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The next meeting of PG 124 will be on January 16th. Discussion of the topic of psychic trauma will continue.

The enclosed discussion remarks were my contribution to a workshop for mental health professionals on November 17/18. The workshop was organized by Chuck Rothstein for the A.Psa.A. The panelists were George Pollock, Eleanor Galenson, R. D. Gillman, Joyce McDougall, Sandy Abend, Brandt Steele, Anna Ornstein, and Hal Blum. Moderators were Sidney Furst and Arnie Cooper. Scott Dowling and I were the Sunday morning discussants. Dowling's discussion isn't yet available, but it will be distributed when it is available.

I've omitted the first page of my discussion, since it contained merely what Bert Lewin referred to as "the usual compliments."

One of my obligations as a discussant, as I see it, is to call your attention this morning to the great variety of views which were presented yesterday. Let me give you just a few examples which will illustrate that variety. Dr. Pollock's presentation focused on object loss. This was natural, since his major, continuing interest over a period of many years has been the psychologic effects of object loss. Dr. Steele, by contrast, focused on the traumatic consequences of physical abuse in childhood. It would have been better for his patient if she had lost her parents, rather than having to live with them for twenty years. Dr. Galenson, an eminent researcher in the field of early child development, told us of a case to demonstrate the traumatic effects of separation at age four on the development of a sense of self. Dr. McDougall, in turn, emphasized the pathogenic effect of isolated, strangulated affect on bodily tissues. Dr. Ornstein addressed the topic of the psychic trauma of the holocaust from the viewpoint initiated by the late Dr. Kohut. Like him, she is what is today often called a self psychologist. Dr. Jucovy spoke to the same subject from the point of view of conflict and defense. And so it went. Each of our speakers illuminated the day's topic from the angle of special interest and importance to them. Each brought to the subject a special and different expertise. So in assessing and correlating what you heard yesterday you should keep in mind the variety of points of view which were adopted and which necessarily influenced what each of the speakers had to say.

No doubt you will hear again a wide range of viewpoints expressed later this morning and this afternoon. In what I have to say, I cannot possibly do justice to all of them. I shall try to limit myself to but a few observations, I shall pick and choose in what I say, as a discussant must necessarily do who is confronted with such a sumptuous and varied feast.

Trauma is a concept borrowed from medicine. When one studies pathology, the first slide one is given to look at under a microscope is labeled "Trauma." It's a piece of tissue which has been cut with a knife. One can see in it the reaction of the body to a simple, physical injury -- to a cut or laceration. A trauma, it seems, is an injury to the body tissues by some external force or agent. The analogue in psychopathology would seem to be an external event which injures the mind -- which traumatizes the psyche. And, in fact, it was in this sense that Freud used the word when he first introduced it in his writings a century ago. Psychic trauma at that time meant an experience, an event in one's life, which injured one's psyche. To return to medicine proper, as one continues studying pathology, one learns that cuts or bruises aren't the only things which traumatize bodily tissues. Tissues are damaged by lack of oxygen, for instance, whether the oxygen lack is due to an external agent, i.e., to suffocation, or whether the oxygen lack is due to arteriosclerosis. Bacterial toxins, i.e., chemicals manufactured within the body by bacteria, can also traumatize tissue. ~~So can an extravasation of~~ In either of these cases, it's not quite so simple to define trauma. If lack of oxygen is a trauma, one must specify how much oxygen deficit it takes to be traumatic. Within a certain range, a diminution of oxygen supply is not traumatic. Below that range, it is. To complicate matters further, some parts of the body are not damaged by a degree of oxygen deficiency which is fatal to other, more sensitive parts of the body. How is this fact to be taken into account in specifying what is traumatic when it comes to oxygen supply? And similar considerations complicate trauma due to bacterial toxins, as well as many other pathogenic influences on the body.

As you see, when it comes to medicine, from which the concept of trauma has been borrowed, it turns out that one cannot specify what is traumatic without referring to what happens to one or more tissues of the body as a consequence of oxygen lack, of exposure to bacterial toxins, or whatever. If the tissue shows signs of damage and attempts at repair, then there was trauma. If the tissue shows no signs of damage and repair, then there wasn't trauma, even though the degree of diminution in oxygen supply, to stay with my first example, was exactly the same as it was in the first instance. In the first case, the oxygen deficit was traumatic because injury resulted. In the second, it wasn't because no injury resulted. There was no way to tell until after the fact. If the tissue in question was damaged, trauma had occurred. If not, no trauma. Moreover, trauma can be due either to an external event, as in suffocation, or to an internal one, as in arteriosclerosis. Or, for that matter, even partly to the one and partly to the other. An arteriosclerotic person will be traumatized by a degree of suffocation which another person survives without damage. Thus, a young, healthy person can walk about comfortably high on a mountain where there is relatively little oxygen while an older, arteriosclerotic person who tried to do the same might die. Persons with arteriosclerotic heart disease aren't allowed by their doctors to even to ride to great heights, let alone to climb there, for just that reason.

Now in my opinion the facts of psychic illness, of psychopathology, justify an analogous descriptive definition of psychic trauma. One can define psychic trauma, I think, only with reference to its effects on the psyche. Something which has a harmful, a deleterious effect on psychic functioning or on psychic development is, by definition, traumatic. I suggest. The same external event, what else can the word trauma, the same environmental influence can be traumatic for one person and not for another, I suggest further. I believe that clinical experience compels such a statement, just as it compels us to recognize that

the same environmental influence can be traumatic for a person at one time in that person's life and not at another time. In addition, it seems to me that one must recognize that when it comes to psychic trauma, it's never a matter of external events alone. I am but echoing Fenichel when I assert that an event is traumatic because of the way in which it impinges on the traumatized individual's psychic conflicts. Let me give you a simple but, to me, impressive example.

It concerns an infantryman in the South Pacific during the fighting on Guadalcanal in the Solomon Islands. He broke down with a battle neurosis and had to be evacuated to a hospital in the States -- the zone of the interior, as it was then euphemistically called. His story was this. His combat experience had included several night patrols, which were feared by all because of the high casualty rate associated with them. It was only after the last of these, however, that he broke down mentally. In each of the others, his position in the group had been directly behind the sergeant who led the patrol. When he attempted to take the same position on the night of his last patrol, he was ordered by the sergeant to the rear, i.e., he was ordered to be the last in line, the one farthest away from the sergeant in command. He obeyed his orders and completed the patrol, though he was very agitated the whole time. The patrol was without incident, i.e., there was no contact with the enemy nor was the patrol under direct fire at any time, but after his return the patient's mental condition was such that he was unfit for further duty. Interviews after his evacuation and hospitalization made clear what in his past life had made the separation from his patrol leader so traumatic for him.

Now if this view of psychic trauma is correct, it means that it is the meaning an external event has for an individual that accounts for

its traumatic effect on him. If you want to use such words as intensity of stimuli, words which Freud used and which were echoed by many of the speakers yesterday, you have to recognize that "intensity of stimulation" cannot be estimated except in terms of the meaning of an event, the meaning of whatever stimuli you're talking about, to the person in question. I think, in other words, that when it comes to ~~psychogenic~~ psychic trauma one must, to take account of the relevant observations, say something like this.

Like physical traumas to body tissues, trauma to the psyche can come about from the outside, i.e. from external events, from the action of intrapsychic forces, or, as much the most frequent case, from a combination of the two. When the latter is the case, it is the meaning which an external event has for an individual which decides whether it is traumatic, i.e. whether it is psychically damaging or not. Moreover, in any case, the word "trauma" can only be used after the fact. If psychic damage occurred, there was trauma. If not, there wasn't.

Having said all this, and having invited, as I do, the panelists to respond to it, I shall anticipate one of the lines of argument I expect will be taken by some of them. There is no doubt that what I have suggested is, at least in part, at odds with what Freud said about psychic trauma. As a number of the panelists have reminded us, Freud said that a traumatic situation is one in which there is an influx of stimuli too great for the psychic apparatus to master or discharge. That definition says not a word about "meaning." It is simply a quantitative, an economic definition. To be sure, when it comes to traumatic neurosis, Freud took back in 1926 what he had said about it in 1920. At the earlier date he attributed battle neurosis to purely quantitative factors: an overwhelming influx of stimuli.

At the later date he was more cautious. He expressed himself as doubtful whether such a neurosis in an adult could occur without "the participation of the deeper layers of the personality," i.e., independent of unconscious conflict. Still, he did stick to his definition of trauma as the result of quantitative factors: an influx of stimuli too great to be mastered by the (immature) psychic apparatus.

I think that he was wrong in doing so, and that he did so for the same reason that induced him to label the affect accompanying even the earliest traumatic situations of life as anxiety, rather than simply unpleasure. He did so because he remained convinced that there is such a clinical entity as what he called actual neurosis. He insisted throughout his life that unhygienic sexual practices in adult life predispose to attacks of anxiety without psychic content, to neuroses that are unanalyzable because there is nothing to analyze. Such neuroses, he insisted, are due to an accumulation of libidinal tension which proves too great for the susceptible individual to master or discharge. Such an individual, according to Freud, falls ill for reasons which have nothing to do with the past, i.e., with conflict over childhood instinctual wishes. They fall ill because their level of libidinal tension is too great for the capacity of their psychic apparatus.

My reason for believing Freud wrong is a simple one. There are no such cases to be observed. What he observed that convinced him were patients whom he saw long before he had developed analysis as a reliable therapeutic and investigative method. They weren't patients about whom he really had analytic data which supported his conclusion. A colleague who knew Freud well once reported asking him how he accounted for the fact that

noone had seen any cases of actual neurosis. "Oh," said Freud, "I don't see them. They don't come to me now. But if you go to the outpatient psychiatric clinic of the hospital (the Vienna General Hospital), you'll see plenty of them. They're there, all right." The colleague concluded, "Freud was wrong, you see. But he never changed his mind about it."

If one recognizes that in this case Freud was wrong, one is no longer saddled with a definition of trauma which is at odds with observable clinical data, and one which claims to define psychic trauma in unpsychological terms, terms which are purely quantitative and which claim to take no account of the effect on psychic functioning of the event in question. Freud's definition says, in effect, "This is trauma. This is what causes psychic damage," rather than, "Whatever it is that causes psychic damage is to be considered as trauma. Let's see what sorts of things do so."

What would the panel members have to say to my suggestions and to my disagreement with Freud's definition of psychic trauma? To judge from the written versions of their presentations on which I am relying in preparing my discussion in advance, Dr. Abend would be pretty much in agreement with my proposed definition of trauma. One might expect Dr. Steele to differ, since he has cast his exposition so explicitly in Freud's language: trauma is whatever breaches the stimulus barrier, the protective shield, and the capacity of an infant to deal with an irruption of stimuli depends on its mother who is, for the first two years or so, the only mechanism an infant has to master overwhelming influx of stimuli. Despite this presumed expectation, my guess is the opposite. In fact, Dr. Steele's ideas, though not his language, are pretty much in harmony with what I have outlined as my own view of the matter. Neither he nor I knows what went on in his

patient's psyche when her mother tried to kill her shortly after her birth, but I think we'd pretty well agree about the meaning to her of her mother's behavior and attitude towards her from the ages of two or three on. Incidentally, I think Dr. Steele is to be congratulated on what he was able to do to help such an extraordinarily disadvantaged and brutalized person as his patient was. A patient whose mother not only wanted to kill her from conception on, but who twice tried to do so, presents a formidable challenge indeed. Was it ever possible, Dr. Steele, for your patient to discuss her responses to her father's sexual relationship with her? It would not surprise me to hear that it was not. One should not hope to be able to go too far in therapy with such a very ill patient. Some things are far better left alone, as witness her reaction to being told that she should be able to pass her exam with one hand tied behind her back.

My attention was captured by Dr. McDougall's list of universal traumas. You will recall the list Freud gave in 1926: object loss, loss of love, castration, and fear of punishment. Dr. McDougall's was substantially different: the discovery of otherness, the discovery of sexual differences, and the discovery of the inexorability of death. I wish Dr. McDougall would tell us the basis for her having revised Freud's list in what seems to be such a sweeping way. Or are the differences more apparent than real? Are they intended to be merely terminological, perhaps? If that is the case, a new turn of phrase, one which redirects attention to what might otherwise be neglected because of familiarity, is certainly both justified and welcome.

In the outline of his remarks which Dr. Pollock was able to send me in advance, he raised such questions as whether being in a concentration

camp can be without psychic consequences for a survivor, whether day care, by which he meant good day care, helps or hinders healthy development, and what the effect is of a one parent family, concluding with the statement, "We know that not all traumas are pathogenic."

To say that not all experiences which ~~was~~ one would expect to be pathogenic are, in fact, the cause of pathology is a statement no one would dispute, I think. To say that events which in fact are followed by pathology, i.e., traumas, are not always followed by pathology, is now quite the same thing. If I understand Dr. Pollock correctly, he meant to say the former, and in doing so in the context of referring to concentration camps he comes close to one of Dr. Ornstein's main points, namely, that not all survivors of death camps are forever psychic cripples. As she emphasized in the first part of her paper, experience even in a death camp is an individual matter. It is not the same for everyone. Even where the external stimuli are the same or nearly the same, the impact on each individual is an individual matter. One cannot, says Dr. Ornstein, assert that for every death camp survivor the experience was the same, massive trauma, due to an overwhelming influx of stimuli. In this regard, her point is well taken. As you may conclude from what I said earlier about the concept of trauma in general, I quite agree with her. I wonder, however, about the reliability of questionnaires as sources of data for supporting her later conclusions. Is not such reliance on non-analytic data as open to criticism as is the assertion that being in a death camp has the same meaning and the same traumatic effect on every survivor? Nor can I see the evidence for her conclusion that what determines the ability to survive, psychologically, and to be less

than devastated by the experience is the integrity and cohesiveness of what she calls "the self." I understand her reason for putting it thus. It's her view of all of psychopathology. I don't, however, see any evidence in its favor that she has adduced from her experience with well functioning survivors of death camps. If she has such clinical data, I, for one, would be most interested in hearing about it.

I'd like to say a word about Dr. Gillman's presentation also. As I write this, I have no way of knowing how much he was able to present of the rich and interesting case material he has to offer, but one of the points he made in connection with his treatment of his young patient was that there was little reconstruction of the traumatic event which gave rise to the patient's severe neurosis. I wonder whether he is correct in saying so. I think he underestimates his success in this regard. Take the first event in his patient's tragic story, his setting a fire among some cardboard cartons. To be sure, the patient was able to say that he had done so from the very start of his analysis. He had not repressed the memory of having set a fire and he remembered easily that he had done so in the basement of the house next door. It took years of analytic work, however, before he could say why he set a fire. In Dr. Gillman's words: "It was now almost Christmas time, the fourth anniversary of his burn. He recreated the original fire play with cartons and recaooed for the first time that the play was an enactment of a rescue fantasy: 'There were jars on shelves behind the cartons and I said, "Let's light a fire and go in and get the jars out." I had heard about someone in the circus going through the fire and I saw a TV show where a blind

man rode a motorcycle through burning paper." He recalled that the burn had occurred right after he discovered his mother and father with Christmas presents and realized that there was no Santa Claus. 'I tried to be magic,' he said."

To me, that is a substantial recapture of memories, one that would be essential to a reconstruction. The circumstances of the treatment obviously didn't permit more at the time, but one is fascinated to know what the idea of a heroic rescue of the jars meant to the little adopted boy who had just been disillusioned about Santa Claus. Perhaps Dr. Gillman can tell us more.

In closing I should like to direct the attention of the other panelists to an aspect of the topic which only Drs. Abend and Steele discussed directly in their presentations yesterday. What do they think is the value of reconstruction of trauma? Is it, in their opinion, always essential or, if not essential, is it always at least helpful and, therefore, desirable? My own opinion is that it is. I should add, however, that when I think of reconstructing a traumatic event in a patient's life I don't have in mind to recapture what an eyewitness would have seen. As my earlier discussion of the definition of psychic trauma indicates, psychic trauma or, better, a psychically traumatic event is not an eyewitness account. The trauma, what is traumatic, is the subjective experience of the traumatized individual. It is what the event meant to that individual which is the trauma. It is the impact of the external stimuli, how they heightened fears, intensified sexual and aggressive wishes, resonated with feelings of guilt and remorse. All of this is what a psychic trauma, a traumatic event, actually is.

That's what really happened to the person who was traumatized. That's what one tries to reconstruct. I personally don't see how any analysis worthy of the name can avoid going as far in that direction as it's possible to go with a particular patient under the particular circumstances of that patient's analysis. What would our panelists say about it?