

Trauma, Repression and Regression:
Towards a Unified Theory of Trauma
and its Consequences

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Introduction

The scars of trauma endure. We know this from our patients and we know this from concentration camp survivors who have courageously confronted their memories to write about their experiences, perhaps in the hope of exorcizing their insupportable memories. Here is Charlotte Delbo – “People believe memories grow vague, are erased by time, since nothing endures against the passage of time. That’s the difference; time does not pass over me, over us. It doesn’t erase anything, doesn’t undo it. I’m not alive. I died in Auschwitz but no one knows it.” (Auschwitz and After, p. 267) And Jean Améry – “It still is not over. Twenty-two years later I am still dangling over the ground by dislocated arms, panting, and accusing myself. In such an instance there is no ‘repression’.” (At the Mind’s Limits: Contemplations by a Survivor on Auschwitz and its Realities, p. 36) The scars of trauma endure in the nightmares of my Vietnamese patients more than thirty years after the war’s end. The effects of trauma endured for Isaiah Berlin’s brother. Berlin, a survivor of Stalin’s torture chambers, unexpectedly encountering his former torturer on a Moscow street, dropped dead. Many who survived for a time, eventually succumbed; Charlotte Delbo to cancer, Jean Améry, Primo Levi, Bruno Bettelheim by their own hand. Was it because, having attempted to convey the unspeakable, they could no longer abide in a world in which they had experienced the full measure of man’s sadism, once the ‘thin veneer of civilization’, as Freud termed it, had been stripped away? We do not know. We do know, however, that their nightmares ended only with their deaths.

So impressed was Freud by the enduring nature of the symptoms of trauma, especially the repetitive traumatic dreams of the participants in the first great war of the

twentieth century, he felt compelled to transform two of his most basic discoveries. Faced with the evidence of dreams which appeared to endlessly repeat the traumatic experience, Freud could no longer maintain the universality of the wish-fulfilling nature of dreams ('Beyond the Pleasure Principle' pp. 12-13 and 22-23). And, he could no longer hold the notion that the Pleasure Principle represented the fundamental motive for human behavior. He found in the repetitive reliving of the traumatic experience, a psychological force that was more basic, more primitive than the Pleasure Principle, and revealed an urgency and pressure which so exceeded the aim of pleasure that he described it as 'daemonic' (op.cit., p. 21). This was of course the Repetition Compulsion, the new 'bedrock' of human psychology.

In my work with survivors of torture and war trauma, the most puzzling challenge I face is this predominance of symptoms which appear to represent a failure of repression. The mental life of these patients is dominated by repetitive memories of their traumas, seemingly unmitigated by repression or even by distortion or other secondary processes. Freud described repression as the cornerstone of the mind's dynamics, and the treatment he created aims at regaining health through the undoing of repressed memories. Confronted with traumatized patients who frequently requested help in forgetting memories they could neither repress nor suppress, I found I had no techniques at hand to accomplish such a goal.

In a previous presentation at these meetings, given in conjunction with a wonderful paper by my co-panelist, Dr. Bentolila, I compared Freud's early description of the traumatic origin of neurosis, which depends upon repression as a vehicle for symptom formation, with the symptoms of that entity known as posttraumatic stress

disorder, in which the symptoms derive from the inability to repress the memory of catastrophic events. These two views of trauma appear to be dichotomous in nature. In fact our own Bonnie Litowitz correctly pointed out to me, directly following this presentation, that my position was dualistic.

Perhaps it is because I believe that there must be a consistency to what is discovered as true in our field that I began to search for unifying principles shared by Freud's early description of the traumatic origin of the neuroses and the phenomenological presentation of catastrophic posttraumatic stress disorder. I believe that what is discovered in depth psychology about trauma and its consequences must ultimately be consistent with its social psychological aspects and with the findings of the neurosciences.

I do not claim to provide a comprehensive view of this topic, and consider this presentation to be, at best, the beginnings of an extended discussion. Hence my subtitle, 'Towards a Unified Theory of Trauma and its Consequences'. I do not hold that there is anything inherently superior to a monadic way of viewing things as opposed to the dualistic one. After all, Freud describes psychoanalysis as a fundamentally dualistic system which pits Eros against Thanatos, ego against id, and Pleasure Principle against Reality Principle. It is possible that, after attempting to find unifying principles in this subject of trauma and its consequences, we may discover that a dualistic representation more accurately fits the facts. My goal is to explore the possibility of finding some pattern in the mental processes consequent to traumatic experiences.

An Unbearable Plethora of Dualities

I shall lay the groundwork of my exploration by describing some of the factors which enter into the discussion and which have resulted in the portrayal of this topic as dualistic. I have already noted my own contribution to the dualistic view of trauma that is repressed verses trauma that appears unrepressible. Dr. Bentolila took a similar position in her presentation in 2004, and I will take the liberty of quoting her here. “We could claim an important and significant difference between two types of patients. We could speak of Neurosis where the trauma has been repressed... On the other hand, we might claim that such patients suggest the existence of unrepressed trauma, a trauma which leaves them prey to its ever present actuality...” (D. Bentolila, “The Word”, presentation at IFPE, 2004). On a separate level, there is the epistemological dichotomy between Freud’s depth psychology and the phenomenological approach of contemporary diagnosis. The analytic approach is one which searches for the unconscious, symbolic meaning of symptoms and the dynamics of mind that produces them. Psychoanalysis is one form of a Critical Theory. Critical theories, as Raymond Geuss summarized, are reflective, aim at producing enlightenment in their subjects and are ‘inherently emancipatory’ in that they ‘free agents from a kind of coercion which is at least partly self-imposed’. (The Idea of a Critical Theory, p. 2) A Critical Theory stands in contrast to positivistic forms of knowledge, which either deny reflection as a valid means of attaining knowledge, or at best, ignore knowledge gained in this manner. The description of posttraumatic stress disorder lies in this second realm, as it relies on a purely phenomenological approach, superficial in that it does not look for meaning in symptoms, but simply enumerates a list of symptoms and requires a patient to evidence a sufficient

number of these to qualify for the diagnosis of PTSD. Thus we have a duality in these two epistemic approaches to trauma, introspective and meaningful versus the phenomenological.

A further duality is represented in Laplanche's concepts of 'traumatophilic trauma' versus 'traumatophobic trauma'. Unfortunately, except for these terms, I have no further explanation of what Laplanche meant by this dichotomy. I had this quotation from Stuart Twemlow, who referred to Laplanche's concepts during a presentation at the 2005 winter meetings of the American Psychoanalytic Association. Dr. Twemlow was unable to locate his reference, saying that he had heard LaPlanche use these terms in a presentation at a conference in Europe the preceding year. We are left to speculate what LaPlanche might mean by his neologism. Perhaps patients who suffer from a compulsion to place themselves in a position to reexperience their trauma may be characterized as evincing 'traumatophilic trauma', as against those who will do everything to avoid such a reexperiencing. By way of example, I think of a patient from Kosovo who suffered years of abuse and torture in her native country. Her torture included repeated incarceration and systematic sexual abuse by authorities when she would travel between Kosovo and Albania to make a living for her family during wartime. She now compulsively watches the news for any tragic stories, which she then relates to me at our sessions. She is especially attracted to stories about young girls who are abducted, sexually abused and murdered. This 'traumatophilia' may be contrasted with a 'traumatophobic' patient from Bosnia, who, when invited to join a therapy group of Bosnia women, adamantly refused, stating that she wished to have nothing to do with other Bosnians, as all they talked about was the war, and she had no desire to remind

herself of this excruciatingly painful time in her life. Unfortunately, we do not know what LaPlanche intended, but the phraseology is certainly dualistic.

Finally, returning to Freud's constructs, Freud himself pronounces them dualistic in nature. As he writes in 'Beyond the Pleasure Principle' (Vol. XVIII, p. 52), "Our views have from the very first been *dualistic* (italics in the original), and to-day they are even more definitely dualistic than before – now that we describe the opposition as being, not between ego-instincts and sexual instincts but between life instincts and death instincts."

The Work of Cohen and Lansky

Into this quagmire of dualities I stride foolishly searching for unifying principles. I am not the first to do so. Jonathan Cohen made an attempt at reconciling the various views of trauma in an article entitled "Trauma and Repression" (*Psychoanalytic Inquiry*, 1985). I shall try to summarize Cohen's article but shall inevitably oversimplify what is an abstract and complex argument. Cohen addresses the problem created when Freud situated the trauma reaction outside of established libido theory. In 1920, Freud determined that the trauma reactions of the soldiers who participated in the First World War did not obey the 'pleasure principle', and their traumatic dreams apparently did not conform to the wish-fulfilling nature of dreams that he had postulated as being universal. Cohen states the problem in the following manner; "Trauma brings about mental functioning that displays the essence of instincts but disobeys the fundamental principle previously thought to explain them and their repression." (op. cit., p 14.) Freud's solution resulted in the creation of a new instinctual theory, the "repetition compulsion", which Freud postulates as being more primitive than the pleasure principle.

Acknowledging that externally inflicted trauma results in the destruction of existing psychic structures in adults, Cohen offers an alternative to Freud's new creation. Cohen proposes that the trauma reaction is better understood by refining and reordering the theory of repression rather than the theory of instincts. Cohen's impetus for this alternative is the fact that the trauma reaction does not arise as a result of purely internal, instinctual events as in the origin of neuroses, but as the result of external, environmental events and failures. (op.cit. p. 173)

Cohen's theoretical construct refers to Freud's relatively unelaborated concept of "primal repression". Freud defined primal repression as the repression of an instinct before it has a chance to reach consciousness. ("Repression", 1915) There is not even a derivative existing of an instinct that has been primally repressed. This situation is contrasted with "repression proper", which refers to the repression of instincts that have seen the light of day, only to be pushed back down below the level of awareness as the result of their producing an excess of anxiety and discomfort in conflicting with other aspects of mind. This is the form of repression that results in symptom formation as the "return of the repressed", the instinct having created derivatives that are altered enough from their original form to be allowed back into awareness, like a disguised burglar under cover of dark.

Without the time or capacity to convey Cohen's argument in all its detail, I shall simply relate his proposal for a unified theory of trauma and repression. In fine, Cohen avers that the traumatic state, "characterized by loss of affective functioning, diffuse aggression, severe anxiety, inability to sleep or dream, and physiological disturbance", is "the behavioral manifestation of primal repression." (p.178) Cohen continues, "If

survived... the traumatic state results in an absence of structure and representable experience in the region of the self. This absence is primal repression. Clinically, the person is unable to represent his needs. Primal repression gives rise to a variety of mentally primitive self-protective operations, all aimed at avoiding the stimuli that provoked it.” (ibid., p. 178) In Cohen’s construct, “repression proper develops as an adaptation to primal repression.” (p. 179) To summarize, Cohen correlates the clinical aspects of trauma with primal repression, while repression proper is associated with the defenses that are elaborated in response to trauma. In this scheme, the most severe instances of trauma result in a kind of psychic ‘black hole’. The trauma remains unsymbolized and there is no comprehension or adequate mental representations of the traumatic events. Primitive defense mechanisms, analogous to Melanie Klein’s paranoid-schizoid position, are depended upon to avoid reexperiencing the helpless terror represented by the black hole of primal repression. Repression proper becomes possible in instances of less severe trauma or under more favorable circumstances following the trauma. Again quoting Cohen, he states, “Through repression proper, terror is internalized rather than remaining interpersonal, and a sense of mastery through mental manipulation of culpable wishes and fantasies is achieved.” (op. cit., p. 179)

Finally, Cohen offers a therapeutic direction for the treatment of severe trauma, based upon these theoretical constructs. “The primal repression cannot be modified by defense formation because it is devoid of representation. It can only be modified by interactions with need mediating objects.” (p. 180). Presumably, the analyst represents such a need mediating object.

I find much that is valuable in Cohen's argument. It is, however, a strictly theoretical construct. Cohen offers no clinical material to support his position. Conversely, Melvin Lansky bases his hypotheses about the same subject entirely upon clinical evidence. In his underappreciated study entitled Posttraumatic Nightmares published in 1995, Lansky, like Cohen, takes up the problem posed by Freud in "Beyond the Pleasure Principle" and addresses the "apparent failure of posttraumatic nightmares to fit into the theory of wish fulfillment." (op. cit., p 172) In a careful study of the traumatic dreams of dozens of American veterans of the Viet Nam war who were hospitalized following crises occurring in their civilian life following the war, Lansky demonstrates convincingly why this failure is only apparent. He begins with the observation, one which is confirmed by my own experience, that traumatic dreams are most frequently represented by the dreamer as simple and straight-forward recreations of actual traumatic events. Lansky states that this position is all too often accepted at face value by therapists. He relates that in the literature on trauma, "traumatic nightmares are not conceptualized as true dreams, with latent content that differs from the manifest content." (p. 3) He points out that even Freud was "uncharacteristically" quick to accept the notion that "posttraumatic nightmares were in fact simple replays of the traumatic event, more like memories than true dreams. Since the dream was presumably about the trauma, there seemed to be, almost by definition, no latent content, and therefore no dream work, no defensive function, and presumably no wish fulfillment." (p. 7) A typical example of this belief in the analytic literature is a statement by Charles Rycroft, quoted in Cohen's work cited above; "Traumatic neurosis differs from other neuroses in that its symptoms, including the traumatic dreams, are not amenable to interpretations. In

other words, traumatic neurosis has no unconscious meaning.” (Rycroft, C. (1968) A Critical Dictionary of Psychoanalysis, p. 171, quoted in Cohen, op.cit, p. 169).

In his analysis of posttraumatic dreams, Lansky relates the following discoveries: (1) the manifest content of the dream always differs from the actual traumatic events as described by the dreamer, even though the dreamer frequently reports the dreams as being a simple replication of the trauma; (2) daytime residues can be found as instigators of the traumatic dream, just as in ordinary or neurotic dreams; (3) dreamwork transforming the latent content into manifest content of traumatic dreams is consistently discovered if looked for carefully enough; (4) the latent content of dreams that are manifestly about adult traumas, in many instances, can be linked to childhood events comprising trauma and shame; and (5) a wish-fulfillment function can be described for traumatic dreams. In other words, Lansky demonstrates that traumatic dreams, so often thought to be simple recreations of traumatic events and to have no meaning beyond the manifest content, have all the elements and functions of dreams as described by Freud in 1900.

In particular, Lansky discovered that in almost every instance, the traumatized Viet Nam veterans represent themselves in their dreams as being in a frightening situation of external danger, yet psychically intact and functioning capably in an attempt to escape or otherwise combat the external danger. This dream image of an integrated self differed greatly from the dreamer’s daytime experience of a self in disarray, disorganized, inferior, damaged and humiliated. The repetitive pattern Lansky observed in his subjects was one in which the dreamer was able to transform this shattered and shame-filled self of waking hours, into a fearful, yet intact self in the dream, valiantly

attempting to elude the anxieties that now had been projected onto external elements.

(op.cit., p. 15)

Lansky states, “From a metapsychological point of view, any scenario depicting the source of upset as though it were diminished or significantly altered is a fulfilled wish, even if it is not a conscious or unconscious desire in the usual sense of the word.” (ibid., p. 66) In essence the wish consistently fulfilled in the traumatic dream is the wish to transform a fragmented self into a more integrated self, albeit one still filled with anxieties and fears related to the overt trauma of adulthood.

Clinical Material at Last

In my work with traumatized refugees, my findings are entirely consistent with Lansky’s discoveries. Because the vast majority of my patients do not speak English and were interviewed with the aid of an interpreter, my findings do not contain the fine analytic details of an associative nature typically reported in Lansky’s work. Nonetheless, I hope to convey material that will support and in some ways expand on what Lansky, always modest in his claims, demonstrates about the depth psychological processes in response to adult trauma. My clinical data comes from two decades of work with approximately a thousand adult survivors of trauma. The majority of these, about 600, come from Viet Nam, and many of the men in this group were combatants in the war we call the Vietnam War and that they refer to as the American War. Most of these male subjects, especially if they were ranking officers in the Army of South Viet Nam, spent time in prison camps after the war, euphemistically referred to as ‘Reeducation Camps’. The second largest cohort, about two hundred patients, comprises refugees from

the war in Bosnia. In addition, I have evaluated and treated dozens of patients from South America, from several African nations and from the Eastern European countries of Romania, Kosovo, Bulgaria and the Ukraine. Whatever the country or culture group, the human response to severe trauma is monotonous in its presentation despite its horrifying component parts. Emblematic of this response are terrifying nightmares which, on their surface, represent elements of the trauma as experienced by the dreamer.

And, as Lansky states, there is a tendency to accept the superficial statements of the adult victim of severe trauma, that their chronic nightmares are always the same and that they simply represent a reliving of that trauma. I believe that one motivation for this is defensive in nature. The events upon which the dream is manifestly based are so painful that the dreamer frequently wishes to avoid any further exploration or discussion of the dreams that would then take him or her back to the exceedingly painful memories of the trauma itself. When I ask about the dreams of the trauma survivor, I am most often met with some version of the following statement, "It's always the same, it's just a reliving of the war." I believe this defensive response is meant to distract the therapist from probing any further into very painful territory. Resultantly, I find that I am quite cautious about pursuing the subject and often wait a long time until the relationship is quite secure before I do so. When patients become ready to discuss their dreams in more detail, I find, like Lansky, that the details of the dream do not correspond to the actual traumatic events.

Case 1: The Vietnamese Veterans

The most glaring example of this is a dream that is typically reported by my Vietnamese patients who were incarcerated after the war, often for many years, in the ‘reeducation camps’. The dream is so consistently reported by the men with this experience, I sometimes get the impression that they have met to agree upon what they will tell me. With only minor variations, the dream goes like this, “I am being chased by Viet Cong soldiers. They are trying to capture me to take me back to the reeducation camp. I feel tremendously afraid. I wake up in a panic. My wife tells me that I have been screaming and thrashing about in my sleep.” I have heard this dream from a hundred Vietnamese veterans. Variations include such events as the Viet Cong shooting at the fleeing subject; rarely, the dreamer envisions himself shooting back. Almost always, the dreamer awakens before being captured. Only on a rare occasion did the dream continue to the point that the dreamer was captured before awakening, but then awakens not only panicky but relieved.

There are two things that I find remarkable about these dreams. One is the great similarity, as mentioned above, of the manifest content of the dream among at least a hundred patients. Second, the events of the dream, although often preceded by the comment that the dream was simply the same one about the war, in fact never took place. “The Viet Cong are chasing me to return me to the reeducation camp.” No such thing ever happened. Once released, survivors of the prison camp were not returned. They were not chased in the first place, but were simply arrested after the war’s end and imprisoned. As Lansky observed, the dreams are never simply replays of a lived experience. (op. cit., p. 27)

I could add a third remarkable aspect of these nightmares. Almost all of the patients who had been interned in the prison camps had seen extensive combat. Yet it was their experience of internment after the defeat of the South that was most prominently featured in their nightmares, not the frightening aspects of combat. While I can not be certain of the reason for this curious fact, I believe that Lansky's emphasis on the extreme shame that attends the trauma experience sheds light on this phenomenon. There is no shame attached to the act of fighting for one's country and beliefs. Participation in combat, as frightening as it may be, was at least to some extent volitional. However, great shame may be attached to the status of being a member of a defeated army, imprisoned for years, separated from family and other support systems, and having lost all autonomy in being subject to the whims of ones' captors. Lansky demonstrates that shame often precipitated the psychological disarray and the attempt at repair of the self in the traumatic dream. The dreams of the Vietnamese veterans of the Viet Nam war fully confirm and support Lansky's observations and constructs. These former officers, humiliated by years of degradation in prison camps and having lost their status and authority, to say nothing of their homes, their country, friends and family members, now picture themselves frightened but intact, fleeing from an external danger. What remains a mystery is the question of why, as we are authors of our dreams, these traumatized survivors of war never dream of a triumphant self, overcoming the enemy. Perhaps this would be too far from the reality that must be acknowledged in a dream which represents a compromise between this reality and the dreamer's wish to experience a more intact self.

Case 2: Leyla

I now present more detailed material about one of the more traumatized individuals I have met in my work of the past twenty years. Among all the survivors of trauma and torture I have treated, this woman has a history, the details of which are exceptional for the degree of brutality and sadism displayed by her tormentors. Leyla was born in Bulgaria in 1956, of Turkish and Roma heritage. These ethnic groups were despised by many in the majority Bulgarian population. In the 1980's, pogrom-like actions were launched against the Turkish, Muslim population of that country. Bulgarian citizens of Turkish descent were subjected to extra-legal detention, torture and execution. Leyla, her husband and two young sons were among those arrested. She and her sons were beaten. She was raped repeatedly in front of her children. She never saw her husband again and after her release a coffin was delivered to her. She was told that it contained the body of her husband and she was warned not to open it. Over the next few years, she was repeatedly arrested and subjected to interrogations, beatings and rape. She was burned with cigarettes. She reports that during one of these detentions, a broken bottle was inserted into her vagina. The lacerations resulting from this particular abuse became infected. Fearful of further torture, she did not seek medical attention immediately. Her wounds subsequently required surgery, including hysterectomy and repair of the damaged tissue, resulting in her now having a significantly foreshortened vagina. During a later detention, when her jailers discovered they could not have intercourse with her due to the damage previously inflicted, they reacted with rage, stabbing her in the groin. The stab wound was crudely repaired by a neighbor following

her release. All of her injuries have been confirmed and documented by forensic medical evaluations carried out as part of her application for asylum in the United States.

I have treated Leyla, in conjunction with a psychotherapist, since 2001. Her symptoms, while mitigated by medication that finally allows her to sleep through nightmares that previously prevented restorative sleep, are chronic. She experiences auditory hallucinations. The hallucinated voices are masculine and are usually demanding in tone. They tell her to take off her clothes, to give away all her belongings, or to kill herself. They taunt her, telling her that she will never see her sons again. Sometimes the voices speak kindly for a time before they suddenly turn harsh, accusatory and commanding. Leyla relates that this follows the pattern of some of her interrogations. She attempts to ignore the voices but is aware of their constant presence. Every night, as she is falling asleep, she has a vision of a pair of blue eyes staring at her against a black background. Frequently, she will have daytime hallucinations of the blue eyes. She recently described being in her bathroom and seeing the blue eyes as if in a puddle at her feet. This image transformed into the black mass she always sees at night, and then rose up and hovered around her.

In addition to her psychological symptoms, Leyla has suffered many physical problems as a result of her abuse. She has had extensive dental work necessitated by the fact that most of her teeth were kicked out during beatings. She experiences chronic pain, develops frequent urinary tract infections, and has been diagnosed with kidney cancer and a thyroid disorder, for which she is being treated.

On occasion, Leyla's symptoms have become so intense and her agitation so extreme, that she has to be hospitalized for brief periods. Despite these difficulties, Leyla

has the capacity for forming secure and adaptive attachments. She is a skilled linguist who rapidly added English to her seven other languages, so that within six months of starting treatment, she was able to dispense with the use of an interpreter. Recently, after years of treatment, she has been able to make room in her mental life and in her sessions to recall happy memories of her life prior to her trauma. We have not been able to understand the nature and meaning of many of her symptoms. However, she acknowledges that one of her tormentors had blue eyes. I have come to believe that her auditory hallucinations, especial those which tell her to kill herself, serve an adaptive function, projecting a despairing and suicidal part of herself onto an external object. As long as her suicidal feelings remain projected, she can prevent herself from acting on them. Frequently despondent about her circumstances, her terrible history, her many physical problems, her separation from her sons who live in Europe, Leyla has nonetheless, never seriously entertained the idea of killing herself.

What I am getting at here is that Leyla has been able to transform a horrendous historical reality into a frightening but fantastic inner world of distorted images and hallucinated tormentors. On the surface and in reality, this is a nightmarish inner life. Nonetheless, it is a creation, a transformation of past reality that appears to allow Leyla to survive, to live and to function in a more integrated fashion than possible during her periods of captivity and torture.

Case 3: Song

Not long after I began treating Vietnamese refugees, I was referred a patient from the Vietnamese Association of Illinois, and was told that the woman had ‘multiple personalities’. When I met Song, I recognized that I was confronted with an old-

fashioned case of hysteria. She was accompanied by her husband, and occasionally by their adopted daughter, who was, at that time, in her teens. This 40 year old woman presented herself as if she were a young child. She usually carried a doll or a stuffed animal. She rarely spoke and when she did, it was with childish inflections. If asked how old she was, Song would respond variously that she was 3 or 5, or occasionally older. She referred to her adopted daughter as her mother. Her husband provided the history that she was unable to give. His father had been the mayor of a village in South Viet Nam. It was the practice of the Viet Cong to gain control of an area by assassinating the local political leaders. The V.C. invaded their home, guns blazing, intending to kill his father. They succeeded only in killing the couple's two young children and wounding Song. When Song's husband returned home, he found his children dead and his wife in a state of shock. Subsequently, while recovering physically, she transformed emotionally, assuming the aspect I encountered, with no memory of ever having children. She denied her husband, saying she could not be married as she was just a child and that she did not know who he was. As it was his father who had been the object of the assassination attempt, Song's husband felt responsible for her care, although he told me privately that he would much prefer going to work to support the family. In an attempt to mitigate Song's loss, the family adopted an Amerasian infant who had been abandoned by her American father and Vietnamese mother, but as stated above, Song remained confused about what her relation was to this adopted child. After some years of treatment, I felt emboldened enough about our relationship that I attempted to interpret to Song that the death of her children was so painful that she had replaced them by becoming a child herself in her mind, with the hope of erasing this painful memory. My interpretations

appeared to have no effect on her mental state. Eventually, the family moved away, too far to continue their treatment, but I learned from my interpreter that Song had matured enough to be left on her own and her husband was able to achieve his desire to go to work. My point is that in the face of a massive trauma, this woman was able to construct a creative and adaptive transformative regression to avoid the unbearable pain of memory and to be able to continue living.

Case 4: Hallowe'en

I turn now briefly to a different type of trauma. Some years ago, when my practice included hospital work, I received one October the admission of a young woman who had symptoms of panic. At our first and only interview, she informed me that she had sought hospitalization as protection from her father. She feared that her father, who had been dead for many years, would reappear on Hallowe'en and attempt to murder her. She related that her father had been the leader of a satanic cult that practiced infanticide. The witches and warlocks of this cult, she said, would sacrifice babies, whose blood they drank. They would engage in sexual acts with children, including her when she was a child. I had no doubt that this fantastical account was a creative transformation of sexual abuse she had experienced early in life. I expressed interest in my new patient's story and said something to the effect that I would be pleased to work with her if we could look at elements of her story as representations of her inner emotional states, but that I hoped she would not expect me to believe that her story reflected any reality other than the one in her mind. In response to what I considered an invitation to treatment, she picked up a chair in her hospital room and flung it at me. The chair was heavy. She was a healthy young woman. I took this gesture as indication that she was declining my offer. In

confirmation of this assumption, she said that she would like a different psychiatrist, in fact she would like to be transferred to a different hospital, one where she would be permitted to smoke. I promptly complied with her request.

My point is that this young woman had been able to transform creatively what I presume was a real and terrifying childhood sexual trauma into a fantastic drama, one in which she was able to seek protection from an imaginary external danger, rather than reexperiencing the full weight of helplessness, terror and aloneness that I expect accompanied her experiences as a child. This is not unlike the reaction to trauma by my Vietnamese veterans who fled the pursuing Viet Cong soldiers in their dreams.

I am proposing that the internal response to severe trauma is a transformation of the memory of the actual events and the accompanying feelings of extreme helplessness, terror, shame and psychic disarray into something else, something that while extremely frightening, is more bearable than the 'mortal terror' (in the words of Frank Marotta) that accrues to the trauma itself. This transformation is both defensive and adaptive, making life itself bearable following an experience that can not be adequately represented psychically and can not be spoken of in a fashion that can accurately convey its essence. Freud's first patients repressed both the memory of and the impulses evoked by their traumas, transforming their experiences into hysterical symptoms. Lansky's Vietnam veterans transformed self-fragmenting traumas of childhood and war into nightmares in which the self was experienced in a more integrated fashion. I have described how my Vietnamese veterans did the same.

Once survived, a catastrophic trauma leaves the survivor with the determination to avoid a return to the intensity of feelings that a complete immersion in the memories of

that trauma would evoke. Nonetheless, the traumatic experience is a reality that must be accommodated in some psychological fashion. I am hypothesizing that what is common in the response to catastrophic trauma is the defensive transformation of the events. A compromise is created which both acknowledges the reality of the experience and distorts it into something bearable. The survivor is able to continue to live in the face of enormous psychic destruction and loss.

To return to Cohen's article on "Trauma and Repression" and his thesis that the traumatic state is "the behavioral manifestation of primal repression", I find that I can agree with this only if he means this in a metaphorical sense. Since Freud writes of the primal repression of instincts as a purely intrapsychic phenomenon, trauma that is imposed from without cannot be literally equivalent to primal repression. We might say that primal repression is to repression proper as the traumatic experience, in its inability to be represented psychically, is to the development of the symptoms of posttraumatic stress disorder. This would correspond to Cohen's statement quoted above and here again, that trauma of this nature "results in an absence of structure and representable experience in the region of the self". The trauma experience must be transformed in order to be represented, or as Cohen puts it, "through repression proper, terror is internalized rather than remaining interpersonal, and a sense of mastery through mental manipulation of culpable wishes and fantasies is achieved." My desire is that my clinical examples make Cohen's abstract arguments more concrete and understandable.

Finally, I want to add some small details to the skeleton of a hypothesis that I have proposed. In the nightmares, fantasies and hallucinations that I have described as defensive transformations in response to extreme trauma, I believe there is also a

regression to the type of defenses seen in children when they are terribly frightened. The themes of children's fairy tales and the work of Melanie Klein are instructive here. Klein's portrayal of the split between the good and bad breast, and the occasional transformation of the good mother in the child's mind into a witch-like mother, is similar to the process which occurs during mortal terror. The monstrous and terrifying images in the nightmares and hallucinations of trauma survivors have some of the qualities of the monsters of children's fairy tales. Even when these images appear realistic, as when my Vietnamese veterans are chased by their enemy, the Viet Cong in their dreams, this has a fantastical quality to it. I do not have the time here to elaborate on this idea or explore it further, but want to add regression as characteristic of the symptoms of reliving that have been so often described as part of the posttraumatic picture.

In essence, I believe that Melvin Lansky's discovery, that the dreams of the American veterans of the Vietnam War represent a wishful transformation of a fragmented self into a more cohesive self, contains a more general truth. Lansky, always moderate in his claim that his findings are limited to the specific population of his study, points us in the direction that is most helpful in discovering how people survive the terrible consequences of humanly designed, catastrophic events.

In the end, much about the relation between severe trauma, and memory and repression remains a mystery. To illustrate this mystery, I turn to data, not from a patient, but from a creative and accomplished artist, presumably a relatively mentally healthy individual, if judged by his high level of artistic functioning and achievement. Poet, film maker and novelist, Michael Ondaatje, perhaps best known for The English Patient, returned to his native Ceylon after having left that island country at the age of eleven.

His visit, a quarter of a century after he left, was motivated by the desire to collect information for a memoir about the lives of his parents and their times. During this visit, his sister told him the story of how at age five, he and several of his schoolmates were brutally treated by the nurse who bathed them at school. Musing about this story, which he evidently did not remember, Ondaatje writes, “I am dreaming and wondering why this was never to be traumatically remembered. It is the kind of event that should have surfaced as the first chapter of an anguished autobiographical novel.” (Running in the Family, 1982, p 114) We may ask, as the author does, why he repressed this particular childhood trauma. The woman who maltreated the very young boys is described as vicious and violent, and her harsh methods were practiced on the boys’ bodies on a regular basis for the duration of the school year. Why was this set of experiences of childhood forgotten, but not others? Did it resurface later, disguised, in his poetry or other creations? I might add, by way of footnote to this question, that I read all I could find of what Ondaatje wrote prior to learning of his childhood trauma. I was looking for any indication that an unconscious derivative of this experience might be represented in his work. I could find no obvious reference to these events. However, in his wonderfully creative novel entitled “The Collected Works of Billy the Kid”, there stood alone, at the top of a page in the middle of the story of Billy the Kid’s short and violent life, these few phrases – “A motive? Some reasoning we can give to explain all this violence. Was there a source for all this? yup ---“ (p. 54). The creative artist understands, just as well as the good therapist does, that human behavior is deeply motivated.

If we have no particular clues to the reasons for the repression of a relatively ordinary childhood trauma, for who can claim to be perfectly free from ill treatment by

some adult during his or her childhood, then how much more puzzling is it to understand why catastrophic traumas that occur in adulthood or childhood, are both partly forgotten and partially remembered through a distorted transformation in their memorialization.

Finally, Some Final Words

For many years I have entertained a thought that I now wish to acknowledge and commit to writing. I believe that Freud's creative genius resulted in valuable insights even when he was wrong. He was wrong in believing that the repetitive traumatic dreams of trauma survivors contradicted his discovery of the universality of wish-fulfillment as postulated in The Interpretation of Dreams. Melvin Lansky convincingly demonstrates that Freud was right all along in his original theory, which can successfully be applied to traumatic dreams. Yet, as consequence of his error, Freud discovered the repetition compulsion, one of the most powerful and useful tools of psychoanalysis. In the end, it is wonderful how it all turns out with the mind, especially with the mind of a genius.

References

1. Améry, Jean: At the Mind's Limits: Contemplations by a Survivor on Auschwitz and its Realities, translated by Sidney Rosenfeld and Stella P. Rosenfeld, Indiana University Press, Bloomington, 1980.
2. Bentollila, Donna: "The Word", paper presented at the International Federation of Psychoanalytic Education fall Conference, Chicago, 2004.
3. Cohen, Jonathan: "Trauma and Repression", *Psychoanalytic Inquiry*, 5:1985.
4. Delbo, Charlotte: Auschwitz and After, translated by Rosette C. Lamont, Yale University Press, New Haven and London, 1995.
5. Freud, S.: (1920) "Beyond the Pleasure Principle", The Standard Edition of the Complete Psychological Works, Vol. XVIII, ed. by James Stracey, The Hogarth Press, London, 1975.
6. Freud, S.: (1915) "Repression", SE, Vol. XIV, The Hogarth Press, London, 1975.
7. Geuss, Raymond: The Idea of a Critical Theory: Habermas and the Frankfurt School, Cambridge University Press, New York, 1981.
8. Lansky, Melvin R.: Posttraumatic Nightmares: Psychodynamic Explorations, The Analytic Press, Hillsdale, NJ, 1995.
9. Ondaatje, Michael: (1970) The Collected Works of Billy the Kid, Vintage International, NY, 1996.

10. Ondaatje, M.: (1980) Running in the Family, The New Canadian Library, Toronto, 1993.