

TRAUMA: A PSYCHOANALYTIC PERSPECTIVE

A Public Lecture by Rick Curnow, Adelaide, 22/3/07

Tonight I will present an overview (necessarily incomplete) of psychoanalytic ideas about trauma – a personal view about the effect of psychological trauma. First I'll talk in a general way about trauma, and its effect on the individual, and I'll discuss post-traumatic stress disorder. And I want to consider why some people are so disabled after a catastrophe, whilst others are unscathed? Then I'll move on to a discussion on the corrosive effect of trauma on personality development. And again, the puzzle as to why some children emerge from a traumatic dysfunctional family situation so damaged as to present with borderline personality disorder, whilst others become resilient fulfilled individuals.

The talk grew out of my own clinical interests, because psychoanalysis can be effective therapy for selected patients with severe personality disorder. (*These are patients who have long histories of dysfunctional family relationships. As adults they present with a core anxiety about fear of abandonment, and fear of losing close relationships, and disordered behaviours such as suicidality, drug abuse, and self-mutilation proliferate as a means of controlling this anxiety.*) In psychotherapy these patients reveal painful stories of abuse of one sort or another – sexual, physical, emotional – and these abusive relationships are enacted vividly in the transference- countertransference interaction which is part and parcel of psychoanalytic therapy. They are difficult patients to bear, often in a parlous social plight, and their destructive behaviour can be an enormous cost to the community.

So this is the link to trauma. It seems that trauma plays a significant role in genesis of these entrenched and destructive psychiatric illnesses. – and that when it is the caregiver who perpetrates the trauma, developmental processes are also profoundly disrupted. (Fonagy et al 2002).

My other interest in trauma is through my work in the past 5 years or so at STTARS with patients who are specifically designated as Survivors of Torture and Trauma. There I treat refugees who have experienced trauma as a terrifying real experience. These patients have experienced torture and death threats, witnessed death of family members, fled for their lives, and then been incarcerated in Australian detention centres. Such events are a terrible intrusion into the reality of their world. I'll mention a few thoughts about a psychoanalytic perspective on PTSD.

TRAUMA AND THE INDIVIDUAL

Initially, Freud believed that all neurosis was a result of previous traumatic experience ("seduction"), and could be cured by abreaction and catharsis. His view changed. The seduction theory was granted less significance, in favour of an emphasis on the child's sexual fantasies and the excitement they provoked. Actual, real trauma was downgraded as a causative factor, in favour of the excitement and guilt over instinctual sexual fantasies.

In the 1950s, a number of analysts emerged who placed more emphasis on the importance the mothering relationship provided for the developing infant. Minor failure by mother was seen as a stimulus to infantile development – major failure as a catastrophe. Nowadays we think it is important to keep both aspects in mind, understanding the importance of failures on the part of the caregiver, whilst respecting the disruptive power of instinctual forces that emerge from within the individual.

So what is the psychological effect of trauma on the individual? Freud (1920) and later authors (Garland, 1998) suggest that we experience trauma when there is a disruption of a protective barrier in our mind, which protects us from harmful and painful excessive stimulation. In young children this filtering, protective function is largely provided by the mother/caregiver, through her sensitivity in knowing what her child is able to manage at any one time. As we get older we take over this filtering function ourselves, of course, with varying degrees of success.

After a traumatic event (such as the Port Arthur massacre), there may be two distinct phases. There is an initial breakdown when the protective shield is breached by trauma, and there may be a catastrophic disruption of functioning. There is a sense that death is imminent, or that one is threatened by total

annihilation of the self. The victim is often shocked and confused, perhaps unable to take in what has happened. He may be silent and withdrawn, or talkative and excited. Sometimes we describe people in this state as "dissociated".

There may be a further elaboration of psychological symptoms, which could be more insidious. The victim/survivor may attempt to return to normal functioning by seeking a rational explanation for the event. They seek to attribute cause or blame to an agency either external to themselves ("It was the other driver's fault."), or internal ("If you hadn't made me feel so bad....") that is felt to be responsible for their predicament. In the wake of a catastrophe, we are all likely to feel intensely persecuted, and we may link this with deep suspicions we harbour (sometimes unknowingly) about the unreliable nature of those whom we usually trust to care for us. There is a loss of belief in the fundamental goodness of loved ones – how could they let this happen? Sometimes people wish to make sense of the experience by searching for meaning. A trauma in the present may be linked up with troubled relationships and disturbing events from the past which have previously been more or less manageable. And the sense of meaning that is discovered is held on to in an entrenched way that may eventually influence later relationships.

I'll give an example to illustrate these last points. A single woman in her thirties survived a life-threatening cliff-climbing accident. At the time she was referred for therapy, she was depressed and afraid of losing control of her angry feelings. The significance of the accident to her illness only emerged incidentally. She was a fit athletic woman who enjoyed risky sports, proud of her ability to survive by using her own powerful strength, and her careful assessment of the risks involved. However, in the climbing accident, outside circumstances overcame her careful planning. Since the accident, she had "lost her cool." To her surprise and alarm, she found that she was overtaken by contemptuous rage at male colleagues, in angry outbursts that threatened her job. She perceived these men as weak and unsure of themselves. She sought treatment in an attempt to understand the compelling sense of anger she felt at work. I'll sketch in her background. She was an only child. When she was 3 years old her father left home to study overseas, and her mother developed a depressive illness. He was supposed to be away for one year, but only revisited the family sporadically after his departure. He was very successful, and was seen as an ideal achiever by his daughter, whereas she had a rather dismissive attitude to her depressed mother. I might think that she was a woman who had lived reasonably successfully by identifying herself with her successful father, becoming strong and independent, like her admired father. The accident undid that. It seemed that the trauma of her accident had overwhelmed her defences, leaving her feeling like a helpless child. Suspended on the cliff-face she felt weak and completely dependent on her rescuers.

In therapy we could link this sense of weakness and dependency with her feeling of intense vulnerability at the time of her parents' marriage breakdown. One could think that in 'attributing blame to an agent' (see above) she may have felt that the idealised strong masculine figure she had identified herself with had let her down. (Becoming like Dad didn't work when she needed him to be there most.) Furthermore, it became apparent that the time of her father's departure was crucial. She recalled the fearful sense of loneliness when she was left alone with her depressed and apathetic mother. She recalled that she became a little girl who was hypervigilant, ever alert to mother's every need – keeping mother going in order to insure her own survival. The 'sense of meaning' (the second point above) that emerged in therapy was that, as a woman, she had now identified herself with the helpless depressed state of feminine experience as exemplified by her mother when she was abandoned by her husband. Now my patient felt abandoned and depressed in a world where men could not be relied on. Helping her to understand how much these links with her past governed her relationships allowed her to make new and different choices about her emotional life in the present.

This is an important plank of the theory that underpins the psychoanalytic method of therapy. One seeks to understand the way in which the survivor links the recent traumatic event with the frightening phantasies of their internal world that belong to an occasion in earlier life when the survival of the self was threatened.

Two further results of trauma may become apparent. An important sequel for some people, is the loss of a capacity for thinking about mental states and emotional experience, after the event. For example, it may be as though the mind no longer has a capacity to sort out incoming signals – if the feared sound,

sight, smell, etc. is re-experienced, the mind responds with an immediate flood of anxiety. The fright of a sudden car backfire is linked emotionally with the gun-shots of the traumatic event, instead of being processed cognitively as belonging to the old jalopy on the road outside. This is the experience known as flashbacks, and it refers to the sense that you are not just thinking about something that happened in the past but reliving it in the present. It is as though a function of the mind that previously provided an ability to contain anxiety has been disrupted. The internal space or place in the mind in which one could think about events has been lost, and the past becomes real in the present and is accompanied with a flood of anxiety.

Another important aspect to understand is the occurrence of the compulsion to repeat the event, either in a directly recognisable form, or symbolically. This repetition is, at the very least, a sign that something is stuck and has not been worked through, not digested by the mind.

I see a young man at STTARS who survived a massacre, in which members of his immediate family were slaughtered. He survived by hiding for days in thick jungle. He sees several other medical practitioners. He has somatized his emotional pain into severe physical pain, and numbness on one side of his body. He has survivor guilt ("I should have died to save my family.") He is unable to work. He is hyper-reactive to stimuli and he has recurrent nightmares of terrible events that interfere with his sleep. He compulsively relives the traumatic experience daily in flashbacks, and nightly in recurrent nightmares. He has married since becoming a refugee, and has 2 children, but he wishes for death every day, to save his family the torment of living with him. He has severe and intractable PTSD.

Psychoanalytic theory would suggest that the patient is so overwhelmed by this trauma in his adult life, because it links with, re-enacts, a previous circumstance in which the infantile self was overwhelmed by a feeling that the very survival of the self was threatened. This doesn't seem a completely satisfactory explanation. Asking him to re-tell his traumatic experiences, in the hope of relieving his stress, only exacerbates the severity of his painful symptoms. It seems that the trauma he has experienced has resulted in neuro-biological brain damage.

THE BRAIN AND TRAUMA

I'll give a brief survey of reasonably current neurological and psychological research on memory, relevant to thinking about this problem.

For our purpose, I'll discuss two memory systems. Explicit (Declarative, autobiographical) memory is involved with conscious retrieval of information, and relates to remembering events. This is to do with the autobiographical memory of our lives. (eg. I first saw a giraffe at the zoo when I was 4) Implicit (Procedural) memory is content free, and information can be retrieved without the experience of remembering – the example often given is of riding a bike. For the purpose of this talk, it is interesting to think that this (implicit memory) also involves remembering material from very early in our emotional lives, before we had words to encode such events. Emotional experiences of early relationships may be encoded within this memory system. A phrase has been coined that describes this system: the unthought known. This captures the sense of those things that we know, that we are not even conscious of knowing.

Neuropsychological research suggests the two systems (Explicit and Implicit) are independent of each other. The hippocampus and the temporal lobes are involved in the recording of memories of autobiographical events. Explicit memory does not come on board in early infancy, simply because the hippocampus is undeveloped and immature. Thus, early childhood (pre 18 months) amnesia is a reality for sound neurological reasons.

Nuclei within the brain called the basal ganglia and the amygdala are well developed at birth, and these are involved in implicit learning/the unthought known. Relationship-related memories are laid down in implicit memory early on. They are not available for conscious recall because the two memory systems are not related, and therefore these memories are not available for conscious recall in the autobiographical memory system. So we don't 'remember' early autobiographical details or events, but

we have a memory of an emotional sense of ourselves in those early years. And these may be re-experienced in the psychoanalytic relationship, which may be able to make sense of them. (eg. feelings of frustration, or of lack of safety)

I believe that, in severe PTSD, such as suffered by my refugee patient, there is a strong possibility that there is atrophy of the hippocampus, and alteration of the normal function of this aspect of autobiographical memory, as though memories are re-played on endless looping spools of tape.

(Those interested may read further in Pally and Target.)

Some years ago there was a controversy over the work of 'recovered memory therapists' who claimed to recover repressed memories of past parental abuse. I mention it here because the work done in elucidating the association between trauma and memory is of relevance to my talk. Some of these recovered memories became a basis, in a few cases, for sensational legal claims against allegedly abusive parents.

As I read it, the evidence seems to suggest that recovered memories are unreliable. The onset of verbal ability parallels the coming on line of the hippocampus at 18 months. Perhaps the narrative interactions of parent and child during later years ("do you remember when...?") may enhance explicit memory processing – ie. memory of certain events may be enhanced when it is encoded within a secure parent-child relationship. But evidence from severely traumatised patients suggests that excessively high levels of emotional arousal can actually impair memory. Very high levels of the circulating stress hormone, cortisol, may cause damage to the hippocampus, thus interfering with explicit memory. Thus, it would seem likely that memory for events experienced under high stress may be poorly encoded in the mind. Fonagy (1999) goes so far as to state that "perhaps one of the most important signs of actual trauma may be irremediable damage to memory processes."

Target reviews the psychological literature on memory and concludes, amongst other things, that the process of reconstruction of memories of trauma is unreliable and strongly influenced by motivation. (eg. to please a suggestive therapist.) She points out that the defensive mechanism most likely linked with trauma in childhood is **dissociation** (which is a splitting off from emotion, and I'll talk more about this later) rather than **repression**. Repression is thought to be a more mature defensive process - the immature and unstructured mind of the infant has no recourse to repression as a means of keeping unpleasing material out of awareness. Target states: "People who have been seriously traumatised in early childhood are more likely to generate *false* memories of trauma; they sense that something happened, and may feel a pressure to remember, but their reconstructions are particularly likely to be wrong, for example the wrong adult may be identified as the abuser, or medical treatment may be remembered as sexual abuse."

TRAUMA AND PERSONALITY DEVELOPMENT

ATTACHMENT AND CONTAINMENT

I'll describe some work that has been done around Bowlby's Attachment Theory, because it allows us a way of thinking about what is damaging to the developing personality, and what is protective. John Bowlby emerged from the mainstream of the British psychoanalytic group in the 1950s, with his own scientific theories about childhood attachment and separation anxieties, and he was thoroughly rejected by orthodox analysts, perhaps because his theories emphasised the possibility that the environment may be damaging to the infant, in contrast to the enshrined classical instinctual theory.

Attachment Theory was shaped by Bowlby's conviction that loss and separation from parents in childhood were traumatic, and that these experiences initiated **attachment behaviour** based on fear. It is important to realise that the word "attachment" describes a pattern of behavioural response – not a relationship. We describe children as having Secure or Insecure patterns of responsive behaviour. The securely attached child is able to clearly express upset feelings on being separated from a caregiver, and then settles down on reunion. The insecure child lacks the freedom of such lusty expression of upset feelings, and also of

spontaneous recovery from upset. The good news is that the majority of children (65%) are in the secure category.

But there is an additional tiny group of behavioural patterns described when talking about patterns of attachment, and these are labelled **Disorganised**. These are children who live in grossly disrupted, disorganised households where they develop behaviour patterns classified as disorganised. Whereas the majority of children develop a behavioural strategy for dealing with separation, these children seem rather to experience a collapse of strategy. (I'm talking in very broad generalisations here – I am aware of work of great subtlety that examines these difficult areas with careful precision.)

Allen Schore (1994) - neuroanatomist and psychoanalyst – discovered that infants from severely disorganised attachment relationships had a brain deficit. They lacked a tract from the frontal cortex to the thalamic region in the mid-brain - a tract which is thought to be essential in the development of affect regulation (learning to moderate emotional response). All of these neuro-biological research discoveries (including those I talked of previously) lead me to conceptualise personality disorders as brain disorders, rather than behaviour disturbances (Bad Behaviour).

Fonagy (1995) wondered why some children were badly damaged by trauma, and others were more resilient. In his view, a child with a **Secure Attachment** is likely to be less damaged by a traumatic episode because the child is more likely to sort out his or her feelings about a frightening event with benevolent parents.

Reflective capacity is another factor that protects a child from effects of trauma. This has been studied by Fonagy (1995). It refers to the capacity that is present in some people to reflect on their own feeling experience, and also to reflect on the state of mind of another person such as a child. (I'd expect a group like this audience to have a high reflective capacity, by nature of your interest in the topic.) He found the parents' capacity to reflect on the state of mind of their child was helpful in establishing a secure attachment. Thus, in a stereotyped dysfunctional family there is a much higher occurrence of insecure and disorganised attachment in the infants. However in a group of highly-stressed, deprived mothers, those who showed a reflective capacity, with an ability to reflect on their child's state of mind all had children with secure attachments. This capacity of the caregiver to reflect on feelings of others assumes a significant protective function for the child's emotional development.

But what happens to the child of an abusive parent, whose wishes for the child are cruel and perverse. To introduce this, I want to mention a concept from another stream of psychoanalytic thinking: the idea of **containment**.

CONTAINMENT

When all is going well, the quality of **containment** is fundamental in the relationship between parent and infant. It means that the mother can grasp and take into herself, as a container, something of the baby's earliest anxieties. We conceptualise these early anxieties as being a fear about such terrors as being dropped, of falling forever, of annihilation, of ceasing to exist, of death. It has been called a 'nameless dread'. (*My homely example*) The mother can think about the infant's emotionally painful experience in her own way, without being overwhelmed by it. "Containment" is my word to describe the mechanism by which a mother can process the infant's feelings in a state of mind that has been nicely described as "reverie". She can take the panic out of the child's anxiety. Eventually the infant can begin to take into himself something of mother's ability to handle anxiety. A psychoanalyst might say that the infant has begun to internalise the containing function, and will eventually be able to deal with anxiety and frustration without a mother's intervention. The child is now developing the capacity to think about an event, rather than just reacting emotionally to it. We might say that the child has been able to transform the unbearable experience into something that can be thought about. This is a function that attuned parent's are able to do for the child – and that the therapist may do for the patient.

An anecdote: A man who is a successful research scientist has a well-developed cognitive, abstract thinking ability. But he suffers profound anxiety that a severe somatic catastrophe (cancer, heart attack, etc) will annihilate him. In therapy, we hypothesised that he may have experienced a failure in early maternal provision of care – a lack of containment. Luck provided a collateral source of history that confirmed this idea. His mother had severe post-natal depression, and an aunt used to visit daily to check on the survival of the infant. He learned that as an infant he was twice admitted to hospital with a ‘failure to thrive’ diagnosis. We can now talk about his current anxiety and make links with the terror of an infant starving to death. This enables us to develop a sense of emotional truth about his present anxieties – he is able to understand that his fear of death is not a random haphazard visitation, but that it can have this particular meaning attributed to it, that the infant within is in dreadful fear of abandonment and death.

When I say that the infant internalises a function, such as containment, I also want to say that the infant will internalise a representation of the containing figure herself – ie, the caregiver/mother – and a sense of her mind. And this becomes part of the sense of being a container for one’s own aroused feeling states. This is fine in a benevolent relationship. We’ll think later about the destructive quality that might be there in a relationship that harbours abusive intent to the child.

CONTAINER PRESENT AND INTACT

A personal anecdote: - *Anecdote removed for reasons of confidentiality. It concerned a woman who stated she had been abused in late childhood by a family friend, and she claimed that she had experienced no harm. Rather, she perceived it as an introduction to the pleasures of mature sexuality. My point was that the woman very likely had a secure and reflective family structure, which was helpful to her sense of resilience.*

I don’t mean to trivialise this issue. Awful events still happen to children from the most secure homes. But, I think they will have a resilience lacking in children with less secure, or more disrupted, attachments. It may be that, if they seek therapy, they will have a better chance of making contact with the secure relationship offered by the therapist.

My anecdote makes my point that these strong attachment patterns, and parental relationships may provide protection for the child in the event of trauma that arrives from outside the family. But what of the situation where the caregiver is cruel and unloving, or if the child is met with the vacuous emotional state provided by a deeply depressed caregiver?

CONTAINING FUNCTION DISRUPTED

We must now look at the result of lack of containment and disrupted attachment. Here we see how trauma disrupts attachment patterns. For brevity, this will be schematic, and I’ll focus mainly on the effects of sexual and emotional abuse.

(Trauma is not limited to obvious matters such as sexual or physical abuse, but occurs in much more subtle relationships. At a clinical level, in therapy, one is aware of how much anything that disrupts the all-important emotional play within the infant-caregiver couple, may be experienced as trauma and bring about similar disrupted patterns. If the caregiver is not attuned to the infant’s state of mind, and appropriately responsive, the infant is forced habitually to employ defensive behaviours to protect him- or her-self from the psychological presence of the caregiver.)

It is widely known now that abuse does recur down through generations. (One study shows one third of victims of childhood abuse will grow to re-create abusive relationships in adulthood, one third will become abusive under severe stress, and one third will grow to become resilient adults who do not abuse others.)

When an infant is not fortunate enough to have a caregiver who provides benevolent parenting, one way he may deal with the feeling of nameless dread, which is unbearable, is to expel it – to ‘evacuate’, say some analysts graphically. These children become adults who cope with stress by lashing out, physically, psychologically, or both. Their learned response to stressful arousal is to lash out. The child may become

an adult who has learned to deal with a stress such as a crying baby who can't be soothed by lashing out and abusing his infant, thus repeating the folly.

Fonagy (1995) proposes a model to explain why abuse might occur at such a high rate across generations. He refers back to the importance of the capacity to think about our own experience, which is developed in concert with the parent. If the parent is abusive, this process in the child is undermined and under-developed. If you remember, I suggested that containment involved the mother being able to think about the child's painful experience, and taking the panic out of the anxiety. But what if the caregiver is the cause of the painful anxiety? Then surely it becomes unsafe to take in the thoughts and wishes of the parent who actively wishes to harm the child, because that implies taking in and contemplating the real wish of the parent to harm the child. Because of this, the child's development of the ability to think about his personal experience is inhibited. The child learns a defensive disavowal of painful thoughts and feeling states – we call these states dissociative). This has the advantage in the short-term that the child does not have to think about an unbearably painful psychic situation. But the serious long-term consequence of this short-term advantage is that the developing child never acquires the ability to think about personal painful emotional experience. The child never develops the capacity to think about the pain that I have called nameless dread. The child becomes an adult who may learn to "evacuate" his painful feeling in action – and one way of doing this is to re-enact on his or her own children, or towards other people, the same abuse that he or she suffered in childhood.

I said in my introduction that people with a personality disorder respond to the fear of loss with disordered behaviour. Perhaps we can now begin to understand why this might be so. Take the case of an infant living within the chaos of a disorganised attachment. (Mother psychotic/drug addicted, father absent, no thought for child welfare) And in such relationships, we know from research that the caregiver may respond to the infant's distress with behaviour that is either frightening or frightened. This is a mother who responds to distress in the child by either becoming excessively emotionally withdrawn, or overpoweringly angry in a terrifying way. The child learns through repeated experience that any expression of distress will be responded to by a caregiver who abandons him emotionally in a state of anxiety or rage. A developmental tragedy is now unfolding. For such a child, the emotional world remains chaotic. Perhaps in an effort to sustain some sense of structure and coherence in such a chaotic experience, the child incorporates a sense of the other (the raging frightening indifferent other) into his internal world. When confronted with a frightening or frightened caregiver, the infant takes in as part of himself the parent's rage, hatred or fear. As an example: *anecdote removed, concerning a patient who had a physically abusive mother, and who has internalised a representation of Mother who is a vivid aspect of his own personality - which appears in the transference interaction.*

One further gloomy thought. A dangerous development may take place in the post-traumatic situation, and in the treatment situation. The patient may begin to mobilise some anger, which may be murderous in nature. But it may not be immediately possible to express this outwardly, to people in the external world. The anger may get linked up with internal representations of the cruel parental figures, and the anger is then directed at the self. A suicide script may then be in place, ready to be acted on.

TREATMENT

Having reached the darkest moment of my talk let me conclude with a brief overview of treatment possibilities. I hope to finish on a more optimistic note.

It will be apparent that the therapy I offer comes from a psychoanalytic background, but I think there would be many common features in therapies from other perspectives. (Cognitive therapy, group therapy, narrative therapy, counselling, etc, etc) The basic ingredient is to listen. Rather prosaically, I call this "active listening", in that one listens very intently, and responds actively. It has been expressed more forcefully as "the constant availability of the analyst's mind so that within it the patient can discover himself." (Fonagy 2002 p 391) But the listening can be difficult, because one is hearing powerful distress and pain. The therapist is engaged in a kind of balancing act all the time – entering into the painful experience, yet struggling not to be knocked off balance at the same time. And these patients draw one in to re-enactments of past painful relationships as one listens. So there is a sense of being drawn out of a

therapeutic role, and then having to re-find it again. At the same time one must be able to make an imaginative identification with the patient, to enter into the world of their distress.

I find that these ideas I've been speaking about tonight are themselves helpful in the process of listening – they provide a way of understanding, and help me to maintain a balance. (Theory itself offers a containing function.)

I'll return, for the last time this evening, to the idea of containment.

What one hopes to offer to one's patient or client, ultimately, is an experience in which containment of his distress is a possibility. The therapist undertakes to attempt to understand and take the panic out of the patient's most painful anxieties. This can prove to be very hard work. It involves reworking all the traumatic experience with all the emotional impact that entails. A measure of a successful therapy might be that there will come a time when the patient can become aware to a realisation that the therapist, too, has a mind with a point of view. They are both, therapist and patient, engaged in the task of attempting to think about their thinking. Hopefully, the patient will eventually be able to make use of this newly found skill in thinking in order to begin to think (no doubt with a great deal of sadness) about his own painful experiences, rather than expelling them in painful acting out episodes.

Then what is the outcome of a "successful" therapy? A greater understanding and knowledge of one's own internal pain! And an ability to think about one's reaction to pain, and a freedom to make other choices in the future about one's response to pain.

READING LIST

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