

Understanding Trauma

through our own thinking about the significance of what we have seen and heard, both for them as individuals and for the understanding of trauma in general.

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Thinking About Trauma

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What is a Trauma?

Trauma is a kind of wound. When we call an event *traumatic*, we are borrowing the word from the Greek where it refers to a piercing of the skin, a breaking of the bodily envelope. In physical medicine it denotes damage to tissue. Freud (1920) used the word metaphorically to emphasise how the mind too can be pierced and wounded by events, giving graphic force to his description of the way in which the mind can be thought of as being enveloped by a kind of skin, or protective shield. He described it as the outcome of the development in the brain (and therefore mind) of a highly selective sensitivity to external stimuli. This selectivity is crucial: shutting out excessive amounts and kinds of stimulation is even more important, in terms of maintaining a workable equilibrium, than is the capacity to receive or let in stimuli.

For infants and young children, when all goes well, that filtering function is largely served by the mother, or primary caretaker, through her sensitivity to what her baby is able to manage at any particular time. She acts to protect her baby from the extremes of experience, both environmental and emotional. Adults are in a different position. Some will have built up inside themselves, partly as the outcome of good parental provision, a capacity to take care of themselves in the best meaning of that phrase. Others will have been unable to achieve this degree of autonomy. Still others, for a variety of complex internal reasons, will actively seek out situations of risk, or extremes of stimulation, whether for positive or at least comprehensible reasons, or in more darkly self-destructive ways. Yet however well any individual feels he is normally able to take care of what he feels to be his own well-being, some events will overwhelm that capacity, will knock out ordinary functioning and throw the individual into extreme disarray. Much of the immediate disturbance and confusion is visible to the observer but

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eventually it extends far beyond the visible, into the depths of the individual's identity, which is constituted by the nature of his internal objects – the figures that inhabit his internal world, and his unconscious beliefs about them and their ways of relating to each other.

Not all traumatic events of course are that devastating. Sometimes one can see the mind engaged in protecting itself from the potential rent in its own fabric by engaging in a variety of defensive strategies. A man who slipped and fell on some icy steps outside his own front door and broke his ankle clearly heard the radiologist say that it was broken, but he 'knew' the radiologist was mistaken: he 'knew' it was only a sprain. Half an hour later, when the shock of the event had somewhat subsided, he was able to acknowledge that it was indeed broken and that he would be spending Christmas with his foot in plaster. This man was *denying* the extent of the damage so that he could absorb the news more gradually, at a pace that he could manage without feeling overwhelmed.

Sometimes when a piece of reality is felt to be quite unmanageable, the defence is correspondingly extreme. Freud (1924), talking about the route into psychosis, describes the genesis of delusions: 'a fair number of analyses have taught us that the delusion is found applied like a patch over the place where originally a rent had appeared in the ego's relation to the external world.' In a vulnerable character, the delusional 'patch' is clung to and embroidered to avoid the breakdown that would follow if the reality were admitted. A woman who had always had some difficulty accepting the exigencies of reality learned of the death of the youngest of her five children abroad. She was unable to deal with this agonising fact. She believed that he was alive, and that she was the victim of a police conspiracy designed to prevent her from discovering the hospital he had been taken to. Gradually the patch came to take over her whole functioning. She was unable to maintain relations with her older children who were themselves desperately upset not only by the loss of their brother, but also by what effectively became the loss of their mother. Thus the fear of one kind of breakdown, with which she could in time have been helped, was replaced by a more severe and more intractable breakdown in her functioning, in which all help was rejected – to accept it would have been to acknowledge the delusional nature of her belief that the boy was still alive.

So a traumatic event is one which, for a particular individual, breaks through or overrides the discriminatory, filtering process, and overrides any temporary denial or patch-up of the damage. The mind is flooded with a kind and degree of stimulation that is far more than it can make sense of or manage. Something very violent feels as though it has

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happened internally, and this mirrors the violence that is felt to have happened, or indeed has actually happened, in the external world. There is a massive disruption in functioning, amounting to a kind of breakdown. It is a breakdown of an established way of going about one's life, of established beliefs about the predictability of the world, of established mental structures, of an *established defensive organisation*. It leaves the individual vulnerable to intense and overwhelming anxieties from internal sources as well as from the actual external events. Primitive fears, impulses and anxieties are all given fresh life. Trust in the fundamental goodness of one's objects, that is to say the world itself, is shattered – who after all let this terrible event happen? Failed to protect you from it? Worse, might even have wished for or provoked it? Loss of a belief in the predictability of the world, and in the protective function of one's good objects, both internal and external, will inevitably mean a resurgence of fears about the cruelty and strength of bad objects. There is a rapid slide into primitive paranoid beliefs about one's status in the world. Crucially, the anxieties coincide: the external event is perceived as confirming the worst of the internal fears and phantasies – in particular the reality and imminence of death, or personal annihilation, through the failure of those good objects (internal and external) to provide protection from the worst.

Thus a trauma is an event which does precisely this: *overwhelms existing defences against anxiety in a form which also provides confirmation of those deepest universal anxieties*. The damage done, more often than not, is neither trivial nor temporary. Some kind of help is therefore important, whether arrived at fortuitously or sought out, intentional and organised.

Although Freud's description of the way in which such events breach the protective shield is an important, indeed necessary, part of understanding trauma, it is not on its own, as I have already suggested, sufficient. It still has a mechanistic quality. It describes the breakdown in the smooth running of the machinery of mind, but not the collapse of meaning: the failure of belief in the protection afforded by good objects, and from that point onwards the longer-term consequences for the entire personality.

In the Trauma Unit's Workshop, we have come to think of the ensuing processes as the transformation of the traumatic event, whatever it might have been, into a shape that is recognisable as an existing form of internal object relationship. Since an object-relations perspective in psychoanalysis believes that all events are attributable to some notion of an agent held to be responsible for them, for both good and

ill, a traumatic event, not surprisingly, is attributed to some very noxious agent indeed. As I have said, the event provides *confirmation* of the most persecutory of unconscious phantasies about one's objects, even the world itself. The internal good object that one believed one might turn to for protection or for help has been revealed to be careless, or unconcerned, or worse, malignant. Bion (1962) points out how a hunger pain is interpreted by the infant not as the absence of a feeding object, but as the presence of an attacking object. The implication is that as trust in the goodness and strength of one's internal objects is undone, the power and malevolence of bad internal objects increases. It was Melanie Klein's view (1940) that if the loss of the good object, around which the ego has organised itself from the beginning of life, cannot be mourned then the outcome can be a progressive deterioration in the personality. In the Unit, we hear this at almost every consultation: *I'm not what I was. My life has just gone to pieces. I used to get a lot of pleasure from my kids, but nowadays they just drive me mad. I don't care about anything these days.*

Interestingly, whatever the nature of the event, whether an act of God, or man-made, or an intentional personal assault, the outcome is the same: although the individual may struggle to defend himself against this process, eventually he comes to make sense of the event in terms of the most troubled and troubling of the relationships between the objects that are felt to inhabit his internal world. That way the survivor is at least making something recognisable and familiar out of the extraordinary, giving it meaning. Not surprisingly, the internal object relationships that give most immediate sense and meaning to the traumatic event will be those that resemble it, both structurally and in terms of associations. The sunken ship full of dead babies is the mother who struggled and failed to keep herself and her children afloat. The smoke that is heard choking someone to death recalls the loss of a young sibling to muscular dystrophy, similarly choking for air. Yet in a psychoanalytic way of thinking, the most telling of these links will be made less with remembered events than with the non-verbal or pre-verbal registers of experience, which link with primitive notions of the earliest failures of the primary object, and with the unconscious yet annihilating impulses and phantasies that these provoked.

These primitive fears and phantasies, up to the point of impact with the traumatic event, may have been invisible because accommodated to and managed, more or less successfully. From the point of impact, they seem to take on increasing significance. The process of making sense of the senseless, while in some ways recreating order and meaning in the

internal world, will inevitably imbue the event in the present with disturbing meaning from the past; and it is this connection of past with present that is part of what makes the after-effects of trauma so hard to undo.

Freud and Trauma

It is beyond the scope of this chapter to trace in detail the evolution of Freud's thinking on trauma, and its development in the work of later analysts. I am instead going to pick out certain of Freud's ideas which, when put together, seem to offer a sound working basis for the clinician. Later theoretical and clinical developments add to, deepen and enrich this three-dimensional structure, but do not contradict it. It is clear that the history of psychoanalysis and the development of Freud's understanding of trauma are linked. Hysterics, he said in 1893, repress the memory of certain very intense or painful experiences, as well as cutting off the feeling associated with those experiences, preserving it in a 'strangled' state (i.e. bottling it up). The feeling then makes itself visible via 'hysterical symptoms' (i.e. symptoms for which there is no detectable organic cause), which also manage to be symbolic of the repressed memory. The conclusion he reached is that *catharsis cures*: once the original events are brought into consciousness, most importantly along with all the original intense feeling that accompanied it, the symptoms will disappear. Until that point, 'the psychical trauma – or more precisely the memory of the trauma – acts like a foreign body which long after its entry must continue to be regarded as an agent which is still at work ...'

Modern clinicians may still find something useful in this early attempt to understand trauma, disturbance, and its treatment. Certain thoughts or feelings can from a functional point of view become 'forgotten', or sealed-off, existing as foreign bodies within the rest of that mind's functioning until released intact, perhaps by treatment, perhaps by particular events, or by time itself, years later. Moreover, the obsessional preoccupations which are such a feature of the thought processes of the traumatised may represent continuing attempts to process ('discharge' in Freud's language) the intense affect surrounding certain painful experiences. They are perhaps only a short step further on from the flashback itself, the sudden sense of being caught up once more in the overwhelmingly painful events (see Chapter 8) instead of being able to think back on them from the position of the present.

As an example, a successful young Consultant Anaesthetist was

referred to the Unit following a motorway crash, in which he had been severely injured. He was recovering from his injuries, but found himself depressed, brooding over the events of the accident, unwilling to drive, feeling nothing for his girlfriend, and worse, unable to work. He had taken sick leave and stayed at home, but he was aware even after three months that he felt in no state to take up his job again. He was irritable in the consultation, wanting to know where 'the treatment' was, and why I was making no helpful suggestions. I pointed out to him that as he worked in the Health Service he must have been aware that the Tavistock Clinic offered psychological help, a 'talking cure.' I said to him that I thought he must have come here because he had something he wanted to talk about. I wondered what it was. Full of the same irritable scepticism he began, somewhat watchfully, to tell me about himself. It seemed that during his childhood – he came from a Welsh farming family that had struggled endlessly to make ends meet – he had never had a holiday. He had always worked for his parents on the farm, and they had paid him for this work, putting it into a savings account to pay for him to have a good education – to go to University, which would have been a first for his family. He did in fact go to Medical School and was clearly doing well, and had been enjoying his life and although he recognised that his parents' motives had been good, he had nursed a considerable grievance towards them for depriving him of his childhood, as he saw it. During the accident, when he was lying severely injured with a punctured lung in Casualty, he managed to get on the bad side of the Ward Sister, who told him injured doctors always made more of a fuss than anyone else, then mishandled his treatment and left him in a great deal of pain. He found himself frightened, helpless and enraged. He thought to himself that if ever he had to give her an anaesthetic he would make sure that it was light enough for her to suffer deeply. In fact, he wished her dead. The analysis of his history, and his thoughts and feelings about the accident – why had his girl-friend travelling in the car behind not flashed her lights to warn him of the impending disaster since she said she'd seen it coming? – left neither of us in any doubts that he had had quite murderously retaliatory impulses toward the Ward Sister and to the girl-friend, and behind them in the distant past the mother, all of whom should have taken proper care of him, just as my waiting and listening stance in the consultation felt like yet another failure of 'proper' care. These thoughts had frightened him, since an anaesthetist in a very real way controls not just pain but also life and death. He had suppressed the memory of those murderous impulses (i.e. split off the affect) but produced a symptom (being unable

to work) which carried some considerable symbolic significance – he was avoiding putting himself in a position where he could have someone's life in his hands. Three meetings later, relieved by our discoveries, and even amused by the recognition that he too had an unconscious – he had thought it was a 'symptom' that belonged only to neurotics – he went back to work. He also went back to driving a car and he and his girl-friend began to talk of planning a family. In the short term at least, it seemed as though the problems had resolved enough for movement to occur. (I was rather taken by the fact that when his way of dealing with pain, namely through unconsciousness, was inadequate for his own mental pain, he should have turned to someone who increases, rather than reduces consciousness ...)

Freud's original paradigm for a traumatic event was sexual seduction, and his original understanding of anxiety was that it consisted of undischarged libidinal excitation. However, we read of his frustration and puzzlement in 1914(a) on learning that many of the seductions his patients had described had been products of phantasy rather than fact. Yet this same disappointment made possible his momentous recognition of the importance of infantile phantasy – 'this psychical reality requires to be taken into account alongside practical reality' – freeing him from having to remain wedded to the notion of infantile trauma as the sole basis of neurosis.

Yet even in 1893 he had been clear that the trauma was produced by the *effect* of the event upon the mind. 'Any experience which calls up distressing affects – such as those of fright, anxiety, shame or physical pain – may operate as a trauma of this kind.' Repression is then called into play when the feelings provoked by an experience are felt to be too intense to be accommodated by a mind concerned with keeping the level of excitation or feeling within certain limits.

The shift of emphasis from fact to phantasy marked a fork in the development of Freud's thinking about trauma. Recognising that although phantasies of seduction were universal, actual experiences of seduction were not, Freud's primary interest branched off from the path it was following, concerning the pathogenic nature of the external experience – 'practical reality' – towards a detailed and revolutionary exploration of the unconscious – the 'psychic reality'. Traumatic situations were now seen primarily in terms of unconscious phantasy and the internal world, and this remained his central preoccupation. However, he picked up again later on his original interest in the significance of the external event, possibly stimulated by the appalling legacy of the battlefields of World War One, when he began to speculate upon the

significance of repetitive traumatic dreams, and the repetition compulsion. These phenomena had obliged him, for instance, to rethink the role of the Pleasure Principle as the only determining factor in the formation of dreams.

Two later developments then add significantly to our modern understanding of trauma. First, by 1923 Freud had arrived at a final formulation of his model of the mind. In 'The Ego and the Id' he describes mental structure as consisting of relations between three agencies, three modes of mental functioning, namely the id, the ego (the organised and conscious part of the id), and the superego – that part of the ego that sits in judgement on all its own activities. Correspondingly, Freud now viewed mental activity as the constant relations, negotiations and equilibrations that went on between these parts of the mind; and in this he began to come close to the more modern concept of an internal world consisting of dynamic relations between internalised objects.

Second, by 1926, Freud had also reworked his understanding of the origins of anxiety. This development provides a crucial piece in the three dimensional structure that composes our modern understanding of the effects of trauma. When a sufficiently extreme external event impacts on the mental organisation, its effect is to obliterate all defences against anxiety. The anxiety that then overwhelms the mind comes from *internal* sources, although the anxiety-provoking event is external. Freud lists five primary anxieties, felt to be both universal and potentially traumatic for anyone. They are birth; castration anxiety; loss of the loved object; loss of the object's love and, finally and overwhelmingly, annihilation anxiety. I think these anxieties have a single crucial feature in common: they consist of the separation from, or the loss of, *anything that is felt to be essential to life*, including life itself. They therefore bring the individual closer to a psychic recognition of death (see Freud, 1915a).

Once Freud had moved away from the notion that all anxiety derived from undischarged libidinal excitement, he relocated anxiety firmly within the ego, using his new structural model of the mind. The ego can tell the difference between anxiety experienced in an *actual* situation of danger (automatic anxiety) and that anxiety experienced when danger *threatens* – which he called signal anxiety (1926). Signal anxiety warns of an impending situation of helplessness. This distinction continues to hold good in most lives, but once the threat of annihilation has been encountered face to face, something changes. My own view is that *the ego, once traumatised, can no longer afford to believe in signal anxiety*

in any situation resembling the life-threatening trauma: it behaves as if it were flooded with automatic anxiety. This is a crucial factor in the loss of symbolic thinking, at any rate in the area of the trauma, which is such a marked feature of the behaviour of survivors. Certain smells, sounds, sights, situations, even words connected with the traumatic events all produce states of immense anxiety, and the mental state known as the flashback. There is no capacity and no place for belief in 'signals' or 'warnings': *this is it.*

The devastation of World War One stimulated in Freud the short paper, 'Thoughts for the Times on War and Death' (1915a), which is also one of his richest. It suggests a rekindling of his interest in the traumatic neurosis, predating by five years the culmination of that original line of thought in 'Beyond the Pleasure Principle'. This earlier paper addresses the subject of death itself, and man's attitudes to it, giving flesh and blood to the statement that annihilation is man's most fundamental anxiety. Amongst much else, Freud recognised not only that 'in the unconscious every one of us is convinced of his own immortality,' – that is to say, to conceive of a personal death is virtually impossible until we meet it face to face – but that in the death of another, even when it is someone we love, there is something of triumph for the survivor, since 'in each of the loved persons there was also something of the stranger', and hence the rival. Ambivalence, which 'governs our emotional relations with those whom we love most', means that even our loved ones can arouse in us some degree of hostile feeling, and unconsciously we feel satisfaction that we are still alive when our rival is not. This paper has not only great theoretical significance, but also considerable clinical usefulness. Survivors of traumatic events have often witnessed the death of others, even relatives and loved ones. Added to the impact of the traumatic event is the task of mourning the death of others important in one's life – difficult under any circumstances, but made more so by the guilt evoked by having survived – perhaps particularly when the relationship was troubled or deeply ambivalent. Mourning is always immensely hard work, even when the relationship was relatively straightforward. The individual may feel he simply does not have the internal resources to do this work in the context of feeling that his own personal world is in pieces. Some of that mourning, as has often been pointed out, must be for himself – for his own lost world, his own pre-trauma life and identity.

Rather than face the guilt of survival, and the rage at being abandoned by those who have died, some survivors may unconsciously choose a path of lesser resistance. The task of mourning for both the

pre-traumatised self and the other, the lost object, particularly in a world that seems irrevocably damaged, is felt to be unmanageable. Some survivors turn away from this task, and instead, make an identification with the dead object. Rather than mourn the dead, or mourn the loss of their own earlier undamaged identity, they will descend into a pathological substitution for mourning – melancholia. Freud's great paper, 'Mourning and Melancholia' (1915b) spells out these processes in detail. Although 'Mourning and Melancholia' is not in fact about trauma, this paper, together with 'Beyond the Pleasure Principle' (1920), and the revised view of the nature of anxiety, provide the basis for all later psychoanalytic developments in the field of trauma. They also incidentally add considerable richness to much of the psychiatric understanding of the impact and after-effects of trauma.

At the beginning of this chapter, I described one of the central passages in 'Beyond the Pleasure Principle' – Freud's theory of the way certain events actually achieve their traumatising effect upon the mind, after which the personality begins to take account of and adapt to these changed internal conditions. A significant element in this rapidly developing process is what Freud, still in the 1920 paper, called 'binding.' It is hard to be sure what precisely he meant by 'binding' since he used it at different stages of his work in slightly different ways (Laplanche et al., 1973). However, by 1920, it has taken on the general meaning of a defensive operation that restricts free-flowing 'excitation', and this is its particular significance for the understanding of the longer-term effects of trauma. Once the catastrophic breach in the protective shield has taken place, and mental functioning is in turmoil and disarray, the problem is one of 'mastering the amounts of stimulus which have broken in and of binding them, in the psychical sense, so that they can then be disposed of.'

I described some aspects of this process in an earlier paper:

By creating links with what is already there, by joining up what pours in with an existing feature or function of the mind, the ego is attempting to create once more structures of some permanence in which ego functioning is possible ... The central difficulty with a disaster lies, I believe, right here: the very intensity of the struggle to deal with the flood of unmanageable material in the absence of the apparatus for thinking itself locks that material powerfully and precisely to whatever has been released by the breaking down of internal barriers and structures. (Garland, 1991)

In other words, the traumatic influx of stimulation from the present stirs up the early phantasies of devastation and cruelty, and paranoid

views of relations between objects, which then get bound up with the present events in a way which is hard to undo. It seems that the more intense and long-lasting the traumatic event, the greater and more lasting the emotional loading that it carries, which makes it still harder to disengage from the newly-released and highly charged material to which it gets attached.

Sometimes events in the present have a specific meaning for those who endure them, certainly when they seem to confirm the worst of those early phantasies and object relationships (see Chapter 8). In such cases, what Freud might have called *binding* seems to intensify and become a kind of fusion. The past and the present become indistinguishable: each not only makes sense of the other, but each seems to confirm the most pathological features of the other. Segal's (1957) description of uneven development in the personality offers a clear way of understanding this phenomenon. She shows how where there is only a partial attainment of the depressive position (Klein, 1952) the result can be a situation in which earlier, unintegrated ego experiences are retained in a split-off, sealed pocket of vulnerability whose existence forms 'a constant threat to stability. At worst, a mental breakdown occurs and earlier anxieties and split-off symbolic equations invade the ego.' The experience of an external traumatic event will open up such pockets of disturbance, and through the process of binding, keep them open, giving their contents fresh life and imbuing the present with the significance of the past.

Although 'Mourning and Melancholia' predated 'Beyond the Pleasure Principle' by five years, it laid the foundations for modern psychoanalysis. The recognition that the ego could, by dividing itself into parts, take a part of itself as its own object, opened up the possibility of an internal world populated by objects in dynamic relations with each other. Moreover, understanding that parts of the ego could become identified with objects was revelatory when it came to recognising what was happening when mourning went wrong. The processes of mourning, and its pathological counterpart, melancholia, have particular significance for the final outcome of trauma for the individual. So often the long-term outcome presents as a state of chronic melancholia. In this case, the identification with the lost object becomes a way of avoiding unbearable guilt – ultimately the guilt of having survived at all, sometimes compounded by the survivor's feeling in some way responsible for the deaths.

As a clinical example, I saw a 16-year old survivor of the Hillsborough tragedy, at the request of the team responsible for treating him.

They were worried by his state and contemplating giving him ECT for his suicidal depression. He had been lifted out over the heads of the crowd 18 months earlier in the disaster in the football stadium, when a sudden rush of spectators pouring in at the back of the standing area meant that nearly 100 fans at the front were crushed to death against the barriers. Although this boy had been treated for depression, he had not responded, and worried about his failure to recover, his local psychiatrists had sent him away from his home town to a major psychiatric institution in the South. There, by now away from home for over a year, he had been exposed to systematic 'desensitisation'. The walls of his room were papered with newspaper photographs of agonised faces crushed against the wire and daily he was required to watch television newsreels of the catastrophe. He had become suicidally depressed, curled up in his room, crying out in pain, and whimpering for his mother. For a long time in the consultation he was unable to speak to or look at me. He began to uncurl mentally, as it were, as I asked him about his mum and dad, his little brother, and his early life in a rather ordinary way. My feeling was he was immensely relieved he was not going to be put through a rehearsal once again of the events in the stadium. As this ordinary conversation progressed, and he told me a bit about his parents and his home life, I began to get a picture of a boy with a fiercely Catholic mother, who had taken in from her and identified with some quite strong ideas about good and bad. Although he had just reached the age of puberty, with all its resurgence of Oedipal interest in the mother, this boy had not yet taken the step of going out with girls. Instead he was at a transitional state, allying himself with the definitively masculine world of football, and projecting the fierce Oedipal rivalries he felt with his father out on to the football field, where the battles could be enacted by the opposing teams on his behalf. In this way, he could enjoy the area in which he and his father were on the same side, and avoid the area in which they were rivals. However, when the symbolic battle went horribly wrong and the violent and symbiotically-shared crowd emotions resulted in death, the boy was faced with something he felt deeply implicated in, identified with through a massive pre-existing projection. In order to avoid the truly unbearable guilt of feeling responsible for the opposing team's supporters' deaths, he entered into a state of identification with the dead, thus avoiding the cruelly violent and persecuting superego which told another part of him that he was a murderer, a worthless criminal. I suspected that the reason the desensitisation treatments could not help is that they coincided with deadly accuracy with the state of affairs in his internal world. The

treatments were perceived to be both a confirmation of his irredeemable guilt and also a torture rightfully and justly inflicted upon him as a worthless criminal. Anything good or lively in him he had projected into (attributed to) certain of his doctors and caretakers, where it could not be contaminated by his own terrible badness. He was, I felt, dominated internally by a very pure culture of deathliness. What was significant for his treatment was that this state of identification with the dead had for him a distinct survival value, because it saved him from the unbearable guilt which made him feel most like killing himself.

There was a point in the interview in which this became poignantly and painfully clear. For a short while he became free of the crying and persistent nose-blowing and nose-bleeding (I felt he was perpetually engaged in trying to empty his head of the torturing feelings) and appeared to become more alive and even quite interested in some of the things we were talking about. He looked up from his collapsed position, made eye contact and even smiled. But then, as though he had suddenly caught himself in a forbidden activity, he cried out in a renewed agony that he could not get better (i.e. less depressed) because then his body would be in such pain again and he would feel so guilty. I felt during the interview that I could see his identifications shifting between the dead, the criminally worthless him, and the cruelly harsh judge; and I could also feel the sense of his pushing me into becoming identified with his own capacity for life, as well as the more loving and kindly aspects of the maternal object – manifested as the wish in me to urge him not to think so harshly of himself, to treat himself more benignly. Some of this process I tried to describe to him, particularly the way in which he attacked his own capacity to cheer up, as well as the reasons for it, since I knew I would only be given the opportunity to see him once.

How does one help someone in this state? I recommended to the team that the idea of ECT, and the desensitisation treatments be ended, for the reasons I have outlined above. I thought that the events of the disaster should no longer be the focus of his treatment, because they were not in fact the problem: the problem was the shape and form that those events had taken up in his internal world and the meaning he had given them. In fact, I thought, given his youth, he should be helped by stages to go back home, go back to school, be given some once-weekly psychotherapy, plus medication at night to help with the bad dreams. (I never heard what if any of these recommendations the team accepted, but six months later I did hear, to my great relief, that he was back at home and attending school.)

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In any traumatic event it is possible that particular external events and certain aspects of psychic reality will fuse in an intractable way, and will need treatment. The point about this particular case is that it bore out so precisely the clinical picture Freud presented in 'Mourning and Melancholia.' It is not hard to see in the clinical picture arrived at in 'chronic PTSD', or more recently, 'complex PTSD', what we in other circumstances might call melancholia.

Since an object relations perspective on human development and emotional functioning developed out of Freud's, Klein's and others' work on identification, it has become increasingly possible to understand in detail the effects of traumatic events on the personality. Much of this is contained in the chapters in this book, each of which focusses upon that aspect of theory that is felt to be most helpful to the author's understanding of the clinical material. I have already touched on Freud's major contribution to the understanding of the damage to the personality that is done by a traumatic event. Segal's work on the breakdown in symbolisation when there is a loss of the containing object is crucial, as is Bion's later development of this concept of containment. Bion described the process of the transformation of unassimilatable raw material ('beta elements') into something that can be processed mentally ('alpha functioning') and this is felt to be highly important to the outcome of treatment. Again, I have described this in detail in the earlier paper (Garland, 1991), and its particular significance is touched on in the present volume in Chapters 3 and 7, as well as others.

This chapter has followed one particular line of conceptual development. There are other significant contributions by major authors, each with their own particular contribution to the understanding of object relations and the impact of trauma on the human mind (Abraham, 1907; Ferenczi, 1933; Greenacre, 1953; Winnicott, 1958; Balint, 1969; Khan, 1963, 1964; Furst (Ed.), 1967; Yorke, 1986; and others). The reader who wants to investigate further the background to this book might begin by exploring the section in the Bibliography called *Suggestions for Further Reading*. But for the time being, I want to go back to the practical issues that face the clinician.

The Individual and the Event

So far I have been writing as though two things were always the case: that individuals are the same when it comes to the response to a traumatic event, and that getting caught up in such an event was an

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involuntary matter, just sheer bad luck. Yet clearly individual differences, or individual vulnerabilities are immensely important. However precisely we might be able to identify and quantify the nature of the stressor, it is not sufficient as a way of understanding the impact on the individual. The individual has a constitution and a history which have shaped his internal world; hence a character and personality. He also has a culture. So he is someone who is more or less vulnerable to that particular event at that particular moment in his developmental history. That vulnerability is a function of the inevitable interplay between objective and subjective, external and internal reality. In practice it is a complex business.

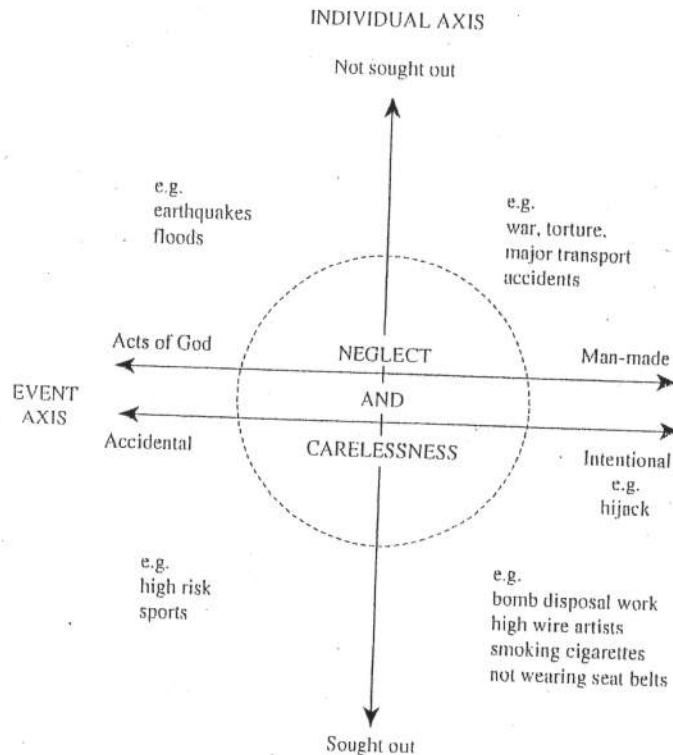
As far as bad luck is concerned in the collision of individual and event, sometimes this is indeed the case. To have a life worth the name will inevitably involve some risk. We leave the home in the morning, cross the road, take public transport, go to the bank, go for walks along cliff-paths, eat unpasteurised cheese because it tastes nice, even steak, put cars on ferries, holiday in countries where there have been earthquakes or hijacks, decide to go skiing or hot-air ballooning. Any of these activities could land us in a crisis, but still we think they are worth the candle.

More complicated are those activities that involve a disavowed risk, the turning of a blind eye to carelessness or a wilful disregard for known hazards. These might include smoking, or the use of drugs, or – these days – casual sex, or not bothering to wear a seat belt for a short journey. Here there may be many factors at work. There may be a kind of defiance or challenge to an object who is perceived as restricting or depriving or judgemental. There may be an omnipotent identification with a careless (carefree?) object who is felt to take insufficient care of the well-being of the baby, and this may involve a corresponding contempt for the feelings of that frightened infant. There may be a wish to provoke an external crisis, with all its drama and its heightened emotional concomitants, in order to avoid having to address some feared internal state, such as conflict, or loss, or emptiness. Whatever the detailed analysis of a particular event turns up, it has to be faced that human beings sometimes have immense potential for self-destructive behaviour without, perhaps, quite recognising what the impact of that same destructiveness on their lives will turn out to be.

I include here a simple diagram that we have used in the Tavistock's Unit for the Study of Trauma in order to orientate ourselves when first contemplating the conjunction of a particular event with a particular psychopathology. Could this have been foreseen or was it an act of

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God? How much has this individual brought this event on himself? How aware is he of some process of destructiveness in himself? Is he fascinated by it? Does he indulge it?



The two axes represent the individual and the event. Events are categorised along the horizontal axis, moving from so-called acts of God (earthquakes, floods), through the ambiguous area of the man-made but still accidental (for example, major transport disasters, or collapsing buildings) to the man-made and frankly intentional – hi-jacks, wars, robberies, muggings, torture. The vertical axis that represents the individual's motivation travels from the unsought-out (the mugging, the bank robbery, the train crash), through the area of ambiguity (falling off ladders, road traffic accidents) to those events that are frankly sought-out. It is important to recognise that an event may be no less traumatic

1. Thinking About Trauma

because it was sought out. The test pilot, the demolition expert, the high-wire artist, the man who visits a club designated for those who seek out sado-masochistic sex are no less traumatised when they crash, are blown up, fall, or are beaten-up and raped (all of these cases were seen in the Unit) than those who were caught in transport disasters, or trapped in fires. The reality for each of them turned out to be very different from the phantasy. We are constantly reminded of Freud's statement that in the unconscious there is no such thing as death. If the actual reality of the outcome of their self-destructive activities can be faced, there is the possibility of improvement. However, the treatment of these patients is complicated and lengthened by those personality factors that originally led them into their high-risk activities, and by the fact that they now have to face their own complicity in the tragedy. The unconscious sense of guilt that may have contributed to the tragedy might have been assuaged by the ensuing damage, but that damage then has to be faced and lived with; and this fact has not been anticipated by the unconscious, which sought only relief from the torment of guilt. Treatment may only be able to make the best of a bad job. Thus for every survivor mapped onto this grid, the encounter with death is still powerfully traumatising because somehow still unanticipated. As Freud says in 'Thoughts for the Times on War and Death', in our unconscious there exist two opposing attitudes towards death: 'the one which acknowledges it as the annihilation of life and the other which denies it ...' They come face to face when the reality of death is encountered, either one's own or that of a loved object, who is, by virtue of that love, also 'an inner possession', a 'component of our own ego.'

The Death Drive

In studying the effects of traumatic events on the human personality, or in attempting to mitigate those effects through treatment, sooner or later one has to confront the clinical expression of what Freud (1920) called the death instinct. In 'Beyond the Pleasure Principle' he makes explicit his carefully arrived-at belief that all human activity can, broadly speaking, be placed into two categories: that which pushes in the direction of constructiveness, connectedness and life, and that which pulls in the opposite direction, towards destructiveness, disintegration and ultimately, death. 'All pain comes from living,' Hanna Segal (1993) points out. The wish to avoid that pain, to end the struggle, can become very powerful. 'Life itself', Freud writes in 'The Ego and the Id' (1923), is 'a conflict and compromise between these two trends.'

Freud pointed out how these two great opposing forces stimulate each other, provoke each other into renewed activity. Perhaps the battle with the environment pursued in the proper practice of certain kinds of sporting activity – sailing, skiing, or mountaineering for example – is one way of representing externally and enacting this internal struggle, so that death can be confronted and evaded positively, enjoyably and even creatively. Yet one behaviour that appears regularly in those who have been traumatised is the apparent compulsion to repeat the events, either in a directly recognisable form, or symbolically, and sometimes in a way that is less than positive or creative. This repetition is a sign that, at the very least, something is stuck and has not been worked through.

Freud (1920) gives a nice example of a symbolic reenactment in his description of the little boy's game with the cotton-reel following his much-loved mother's sorties from the house. He repeatedly throws a cotton-reel out over the edge of his cot, saying mournfully to himself as he does it, 'Gone!' Then he hauls it in again on its piece of string, saying joyfully as it bobs back into sight, 'There!' Why, Freud asks himself, should the little boy repeat a distressing experience in this way? He sees part of its function as converting a painful passive experience (being left) into an active game, and so through practice achieving an inner mastery of those feelings. Yet this is not the whole story. The wish for revenge may come into it, enacted on the symbolic substitute for the mother rather than on mother herself. The trauma, however minor, is reversed, and the other is vengefully made the passive recipient of the unpleasant experience.

However innocent this particular instance of repetition, reversal and the wish for revenge, such impulses play a major role in attempts to work through more seriously traumatising experiences. The literature is full of accounts of the painful counter-transference experiences that may have to be lived through by therapists treating traumatised patients. (See Chapters 4 and 8) The reversal of the trauma may not simply be an expression of revenge on a substitute, nor simply the wish to evacuate the mental turmoil and distress into an object that he hopes can manage it. It may be the only way the survivor has available of *communicating* some of the intensity of his distress and pain, which are outside the compass of words. Projective identification, our most primitive and powerfully effective means of communication, may be the best a patient can do when *in extremis*, and before a therapist can help him find words that do justice to his state of mind.

Thus when a survivor of traumatic events contrives to repeat them in one form or another during his lifetime, actively or passively – and it

is astonishing how often they manage it – the understanding of this phenomenon is not a simple matter. It may be, as it was with the little boy, the conversion of passive into active, in an attempt at mastery of the feelings evoked. It may be, in the passive form, the repetition of something that has not yet been remembered or understood, in an unconscious attempt to get the original event into conscious mental life, as Freud describes in 'Remembering, Repeating and Working Through' (1914b). When this occurs in symbolic form in the treatment setting we think of it as part of the transference, an opportunity to enlist the therapist's understanding of the past, and thus an expression of life. On the other hand it may be a pull to something more destructive, whether to others in the form of a reversal of the trauma (what has been called an *identification with the aggressor* – Anna Freud, 1946), or to the self, where it can emerge as an expression of masochism and hence of a deathly drive. These are the kinds of questions that emerge, and can only truly be approached, in the clinical setting.

Freud's formulation of the conflict between life and death helps to make sense of many observable phenomena, as Segal (1993) has made clear with her clinical examples. In everyday life, the same things can be seen: for example, risk-taking in certain sports can be a finely-honed expression of that very conflict. To exert one's physical and mental mastery over the obstacles afforded by the environment refuels a pleasure in actually being alive, keeps in good shape the skills required for doing so. This might be an expression of that fundamental conflict in which the balance is tipped in favour of life.

Sometimes the balance is more evenly weighted. One of the survivors of a major fire, a man who enjoyed his life, described his struggle to go on making the very painful effort to escape and survive while he was trapped underground. The temptation was to let go, to give up and relinquish his burned body, his pain, and his life, consigning them and the effort to oblivion. He described being overcome by an immense lethargy, wanting simply to close his eyes and submit to the fire. Only the thought of his children, who would be fatherless without him, drove him into continuing the immense effort to go on fighting to stay alive and to reach help. As he talked, it seemed as though he was describing a force that had almost seductive powers, soothing and cajoling him to give in, to end the pain and the struggle. He survived, but he knew that the narrowness of the achievement had been an act of will on behalf of his objects rather than himself. Here we can see how love, itself an expression of life and connectedness, only just succeeded in outweigh-

ing the negativity and the dissolution of death, which would have ended his own pain.

At other times, the balance tips more frankly in favour of death. The young woman who answers advertisements in the back-pages of certain magazines for sado-masochistic sex with strangers, or the climber who tackles ever more fearsome and isolated mountains under chancy conditions and with inadequate equipment, or the compulsive smoker, seem to the ordinary eye to be courting death. Some of the factors that drive this kind of behaviour can eventually be understood if the risk-taker is willing and able to engage in and sustain the process of enquiry. However, enquiry pre-supposes curiosity, and one of the striking features of the repetitive urge towards potentially deathly situations is the marked absence of a wish to know, of self-scrutiny, of more than a superficial curiosity. Any of these might take the enquirer too far in the direction of recognising the existence of desires, preferences, needs, feelings – in other words towards life.

Yet however far we take the investigation, there is a deep core of this apparent negativity which remains enigmatic, even mystifying: where the investigator seems to reach a brick wall, the survivor turns away from the process of investigation, and the room and both people in it can seem suffused with a deadly despair. We can assume that our methods of enquiry are still too crude to take things further, or that we ourselves are not up to using them adequately. We can assume that there may be constitutional factors at work, something taken seriously by both Freud and Klein. Yet when a patient who has ostensibly come for treatment repeatedly turns away from enquiry and from the struggle to make things better, who undoes the progress that was hard-won in the preceding session, who slides away from attempts to understand, it is hard not to feel you are up against something impenetrably negative that may be beyond both of you. Segal (op. cit.) points out how 'the wish to annihilate is directed both at the perceiving self and the object perceived,' or in this case at both the patient-self and the analyst-other, 'hardly distinguishable from one another.' It is in grim reality a conflict between the forces of life and the forces of death.

Yet for those patients in whom the drive for life just outweighs that pull towards death, treatment has much to offer. Treatment is, at its best, about connectedness, about emotional contact, about making sense of the apparently meaningless, and of refinding one's good objects, however long and difficult and bloody the process on the way to those goals.

Treatment

Clinical experience and knowledge inform and illuminate theory; but the theory is necessary if therapists are to understand and account for the effect that violent and unanticipated events have on those who suffer them. We need theory behind us for at least two reasons. First, we know that when survivors come for treatment it is because the sympathy and support of family or friends or neighbours or colleagues has not, on its own, been enough to help repair the damage. Instead of getting gradually better they find themselves getting gradually worse, and that is when they may find themselves turning to professionals. Professionals use theories to *organise* their knowledge and often wide experience, and to *account* to themselves for why this is happening and not that, why this person is reacting in this way and not that. Second, when we listen to someone in deep distress because terrible things have happened to them, it can also be very distressing for the listener. Real listening involves, in part, making an imaginative identification with the speaker, and with his or her experience. We need to be able to listen without being so overwhelmed by the raw intensity of our patients' experiences that we retreat from the emotional impact of what they are saying, shut down so that we don't really take it in. If we retreat in this way then we confirm the survivor's view that what happened to them, and is still happening inside them, is indeed unbearable. There is no-one who can help them with it, help them see it through to the point of having a life once more.

Yet it is the essence of trauma that it is overwhelming – that it knocks out ordinary thinking and behaviour, the capacity to think straight or act sensibly. The survivor is looking for help to regain his or her equilibrium. If we want to understand this process in a way that is helpful, we must not be overwhelmed ourselves. We have to sustain a complicated balance: to be open enough to the survivor's experience to take in a real way his or her state, but steady enough not to be knocked off balance by it. In psychoanalytic therapy, the capacity to do this thing (containment) is felt to be centrally important and very difficult. *Important* because without a renewed experience of containment there is no real treatment; *difficult* because it may involve our being feared and hated for long periods until the survivor can begin to trust us in a realistic way as reliable and humane – neither ideal or omniscient, nor dangerous and malignant. A theory then acts as an important container for the therapist, a supporting structure that helps

the therapist keep his own equilibrium. (These are the positive uses of theory; it can of course also be used defensively, to act as a barrier to emotional contact under the guise of 'professionalism'.)

The treatment we offer, as with all psychoanalytically informed treatment, follows rather than leads the patient. Most importantly, it is not 'focal', in the sense of concentrating on the traumatic event. Instead it takes the transference – the progressive unfolding of the relationship between therapist and patient – as its basis, although of course not exclusively so. This attention to the transference is because, as I have outlined in this chapter, the event has become translated into a relationship, or several kinds of relationship, all of which eventually become visible and alive in the room between the patient and the therapist.

What is offered by the therapist is that particular way of understanding, in a setting that offers a new experience of containment. Attention to the transference will, bit by bit, help re-establish the capacity to think about the traumatic events and their significance without the patient's being overwhelmed by flashbacks. At the same time it offers the opportunity for the gradual amelioration of the damage to the internal world brought about by the longer-term impact of the trauma. Containment is hard work. It involves a reworking of the traumatic experience with all its emotional impact, and all the guilt, fear and hatred released by the original event, with someone who can, in spite of the severe internal buffetings of the counter-transference, provide for the survivor something of what the mother (or primary caretaker) unconsciously offered her very young baby when it was overwhelmed by anxieties. This is not an easy or simple task. Not all traumatised individuals can be helped. Some, particularly those who were severely ill-treated in a brutal and sustained way in childhood, cannot tolerate the constraints and the demands of the one-to-one treatment setting, which may stir up intense claustrophobic or paranoid anxieties (Garland, 1997). These patients are often those most in need of treatment. Here, group therapy, or the loose but stable containment offered by a district's psychiatric or forensic service can be very helpful.

However, the rest of this book is about our attempts to get to grips with the task of individual treatment for those patients who recognise that they need help, and are able to tolerate what it may stir up along the way towards what they hope for and expect – namely to feel better about themselves. Those who manage it may eventually even find that their lives have in some ways improved. Matters shift internally, sometimes profoundly and constructively. Knowledge about oneself

deepens; priorities become clearer. Above all the significance and pleasure of being alive can more keenly be appreciated and fought for.