosomatic reactions (e.g. tension headache, insomnia, gastrointestinal disturbances). and psychosomatic disorders (e.g. asthma, ulcer, hypertension). He related this to “resomatisation” of negative affect and hypothesised that: *“..the enforced regression to pre-oedipal stages during persecution resulted in a revival of the body-self and of an archaic body-image”* (Hoppe, 1968*, p. 326)*. The survivors’ withdrawal and pointed to the lack of basic trust indicating the preponderance of negatively valued inner representations of self in relation to

others. Later research on affect regulation and the importance of internal object relations for regulating affect confirms this view.

The findings and theorization of Niederland and Hoppe is based on encounters with patients who has experiences of prolonged and/or repeated suppression, aggression and traumatisation which repeatedly placed them in a situation where the inner supporting structures fail and a situation where object loss may occur. The inner representation of the persecutor may serve as the only “object resource”. The attachment to the torturer and repeated hallucinations of them may be conceptualised as secondary to the loss of the inner empathic object and the consequence may be impaired relation to this inner supporting structure. This may be contrasted to the healthy infant’s omnipotence with a conviction of invulnerability that is related to a harmonious symbiotic mother-child relationship. When this area in the mind is preserved, even during very harsh conditions, it becomes possible to seek nurturing relationships.

Krystal distinguishes between infantile and adult trauma (Krystal, 1978). While infantile trauma is characterised by the development of automatic anxiety, a condition in which the ego is incapable of dealing with impulses and excitations, and is thus rendered helpless, adult trauma of the massive kind is characterised more by a surrender reaction. The infant becomes overwhelmed by affects without possessing the adult’s possibility of making use of defensive mechanisms and coping strategies, and experiences a state deadly anxiety — not so much a fear of death but rather a mortal biotraumatix terror. Krystal asserts that the adult, in contrast, owing to the existence of some integrity in ego functions, is unable to feel the almost complete regression and terror an infant may feel. The adult ego may then maintain a stimulus barrier to some degree and maintain what Krystal observed as the most important distinction between adult and infant trauma, namely an observing ego.

These contributions related to extreme traumatisation represented important advances in the trauma-field- They showed that this kind of traumatisation may produce prolonged regressive situations that have devastating effects on

the personality in the form of non-integrated traumatic selves and foreshadows many of the central themes in today's discussion on traumatisation.

An important psychosocial dimension needs to mentioned demonstrated in Hans Keilson's seminal research (Keilson and Sarpathie, 1979). He studied Jewish orphaned children after World War II. He described a sequential traumatisation which he divided into three sequences: (1) the persecution, beginning with the occupation of Holland in 1940, ending with a separation from mother; (2) the time in hiding or in concentration camps until liberation and the return to Holland; and (3) the post-liberation period, in which some children remained with their wartime foster parents and others returned to the Jewish community. Not only loyalty and identity conflicts, but also the problems of mourning their deceased parents beset the children.

He found that children who had been more traumatised in phase two, but had had good support after the war, had a better course of adjustment than those who experienced unfavourable circumstances in phase three. If the wartime foster family had been unable to provide favourable support, it reinforced the effects of the traumatic events.

There has thus been an important development in the understanding of traumatised patient after Freud the main perspectives developed was the following:

1. The object-relational dimension of traumatisation and posttraumatic conditions was developed, first by Ferenczi and then Bergman and others.

2. Affect and affect regulation in relation to extreme traumatisation and the role of the body in the regressive states was developed.

3. The devastating consequences for adaptation to family and social life was highlighted.

4. The understanding of the importance of the developmental phase and the difference between childhood and adult traumatisation was better understood.

Trauma - an elastic concept?

Trauma has not had a clear and well-defined meaning in psychoanalysis or psychiatric theory. In the clinic the concept is applied to a variety of experiences and is often loosely used as shorthand for experiences that are burdening, abrupt, distressing, etc. This reflects basic conceptual problems but might also be related to the subject itself in that trauma, in essence, is a failure of symbolisation and evades meaning.

Different types of trauma have been suggested, including shock trauma, cumulative trauma, seduction trauma, strain trauma, extreme trauma, war trauma, incest trauma, etc. This typology refers both to different situations (war, family), different types of exposure (strain, cumulative, etc.) and different types of reactions (shock). There is often a blurring of the distinctions between the traumatic situation, the traumatising process (understood as the process whereby the situation influences the subject), the immediate reaction to the external influence, the later reaction and the end result in the form of a specific condition (e.g. acute or chronic PTSD, personality disorder). There is, furthermore, often confusion as to what constitutes an experience that is traumatic. The term extreme traumatisation usually refers to situations that would have been traumatic for (almost) everyone. Other experiences will be traumatic only under certain conditions (e.g. loss of a close relative).

A key concept in trauma research is memory, and the diagnosis of PTSD may be seen as a way of structuring the “traumatic memory. Freud’s original idea was that it was not the event per se that was traumatic, but the fact that the recollections of them took on the character of pathogenic memories (“Hysterics suffer mainly from reminiscences”, (Breuer & Freud1895) p. 7). What was traumatic was then constructed post hoc based on the effects, and it needed a second factor in order to become traumatic. The memories appeared in a new internal and external context and then achieved their significance as traumatic.

A distinction was made between the immediate overwhelming of the ego and the subsequent psychic trauma. That is, a shock may later become a psychic trauma when experienced as memories in context. It is the *handling* of the

mental impact or later memories that fails. The first phase may then be silent for the trauma to appear later, or the two elements may collapse into one, and the immediate effect of the impact may be traumatic. The first may happen when the subject is able to dissociate at the time of the extreme experience only to be overwhelmed later when the significance of the event poses a threat.

This, then, points to the problem of *what* these memories consist of and how trauma is represented, and further, the nature of the handling or processing of representations and memories of trauma.

Several, for example Anna Freud (Freud, 1967), argued for a restricted definition of trauma. Trauma should be distinguished from other ego-damaging circumstances such as developmental disturbances as the intrapsychic processes are different. A distinction was made between the immediate effect on the ego and the later effects of the posttraumatic condition consisting in further adaptation to an internal environment where ego capacities have been impaired and continue to be so in the face of circumstances provoking traumatic memories. This often results in major inhibitions of ego functioning, anhedonia and general lack of vitality. Developmental interference results also in inhibitions in ego functioning, but more often as adaptations to accumulated environmental failures.

The concepts of cumulative trauma, strain trauma, silent trauma refer to events that in themselves do not constitute trauma but which in sum may exceed a threshold, thus breaking the ego's protective shield (stimulus barrier) and resulting in a traumatic situation, conceptualisations that may have contributed to confusion between developmental interference and trauma.

Some clarifications and several problems follow from this:

Clarifications:

1. Psychic trauma is a complex event involving a individual's personal reaction to an event that is for the individual outside the normal range of experience or outside the average expectable.

2. It is not the event itself but the experience of the event, the personal apprehension, which determines whether it is traumatic.

3. Trauma concerns the ego's inability to deal with the stimuli and the affects aroused because of the impact of the event and later because of the memories of it.

4. Trauma refers thus to something prior that has the status of a basis of something meaningful (expectable environment, personal apprehension) (Bohleber2000).

5. Trauma is always defined retrospectively. It is the effect on the personality that leads one to look for the traumatic origin.

6. Trauma has an effect on development and is in itself a developmental disturbance. Trauma must, however, be distinguished from other developmental interference that does not have the quality of trauma.

Problems:

1. Is trauma a situation imposed exclusively from without, or does the situation become traumatic only when it arouses internal stimuli and affects which are impossible for the ego to deal with? I have in the foregoing opted for the second alternative, but it still is an area of controversy and confusion in the literature.

2. What characterises the memories of traumatisation, and process of remembering traumatising experiences? Is there a specific "traumatic memory"? Do these memories undergo later elaborations?

2. What is the character of the failure of the ego's integrating and synthesising functions?

3. Should the posttraumatic condition be seen as a defence against or as an adaptation to a traumatised internal reality?

4. What is the nature of the posttraumatic process? Are there self-healing processes (posttraumatic growth) and/or posttraumatic destructive processes. Which role does environment play (e.g. psychosocial aid, psychotherapy) in

determining outcome? Under what circumstances do the posttraumatic condition lead to further deterioration?

The trauma field is dominated by a diagnostic approach - a critique

The DSM system resulted in a multitude of illnesses. It represents a neo-Kräpelian descriptive approach and was established as a reaction to the dominating psychodynamic trend in American psychiatry. According to Nemiah this approach succeeded in throwing the baby out with the bathwater (Nemiah, 1998). Years of empirical clinical research and observation were discarded in the process of reaggregating symptoms according to the Kräpelinian model. Hysteria, which was seen as a disorder with both sensimotor and mental manifestations, was split apart by .. “assigning the mental symptoms of hysteria, including amnesia, fugue states, and multiple personality disorder to the major diagnostic category of dissociative disorder and by allocating the sensimotor symptoms (designated as conversion disorder) to the entirely different major category of somatoform disorder” (Nemiah 1998, p.16). The major drawback of such surface descriptions is that disorders that clinically belong to the same complex are treated as distinct and totally unrelated disorders. When they appear in the same person, the clinician has to deal diagnostically with a patient with two illnesses, while he/she hopefully in his clinical work is dealing with one person with one disease. What seemed in the eighties to be an advantage concerning the reliability of diagnostic practice has thus proven to be a major obstacle in clinical practice.

The advantage of establishing the relation between the traumatic event and the later sequel, a relation Freud and Breuer established more than a century ago, is in the DSM system counteracted by dissociation and disaggregation of clinical manifestations and may lead to the development of problematic clinical technologies by concentrating on single symptoms or a single disease instead of the whole person whose problems and symptoms are viewed in the context of the individual’s entire life and personality.

Influences from developmental research, cognitive- and neuro-science

Freud's (1920) conceptualisation of trauma as the breaking of the stimulus barrier, implying a deterioration of the perceptual apparatus' ability to sort out and differentiate stimuli, entails an overwhelming experience where impressions can not be dealt with by the ego-processes, such as thinking and dream work. Torture and concentration camp experiences are maliciously designed to make these "impressions" not only overwhelming and incoherent, but also dehumanising and thus "playing on" primitive and violent aspects of the mind (perverse and psychotic). These man-made disasters have the effect of destroying the process of construction of meaning creating a situation of shock and unexpectedness. To be able to experience something as shocking and unexpected, however, there must be a background of the expected, the normal. The expected is the basis of the common, preconscious, symbolic mediated world or in the words of Hartmann, the "average expectable environment" (Hartmann, 1939). The symbolic mediation concerns symbols on all levels, from verbal high-level to bodily signs and gestures that constitute the environment of the mother and child. The devastating effects of extreme traumatisation, and perhaps what distinguishes it from the more circumscribed single-shock trauma, may be that this background of the average expectable or the background of safety is destroyed.

This view has important consequences. The common symbolically mediated world that we presuppose in all interactions is a construction, the force or effectiveness of which is based on belief and trust. Developmental psychology tells us that this basic trust is constructed by and contained in early-established attachment patterns and structures. These function as templates for the continuous construction of emotionally validated meaning in a dialogic process with internal objects or real persons especially concerning negative emotional states. This is also the basis for meaning construction in therapeutic work. This is, from an existential perspective, an act of faith and involves both trust in oneself and in the other. The internal organisation of these meaning-producing structures may be conceptualised as attachment styles, internal object relations, emotional schemas etc. and is a continuous

activity of the mind. The background safety feeling is based on a set of presupposed structures of meaning, which may not, or at least not excessively, be questioned if breakdown is to be avoided.

This background structure may become defective after extreme traumatisation a view based on developmental research and on internal object-relations as basically dialogic.

Infant research has demonstrated that well-functioning mother-infant dyads give room for “time-outs” where the baby can “process” experiences (Brazelton et al., 1974). This “processing” is the moment where meaning is established (Muller, 1996). The semiotic universe of the mother-infant dyad is in this process internalised by the infant, and lays the groundwork for the establishment a background of safety.

Attachment research hold that the need for protection is a basic motive. Based on experienced and assumed responses from the caregivers, the infant establishes age-specific ways of securing basic needs. Three differences in parents’ response to infant behaviour are envisaged:

1. Sensitively, by transforming infant distress into comfort through positive reinforcement of affective communication and by transforming experiencing into meaningful constructs in an age- and context-specific way. This lays the groundwork for a secure and flexible attachment (type B).

2. Insensitively, by increasing the infant’s distress in a predictable way, i.e. by using predictable punishment for negative affect and thus signalling/teaching the infant that negative affect is dangerous and should be avoided. This has the effect of making the infant rely on cognitive information to enhance security and to suppress affect. This is the basis for the dismissing attachment style (type A).

3. Inconsistent response by unpredictable, intermittent reinforcement of negative affect and by teaching the infant that there is no information that in a reliable way can change the caregiver’s behaviour. This reinforces attachment strategies that rely on maintaining negative arousal and display of affect in

attempts at eliciting protection from caregivers, that is, the preoccupied attachment style (type C).

When confronted with overwhelming danger it may be useful to be able to apply all the different strategies depending on the danger and the circumstances. In situations of extreme traumatisation, avoiding affective display may help survival, while returning to circumstances of possible comfort, such as the possibility of being taken care of by others or, later, in therapy gain empathy from the therapist, type C-behaviour may yield comfort and protection. The uses of different strategies are context dependent and, not surprisingly, sleep and relaxed situations prepare for intrusion while daytime may promote more avoidant behaviour. The dilemma for many survivors is that no strategy gives rest and comfort, and they consequently often experience lack of safety and protection. Central in this line of reasoning is that secure attachment behaviour relies on the use of higher brain functions, especially the integrative function of the prefrontal cortex. Type A and type C strategies preclude or hinder the integration of emotional and cognitive information, and the person is not able to be flexible in evaluating new situations and securing comfort and protection when needed. Both tend to evaluate new situations as if they were replicas of past dangerous events. Thus, when one has had the experience of having been betrayed or felt let down, all interpersonal relationships seem unpredictable (type C) or unreliable (type A) (Crittenden, 2011).

Therapy under such internal circumstances is felt as a dangerous prospect. The reliving of past traumatic experiences may yield some comfort and security but will, on the other hand, often result in new disappointments because the ability to symbolise (use higher brain functions) and thereby integrate, is unstable or often almost not present. The alternative strategy of avoiding affect leaves the subject alone and in isolated despair. Overly displaying affect in relationships may, however, lead to confusion.

Central here is how traumatising experiences are represented in the mind and body and thus remembered. This brings us to the expanding field of memory research.

Memory and trauma

Memory reflects experience. The reminiscences of their traumatic experiences haunt extremely traumatised persons. They appear in modes that are insistent and that feel real, e.g., “flashbacks” and as bodily memories in the form of feelings and sensations, pains and reactions in the autonomic nerve-system. They may be reflected in repetitive behavioural patterns (repetition compulsion), which in therapy is understood as acting in lieu of remembering. These experiences are difficult to reach by verbal reorganisation, often felt as a "hole in the mind" separated from the integrating function of the mind. The memories exist in a mental format that may not be repressed, and thus not forgotten in the way we normally forget shameful and unpleasant experiences.

The central question is how traumatic memories are encoded and possibly reworked by the mind and how traces of these experiences appear in therapy, what the conditions are for working with these experiences in therapy.

Memory research give no evidence for the store-house metaphor of memory described in Freud's archaeological metaphor implying an archaeological search for stored, hidden memories. Perception and encoding are active reconstructive processes using data from different sources to make a picture with a background. Memory retrieval is likewise reconstructive. Linking impressions from experiences to make a more or less coherent picture is made “on the spot” (Pally, 1997) and is not a direct replica of what happened in the past implying constant alteration in memory recall where the context will influence and change the memories. Later recall will contain these changes. A traumatic memory, as far as it is expressed as verbal/conscious memory, may then undergo several changes related to each time it is recalled. This is one of the mechanisms of change during therapy. Pally expresses this in the following way:

> *“In fact, the more often an event is recalled the more memory traces there will be for that event, and the more opportunity for alteration of that memory, since each new retrieval event is a reconstructed*

phenomenon and not an exact duplicate of the original. The repeated re-telling of painful childhood events or conflicts during an analysis alter the memory of those events as more modified memory traces are laid down that include aspects of the therapeutic situation, and therefore they are somewhat less painful and conflicted, it is hoped" (Pally, 1997, p 1228).

Explicit memory (e.g. autobiographical memory) is conscious when it is encoded and may later be retrieved more or less easily. In contrast, implicit memory is the memory for those aspects of experience that are non-consciously processed at the time. Certain information may be stored in memory without us having been conscious of its occurrence, and it can influence current functioning without being experienced as conscious remembering. This concerns memory for shape and form (primed memory), emotion (emotional memory) and skills, habits and routines (procedural memory) each of which is processed in different brain systems. Procedural memory has been central in the discussion on trauma and have been incorporated in psychoanalytic theorising as it concerns how internal object-relations are constructed and affected by hardship or traumas. Clinical experience show that interpersonal trauma involving regression affect basic ways of relating to others and disturb the ability to maintain a sense of basic trust and the ability to establish trustful relationships to others and to preserve a trusting attitude as a capacity that can be held in the mind and used when appropriate. The problem for the traumatised person is at least twofold: there is impairment in the encoding and later mental working through of the experience, and as a consequence the, non-symbolised mental content is forgotten in a less stable way than repressed material. The mental defences against the unwanted mental content are thus weaker in that they are "put away", dissociated, and may easily be triggered by external or internal circumstances.

There seem to be little evidence for the claim that traumatic memories are of totally different kind but the question remains whether memories of traumatising experiences are kept largely unchanged or are worked on and changed later. Dream research seem to confirm the hypothesis that these memories are worked on in a motivated way and modified by unconscious

fantasy processes (Lansky and Bley, 1995).This is also in accordance with dynamic assumptions of psychoanalysis, especially the proposition of deferred action (nachträglich, après coup) in working through of traumatic experiences.

Based on these views therapeutic action for traumatised patients must rely on promoting memorising trauma in a way that activates the integrative forces of the mind. Central in the discussion within psychoanalysis in this connection is the focus on symbolisation.

Symbolisation and trauma.

There have been several attempts in psychoanalysis to arrive at a more comprehensive understanding of the process leading from “raw” unmediated experience to mental representation and then to the establishment of emotional meaning. Central for Freud was the “representation”concept which referred to the representation of the drive, the psychic expression of the endosomatic impulses, which specify the drive as a border between the somatic and the psychic. Representation has preserved its colloquial meaning as a mental representation of the somatic in the psyche. This conceptualisation was broadened and further developed towards a general theory of mental representation and symbolisation.

Freud distinguished between the thing-representation (Sachvorstellungen/Dingvorstellungen) of the unconscious, the word-representation (Wortvorstellungen) of the preconscious and object-representations (Objektvorstellungen) of the conscious (Freud, 1975)[2]. He dealt here with the body-mind problem: how affective-somatic experiences are transformed into psychic experiences. This model of the mind portrays how *binding* is a basic process whereby drive excitation, being a source of anxiety, is bound to mental representation. In this way, automatic (overwhelming) anxiety may be transformed into anxiety that may function as a signal (signal-

[2] Freud combines thus an analogue and a symbolic (digital) representational model, and places the different types of representations in a spatial model of the mind.

anxiety, (Freud, 1926)). Defensive measures may then be taken to avoid catastrophic anxiety implying that the anxiety-provoking situation is interpreted and understood in a way that makes a differentiated action possible.

Mentalisation may be seen as a linking function connecting bodily excitations with endopsychic representations, a process of psychic transformation whereby “unmentalised” experiences are changed into mental contents within a human interpersonal and intersubjective matrix (Lecour and Bouchard, 1997). This is a precondition if these experiences are to play any endopsychic role. There are levels of mentalisation and all psychic content may be placed on a continuum of increasing mental quality between the poles of somatisation and insight. This is an ongoing process in which somatic excitation, and thus psychic content, are constantly reorganised on different levels of mentalisation, including bodily excitation, acting, dreaming and higher levels of abstraction.

Meaning is, however, not only attached to representation in language but is also inherent in the preverbal organisation of emotions (embodied meaning).

What concerns us here is this on-going process of binding excitation and reorganising experience, bodily and psychic, that is, how experience is organised and acquire meaning. Mute suffering of the body, for example in the form of somatic symptoms of psychic origin, is a central concern for the study of trauma. The body may become the scene for the wordless drama of the traumatising experience. Words do not reach the wordless representation of experience. Semiosis, the study of sign processes as a dynamic and dialogic process where meaning is established is thus central for understanding of how traumatic experiences can be worked with.

In the philosopher Peirce's semiotic and interpersonal model for the ongoing symbolising process a sign has a symbolic relation to the object only insofar as there is someone who interprets it as such; another sign functions as an interpreter (interpretant) of the first sign, depicting how this sign is a symbol for the object. The interpretant needs yet another sign (as interpretant) to function as a symbol, and semiosis, symbolisation and meaning creation, is thus in principle a perpetual process. The symptom may be seen as a frozen

sign, where the interpretant is lacking or not available. Therapy may set the process of semiosis in motion.

The interpretant may be a thought, a word, but also an action or affect. Its is an on-going process in all dialogues and lays at the heart of the psychotherapeutic process (Muller, 1996).

In psychoanalytical treatments, repetition compulsion provides an example of the dynamics of a coercive relationship that tends to force the other into the position of a mirror image or projection, a situation that precludes recognition of the other. This enactive and iconic mirroring lack a third position (the logical interpretants in Peirce's system), impedes the other's (for example the therapist) ability to reflect and he/she become less available for the traumatised person's need to symbolise traumatic experiences. The traumatised person gets locked in a dependence with diminished capacity to understand other’s and own motives and ways of thinking (lack of mentalisation).

The on-going process of binding or linking described by Freud may be understood as a process of semiosis. This meaning-making represents the process whereby the individual is connected to culture and where experience is mediated by cultural symbols or signs, that is, given a shared culturally determined meaning. Coerced mirroring is a process by which this link to culture and the social aspect is cut off.

Traumatised people act as if they were partly outside the cultural realm of common meaning and their experiences are often short-circuited by the process of cutting off the cultural mediation by signs; in Peirce’s thinking the interpretants of “logic” are not available in the traumatised part of the personality, which is another way of saying that traumatic experiences may be mediated by dissociated representations in implicit memory, and lead to derealisation as the culturally based meaning of experiences becomes less accessible.

According to this viewpoint, trauma is pathological precisely because of this damage to the link to the cultural and social mediation of experience, damage

that curtails the process of transformation of bodily excitation to mental content and also reduces the further reorganisation of levels of mental representation

Culturally symbolic expressions, including language, provide protection against “raw experience”, and are the medium through which we construct our reality. Traumatised individuals have had experiences that are “beyond the imaginable” and not signified (leading to confusion), badly signified (for example, only as images or bodily sensations (signs) or action-tendencies (e.g. fight-flight or freeze), that is, stored in the “traumatic, implicit memory”), or only partly signified.

The severely traumatised person may experience this uncertainty as a mental state with a lack of ability to comprehend what is happening and doubt whether there can be any meaning assigned to his symptoms and sufferings.

Traumatisation results in a de-differentiation of affects, a loss of ability to identify specific emotions that can serve as guide for taking appropriate actions resulting in further dedifferentiation of emotional meaning towards increasingly primitive emotion-meaning schemas.

In man-made traumas, such as torture, body and mind are attacked. The possibility for meaning-making and healing is affected both because of the tendency towards withdrawal and the subsequent disturbance in the ability to use others in a culturally based symbolising process and because of the ostracising of the politically traumatised individual that alienates him/her from the cultural context. The bodily pain inflicted may be the least devastating part of the experience. The “automatic” anxiety produced by the mortal danger and the unpredictability of the situation becomes devastating, because it cannot be linked to representations other than very primitive images or fantasies. Being humiliated and dehumanised often produces a profound feeling of loss of hope and belief in oneself and others. Furthermore, meaning and values are attacked, which makes orientation in time and space very difficult and reorientation through the use of culturally defined symbols impossible for many.

What is seen in the aftermath of extreme experiences is the person's adaptation to a changed inner reality and a modified perception of external reality. (One would also have to include real changes of external reality such as rejection, "the conspiracy of silence", which are always a part of the traumatised individual's experience.) The affect pathology implies a disturbance in the transformative capacity of the mind, and de-differentiation involves a reversal of the ability to work through emotional experiences.

The understanding of extreme traumatisation is here placed in relation to the other, both internal and external, and to the categories of memory, representation, symbolisation and mentalisation. These are seen as different dimensions of the same process, namely the process of re-establishing a personal history and identity through the restoration of the inner empathic relationship. This process represents, in other words, a possibility of historisation through a relationship with the other. The other is, in a developmental perspective, not only nurturing and safety providing, but also the one who can structure the world, make it meaningful and predictable through representing a symbolising function which is then internalised.

Mentalisation is thus a relational process. In the mother-infant dyad, and later between the child and other significant others, there is a sign-mediated dialogue, which is essential in the process of making meaning of experience. This will later be established as a part of an internal dialogue that goes hand in hand with exchanges with others. I have shown how this dialogue, both external and internal, tends to be hampered in persons who are in a posttraumatic condition.

Summary and future development

The scientific understanding of trauma was until Janet and Freud's pioneering work dominated by theories of disposition and inherited weakness of the soul causing psychic illness. Both opened science for understanding the complicated relation between social conditions and mental illness and especially Freud opened for understanding of the structure and the dynamics of the mind and the understanding of the human mind as meaning-producing

and that behaviour, including illness, is the result of attempts to survive psychic pain and to create meaning.

In light of the fact that Freud opened for the understanding of the relation between social conditions and mental illness, it is striking that present-day psychoanalysis is immersed in a intersubjective, constructivist and narrative understanding of psychoanalytic therapy often at the expense of seeing mental phenomena, especially trauma, in its historical context. The emphasis on the transference-countertransference relationship and on technique as means to help the patient reassemble or integrate warded off self-aspects, has marginalized the connection between mental disease and real social occurrences. On the other hand, the foundation of psychoanalysis in biology and the understanding of bodily processes as part of the psychological domain have also suffered in the narrative approach. This development has, in my opinion, made necessary a reconsideration of psychoanalytic theory of psychic trauma and to investigate whether present clinical theory is suitable for the treatment of psychic trauma. Bohleber has emphasised the need to adapt both a psychoeconomical and an object-relational perspective on trauma (Bohleber, 2000). The first concerns the too much of the traumatic experience (the overwhelming of the ego) while the second stresses the experience of loss of the link, or rather dialogue, with the internal empathic other. As I have shown, notably Freud developed the first perspective while the latter is an achievement of later years' psychoanalysis. I see the structural perspective in psychoanalysis as related to the psycho-economic perspective. The “too much” relates to the ability of the psychic apparatus to organise experience and concerns perception, cognition and memory systems and the more or less stable psychic structures which develops in the maturing personality. Extreme traumatisation has as its effect a destruction of the personality. In this field, there is therefore a need to understand psychic structure and the mental processes that that underlies and upholds these structures.

The relational problems associated with the posttraumatic state are equally important and are seen as reflecting basic disturbances in mental processing of experience. I have emphasised how relational needs and relational regulatory processes may become deeply disturbed in the

posttraumatic state. Under normal circumstances, internal good or empathic objects are mediators between self and environment. The clinically observed mistrust and lack of empathy and ability to understand others in terms of mental states may, accordingly, be seen as reflecting disturbances in these inner relationships or dialogues.

There is, however, a need to bridge the psycho-economic/structural perspective and the interpersonal perspective on trauma and traumatisation. I have introduced theories from semiotics as tools to understand symbolisation and there are arguments that a structural-semiotic approach may develop models may represent such a bridge (Varvin, 2003). The objectrelational and the psychoeconomic/structural are different perspectives on the same processes. It is difficult to conceive an objectrelation without an ego structuring the link to the other as mental representations and it is likewise also impossible to understand the state of being overwhelmed without taking into consideration the concomitant loss of the link to the other both externally and in psychic reality. Further, it is clear the mental processing associated with relational problems is an ego-activity and belongs thus to the structural domain. One may say that the two perspectives more represent difference in emphasis than qualitatively different perspective

The scientific understanding of trauma has been highly influenced by social and political issues and conflicting perspectives has thus not only been connected with disputes in the scientific field. One may argue that these are tension that are inherent to the subject of trauma itself.

Psychoanalysis has been occupied with the unbearable of psychic trauma and the state of affairs can summarised as follows:

1. Trauma has been difficult to situate both in psychoanalytic theory and cognitive theory. Social and political conditions have influenced the acceptance and understanding of the traumatised patient as well as the scientific investigation of psychological trauma.
2. Freud’s early formulations, especially in relations to his reformulation of the theory of anxiety from 1926 has proved useful for understanding the dynamics and structure of the traumatic situation

especially in focusing the possibility for symbolisation and mentalisation.

3. The development in cognitive science and neuroscience has proved useful for understanding of emotions, emotion schemas and mental processing of experience. This has been important both in relation to the understanding of what happens during overwhelming experiences as well as afterwards.
4. The semiotic perspective has helped basic psychoanalytic formulations regarding understanding symbolisation, mentalisation and the process of meaning-formation as well as the interactional and dialogic aspects of traumatisation and posttraumatic conditions.
5. The organisation in schemas and scenarios related to traumas may be seen as reflecting mental survival strategies with the double purpose of defending against unbearable memories and cope with stresses of daily life.
7. The distinction in present trauma theory between the psycho economic/structural and the object relational perspective on trauma are seen as aspects of the same model. That is, the object relational perspective is present in the psychoeconomic model and structural theory is presupposed in the object-relational model. There are still conceptual and theoretical problems concerned with the integration of these aspects.

Trauma thus affects the individual on several levels (body, identity, social adaptation etc.) and man-made intentional traumatisation also has effects on a social level (disturbing family structures, group-cohesion and even the stability of whole societies).

Following this, I will argue that further research on psychic trauma and traumatisation must take the following into consideration:

a. The person's relation to others on *a bodily level*. This concerns the emotional interaction with others as well as basic somatic processes influenced by and influencing the basic somato-emotional level of relating to others (e.g. neuro-vegetative

processes). A symptom at this level would be the disturbance in the ability to regulate negative emotion in intimate relationships.

b. The person's relation to others on a *group-level*. This concerns the formation of identity by being member of a group, family, clan etc. A symptom at this level would be the grave identity disturbances seen in refuges who have been dehumanised in torture. The exile situation often aggravates this situation.

c. The person's relation to culture and cultural discourses. This concerns the role played by the store of cultural praxis, literature, folktales and ways of thinking about and solving conflict and problems. This is the level where the individual can acquire meaning from personal experience by relating to cultural modes and values. Disturbance on this level is seen in the tendency to isolate/dissociate traumatic experiences in the psyche and in the traumatised person's tendency to isolate him/her self from dialogues with others and with cultural praxis.

There are important gaps in our understanding of traumatic experiences and responses and it follows from the foregoing that interdisciplinary approaches are needed. The present psychoanalytic literature in trauma has concentrated to a large degree on symbolisation. There is, however, obvious deficiencies in that often not only the interdisciplinary approach is lacking but even reference to other psychoanalytic colleagues and schools, leaving the impression of a scattered scientific field. This has resulted in conceptual confusion and disturbed development. For a development to occur it is obvious that clinical, empirical and conceptual research has to go hand in hand.

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