CHAPTER THREE: THEORETICAL OVERVIEW OF TRAUMA

3.1   Introduction

This chapter focuses on psychoanalytic theory and concepts related to trauma. As was mentioned in chapter one, psychoanalytic theory reflects my epistemology. Much of the trauma literature in psychology has been based on a psychoanalytic paradigm (Garland, 1998; Van der Kolk, 1987). A brief history of trauma and a discussion of psychoanalytic thinking related to trauma is used as a point of departure and to provide a context for the study. The final section of the chapter constitutes a deliberation of key psychoanalytic concepts which are relevant to the current research.

The historical perspective on trauma indicates that since the earliest involvement of psychiatry with traumatised patients there have been vehement arguments about the aetiology of trauma. Is it organic or psychological? Is trauma caused by the event itself or by its subjective interpretation? Or is it perhaps caused by pre-existing vulnerabilities? Are trauma patients malingerers who suffer from moral weakness, or do they experience an involuntary disintegration of the capacity to take charge of their lives? (Van der Kolk, Weisaeth & Van der Hart, 1996). The way in which clinicians and researchers regard trauma has shifted over the years. Recent authors such as Allan Young (1995) have asked whether this shift reflects a change in the symptomatic expression of traumatic stress in Western culture over time, or rather whether clinicians have focussed on different aspects of the same syndrome during the past century and a half. The question becomes relevant if one looks at the historical meaning of this shift of focus. While not being able to answer these questions with any certainty, the following section attempts to clarify certain aspects of the questions posed.

3.2 A brief overview of the historic construction of trauma[1]

The effects of trauma on humans were described for the first time in the 1860s by physicians such as John Erichsen and Herbert Page. The effects of trauma were mostly associated with railway accidents and were called "railroad spine". From this genesis, the role of mental factors, especially that of fear and the desire for compensation, was recognised in the onset of symptoms (Erichsen in Young, 1995). Thus the concept of trauma as physical injury (*wound*) was extended to include psychogenic ailments whose starting point was the experience of *fear*, conceived as a memory, of traumatic pain. It was discovered early on that fear seemed to play an important part in cases of both surgical and nervous shock: fearful patients sometimes died before their surgery and the surgeons linked their deaths to the power of their emotions (Young, 1995). Van der Kolk, McFarlane and Weisaeth (1996) mention that an association between psychological trauma and hysteria has been noted ever since psychiatry was recognised as a scientific discipline. A traumatic memory was considered to be different from an ordinary memory because the individual was unable to assimilate its meaning (Janet, 1925) and it was noted that the failure to integrate traumatic memories led to dissociation.

The father of psychoanalysis, Sigmund Freud showed an interest in traumatic events during two periods: the years between 1892 and 1896 when he examined the causes of hysterical attacks, and the years following World War I when he turned his attention, very briefly, to the aetiology of the war neuroses. His original theory postulated actual sexual experiences during infancy and early childhood as the cause of all trauma and the basis for neurosis. In his later work with war veterans, Freud acknowledged the role of actual experiences in the development of neuroses, and distinguished between traumatic neuroses and anxiety neuroses on the basis of whether a neurosis was caused by a real occurrence or an imaginary experience.

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[1] This section of the discussion relies strongly on Allan Young's "The harmony of illusions: Inventing post-traumatic stress disorder" (1995). The primary sources are not easily accessible and/or are written in French or German.

According to Freud (1919/1955a), traumatic neuroses were caused by real experiences such as accidents, death and combat, whereas anxiety neuroses were the result of sexual and aggressive fantasies based on early witnessing of the primal scene. In his short paper, "Thoughts for the times on war and death"(1915/1957), Freud recognised not only that "in the unconscious every one of us is convinced of his own immortality", but that in the death of an other, even when it is someone we love, there is something of a triumph for the survivor. Added to the impact of the traumatic event is the task of mourning, for others and for the self - for the person's own lost world, pre-trauma life and identity, as well as guilt feelings. Freud also compared the fear of losing one's own life with the fear of taking someone else's life. This suggested that a person might also be traumatised by the violence he[2] inflicts on others, and thus a soldier can be both the victim and perpetrator of his traumatic violence. With this observation, a place is opened for traumatic guilt alongside traumatic fear.

Freud believed that the pathogenic agency is invested in the patient's *memory* of the trauma. When the attached affect of traumatic experiences is discharged, memories of the events become ordinary recollections and are accessible to the conscious mind. A reaction discharge is, however, not always possible and undischarged memories are said to enter a "second consciousness" (Freud, 1966, p.153) where they become secrets, either isolated from the conscious personality or available to it in a highly summarised form. The paper, "Beyond the Pleasure Principle" (1920/1955b) reflects on Freud's experience with soldiers who had survived extremely frightening experiences during World War I, and who showed a compulsion to repeat in recurrent memories and re-enactments of some of the most frightening moments of the experience, as though they needed to do this in order to master the anxiety produced.

Throughout the twentieth century, wars and its devastating effects on humanity have had a profound impact on the development of ideas surrounding trauma. Most army doctors in World War I were inclined to believe that flawed heredity and constitution

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[2]   Between 1895 and 1974 the study of trauma centred almost exclusively on its effects on white males (Van der Kolk, McFarlane & Weisaeth, 1996). Using "he" is in this sense not ignoring women but reflective of the historic state of affairs.

have a determining effect in the majority of cases of war neuroses (Smith, 1916; Wolfsohn, 1918), which stigmatised the condition. The German neurologist Herman Oppenheim (1885), who was the first to use the term "traumatic neurosis", proposed that functional problems are produced by subtle molecular changes in the central nervous system. Ascribing an organic origin to traumatic neuroses was particularly important in combat soldiers as it offered a honourable solution for all parties involved (Van der Kolk , McFarlane & Weisaeth, 1996). Abram Kardiner (1941), an American psychoanalyst in World War 2, describes the symptomatic reaction that follows traumatic events as a form of adaptation. It is an effort to eliminate or control painful and anxiety-inducing changes that have been produced by the trauma in the organism's external and internal environments. The kind of adaptation that occurs in a particular case will depend on the individual's psychological resources and the person's relations to his primary social group (Kardiner, 1959). In Kardiner's account, traumatic events create levels of excitation that the organism is incapable of mastering, and a severe blow is dealt to the total ego organisation. The individual experiences this as a sudden loss of effective control over his environment which leads to an altered conception of the self in relation to the world. After World War 2, psychological interest in trauma declined until the Vietnam War (1969-1975).

The immense impact of the Vietnam War on the psychological health of veterans lead to the current classification and "defining" of trauma in terms of post-traumatic stress disorder (Young, 1995; Van der Kolk , McFarlane & Weisaeth, 1996). Careful research and documentation of what is now labelled post-traumatic stress disorder (PTSD) began in earnest after the Vietnam War when a large number of American war veterans suffered from undiagnosed psychological effects of war-related trauma. The Vietnam War was different from previous wars in that it was experienced as dreadful, filthy and unnecessary (Allerton, 1970; Bourne,1970; Haley, 1984). Public support was minimal and the meaning of the war was questioned by society. In 1978 the psychiatrist Chaim Shatan listed typical symptoms of what he called "post-Vietnam syndrome" namely, guilt, rage, psychic numbing, alienation and feelings of being scapegoated (Shatan, 1978). Post-traumatic stress disorder was adopted by the American Psychiatric Association as part of its official nosology in 1980 and included

in the DSM-III (APA, 1980). PTSD in relation to the current study will be discussed in chapter four.

Through the years the effect of trauma on people has been called various names such as "railroad spine", "traumatic neurosis", "cardiac neurosis", "shell shock", "war neurosis" and "combat neurosis" and culminated in the current label of post-traumatic stress disorder. Perhaps the most important lesson from the history of psychological trauma is the intimate connection between cultural, social, historical, and political conditions on the one hand, and the ways that people approach traumatic stress on the other (Fischer-Homberger, 1975).

3.3   Shifts and developments in psychoanalytic thinking relating to trauma[3]

What has been largely overlooked in accounts of psychoanalytic theory concerning trauma is that Freud himself used the word trauma rather loosely in a range of contexts and circumstances (Greenacre, 1967), and that the term *trauma* is used just as loosely today among both psychoanalysts and non-analytic clinicians (Yorke, 1986). According to Laplanche and Pontalis (1973), the use of the term trauma or "wound" in psychoanalytic terms implies three ideas: a violent shock, a wound (which would relate to castration anxiety or narcissistic injury), and consequences which affect the whole organisation of the psychic system.

Developments and shifts in classical psychoanalytic thought and the emphasis on the role of fantasy in the development of trauma are well documented by Ulman and Brothers (1988) and Scharff and Scharff (1994). These authors note that Freud's underestimation of the role of actual traumatic experiences in the development of adult psychopathology was challenged in the writings of many classical psychoanalysts including Ferenczi (1913/1952), Anna Freud (1967) and Masson (1984), all of whom emphasise the reality of early childhood traumatic experiences. In line with Freud's

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[3]   This section is organised according to psychoanalytic themes rather than according to a chronologic account of events.

later acknowledgment of *the role of real experience* in the development of the symptoms of trauma, the revisionist school of thought, including the work of Kardiner and Kelman with war veterans (cited in Ulman & Brothers, 1988), represents a shift away from the role of fantasy in the psychogenesis of symptoms in response to exposure to traumatic experiences. According to this view, reaction to trauma occurs as a result of the disturbance in adaptational functioning which results from "a pathological alteration in images of the self and the outer world"(Ulman & Brothers, 1988, p.59). This view adds a valuable contribution to the understanding of trauma in that it highlights the disillusionment that occurs with regard to the individual's *sense of self*. The unconscious meaning of exposure to the trauma of combat is understood in terms of the individual's sense of having failed to live up to an idealised sense of self. The important contribution of this approach is the shift in the person's sense of uniqueness and strength to one of vulnerability, worthlessness and dependency.

Infantile *dependency* is also highlighted by Fairbairn (1941/1952) in all psychopathological developments in adults. Fairbairn's contribution to the development of psychoanalytic theory lies in the shift from viewing the development of personality as a closed system, with emphasis on inner instincts and drives within the individual, to an emphasis on interpersonal or social relationships in which the individual is viewed as an open system, constantly interacting with the environment. This interaction is considered as central to the development of the personality. Behaviour is therefore motivated by a dynamic self, constantly seeking an object from whom it will gain recognition, security and nurturance. More specifically, Fairbairn proposed that central to healthy personality development is the existence of "trusting, good-enough early experiences with the mother (object)" (Scharff & Scharff, 1994, p.50). Incorporated in his view on the development of the personality is Fairbairn's important description of the process of differentiation from the object.

Fairbairn highlights the fact that the individual is constantly dependent upon relationships with others in the outside world, but that the nature of this dependency shifts from one in which the infant does not perceive its distinction from others, to one in which the dependency is mutually beneficial and respectful. This holds important

implications for the victims of trauma, as the traumatic experience is likely to trigger or cause a regression to early immature dependency in which the person is dependent on the other for survival (Scharff & Fairbairn Birtles, 1997). The experience of trauma therefore results in a regression to what Scharff and Scharff (1994) refer to as "the most fundamental trauma" which is "that the child cannot count on being held securely and with respect for the body, the mind, the emotions, and the essence of the child" (p.62). It therefore triggers regression to the earlier state of immature dependency involving early intrapsychic conflicts and directly affects the manner in which the individual relates to inner and external objects in his or her world. Dependency is linked to helplessness; and Freud hypothesised that when the "stimulus barrier" is breached, the mental apparatus is flooded with excitation, causing a feeling of helplessness (Van der Kolk, 1987).

Scharff and Scharff (1994) and Ulman and Brothers (1988) note that the neoclassical school of theorists, including Greenacre and Jacobson, made valuable contributions to the theory of trauma in their focus on *development and regression*, and their emphasis on the central role of the *sense of self* in determining reactions to real traumatic experiences. Jacobson's (1959) major contribution to the theory of trauma lies in her emphasis on the individual's sense of self in the experience of trauma. Her view of trauma is that of a narcissistic disturbance in the ego which involves problems in the development and maintenance of the sense of self as a result of conflicts between different self-representations. Because of the experience of trauma and the resultant narcissistic regression, the patient's initial self-representations, organised in accordance with a healthy sense of self-respect, are altered to form new self-representations based on a painful sense of self as worthless and humiliated. The ensuing conflict between these different self-representations is seen as the major cause of symptoms. Jacobson's contribution to the theory of trauma is important in terms of her emphasis on the *process of regression* as a result of a traumatic experience, as well as her emphasis on the effect of trauma on the *sense of self*.

Greenacre (cited in Ulman & Brothers, 1988) added to the theory of trauma in her proposal that trauma is an "inevitable part of psychological development" which every

individual is likely to experience, and that it is the "timing, type and intensity"(p.50) of the trauma that are the crucial factors in the psychogenesis of symptoms. Greenacre proposed that the "primary traumatogenic event" of witnessing the primal scene renders the individual susceptible to the development of pathology later in life when *traumas are imbued with meaning* based on early traumatic events. Greenacre's work is valuable in that she linked the concept of regression to early experiences of trauma in her understanding of later experiences of trauma. A range of experience may be traumatic. On the one hand, these may be violent and unexpected incidents but, on the other hand, the event may be apparently minimal but one which "owes its importance merely to its intervention in a psychical organisation already characterized by its own specific points of rapture" (Lapanche & Pontalis, 1973, p.467).

Once Freud had moved away from the notion that all anxiety derived from undischarged libidinal excitement, he relocated anxiety firmly within the ego (Garland, 1998). The ego can differentiate between anxiety experienced in an actual situation of danger (automatic anxiety) and anxiety experienced when danger threatens (signal anxiety). Signal anxiety warns of an impending situation of helplessness. According to Garland (1998), this distinction holds true in most lives, but once the threat of annihilation has been encountered face to face, something changes: once the ego has been traumatised (or raptured), it "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" (p.17). She calls this a crucial factor in the loss of symbolic thinking in the area of the trauma, which is a marked feature of the behaviour of survivors.

Through his exploration of the inner world of trauma, Kalsched (1996) found that the traumatised psyche is self-traumatising: "Trauma doesn't end with the cessation of outer violation, but continues unabated in the inner world of the trauma victim, whose dreams are often haunted by persecutory inner figures"(1996, p.5). His second finding is the seemingly perverse fact that victims of psychological trauma continually find themselves in life situations where they are retraumatised: "It is as though the persecutory inner world somehow finds its outer mirror in repeated self-defeating 're-

enactments' - almost as if the individual were *possessed* by some diabolical power or pursued by a malignant fate" (Kalsched, 1996, p.5).

According to Garland (1998), universal anxieties that are potentially traumatic for anyone have a single crucial feature in common: "they (the anxieties) consist of the separation from, or the loss of, *anything that is felt to be essential to life*, including life itself"(p.16). Kohut (1977, p.104) called the distinguishing feature of trauma "disintegration anxiety", an unnameable dread associated with the threatened dissolution of a coherent self. Ulman and Brothers (1988) who based their work on the tenets of Kohut's theory of self-psychology, argue that "it is neither the reality nor the fantasy that causes trauma but, rather, that the unconscious meaning of the real occurrence causes trauma" (p.2) by changing the person's experience of the self in relation to self-objects. At the core of Ulman and Brothers' (1988) theory of trauma is the view that the traumatic experience shatters the individual's sense of self in ways that are intolerable. The self is viewed as the centre of mental activity and plays a vital role in organising the meaning of experience. The trauma therefore takes on an unconscious meaning which challenges and undermines the person's sense of self, and is symbolically represented in the symptoms of trauma.

To conclude, according to psychodynamic theory, traumatised individuals are faced with the task of integrating the traumatic event into their understanding of the meaning of life, self-concept, and world image (Gerrity & Solomon, 1996). The emotional reactions of traumatised individuals are viewed as the result of discrepancies between internal and external information (Horowitz, 1986; Horowitz & Kaltreider, 1980; Schwartz, 1990; Widom, 1989).

The following section attempts to present the basic tenets of the psychodynamic approach which are essential to understanding the discussions and analysis which follow in the dissertation.

3.4 Basic tenets of the psychodynamic approach

The psychodynamic perspective believes the mind to consist of two distinct systems, the conscious and the unconscious[4]. When we deal with an emotionally loaded situation, both systems operate in parallel according to their own ways of experiencing and understanding the meaning of that situation (Langs, 1988). The conscious response is logical and problem solving. The unconscious reaction includes all those frightening desires and painful thoughts and feelings that the conscious mind finds too distressing to acknowledge, much less deal with. A fundamental principle of the psychodynamic approach is that behaviour is the result of conflict between the conscious and unconscious systems. Human behaviour is the product of the unconscious mind's attempts to express and gratify its desires and the conscious mind's defences against those attempts (Freud, 1986).

Freud (1923/1955c) devised a theory of mind to describe the relationship between the conscious, the unconscious and the individual's development of a set of moral values. He formulated a topological structure of the psyche that has three components: the id, the ego and the superego. All three have their own spheres of influence, but are also influenced by each other. The id is entirely unconscious, is governed by the pleasure principle and wants all its needs satisfied immediately. The ego deals with reality, understands logic and is capable of organising experience and behaviour. The essential function of the ego is to master the environment and the id (Brenner, 1973). The superego is defined by Cameron (1963) as "an organisation of mental systems whose major functions are those of scanning ego activities at all levels, of supplying approval and disapproval, self-criticism and self-esteem" (p.188). The superego operates on the conscious level as conscience, is punitive on the unconscious level and (according to some theoreticians) contains the ego ideal. The ego ideal is basically a view of one's self as perfect and loved. It is an unconscious image of being without a flaw or weakness. The ego strives to attain these perfect qualities regardless of

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[4] Some psychoanalytic writings, however, refer to three layers of consciousness, namely, the unconscious, the preconscious, and the conscious.

whether or not they can be realised. The ego ideal has a major influence on one's self-esteem: satisfying the ego ideal brings about pleasurable feelings of self-confidence and self-worth.

The ego tries to satisfy the id and the superego while seeking to maintain some control over them. When the ego fails to satisfy the person's conscience by permitting too much gratification to the id, the person experiences guilt. Feelings of shame result when the ego fails to live up to the expectations of the ego ideal (Piers & Singer, 1971). When the ego anticipates impending shame or guilt, or being overwhelmed by strong id impulses, it experiences anxiety. The ego uses defence mechanisms to avoid feeling anxious when it cannot remove the cause of the anxiety (Freud, 1920/1955b). However, the ego's use of defence mechanisms comes at a price as they "deny, falsify, or distort reality"(Hall & Lindzey, 1957, p.49).

A characteristic of the id is that it permits opposing impulses and feelings to coexist alongside each other and to demand that each be gratified at the same time. But the ego cannot tolerate the simultaneous presence of incompatible wishes, ideas or feelings in relation to someone or something. The term "ambivalence" is used to describe the simultaneous experience of feelings of love and hate for someone or something. The nature of ambivalence is complex. First of all, ambivalence is characterised by the simultaneous operation of opposing feelings and secondly, ambivalence is present to some degree in every emotional experience. Thirdly, when the opposing feelings grow in intensity so that they can no longer be controlled by the ego, repression is used to keep one of the opposing feelings from awareness while allowing the other to become conscious. Finally, it is usually the negative feeling that is repressed and the positive feeling that is given access to consciousness (Moore & Fine, 1968).

Within the context of the development of psychoanalytic thinking on trauma, the following theoretical concepts are deemed most relevant to the currents study and are therefore given further attention below.

3.5   Theoretical concepts linked to a psychoanalytic construction of trauma

3.5.1   Traumatic memory versus ordinary memory

Ordinary memories fade and belong to the past. They are eventually confused and conflated with other ordinary memories and assimilated into webs of remembrance. When they penetrate into the present, it is as nostalgia, regret, and a desire for things now gone. In each of these respects, the traumatic memory is different. Years after its creation it remains unassimilated, a self-renewing presence, perpetually reliving the moment of its origin (Horowitz, 1976). According to Van der Kolk, McFarlane and Weisaeth (1996), the post-traumatic syndrome is the result of a failure of time to heal all wounds. The memory of the trauma is not integrated and accepted as a part of one's personal past (history); instead it comes to exist independently of previous schemata (i.e. it is dissociated). The traumatic memory is dominated by imagery and bodily sensation, and is in these respects similar to the memories of young children (Herman, 1992).

Immediately after a traumatic event, almost all people suffer from intrusive thoughts about what has happened (McFarlane, 1992). These intrusions help them either to learn from the experience and plan for restorative actions (accommodation), or to gradually accept what has happened and readjust their expectations (assimilation) (Horowitz & Kaltreider, 1980). One way or another, the passage of time modifies the ways in which the brain processes the trauma-related information. Either it is integrated in memory and stored as an unfortunate event belonging to the past, or the sensations and emotions belonging to the event start leading a life of their own (Van der Kolk, McFarlane & Weisaeth, 1996). When people develop post-traumatic stress disorder, the replaying of the trauma leads to sensitisation; with each replay of the trauma, there is an increasing level of distress. In those individuals, the traumatic event, which started out as a social and interpersonal process, comes to have secondary biological consequences that are hard to reverse once they become entrenched. These biological (mal)adaptations ultimately form the underpinnings of the remaining traumatic symptoms: problems with arousal, attention, and stimulus

discrimination, and a host of psychological elaborations and defences.

The psychological process through which irreconcilable memories are assimilated is believed to consist of phases and cycles: the conscious mind engages the traumatic memory → this encounter generates anxiety → the conscious mind disengages from the memory through denial, self-dosing with alcohol or drugs, etcetera → the level of anxiety is reduced, the conscious mind re-engages the traumatic memory and attempts to process it (via responses one and two) → anxiety increases, and a new cycle begins. Normally cycling and processing continue until the memory is metabolised, at which point it becomes part of the individual's inactive memory. That is, it is retrievable but is no longer intrusive. In effect it is buried in the past. PTSD is exceptional in this respect because its traumatic memory generates a high level of anxiety. Consequently, the engagement phase is brief and ineffective, and the memory cannot be buried. It lives on for decades, a source of suffering and socially and psychologically maladaptive behaviour (Horowitz, 1986).

Because of the timeless and unintegrated nature of traumatic memories, victims remain embedded in the trauma as a contemporary experience, instead of being able to accept it as something belonging to the past (Horowitz & Kaltreider, 1980; Van der Kolk, McFarlane & Weisaeth, 1996). One of the serious complications that interferes with healing is, according to Van der Kolk, McFarlane and Weisaeth (1996), that one particular event can activate other, long-forgotten memories of previous traumas, and create a "domino effect". A person who was not previously troubled by intrusive and distressing memories may, after exposure to yet another traumatic event, develop such memories of earlier experiences.

The traumatic memory is a kind of pathogenic secret (Ellenberger, (1966/1993). Such memories are "pathogenic" because they are reputed to cause psychiatric disorders and "secret" because they are acts of concealment. Two kinds of concealment are possible. In one, the owners wants to hide the contents of their recollection from other people. In addition, they want to forget the memory themselves or, failing this, they want to push it to the edges of awareness. The second kind of concealment involves

a memory that the owners hide from themselves. They know that they have a secret memory, because they sense its existence, but they are unable to retrieve it; or, what is more common according to Young (1995), they do not remember that they have forgotten and have to learn about their memory from someone else, typically a therapist.

Freud found a home for the pathogenic secret in the patient's anxiety dream. These dreams originate, according to Freud, in the compulsion to repeat or the patient's unconscious urge to return to the situation in which the pathogenic trauma occurred. He stated that dream anxiety is instrumental as it attempts to anticipate, be it retrospectively, the danger that precipitated the trauma.

The discovery of traumatic memory revised the scope of two core attributes of the Western self, namely free will and self-knowledge (Dworkin, 1988; Harris 1989; Johnson, 1993). At the same time, it created a new language of self-deception (Rorty, 1985) and justified the emergence of a new class of authorities, the medical experts who claim access to memory contents that owners (patients) have hidden from themselves (Young, 1995). Post-traumatic stress disorder patients are assumed to have three main ways of responding to the cognitive dissonance that originates in traumatic experiences. They can attempt to reframe their traumatic memories, making the memory content consistent with their pre-existing cognitive schemas. They can attempt to revise the cognitive schemes, making them consonant with their memories. They can also try to empty the memories of their salience and emotional power or erect defences against them via denial, efforts at avoiding the stimuli that trigger recollections, generalised emotional numbing and other defence mechanisms.

3.5.2   Trauma, memory and a sense of self

According to Young (1995), the term "memory" has three meanings in everyday usage: the mental *capacity* to retrieve stored information and to perform learned mental operations; the semantic, imagistic or sensory *content* of recollections; and the *location* where these recollections are stored. John Locke and David Hume proposed

that memory, in the second and third senses, is intrinsically connected to our conception of "self" and "self-awareness" (Richards,1992; Warnock, 1987). "By connecting self-awareness with the past, memory provides the body with a subject and subjectivity" (Young, 1995, p.4). Our sense of being a person is shaped not simply by our active memories, however; it is also a product of our conceptions of "memory".

The capacity to regulate internal states and behavioural responses to external stress defines both one's core concept of oneself and one's attitude towards one's surroundings (Van der Kolk, McFarlane & Weisaeth, 1996). Since a sense of "self" is derived from the interactions between children and their caregivers, and is founded on the important relationships of early childhood, trauma during this period interferes with the development of ego identity and with the capacity to develop trusting and collaborative relationships (Cole & Putnam, 1992; Herman, 1992). Results of recent studies indicate that vulnerability does play a significant role in the development of trauma, as well as in the long-term adjustment to living with the legacy of traumatic stress (Van der Kolk, Weisaeth, & Van der Hart, 1996). A large number of studies has shown that in both children and adults the security of the attachment bond is the primary defence against trauma-induced psychopathology (Finkelhor & Browne, 1984; McFarlane, 1987).

In recent years, much has been written about the effects of trauma on people's sense of themselves and their relationship with their environment (Cole & Putnam, 1992; Herman, 1992; Pearlman & Saakvitne, 1995). Reiker and Carmen (1986) point out that

> confrontations with violence challenge one's most basic assumptions about the self as invulnerable and intrinsically worthy, and about the world as orderly and just. After the trauma the victim's view of self and world can never be the same again, it must be reconstructed to incorporate the abuse experience (p.362).

According to Van der Kolk (1987) the essence of psychological trauma is the loss of faith that there is order and continuity in life.

Age and previous life experiences will profoundly affect the person's interpretation of the meaning of the trauma. Many traumatised individuals, particularly children, tend to blame themselves for having been traumatised. Assuming responsibility for the trauma allows feelings of helplessness and vulnerability to be replaced with an illusion of potential control. Trauma is usually accompanied by intense feelings of humiliation: to feel threatened, helpless and out of control is an incisive attack on the capacity to be able to rely on oneself. Shame is the emotion related to having let oneself down (Van der Kolk, McFarlane & Weisaeth, 1996).

3.5.3   Fear, pain and defences

Intense fear - characteristically, fear plus the element of surprise - is an assault equivalent or analogous to physical violence (Young, 1995). Since it was found that fear (nervous shock) and injury (surgical shock) produce similar effects, the question arose of how they were connected to one another. Erichsen and Page (in Young, 1995) concluded that this occurs through patho-anatomical and/or pathophysiological pathways. Crile and Cannon (in Young, 1995) accepted this proposition but argued that it was only part of the story since there is one more element connecting fear with injury, namely pain. Pain is an experience that the organism strives to avoid, but it is also a signal of bodily injury and an indication of mortality. The meaning of fear lies in its pathogenic effects.

It is common knowledge that an unending state of arousal leads to exhaustion, a drop in blood pressure and death. But when exposure to traumatic shock is intermittent rather than continuous, Young (1995) mentions three possible ways in which victims can respond to their pathogenic memory. Some victims develop strategies and routines that allow them to avoid harmful stimuli (phobias), other victims simply give up (learned helplessness), and thirdly, victims of traumatic experiences may seek out circumstances that replicate their traumatogenic events. The last option is based on evidence that suggests that endogenous opiates (endorphin) may be released into a victim's bloodstream during moments of traumatic shock. In the case of post-traumatic stress disorder, the endorphin may have a tranquillising effect, reducing the

feelings of anxiety, depression and inadequacy that are associated with this syndrome. Over time, these people would become addicted to their endorphins and to the memories that release these chemicals. When the intervals between exposures grow too long, people can be expected to experience the symptoms of opiate withdrawal, namely anxiety, irritability, explosive outbursts, insomnia, emotional lability and hyper-alertness. These symptoms would exacerbate the ongoing distress intrinsic to post-traumatic disorders.

According to Young (1995), pain (of "withdrawal") may build up to the point where individuals are induced to self-dose with endorphin by re-exposing themselves to traumatogenic-like situations. Van der Kolk, McFarlane and Weisaeth (1996) mention the compulsive re-exposure of some traumatised individuals to situations reminiscent of the trauma. Freud (1920/1955) thought that the aim of such repetition is to gain mastery, but clinical experience shows that this rarely happens; instead, repetition causes further suffering for the victims and for the people around them (Van der Kolk, 1989). In this re-enactment of the trauma, an individual may play the role of either victimiser or victim. Van der Kolk, McFarlane and Weisaeth (1996) cite three ways in which the re-enactment of the trauma may crystallise: harm to others, self-destructiveness and re-victimisation.

3.5.4 Avoidance, numbing and dissociation as defence mechanisms

The human response to sudden and overwhelming events is increasingly recognised as a stable psychological entity (Burgess & Holmstrom, 1974; Figley, 1978; Green, Wilson, & Lindy, 1985; Horowitz, 1976). The central nervous system seems to react to any overwhelming, threatening and uncontrollable experience in a consistent pattern. Regardless of the precipitating event, traumatised people continue to have a poor tolerance for arousal. They tend to respond to stress in an all-or-nothing way: either unmodulated anxiety, often accompanied by motoric discharge that includes acts of aggression against the self or others, or else social and emotional withdrawal (Krystal, 1978).

The psyche's normal reaction to a traumatic experience is to withdraw from the scene of the injury. If withdrawal is not possible, then a part of the self must be withdrawn, and for this to happen the otherwise integrated ego must split into fragments or dissociate. Dissociation is a normal part of the psyche's defences against trauma's potentially damaging impact. Kalsched (1996) calls dissociation a trick that the psyche plays on itself, and says that it allows life to go on by dividing up the unbearable experience (trauma) and distributing it to different compartments of the mind and body, especially the unconscious aspects thereof. This means that the normally unified elements of consciousness are not allowed to integrate and experience itself consequently becomes discontinuous. The psychological defence of dissociation against the experience of unbearable pain carries a great internal cost, "the psychological sequelae of the trauma continue to haunt the inner world" (Kalsched, 1996, p.13). Kalsched (1996) describes dissociation not as a passive, benign process but rather as an active attack by one part of the psyche on the other parts, involving a good deal of aggression. Contemporary psychoanalysis recognises that where the inner world is filled with violent aggression, primitive defences are present too. The energy for dissociation originates from this aggression.

When people are traumatised the choice of defences is influenced by developmental stage, temperamental and contextual factors (Van der Kolk, Weisaeth, & Van der Hart, 1996). Once traumatised individuals become haunted by intrusive re-experiences of their trauma, they generally start organising their lives around avoiding having the emotions that these intrusions evoke. Avoidance may take many different forms, such as keeping away from reminders, ingesting drugs or alcohol in order to numb awareness of distressing emotional states, or utilising dissociation to keep unpleasant experiences from conscious awareness. This avoidance of specific triggers is aggravated by a generalised numbing of responsiveness to a whole range of emotional aspects of life. Many people with post-traumatic stress disorder not only actively avoid emotional arousal, but experience a progressive decline and withdrawal in which any stimulation (whether it is potentially pleasurable or aversive) provokes further detachment. To feel nothing is better than feeling irritable and upset. According to Van der Kolk (1987), it seems as though the chronic hyperarousal of post-traumatic

stress disorder depletes both the biological and the psychological resources needed to experience a wide variety of emotions. One of the most distressing aspects of this hyperarousal is the generalisation of threat. The world thus increasingly becomes an unsafe place.

3.5.5 The role of meaning on the experiencing of trauma

Meaning is defined as that which has significance or importance. Gordon Allport writes in the preface to Frankl's (1959) *Man's search for meaning* that to live is to suffer, to survive is to find meaning in the suffering: "If there is a purpose in life at all, there must be a purpose in suffering and in dying"(p.11). Nietzsche, as quoted by Frankl (1959, p.12), says that "(h)e who has a *why* to live can bear with almost any *how*". If they can ascribe some sense of meaning to the trauma, victims often experience the symptoms of PTSD as natural reactions that do not require professional help (Van der Kolk, McFarlane, & Weisaeth, 1996).

The personal meaning of a traumatic experience evolves over time, and often includes feelings of irretrievable loss, anger, betrayal and helplessness. Wolff (personal communication, 1995) attributes many of the delayed-onset symptoms of post-traumatic stress disorder to a loss of meaning of the traumatic event. He postulates that many South African soldiers went through severe traumatic situations during the war in Angola without showing signs of PTSD because they could attribute some sort of meaning to the war. After 1994, when that meaning was questioned, the symptoms of PTSD multiplied and the diagnosis escalated.

The critical element that makes an event traumatic is the subjective assessment by victims of how threatened and helpless they feel. So although the reality of extraordinary events is at the core of post-traumatic stress disorder, the meanings that victims attach to these events are as fundamental as the trauma itself (Van der Kolk, McFarlane, & Weisaeth, 1996). A crucial element of an experience which becomes a trauma is the aspect of loss, be it loss of life, possessions, integrity or beliefs. When people lose their faith that their world is a safe, orderly and just place to live in, it

colours their relation to it. As such, individuals experience a loss of effective control over their environment and perceive the world increasingly as an unsafe place. (In object relations theory the absence or loss of a sense of meaning is linked with the loss of the object.)

After having been traumatised, only a minority of victims seem to escape the notion that their pain, betrayal and loss are meaningless. For many this realisation is one of the most painful lessons that the trauma brings and they often feel godforsaken and betrayed by their fellow human beings. Usually, suffering does not bring an increased sense of love and meaning; it more often results in loneliness and disintegration of belief (McFarlane & Van der Kolk, 1996). The unpredictability of a traumatic event renders individuals unable to prepare themselves and may be viewed as a fundamental reason for the lasting consequences and severe feelings of helplessness experienced. The inability to take action in many traumatic instances emphasises the helplessness which triggers issues of vulnerability and dependency. According to Young (1995), the clinical ideology linked veterans' disorder with a loss of ontological security that was traced to the veteran's inability to reconcile their traumatic memories of Vietnam with their cognitive schemas, the moral codes, self-concepts, beliefs about human nature and notions of cosmic justice through which these men attempted to impose a sense of order and meaning on the world. Trauma challenges previously held assumptions, beliefs and understandings about the world and oneself in the world (Everly, 1995). When a person is victimised, three basic assumptions or beliefs about the self and the world are challenged. They are the belief in personal invulnerability, the view of oneself in a positive light, and the belief in a meaningful and orderly world (Janoff-Bulman, 1985).

3.5.6 Meaning and perceived support[5]

Most researchers recognise that contextual factors are important in determining the

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[5]   Although this section forms part of the theoretical concepts some empirical data is included to illuminate the point.

meaning of the traumatic event and in promoting or impeding recovery (Krugman, 1987). The personal meaning of traumatic experiences for individuals is influenced by the social context in which they occur. Victims and the significant people in their surroundings may have different and fluctuating assessments of both the reality of what has happened and of the extent of the victim's suffering. As a result, victims and bystanders may have conflicting assessments of the meaning of the trauma, and this might set the stage for the trauma to be perpetuated in a larger social setting. This, in turn, may lead to the allocation of blame and responsibility which then often becomes the central issue rather than the trauma itself. McFarlane and Van der Kolk (1996) found the issue of blame to be extraordinarily complicated. Trauma provokes emotional reactions and one way of dealing with these intense emotions is to look for scapegoats who may be held responsible for the tragic event.

Emotional attachment is probably the primary protection against feelings of helplessness and meaninglessness; it is essential for biological survival in children, and without it existential meaning is unthinkable in adults (McFarlane & Van der Kolk, 1996). In recognition of this need for affiliation as a protection against trauma, it is widely accepted that the central issue in disaster management is the provision and restoration of social support (Raphael, Wilson, Meldrum & McFarlane, 1996). Lindy and Titchener (1983) have called the social support that surrounds victims "the trauma membrane". When people's own resources are depleted, outside help needs to be mobilised to compensate for their helplessness (Hobfoll & De Vries, 1995).

External validation about the reality of a traumatic experience in a safe and supportive context is a vital aspect in the prevention and treatment of post-traumatic stress. However, the creation of such a context for recovery can become very complicated when the psychological needs of the victims and the needs of their social network conflict (McFarlane & Van der Kolk, 1996), or if the social network is depleted or unavailable. When there is a lack of validation and support, traumatic memories are more likely to continue to prey on the victim's minds, and to be expressed as anger, withdrawal or otherwise disrupted and disrupting behaviour (McFarlane & Van der Kolk, 1996). It is noted in Kaplan and Sadock (1991) that the availability of social

support may influence the development, severity and duration of PTSD. This social support may be compared to the mother's holding capacity with regard to the infant in object relations theory. A study by Solomon and Horn (1986) found that the more support an officer had from fellow officers, supervisors and administration, the less post-shooting trauma occurred. Lifton (1983) found that many trauma survivors who report a lack of social support or find blame placed on them experience deeper scars as a result of this rather than the traumatic event itself.

McFarlane and Van der Kolk (1996) find it ironic that both the victims of PTSD and the larger society which has to provide support play a part in believing that the trauma is not really the cause of the victim's suffering. On the one hand, society becomes resentful about having its illusions of safety and predictability ruffled by people who remind them of how fragile security can be. On the other hand, many victims suffer from an impaired capacity to translate their intense trauma-related emotions and perceptions into communicable language. As such they find it difficult to articulate their needs.

According to McFarlane and Van der Kolk (1996) victims of trauma are vulnerable to being used for a variety of political and social ends, for both good and evil. Society's reaction to traumatised people is rarely the result of objective and rational assessments. Victims are often perceived as members of the society whose problems represent the memory of suffering, rage and pain in a world that longs to forget: "Repression, dissociation and denial are phenomena of a social as well as individual consciousness" (Herman, 1992, p.8). The issue of responsibility, individual and shared, is at the very core of how a society defines itself (McFarlane & Van der Kolk, 1996). In *The culture of complaint,* Robert Hughes (1993) eloquently argues that trauma and victimisation can become over-inclusive explanations that prevent uncomfortable self-examination. This is true for both individuals and societies.

The complexity of the issue of social support is illustrated by the finding that after suffering from heart attacks, men with good social support and a good internal locus of control fared much better than men who had neither, but that men with good social

support and a poor internal locus of control did worse that those with poor social support but a solid internal locus of control (Kobasa & Puccetti, cited in McFarlane & Van der Kolk, 1996, p.29). This suggests that social support in the absence of an internal locus of control may in fact *impair* healing processes. Since trauma is known to decrease a victim's internal locus of control, the critical question becomes: what is the optimal amount of social support that will restore a sense of self-efficacy? The efficacy of social support depends, at least in part, on the amount of comfort that the individual victims derive from it and the extent to which it motivates them to take charge of their lives again.

Central to the role of victims in any given society are the demands that they place on the community's moral and financial resources. Providing reparation is part of the recognition that someone has been hurt. Contrary to general perceptions, few victims make strong demands for compensation and special privileges (McFarlane & Van der Kolk, 1996). Many victims quietly acquiesce to their suffering; they are contained by their sense of shame and helplessness, as well as a need to maintain their self-respect and independence. Others noisily re-enact their traumas by either retraumatising themselves or traumatising other people. Research has repeatedly demonstrated that once people have been traumatised, they are liable to be traumatised again (Breslau, Davis, Andreski & Petersen, 1995; Russell, 1986). Most victims who are conscious of the effects of trauma on their lives preserve their self-protective instincts and are highly ambivalent about having people find out what has happened to them. The weak are a liability, and, after an initial period of compassion, they are vulnerable to being singled out as "parasites and carriers of social misery" (McFarlane & Van der Kolk, 1996, p.35).

It is widely accepted that the media is a powerful agent in the production and reproduction of dominant discourses (Hamlin, 1988; Masse & Rosenblum, 1988). The media is perceived as an authoritative source of information (Hall, Hobson, Lowe & Willis, 1980) and therefore plays a pivotal role in the ways that societies deal with traumatised individuals. The media is the prime purveyor of traumatic news. With the advent of satellite technology, it has become possible to invade homes with tales of

horror from all over the world which may blunt concern and trivialise the suffering involved (McFarlane & Van der Kolk, 1996). At the other end of the scale, news reports may have the power of secondary traumatisation, where people are traumatised by listening, reading or viewing horror stories.

Trauma research has been mostly conducted in Western cultures and one can expect to find differences in the meaning, support and symptomatology of exposure to trauma within different cultures. Given the rather marked differences in vulnerability and symptoms among Vietnam combat soldiers belonging to different ethnic groups (Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, & Weis, 1990), it is likely that the prevailing culture has a marked effect on the symptomatic expression of traumatic stress (Van der Kolk, McFarlane, & Weisaeth, 1996).

3.6   Conclusion

It is clear from the history of psychological trauma that constructions of traumatic stress are strongly connected with cultural, social and political circumstances. Although current psychoanalytic thinking on trauma acknowledges the role of real experience in the development of the symptoms of trauma, the emphasis is placed on the *meaning* of the real occurrence which causes trauma by changing the person's experience of the self in relation to self-objects. The (often unconscious) meaning is believed to be symbolically represented in the symptoms of trauma. Because of the experience of trauma and the resultant narcissistic regression, the person's initial self-representations, organised in accordance with a healthy sense of self-respect, are altered to form new self-representations based on a painful sense of self as worthless, helpless and humiliated. As discussed, the distinguishing feature of trauma is associated with the *anxiety of a threatened disintegration of a coherent sense of self* (Kohut, 1977).

The self is viewed as the centre of mental activity and plays a vital role in organising the meaning of experience. According to psychodynamic theory, traumatised individuals are faced with the task of integrating the traumatic event into their

understanding of the meaning of life, self-concept, and world image. Universal human anxieties have a single crucial feature in common namely "the loss of anything that is felt to be essential to life, including life itself"(Garland, 1998, p.16).

Traumatic memory differs from ordinary memory insofar as it is timeless and unintegrated, which causes victims to remain embedded in the trauma as a contemporary experience instead of being able to accept it as something belonging to the past. The concept *memory* is intrinsically connected to the conception of *self* and *self-awareness*, and confrontations with violence challenge one's most basic assumptions about the self as invulnerable and intrinsically worthy, and about the world as orderly and just. After the trauma the person's views of self and of world can never be the same again; they must be reconstructed to incorporate the abusive experience. The psyche's normal reaction to a traumatic experience is the utilisation of defences such as dissociation, avoidance or numbing which may lead to a generalised blunting of responsiveness to a whole range of emotional aspects of life.

The subjective assessment of trauma by the victims or the meanings that victims attach to these events are as fundamental as the trauma itself. The personal meaning of traumatic experiences for individuals is influenced by the social context in which they occur as well as perceived social support. It is important to remember that emotional attachment is probably the primary protection against feelings of helplessness and meaninglessness; without it existential meaning is not possible.

Chapter four constitutes the literature chapter and focuses on international as well as South African literature on trauma, with specific reference to the context of policing.