



Trauma and Memory

Vladimir Jović¹

Sverre Varvin²

Abstract

A theory of traumatic memory was developed by Breuer and Freud in “Studies on Hysteria” based on Charcot’s theory on the traumatic origin of mental disorders. This was again developed in DSM-III in 1980 with the introduction of posttraumatic stress disorder (PTSD), where traumatic memory was conceptualized as a core of the syndrome and set in causal relationship with its manifestations. This implied that “trauma” tended to be seen as something static and reified, like a “thing” in the mind. It is shown that this conceptualisation diverts attention from the dynamic and reorganizing processes in the traumatized person’s mind, body and relations to others. The psychoanalytic conceptualization includes a wider spectre of the manifestations in posttraumatic conditions and it differs in the understanding of underlying processes. What is common for both childhood and adult trauma and their posttraumatic manifestations are deficiencies in symbolization processes related to the traumatic experiences. The signal anxiety function fails and the ego is overwhelmed by automatic or annihilation anxiety. The ability to distinguish between real danger and neutral stimuli which function as triggers fails. As anxiety related to trauma cannot be mentalized, fragments of the self are split off and evacuated. These experiences remain as fragmented bits and pieces that can express themselves in bodily pain, dissociated states of mind, nightmares and relational disturbances. Thus, the consequences of psychological trauma may be conceptualised as processes characterised by splitting off of not mentalized inner objects/introjects and parts of the mental apparatus. These processes are illustrated with a short clinical vignette.

Keywords

Posttraumatic stress disorder, posttraumatic processes, psychological trauma, symbolization, mentalization.

¹ MD, Dr. Sci. Med., psychiatrist, training analyst of the Belgrade Psychoanalytical Society in private practice in Belgrade and consultant of the Center for Rehabilitation of Torture Victims, IAN, Belgrade. E-mail: vladimir.jovic@gmail.com

² Professor emeritus, OsloMet – Oslo Metropolitan University. Training analyst, Norwegian psychoanalytic Society. E-mail: svsvarv@oslomet.no

© The Authors 2022. Published online at <https://rppsicanalise.org>, under a Creative Commons Attribution-NonCommercial 4.0 International License. Following the requirement of preserving the anonymity and confidentiality of patients, the clinical material is presented with a change in the patient’s identity and clinical data.

It is said that “Psychoanalysis began as a theory of trauma” (Bohleber, 2007, p. 330). A theory of traumatic memory was developed by Breuer and Freud in “Studies on Hysteria” (Breuer & Freud, 1955); in “Preliminary communication” they define from the start a “precipitating cause” of “a great variety of different forms and symptoms of hysteria” *the event* that provoked the first occurrence of hysterical symptoms. This event may have happened many years ago, patients may be reluctant to talk about it or they are “genuinely unable to recollect it and often [have] no suspicion of the causal connection between the precipitating event and the pathological phenomenon” (p.2). Breuer and Freud argued that “As a rule it is necessary to hypnotize the patient and to arouse his memories under hypnosis” (*ibid.* p.2). How the curative effect is achieved by remembering will be elaborated later in their text, but from these few sentences we see that the event and lack of connection (association) between the event and the pathological expression are seen as the cause of illness and retrieving a memory of the event as the cure.

When Breuer and Freud wrote this, hypnosis was perceived as a technique which can facilitate the retrieval of memories. Trauma was practically equated with „traumatic memory“, i.e. memory of the adverse event(s) was the pathological substrate, external noxa that pierced the mind of the victim, stayed there as an foreign object and created symptoms in an hypothetic pathophysiological mechanism which was almost a pure analogy with physical damage to the tissues. This was famously explicated by Breuer’s and Freud’s sentence that “hysterics suffer from reminiscences” (Breuer & Freud, 1955, p.6). This theory, which in essence holds that hysteria is an “ideogenic” disorder (caused by idea or thought) was meant to solve the problem of inexistent connection between pathological changes in structure of the brain and clinical presentation of hysterical patients and at the same time should be basis for the universal etiological, i.e., causative agent for all neuroses, which was, at that time, recognized in sexual abuse in childhood. As we know, this

theory will later be called “seduction theory” and will be soon abandoned by Freud; in fact he will abandon universality of traumatic experience and focus on unconscious fantasy, that will to be the start of a psychoanalysis as we know it.

Theory of traumatic memory from the “Studies..” was “initially an extension and modification of Charcot’s traumatic theory of hysteria” (Baranger, Baranger, & Mom, 1988). Charcot was able to induce paralyzes by hypnotic suggestions that would fully resemble hysterical paralyzes. His conclusion was that suggestion under hypnosis (“Your arm is paralyzed”), will allow “an idea to enter the mind in a disassociated, unconscious, quite isolated state” (Makari, 2008, p. 18). When Charcot encountered with symptoms (paralyzes) developed after a minor injury in two men who were not hypnotizable, he suggested an equation: suggestion + hypnotic state=symptom had to incorporate trauma; it was trauma that induced a hypnotic state which then allowed an idea to enter and occupy the mind. This “auto-suggestion” (“My arm is paralyzed”) would be treated by doctors with a counter-suggestion - basically reassuring the patient that he/she will be cured. These basics were further elaborated by Pierre Janet; he persisted with the idea of in-born weakness of the mind, which can result in narrowing of the “field of consciousness” in hysterical patients, but he also hypothesizes that hysterical symptoms can be related to the existence of split parts of personality, which he called subconscious fixed ideas, which he saw as highly autonomous in relation to other parts of the psyche. He showed that fixed ideas have “origin in traumatic events of the past and the possibility of a cure of hysterical symptoms through the discovery and subsequent dissolution of these subconscious psychological systems” (Ellenberger, 1970, p. 361). This “discovery” will in technical terms mean to go into details of personal history and find a specific event which caused the symptom to appear. Since the memory of this event may appear to be lost, Janet would (in the case of *Marie*) “put her into a deep somnambulist condition, a state where (as we have seen) it is possible to bring back seemingly forgotten memories, and

thus [he] was able to find out the exact memory of an incident which had hitherto been only very incompletely known” (Ellenberger, 1970, p. 363). The cure would be a *concrete intervention on memory*, i.e. active transformation. In this case one of events that Marie experienced was witnessing of a suicide of a woman who fell of the stairs. Janet managed to cure symptoms “through bringing the subject back by suggestion to the moment of the accident”. Furthermore he writes: “I succeeded, not without difficulty, to show her that the old woman had only stumbled but had not killed herself” (Ellenberger, 1970, p. 363).

TRAUMATIC MEMORY PARADIGM

This is an extremely brief and insufficient overview of Charcot’s and Janet’s complex theories, and this fragment is here just to illustrate how in Janet’s theory and treatment of patients, a traumatic memory served as a main pathological substrate as well as a target of intervention.

Why is this of interest in relation to present discussion on trauma and traumatization? An immediate answer is related to the fact that the posttraumatic stress disorder (PTSD) as it is defined in *Diagnostic and Statistical Manual of Mental Disorder* of the American Psychiatric Association since its Third Edition (American Psychiatric Association, 1980) to the very last one (DSM-5) (American Psychiatric Association, 2013), in fact has an inner “memory logic” (Young, 2007), which means that it is conceptualized in relation to traumatic memory which function as a core of the syndrome and is in causal relationship with other symptoms. This memory logic was created in the times of Charcot and Janet, but the revival of ancient and abandoned theories is a consequence of a complex interplay of social, political and theoretical/philosophical factors that determine development of nosological concepts in the last decades. So, the question – Why bother reading about Charcot and Janet? – should be answered carefully and in at least three different domains. The first domain lays in the realm of the role of psychological trauma in the over-

all philosophy and method of investigation of mental disorders, the second is related to historical trajectories of development of concepts of posttraumatic disorders within the psychology and psychiatry and the third, but not the least in importance, is related to practical implications, i.e. modes of treatment of posttraumatic mental states that are becoming increasingly needed in times of turbulence brought by wars, social crises and ways of living.

Since the publication of DSM-III in 1980 (American Psychiatric Association, 1980) mental disorders were defined as syndromes or as clusters of symptoms that appear together. It was in this edition that PTSD was officially introduced as one of a few etiologically defined disorders, with four diagnostic criteria; the first one being the defining criterion – “Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone” (p. 238), and three clusters of symptoms, causally connected to the traumatic experience. The possibility to have a diagnosis which is described as a direct effect of a traumatic event hugely helped victims to obtain recognition, compensation and treatment. But it also inherited several paradoxes which this newly established PTSD diagnosis shared with other disorders defined with a similar methodology.

The DSM-III approach, it was held, has to be restrained from any theoretical assumptions, especially regarding etiology. The idea that psychological facts could be “described” without a theoretical system has its long tradition reaching back to Karl Jaspers, who advocated such a position in his *General Psychopathology*: “Conventional theories, psychological constructions, interpretations and evaluations must be left aside. We simply attend to what exists before us, in so far as we can apprehend, discriminate and describe it” (Jaspers, 1963, p. 56). The idea to separate description of mental symptoms from any theoretical system is basically anti-psychoanalytic, which is conceivable/understandable if we are reminded to Jaspers’ negative attitude toward Freud and psychoanalysis (Bormuth, 2006).

PTSD was a child of DSM-III, and thus inherited the same main characteristics and inner par-

adoxes. To put it into context, it was conceived in times of and immediately after the Vietnam war, which significantly “redefined the social role of the psychiatry and society’s perception of mental health” (Shephard, 2001, p. 355). The first published account on “Post-Vietnam Syndrome” came in *The New York Times* on May 6, 1972 by Chaim F. Shatan (1972), and it differed significantly from the concept of PTSD defined in the DSM-system. The latter was conceived mostly by Mardi J. Horowitz who published “Stress Response Syndromes” in 1976, based on the “information processing model”, and his influence proved to be decisive in shaping what became criteria for PTSD (Young, 1995). As Shephard argues: “Everything was factored into Horowitz’s equation – except experience with military cases and an awareness of the role of social culture. The building bricks of his model were intellectual not practical. In the battle between the consulting room and the laboratory, the field hospital and the study, the intellectuals had triumphed” (Shatan, 1972, p. 367).

Thus, the implicit pathogenic mechanism of PTSD became a processing of traumatic memory, i.e. memory of a traumatic event. As such memory cannot be integrated, it “jumps up” into the mind in a form of intrusive re-experiencing, that needs to be avoided as it creates an unpleasant hyperarousal. Though included in DSM-III which was declaratively “atheoretical”, its’ composition of signs and symptoms were indicating an implicit theoretical framework of pathological mechanisms. Explaining its “inner memory logic”, Young explicates that within PTSD criteria, it is not the event (Criterion A), but intrusive re-experiencing, i.e., memory, that “drives the syndrome” (Young, 2007, p. 23). At first “the defining symptoms alone (intrusive re-experiencing), without a connection to the stressor, are not regarded as PTSD” (Breslau, Chase, & Anthony, 2002) for example, re-experiencing the stressor and avoidance of stimuli that symbolize the stressor. Temporal ordering is also required: when sleep problems and other symptoms of hyperarousal are part of the clinical picture, they must not have been present before the stressor

occurred. The ICD-10 definition of PTSD follows the same model. The defining symptoms alone, without a connection to the stressor, are not regarded as PTSD (Green et al. 1995). Without intrusive symptoms, there will be no avoidance and numbing nor hyperarousal, which come as a result of re-experiencing of a traumatic event. The practical consequences are manifold.

The first one is a reduction of descriptive power: relying on behavioral analysis only, the concept of PTSD deletes many aspects of patients’ presentations which can be observed in clinical settings, like depressive syndromes, anxiety disorders, somatizations and conversion symptoms, traumatic hallucinations, substance abuse, self-harm and guilt, and many more. In the DSM model, these symptoms are described as “comorbidity”. One factor contributing to this has been “the rule laid down in the construction of DSM-III that the same symptom could not appear in more than one disorder” (Robins, 1994).

If it is the memory which “drives the syndrome”, it is logical to conclude that the “traumatic memory” must be specifically different from other forms or “normal” memory. This notion was elaborated over the years and in essence it holds that: “[i]n contrast to ‘ordinary’ memories (both good and bad), which are mutable and dynamically changing over time, traumatic memories are fixed and static. [...] These harsh and frozen imprints do not yield to change, nor do they readily update with current information.” (Levin & van der Kolk, 2015, p. 21). Further distinction lays in the fact that “ordinary” memories “can generally be formed and revisited as coherent narratives”, while traumatic memories “tend to arise as fragmented splinters of inchoate and indigestible sensations, emotions, images, smells, tastes, thoughts, and so on” (ibid.). The stress on the difference between “coherent narratives” and raw sensations reflects the idea, elaborated by van der Kolk, that the traumatic event prevents consolidation of an explicit memory which can be verbalized and implicit memory which can be “stored” in bodily sensations (van der Kolk, 1994). In the same manner, traumatic dreams became “replicative dreams”, “an exact replay

(‘replication’) of the original event” (Schreuder, van Egmond, Klein, & Visser, 1998) – which designates that they are not dreams proper, that is, mental materials changed by the dream work, but explicit memory of or replication of the event that happened in reality.

The notion that the traumatic memory is different and specific, in the way that it is frozen, unchanged, fixed, helped development of “recovered memory therapy” which is relying on “trauma-memory argument” (Shobe & Kihlstorm, 1997). This, as is well known, led to “recovered memories debate” (Fonagy & Target, 2018), and “memory wars”, which continue still (Patihis, Ho, Tingen, Lilienfeld, & Loftus, 2013) In practical terms, mainstream treatment for PTSD became “trauma-focused psychotherapies” (Rosenbaum, Jovic, & Varvin, 2020). Fonagy and Target systematized findings which are in opposition to this view, which suggests that memory does not have a mechanical but more active nature, such as the one that the individual’s memories correlate strongly with adult outcomes, particularly psychological disorders. That is, memories may be distorted by phantasy and defense, and memory is strongly influenced by the social situation where events are remembered. Memory has thus a self-serving bias, it is distorted to place the individual in a more prominent causal role and memories are affected by mood and expectation of what is to be recalled influences memory (Fonagy & Target, 2018). In other words, what memories are basically reconstructive and dependent on the situation in which events are remembered.

We will not go further in explicating conflictual concepts related to the traumatic memory model. Our main aim in this article is to present psychoanalytical concepts which can help us understand complexities of interplay between past events that have had a destructive power within the psyche and dynamics of posttraumatic mental states that the foundations of different clinical expressions of traumatized persons.

PSYCHOANALYTICAL UNDERSTANDING OF POSTTRAUMATIC STATES

At the descriptive level, i.e. recognition of signs and symptoms in relation to trauma, the DSM concept of PTSD and of posttraumatic states conceptualized in psychoanalytical theory, do not differ much. Nightmares, vivid recollections with hyperarousal, flashbacks, etc. are included in the psychoanalytic conceptualization. The psychoanalytic conceptualization includes, however, a much wider specter of the manifestations in posttraumatic conditions and it is especially in the understanding of underlying processes that differences become apparent.

PROCESSES RELATED TO TRAUMATIZATION

Traumatized persons struggle with mental and bodily pains which are difficult to understand and difficult to put into words. The pains may be expressed as dissociated states of mind, as bodily pains and other somatic experiences and dysfunctions, as overwhelming thoughts and feelings, as behavioral tendencies and relational styles, and as ways of living. The effects of both early and later traumatization may show itself in many diagnostic categories where symptoms characterizing PTSD is only one form. Manifestations related to traumatization in the psychiatric illness picture may include depression, addiction, eating disorders, personality dysfunctions and anxiety states. What is common for these manifestations are deficiencies in the representational system related to the traumatic experiences. The traumatic experiences are painfully felt and set their marks on the body and the mind without, however, being inscribed in the mind’s life narratives. They are not symbolized, or deficiently symbolized, in the sense that they cannot be expressed in narratives in such a way that meaning can emerge that can be reflected upon.

The complex underlying processes of posttraumatic states can be seen in one specific feature of posttraumatic states - “re-experiencing symp-

toms” such as : “[r]ecurrent, involuntary, and intrusive distressing memories”, “[d]issociative reactions (e.g, flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring”, “[i]ntense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)”, and “[m]arked physiological reactions to reminders of the traumatic event(s)” (American Psychiatric Association, 2013, p. 273). War veteran will see a ditch prepared for telephone cables but will have a vivid image of tranches and will have an anxiety attack. Victim of torture will see a postman in a uniform and anxiety will overwhelm him. These symptoms were understood as a direct consequence of a “traumatic memory” mechanism, but in a psychoanalytic perspective they can better be explained by the collapse of the symbolization process.

Freud distinguished anxiety which arouses in actual situations of danger, like in combat, called automatic anxiety, from anxiety which arouses in case of perceived threat, named signal anxiety. The function of the signal anxiety, the normal protective function, is to warn the ego so that defensive measures may be taken to hinder the ego from becoming overwhelmed. In favorable development and in absence of trauma, mature Ego can distinguish between these two anxieties. Trauma is thus a situation in which this signaling function fails and automatic anxiety sets in, the result being that the ego is overwhelmed,

Trauma may in effect unleash annihilation anxiety (unbinds them from neutralizing effects of Eros), and Ego cannot distinguish between automatic anxiety and signal anxiety, i.e. between real danger and neutral stimuli which function as triggers. For Caroline Garland “[t]his is a crucial factor in the loss of symbolic thinking, at any rate in the area of the trauma, which is such a marked feature of the behavior of survivors. Certain smells, sounds, sights, situations, even words connected with the traumatic events all produce states of immense anxiety, and the mental state known as the flashback. There is no capacity and no place for belief in ‘signals’ or ‘warnings’: this is it” (Garland, 2018, p.17).

Within the moment of trauma, an automatic anxiety will arouse of such an intensity that it destroys the protective shield, protective barrier, i.e., safety system developed during favourable psychosexual development. These anxieties, released of its neutralising counterpart – good, soothing, nurturing force developed through the introjection of a relationship with (a good enough) primary object, are deep, comprehensive and may best be understood as annihilation anxiety (Hurvich, 2003) or nameless dread (Bion, 1962). This impending catastrophe reflects the early fear of breakdown experienced in infant life (Winnicott, 1974). Traumatization effected by human beings influences internal object relations scenarios in different ways. Early traumas that bear some similarity to the present traumatization may be activated, causing the present trauma to be imbued with earlier losses, humiliations and traumatic experiences. Even early safe-enough relationships may be coloured by later traumatizing relationships (Varvin, 2013). Unbearable losses may bring the traumatized to eternally seek a rescuer or substitute in others (Varvin, 2016).

Extreme traumatization precludes forming of an internal third position where the person can create a reflecting distance to what is happening and what has happened. The inner witnessing function, so vital for making meaning of experiences, is attacked during such extreme experiences impeding the individual from being able to experience on a symbolic level the cruelties they undergo. When the external witnessing function that can contain the pain also fails, the traumatized person is left alone.

As anxiety related to trauma cannot be mentalized, fragments of the self are split off and evacuated, probably in more than one way and form. The result is often that these experiences remain as fragmented bits and pieces that can express themselves only in bodily pain, dissociated states of mind, nightmares and relational disturbances. The traumatized person will try to organize experiences in unconscious templates or scenarios that are expressed in different more or less disguised ways in relation to others and the self.

“When a patient separates from a painful and unbearable emotion, he is also splitting from the part of the self-capable of having that emotion. This impoverishment occurs in various manners. The person loses a sense of continuity of his mental life so that his capacity to hold himself responsible for his feelings and actions is diminished, and thus his capacity to interfere in his destiny is brutally affected. On splitting due to loss of links between emotional experiences, the capacity for symbolizing and the possibility of construction of mental representations is sensibly hindered” (da Rocha Barros, 2009, p. xviii).

Thus, the consequences of psychological trauma are a result of a schizoid process, governed by a splitting of more or less large “chunks” of mental apparatus and damage being done by this process.

At the descriptive level, symptoms of PTSD as well as other manifestations of posttraumatic mental states are possible to explain by recognizing manifestations of disturbed symbolisation. Lecours and Bouchard describe one possible categorisation of different levels of mentalization, i.e., “five descriptive levels of affect tolerance or containment and abstraction: disruptive impulsion, modulated impulsion, externalisation, appropriation of affective experience and abstract-reflexive meaning association” (1997, p.860). At the most basic level of disruptive impulsion, when drive/affect experiences are neither tolerated nor contained we can find many aspects of posttraumatic states recognizable. Affects related to the trauma are expressed basically without mentalization, through different “channels”: at the somatic level we can see chronic somatic complaints, usually different pains, often resistant to medicines. At the level of motor activity, we will recognize proneness for self-stimulation (substance abuse, risky driving and sports), outbursts of anger which result in physical fights, etc. At the level of imagery, we see what is usually described as re-experiencing: hallucinations and obsessive, intrusive images, and finally at the verbalization level, there are frequent argu-

ments, uncontrolled or inappropriate shouting and insulting, usually triggered or accompanied by trauma-related incidents, etc.

There is increasing evidence that psychoanalytic therapies are helpful for traumatized persons in comprehensive ways, in that this approach may help address crucial areas in the clinical presentation of posttraumatic states that are not targeted by other currently so-called empirically supported treatments. Psychoanalytic therapy has a historical perspective and works with problems related to the self and self-esteem, enhancing the person’s ability to resolve reactions to trauma through improved reflective functioning. It aims at internalization of more secure inner working models of relationships. A further focus is work on improving social functioning. Finally, and this is increasingly substantiated in several studies, psychodynamic psychotherapy tends to result in continued improvement after treatment ends (Schottenbauer, et al., 2008).

In our recent papers (Jovic, 2018; Rosenbaum, Jovic, & Varvin, 2020; Jovic, 2022) we presented short clinical vignettes of individuals who were traumatized by recent wars and in their adult life or late adolescence. Here we would like to present a case where acute disruption of symbolization led to a psychotic state of mind which happens to be related to an early childhood trauma.

A woman in her early thirties engages in psychoanalytical therapy mostly due to her anxieties related to love relationship with a man who is not willing to commit to her. She was working in a day care for children and often felt anxieties about her competence, which appeared as overwhelming anxieties. She describes herself as a sensitive child, who for a prolonged period during childhood suffered from severe fears (which were not understood by her family). During the second year of psychotherapy, it was obvious that the man whom she was seeing was having another relationship, and she reacted in severe panic. When she encountered information that could function as trigger, she reacted with severe anxieties and she could not control herself. She was unable to focus on tasks, even the simplest one, she could

not sleep, she would cry endlessly. At some point during the second year of psychotherapy she reported a dream:

There is a car of her boyfriend, parked on the hill, and it is full of his children. She sees that the car will slide down the hill and that the children will be in danger – so she jumps up into the car and pulls up the breaks.

At that moment therapist interpreted her jealousy toward possible future relationships of her boyfriend and his babies that he will create with other women, which she accepted. Other anxieties related to her relationship or rivalry with her sister, jealousy toward other women came up. She understood that in her unconscious phantasy, all other women who have husbands, or boyfriends, or children (especially sons), were „complete“, or successful, or worthy, while at the same time she felt as worthless, empty and without any values.

Over couple of weeks her anxiety developed into a psychotic crisis, and antipsychotics had to be introduced. She brought several dreams that were related to pregnancy. In one of them *she is walking with her sister-in-law, who is on roller skates and seven-month pregnant* (in reality as well as in the dream). *She is worried that she will fall and hurt the foetus, and she is holding her at the hand.* In the session she spoke about anxiety and confusion she had over the weekend: she went out, but every remark about marriage or children would create overwhelming anxiety. She was perceiving that all other people were looking at her and talked about her, thinking of her as being crazy. When the fear that she will hurt somebody other's child came up, a memory while she was approximately two and a half year old came up: it was several days after her grandfather on mother's side died, that her mother had a miscarriage in a late pregnancy. She entered the room, where mother was with other women, but she remembered only seeing blood.

This early childhood trauma was created by the situation in which child omnipotently connects her envious feeling toward mother's pregnancy with the real outcome in a form of a dam-

aged mothers body and baby being dead. The ensuing overwhelming guilt, connected with envy, desire for her own babies and for a man who can give her babies, were dissociated, split off and were never really integrated and mentalized since the trauma of her early Oedipal period (first realization of mother's pregnancy and then a shock of observing an abortion). This prevented her to understand the "facts of life" (Money-Kyrle, 1968, p. 693), to suffer the pains of an Oedipus complex, and eventually to become reconciled to the parental relation and achieve maturity. This situation in her adult life which revoked her envy, aroused thus signal anxiety that became unbearable. Her harsh superego had been projected in a massive chunks and created symbolic equation, which led to her experience she did actually murder a child.

CONCLUSION

We have argued that it is essential to focus on processes underlying symptoms and signs that appear after traumatizing experiences to be able to understand and organize rational treatment. The word "trauma" is often used in a confusing way naming the traumatizing agent, the effect in the personality, the cause of mental illness etc. We hold that this implies something static and reified, like a "thing" in the mind, that tends to divert attention from the dynamic and reorganizing processes in the traumatized person's mind, body and relations to others that happen after being exposed to events that trigger overwhelming anxiety. Posttraumatic processes depend on the level of personality organization, on past traumatizing experiences, on the circumstances during trauma and on the context that meets the person afterwards. We have argued that the "reified" understanding of posttraumatic states rely fundamentally on the traumatic memory concept described earlier. We hold that understanding of posttraumatic states and their phenomenology, should rely on understanding of dynamic forces and psychic structures that are part of the developmental process but that may be shattered when

person experience catastrophic events. Recovery can thus be seen as reintegration of fragmented parts of personality and reparation of symbolic function. ❖

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Trauma e Memória

Resumo

Uma teoria da memória traumática foi desenvolvida por Breuer e Freud em “Estudos sobre a histeria” baseada na teoria de Charcot sobre a origem traumática dos transtornos mentais. Isso foi novamente desenvolvido no DSM-III em 1980 com a introdução da Perturbação de stress pós-traumático (PSPT), onde a memória traumática foi conceituada como um núcleo da síndrome e colocada em relação causal com suas manifestações. Isso implicava que “trauma” tendia a ser visto como algo estático e reificado, como uma “coisa” na mente. Mostra-se que essa conceituação desvia a atenção dos processos dinâmicos e reorganizadores na mente, no corpo e nas relações da pessoa traumatizada com os outros. A conceituação psicanalítica inclui um espectro mais amplo das manifestações em condições pós-traumáticas e difere na compreensão dos processos subjacentes. O que é comum tanto no trauma infantil quanto no adulto e suas manifestações pós-traumáticas são deficiências nos processos de simbolização relacionados às experiências traumáticas. A função de ansiedade de sinal falha e o ego é dominado pela ansiedade automática ou de aniquilação. A capacidade de distinguir entre perigo real e estímulos neutros que funcionam como “gatilhos” falhados. Como a ansiedade relacionada ao trauma não pode ser mentalizada, fragmentos do self são cindidos e evacuados. Essas experiências permanecem como pedaços fragmentados que podem se expressar em dores corporais, estados mentais dissociados, pesadelos e distúrbios relacionais. Assim, as consequências do trauma psicológico podem ser conceituadas como processos caracterizados pela cisão de objetos/introjectos internos não mentalizados e partes do aparelho mental. Esses processos são ilustrados com uma pequena vinheta clínica.

Palavras-Chave

Transtorno de estresse pós-traumático, processos pós-traumáticos, trauma psicológico, simbolização, mentalização.