

The Three Faces of Trauma: A Self-Psychology

Viewpoint

Ronald R Lee Ph.D.

The opening session of the Twenty Fourth Annual Self Psychology Conference in San Francisco in November 2001 presented an ongoing, eight-year psychotherapy case of Ann, a 42 year-old woman who had been horribly humiliated from her father's physical and sexual abuse over many years, and who had attended her initial psychotherapy sessions sleep-deprived, full of self-loathing, and with a tendency to dissociate. Six respondents then reflected about the case from their theoretical perspectives. But the significant implication of this conference was not just its organizing focus on this case of trauma, but the significant shift from the issues of narcissism to those of abuse; a refocusing from Kohut's "tragic man" to what could be called "traumatized man."

Any significant attention to "traumatized man," stands in comparison to Kohut's theoretical concepts of "tragic man" and "guilty man." Of these latter concepts, Kohut (1977) defines "guilty man" as living within the pleasure principle and seeking to satisfy pleasure-seeking drives. In contrast, his "tragic man" is influenced by the pattern of his nuclear self and striving to go beyond the pleasure principle (p. 133). Kohut makes a distinction between these two categories because "drive theory and its developments explain guilty man but they do not explain tragic man (p. 224)." He continues, "the psychology of the self is needed to explain the

pathology of the fragmented self (from schizophrenia to narcissistic personality disorder) and of the depleted self (empty depression, i.e., the world of un-mirrored ambitions, the world devoid of ideals) – in short, the psychic disturbances and struggles of Tragic Man” (p. 243). How, then, could “traumatized man” be described?

In what follows we shall (1) examine evidence for the clinical concept of traumatized man, (2) summarize Kohut’s concept of trauma, and (3) explore some treatment issues.

1. Traumatized man.

The idea of “traumatized man” as a distinct self-disorder began crystallizing in the clinical literature some time ago. Making traumatized man a focus in psychotherapy theory, however, is only justified by the concept’s ability to increase clinical effectiveness in treating such patients. Certainly the case for a distinct clinical entity of traumatized man has grown persuasive enough to have the diagnostic entity “Post Traumatic Stress Disorder” included in the diagnostic manual of the American Medical Association (DSM.III & IV). Van der Kolk (1996), for example, not only has emphasized the importance of trauma in psychopathology but, through a series of studies, has shown that a common feature of patients diagnosed as Borderline Disorder, Dissociative Identity Disorder or Multiple Personality Disorder, is the evidence of their sexual and/or physical abuse when children. As he points out, (Saxe et al., 1993, 1994) of 111 consecutive state hospital admissions, all reported sexual abuse, 86% had histories of physical abuse, and 79% reported witnessing domestic

violence. Revealing the overlap of clinical syndromes, of 16 (out of the original 111) who scored high on a Dissociative Disorder scale, 100% of these also met the diagnostic criteria for Post Traumatic Stress Disorder, 71% for Borderline Personality Disorder, and 64% for Somatization disorder. Van der Kolk also claimed that childhood trauma set the stage for disorders that involve self-mutilation, eating, and substance abuse. So, studies on diagnostic categories with a high co-relational overlap make it clear that a child's physical and sexual abuse plays a major role in a number of severe, adult self-disorders. This belief that abuse, particularly incest, has an etiological role in psychopathology is consistent with Freud's discoveries when studying at the Salpêtrière Mental Hospital, Paris, in the mid 1880s.

Investigations by such clinicians as van der Kolk also lead to conclusions consistent with the theory of self-psychology - that treatment of self-disorders needs to focus on the underlying subjective experiences rather than the symptoms and/or behaviors themselves, and especially on understanding the patient's relationship with parents during early childhood. Importantly, van der Kolk's investigations suggest that placing an emphasis on a symptom-based diagnostic system with its privileged notions of objective clinical reality discourages exploring the subjective experiences behind the symptoms. As one traumatically abused patient screamed, "I don't care about your labeling, I want to be sure you understand how terrified I am of being retraumatized by seeing you."

This patient's concern about being retraumatized takes us into the heart of the diagnostic (and treatment) issue. Kohut repeatedly stated that the best indicators for

narcissistic disorders were the selfobject transferences that emerge during psychotherapy (idealizing, mirror, twinship). He (1971) insisted that a “spontaneous establishment of one of the stable narcissistic transferences is the best and most reliable diagnostic sign which differentiates these [narcissistic] patients from psychotic or borderline cases, on the one hand, and from ordinary transference neurosis, on the other” (p. 4). This means that if a traumatized disorder is dissimilar to a narcissistic or neurotic disorder, it will reflect a significantly different transference from either of these, especially in a long, drawn-out initial phase of psychotherapy, measured more by years than weeks. The key to this traumatized transference is what Anna Ornstein (1974) called “the dread to repeat.” Such a dread conveys an extreme fear of being retraumatized, and the terror of the patient who attempts to establish a therapeutic relationship. No wonder, then, that many traumatized persons resort to dissociation (Janet, 1889) when difficulties threaten their relationships with family, friends or psychotherapist (van der Kolk, 1996, pp. 191-193). A patient’s heavy use of dissociation in order to reduce severe distress – hence reduce somatizing - and the need to relive early traumatic experiences are suggestive of Bergson’s (1988, pp. 75-76) concept of difference in “kind,” not just “degree,” when severe traumatization is compared with the disorders of tragic man or guilty man.

Compelling evidence for considering traumatic disorders different in kind to narcissistic or neurotic disorders comes from studies on the startle affect. When healthy infants encounter over-stimulation, they habituate to the stimulus that startles, close down their nervous system, tighten their flexible extremities, and reduce their capacity to blink

Such a capacity in healthy babies to habituate to a stimulus is an important means of self-protection that confirms the need for parental regulation of early affect states (Brazelton and Cramer, 1990). Those who are damaged by trauma lose this defensive capacity to habituate, a research result that would not have surprised Kohut (1950) who, over half a century ago, recognized the startle affect's link to stress and trauma (p. 139). Van der Kolk (1996) too recognizes the importance of the startle affect, and especially when he claims it as a marker for the vulnerability of persons to a post-traumatic stress disorder (p. 221). The traumatized person's incapacity to habituate to an experience, such as a loud gun shot, is the opposite to non-traumatized persons who startle less each time they hear the shot. The implication of the traumatized person's inability to habituate to a startle stimulus is support for a distinction between narcissistic and neurotic disorders on the one hand, and severely traumatized disorders on the other.

A failure to habituate to a startling sound is a failure to learn. Kolb (1987) proposed that this lost ability to learn, results from an excessive stimulation of the central nervous system at the time of the trauma, resulting in permanent changes to some neural circuits of the brain. Such an idea is supported by studies on the sea snail (*Aplysia Californica*) by Kandel (1995). This simple creature of 20,000 neurons withdraws its gills when touched. If the touching is repeated after a short period, the snail quickly recognizes the unwelcome touching and becomes more adept at withdrawing its gills. In other words, it remembers; it learns. But a key feature of Kandel's *Aplysia* studies is that this learned, enhanced withdrawal response disappears after a few minutes - the learning is short-term. Kandel then demonstrated

that the *Aplysia*'s short-term memory involves an enhanced release of neurotransmitters at the neural synapses.

Kandel then took a further step. He significantly increased the number of unpleasant stimulations, noting that the *aplysia* learned to withdraw its gills for longer and longer periods of time. In effect, through continued stimulations the short-term memory was consolidated into long-term memory. Then, when Kandel examined the neurons of those *aplysia* with a long-term memory of excessive, unpleasant gill stimulations, he found evidence of protein synthesis and the growth of new dendrites and synapses. Importantly, he concluded: "on the cellular level the switch from short-term memory to long-term memory facilitation is a switch from a process-based memory to a structural-based memory" (Abel, 1995, p. 302).

Studies pointing to structural change also raise the question of what happens if the created distress increases to a traumatic degree? The answer seems to be that trauma involves a destructive kind of structural change that inhibits new learning, short-term and long-term, after the traumatic experience. For example, in the study of humans, the startle response has been shown to release the secretion of cortisol in the neurons of the right prefrontal lobe (Wittling and Pfluger, 1990). This finding is supported by Stanton (Stanton, Gutierrez and Levine, 1988) who found that rats exposed to novel situations in the absence of attuned mothers had high levels of corticosteroids, suggesting that human traumatic experience may permanently damage neurons during an infant's development. DeKosky (DeKosky, Nonneman and Scheff, 1982) highlighted such neural toxicity when he demonstrated that increased cortisol levels permanently reduced postnatal brain growth. This is because high cortisol

levels reduce levels of nerve growth factor (Simonoski, Murphy, Rennet and Heinrich, 1987), which rat studies show is needed to stimulate new sympathetic axons and dendrites (Unsicker, Kirsch, Otten and Thoenen, 1978).

Trauma damages the neurons in specific brain areas. In an important finding, excessive amounts of corticosteroids lead to shrinkage of the brain's hippocampus, and amygdala. Gurvitz (Gurvitz, Shenton and Pitman, 1995), for example, found that Vietnam veterans who had participated in intense combat had an average shrinkage of 26% in the left hippocampus and 22% in the right hippocampus, compared with veterans without combat exposure. Such shrinkage suggests the occurrence of cell death, atrophy of dendrites, or both. Van der Kolk (1996) believes the most likely explanation for these results is that "shrinkage in the hippocampus is due to the effects of heightened levels of cortisol, which is known to be toxic to the hippocampus" (p. 253). Teicher (2002) believes a special vulnerability to damage exists in the hippocampus because neurons normally continue to grow there after birth.

Studies of childhood abuse victims also reveal hippocampus shrinkage. Teicher (2002) studied abuse victims by using a checklist and reading encephalograms (ECGs), Davies did the same using ECGs, and Bremner studied abuse victims through magnetic resonance imaging (MRI). These studies point to a reduction in size and activity in the left hippocampus particularly. The Bremner left hippocampus reduction was 12%, not as large as in the Vietnam veterans study, but still a significant result. In addition to hippocampus damage, a German study by Driessen reported some reduction in the amygdala, a result that Teicher had found too. In summary, then, these post-traumatic soldier and child abuse studies, supported

by animal studies, clearly demonstrate the high vulnerability of the hippocampus and amygdala to neuron damage when a person is traumatized.

More specifically, these studies indicate more damage occurs in the left hippocampus and left amygdala, compared with the right hemisphere. This suggests that traumatized persons may learn to compensate for left-brain damage by relying more on right-brain imaging functions than non-traumatized persons. It also suggests that treatment, which focuses on the imaging capacities of the patient in such fields as art or music, may be more effective in communicating with traumatized patients than treatments based solely on language.

As the control of the production and release of dopamine and norepinephrine neurotransmitters is also known to involve the cerebellum, research has now focused on the vermis area of the cerebellum because, as with the hippocampus, this brain circuitry continues to grow neurons after birth, and has a high density of cortisol receptors. Teicher found, using MRI blood flow readings as an indication of neural firing, a marked decrease in the blood flow in the vermis area with child abuse victims, suggesting that there is a functional impairment of the cerebellum with traumatized disorders, as well as the hippocampus and amygdala.

Although these studies on startle, post-traumatic stress disorders and physiology of the hippocampus, amygdala and cerebellum, buttress the idea of a traumatized personality, unfortunately, they also may encourage the belief that brain damage from trauma is permanent because of the toxic effects of cortisol. This means that, at the same time that psychoanalytic psychotherapy is becoming convinced of the

importance of understanding a severely traumatized self-disorder, it may be discouraged from believing that the empathic method can be effective with a such a disorder because of the idea of permanent brain damage. As Teicher says, “Such abuse, it seems, induces a cascade of molecular and neurobiological effects that irreversibly alter neural development” (p. 56). In view of this permanent cell damage, we ask, how can empathy, the therapeutic method of self-psychology, repair such permanent physical damage?

In asking this question, it seems that our brief excursion into brain neurology has shifted attention from the traumatic self to the traumatized neuron. Inadvertently we have moved from a view of the whole self to a physiological component of the brain. Any answer, therefore, needs to refocus on self-psychology’s goal of healing the self-organization’s functioning as an integrated system. This means that empathy does not need to aim at repairing irreparable physical damage – empathy is not magic - but at repairing the functional attunement of the self-organization using those cells still able to develop axons and dendrites.

That a self-organization can function despite damaged cells should come as no surprise. It coincides with what we know about stroke damage and the way in which new groups of neurons can be retrained to take over functions previously covered by the damaged neurons. Such a view also coincides with the brain’s planned redundancy where, by design, apoptosis of unused cells takes place soon after birth so that approximately half of them are left after six months post-partum. But the most telling support for the idea that permanently damaged cells do not necessarily prevent an integrated self, comes from Edelman’s group neural theory and the way neurons

participate in a Darwinian-like selection process to decide which are influential and grow stronger and which die from disuse. It is possible, therefore, that the plastic brain, with its strategy of planned surplus, will have the resources to cope with cells damaged by trauma. The issue for us, as psychotherapists, is the repair of the out-of-tune self-organization as a result of trauma. It may be that repairing the traumatized self, as Kohut suggests, involves fostering the development of “compensatory structures” where undamaged cells take over the functions of the damaged cells, thereby offering new interactive patterns and new self-structures. In asking how can this be done we turn to Kohut’s concept of trauma.

2. Kohut’s theory of trauma

Kohut’s theory of trauma is much broader than the one depicted by studies of abuse, post-traumatic stress disorder, or brain physiology, touched on in the previous section. For example, Kohut includes “selfobject disappointments” (1971, pp. 18 and 52) as traumatizing and, because he believes that such disappointments impinge on us all, thinks that no one escapes experiences of trauma (Kohut, 1984, p. 181). If this is true, all of us suffer some cell damage, at least, in the hippocampus, amygdala, and cerebellum vermis, because, as Teicher reminds us, neurons have not finished developing in these areas during early infancy. It would seem then that all of us are involved at repairing our self-organization because of stress-related cell damage. How, then, can we think about trauma so as to incorporate traumatic experiences into our self-organization and be able to understand the established ways we already deal with it. Such a question invites a broad theory of trauma.

Kohut sees thinks the major source of trauma is not abuse as an external event (Freud's "unbearable situation"), but the lack of internal self-structures to cope with the external experience. This inadequate internal structure is the first "face of trauma." He says (1960),

The traumatic nature of childhood is due to traumatizations which the adult psyche could master easily – or at least master differently, with less propensity for the permanent sacrifice of whole areas of psychic functioning. We assume furthermore that the adult [self] strength rests on its gradually acquired structure, slowly built up in consequence of innumerable frustrations of tolerable intensity. This structured [self] serves as a stimulus barrier and buffer in the interactions with inner and outer environment...Stimuli that once created panic, for example, now lead only to the anxiety signal (p. 272).

Kohut's key idea is that lack of adequate self-structure comes from the failure of infants and children to experience empathic attunement from their family environment, particularly the mother. Such a view is supported by the rat studies of Stanton, which showed the absence of a rat pup's mother turned on cortisol and turned off cell and dendrite growth. Kohut states (1987), "It is traumatic...when this early [mother-child] relationship is interrupted, massively and prematurely so" (p. 57). In other passages (1971) he also states his position clearly:

The trauma, which they suffered, is most frequently the severe disappointment in a mother who, because of her defective empathy with the child's needs (or for other reasons), did not appropriately fulfill the

functions, which the mature psychic apparatus should later be able to perform (or initiate) predominantly on its own (p. 46).

In an example of early empathic failure, Kohut (1977) describes a patient who had been abandoned by his natural mother and ... been in an orphanage until he was three months old. Taking this into account, he says, "I believe we do not go far astray if we conclude that the disruptive effect of the traumata he suffered because of the faulty empathy of his adoptive mother in his later childhood...cannot be fully appreciated unless we consider the vulnerability of the child's psyche due to analogous earlier traumatizations. Not only must he have been traumatized by the repeated failure of his adoptive mother to respond appropriately to his needs during the preverbal period, but behind these layers of frustration there hovered always a nameless preverbal depression, apathy, sense of deadness, and diffuse rage that related to the primordial trauma of his life" [p. 25].

Thus the presence of cortisol in a vulnerable partially developed brain makes antecedent trauma so potent, not the perceived severity of an external event such as physical or sexual abuse.

When he died in 1981, Kohut still firmly held his position that the selfobject failures of childhood were the original experiences of trauma (Kohut, 1984, p. 107). Self-psychology, then, emphasizes a primordial trauma that leaves a person primed and vulnerable to further trauma from later harsh, wounding, or even disappointing experiences, which form the second "face of trauma." Although Kohut does not deny the importance of childhood abuse, he refuses to accept that this abuse alone was the reason for the experience of trauma. In effect he was proposing a double faced theory

of trauma: a traumatic priming experience that is antecedent to the later experience of being overwhelmed by physical, sexual, or other experiences, that feel outrageously abusive.

Kohut's theory of trauma uses the traditional psychoanalytic "economic" concept. As Kohut (1963) says, his theory of trauma

Refers principally not to the content of the experience but to its intensity.

Trauma is over-stimulation, whether from over-gratifying or over-frustrating experiences; it involves not just what occurs externally but the dovetailing of external events and inner psychic organization (p. 358).

Freud's economic definition of trauma as "unbearable affects," supports the possibility of self-psychology's view of a "double trauma," an experience that Kahn (1974) called "cumulative trauma." Unfortunately, social scientists who define trauma as the objective event that creates Freud's "unbearable situation" have misinterpreted Kahn's concept of cumulative trauma to justify a mechanical adding of events, as developed in the Holmes/Rahe (1967) stress scale. Yet, this adding together of stressful situations is almost the antithesis to what Kahn meant. He (Kahn, 1974) clearly focused on "the failure of the mother's role as a protective shield, which" he says, "I am designating as cumulative trauma" (p. 54). Kahn's idea is, therefore, similar to and supportive of the emphasis in self-psychology on the potential traumatic priming experiences associated with the mother/child relationship. Further, the ideas of traumatic priming help us understand why Kohut included seemingly minor disappointments and wounding as traumatic.

By emphasizing the role of the priming experiences of selfobject failure in early childhood, Kohut also had ventured into understanding a third “face of trauma” - a traumatic experience subsequent to being abused. This third face comes from the rejecting response of significant others (or substitutes) to the patient’s traumatic situational experience, such as incest. Kohut illustrated this subsequent trauma when he used the example of illness as a potential traumatic event. He (1987) says,

The actual fact of the child’s illness, even when severe, is not necessarily a trauma. It is only when there is parental rejection because of physical illness that the drop in self-esteem becomes traumatic.... it was not illness per se, but the narcissistic blow of the child’s illness to the parents, precipitating a drop in their own self-esteem and their rejection of their child, that was decisive. (p. 248).

Examples of this third face of trauma are numerous among patients who indicate experiences of humiliation after reporting a rape to police and not being believed, or even blamed for the event. This subsequent trauma is experienced particularly by female patients whose mothers refused to do anything after being told of incest, for fear of the father. The third face of trauma occurs if parents do not believe patients who report sibling incest. Thus, rejection when a selfobject experience is needed and sought, after an incest experience or a rape, is a powerful, toxic experience, made worse for being a repeat of the priming traumatic experiences of earlier selfobject failures. This subsequential trauma is particularly damaging because it discourages and virtually destroys any patient attempt at modifying the traumatic experience of an event after it has occurred.

In summary, my view of a self-psychology theory of trauma involves three faces to the traumatic experiences that trigger toxic mental conditions and, in turn, inhibit learning and growth. These are (a) the antecedent priming experiences which involve a failure in structuralization because of lack of selfobject experiences, (b) an extremely distressing major situation or series of events and (c) subsequent traumatic rejection experiences after the traumatic event when significant others fail to function as needed selfobjects. Seen this way, trauma theory needs to have a triple focus with the first and third faces of trauma linked to selfobject failures.

3 Treatment issues

Treatment generally involves psychotherapeutic responding so that the patient eventually experiences a modifying of all three faces of trauma. Treatment involves exploring the patient's affective experience of humiliation, and an investigation into the impact of the traumatic experiences on the patient's capacity for trust. As Brothers (1995) has pointed out, after trauma, trust in the abusive or non-responsive parents, is shattered, and their own self-trust is undermined. Treatment involves a need to share betrayal experiences in a context of acceptance. It also means that psychotherapy with traumatized patients generally needs a long preliminary phase to gradually build a trust in the psychotherapist and, consequently, self-trust.

The results of such a gradual building of trust can be ascertained through the case of HS. As a middle-aged woman she had twice-weekly sessions for depression from an experienced female psychotherapist for over five years. The initial sessions

revealed that the reason for her depression was feeling dominated by the needs of a partner at the sacrifice of her own. Although she functioned as a selfobject for her partner, but when she, in turn, needed the partner as a selfobject to listen and understand, a “reverse selfobject experience” (Lee, 1988), the partner could not reciprocate.

After several years of treatment sessions, HS developed trust out of her psychotherapist’s consistent attempts at empathically understanding her. At the same time as her trust grew, her depression abated, but returned intermittently during periods when her psychotherapist was not able to sustain her empathy because of tiredness, or when the psychotherapist attended to her own needs with a vacation. HS had been traumatized in childhood from incest. Not only did HS experience humiliation associated with this incest, more importantly, she was further traumatized when, in attempting to tell her mother, her mother refused to hear about it. When this happened she felt horribly alone, and adopted the strategy of coping with her father’s sexual behavior by tuning the event out as it occurred (dissociating). In the initial psychotherapy session, the incest was mentioned but not described in detail. Nor did the patient attempt to relive the experience, and the psychotherapist did not press for details.

After a long Summer vacation during the fifth year of psychotherapy, HS experienced a flashback to a sexual scene from her past and hesitatingly described details from the scene to her psychotherapist, including painful penetrations and anal sex. Recognizing the reparative potential of this re-living, the therapist responded to

her patient's distress as if the event had just occurred. The psychotherapist understood that the major need to repair was not the incest experience itself, but the subsequent trauma because of the failure of the mother to respond to the incest with empathic understanding. After the therapist had quietly and uninterruptedly listened to the patient, the patient reported experiencing herself being believed and understood. Although the session exhausted her, she felt calmer, confirming Kohut's (1987) view that "the reassurance and the calming effect on a person who is in a traumatic state is initiated by the other person's understanding" (p. 218). The possibility of a significant repair of trust was then supported in the next session when the patient reported feeling better and different, and when such feelings remained relatively stable for several months. During the sessions that followed the flashback and reliving, HS focused on interactions with her partner that indicated she was able to be much firmer in presenting her own needs and point of view, which the psychotherapist viewed as a sign that HS was feeling more cohesive, adaptive and functional.

Repairing of some of her capacity to trust set the stage for the patient to gradually share her many new current experiences and have them mirrored, which in turn resulted in new structuralization in the patient's self-sectors in which she had had little previous experience. The shift from trusting the sharing of negative experiences during the first years of psychotherapy to sharing positive new experiences after the fifth year did much to build up new compensating structures in the patient's self-organization. These compensatory structures helped repair the lack of structuralization resulting from antecedent priming traumas in early childhood. As Kohut (1981) observed, "the most productive and creative lives are lived by those

who, despite high degrees of traumatization in childhood, were able to acquire new structures by finding new routes toward inner completeness” (p. 724).

This quotation from Kohut’s later writings indicates that he thought the main need of patients was for new structures based on new experiences mirrored by the psychotherapist and others functioning as selfobjects. Gone is Freud’s influence that “The ultimate goal of psychoanalysis [is] the therapeutic revival and recovery of the unconscious memories of traumatic experiences” (Kohut, 1978, Vol. I., p. 361). Gone is the uncovering method used successfully with neurotics, but shown by Kohut to be non-mutative with narcissistic disorders and running grave risks of retraumatizing those with traumatized disorders. The major goal with narcissistic and traumatic disorders is the building of new structures, not dredging the unconscious. Unfortunately, the mistaken goal of recovering traumatic memories in the hands of a non-empathic therapist determined to uncover traumatic memories may pressure a patient to describe an abusive trauma. This pressure can be downright dangerous, especially if a deep sense of trust has not developed, because such a procedure risks recreating the very retraumatization that the patient fears.

Even where the therapist does not actively encourage the patient to recover traumatic memories, patients may attempt this anyway. The notion that healing takes place by sharing traumatic memories now so permeates our Western culture that patients entering psychotherapy believe this is the way to recovery. I have supervised many cases where, although the psychotherapist did not seek the details, the patient shared traumata details in the expectation of healing. Unfortunately, if no immediate

change then occurred, they became increasingly depressed because their hope that sharing traumatic memories would automatically cure, was deflated. With traumatized patients it is necessary to make them aware that, although the therapist is interested in what happened when they were abused, such sharing is a risky maneuver and may retraumatize the patient if they have not spent time developing a secure bond with the therapist first. There is considerable risk that attempts to recover memories, may make patients worse.

One further major theoretical difficulty with the idea of memory recovery as the essence of a therapeutic cure with traumatized patients has to do with the distinction between Janet's concept of dissociation and Freud's concept of repression. Although the modern concept of dissociation has many meanings, Janet's original concept was that the traumatic event was not registered in the long-term memory of extended consciousness because it is cut off in the hippocampus, a view supported by evidence of decreased neural firing in the hippocampus during dissociative states. Freud's concept of repression, in contrast, involves a consciousness that has then been sealed up in the unconscious. The point of Janet's concept is that with patients who dissociate during a traumatic event there may not be a memory of traumatic details to be recovered, or if there are, these may be sparse. Years of psychotherapy aimed at recovery of memory with such patients is not only an exercise of futility to recover that which is not stored, but tends to create a situation of inevitable failure, hopelessness and shame, and eventual fragmentation that the patient feels can only be solved by suicide.

After several decades of thinking about the risks of retraumatization in conducting psychotherapy with traumatized patients, it was my exploration of affect theory that offered me another piece of the puzzle. Huttenlocher (1990, 1993) reported on the studies by Schanberg and Field on premature babies and rats. Premature babies were dying in a hospital, despite their medical needs being attended to, so Schanberg and Field were asked to investigate. On visiting the hospital, they observed that the “premmies” were all kept in incubators bearing a sign “do not touch.” They had been hired as consultants because their experiments on rats had discovered that separating newborn rats from their mothers caused the pups to go into survival mode when, to conserve food and energy, their bodies stopped growing. Cortisol stress hormones, released to subdue the body’s need for nourishment, turned off genetic activity so that cells could not divide. When the mother rat was returned to its pup, the cortisol hormones in the pups subsided and these pups began physically growing again. Further studies revealed that the mother’s licking was the key to keeping the cortisol levels down in the pups. By simply swabbing abandoned pups with a wet paintbrush Schanberg and Field achieved the same result, the reduction of cortisol in the rat brains.

Autopsy findings on the premmie babies revealed the same findings as with the rat pup brains. Cortisol levels were up and DNA synthesis was down in babies not touched. When Schanberg and Field instructed the nurses in the premmie unit to schedule periods for holding the babies and rubbing their backs, the infants grew stronger and thrived. Touching then, is a way to keep the cortisol levels down in stressed rat pups and in severely traumatized persons.

We also know from studies, cited earlier, that extreme distress produces high levels of cortisol in the brain. In view of the fact that many traumatized patients wish they could be held, hugged, or touched in some way during psychotherapy sessions, it may be that they are expressing a primary need to reduce their cortisol levels, which have increased dramatically the fear of retraumatization, stirred upon entering psychotherapy or as they have struggled to recover traumatic memories. There are, unfortunately, no studies of which I am aware that test to see if entry into psychotherapy increases cortisol levels in patients with traumatized disorders. These studies need to be done. It also would be especially valuable to have tests of cortisol levels after a recounting of traumatic experiences in a patient's life. The critical point about cortisol levels is that as long as they persist, new learning (therapeutic change), cannot occur, or at best, will be minimal. This is because the growth of new connectors will be blocked by cortisol and the absence of growth hormone. Unfortunately, I know of too many cases that have gone on for years without resolution because the patient was not encouraged to avoid retraumatization and was not responded to by the psychotherapist when soothing, including hugging, was sought. Hence, reduction of cortisol levels went unrelieved.

Understandably, the use of touching/hugging as a therapeutic response raises fears inside and outside the therapeutic community that have shifted into and out of focus ever since Freud commenced psychoanalysis. The major criticism of traditional psychoanalysis has been that touching was not psychoanalytic, with the implication that only "orthodox" psychoanalysis can produce lasting, beneficial structural change.

The truth is that the results of strictly conducted orthodox psychoanalysis with traumatized patients has been very poor, at best, and only with the introduction of “parameters” was there hope that therapeutic gains could be made (Eissler, 1953). Significantly, psychotherapists from a more humanistic background, beginning with the example of Ferenczi, have been able to get better results with traumatized patients because they were more responsive to the patient’s needs, and believed in a more symmetrical and sharing relationship with the patient.

Such a humanistic approach to psychotherapy, prepared as it is to conservatively use touch where needed, raises a danger that sexualization will undermine the treatment. This danger is real because many incest patients have grown up with the experience that if they wanted to reduce distress, their way was through incestuous behavior. So, even though the matter of touch without sexualizing the relationship is discussed openly, agreed to by both therapist and client and signed as a contract by both, and even if the therapist in no way gets involved sexually with the client, there is, nevertheless, the possibility that touching the patient will retraumatize because of the sexual images that the touching stirs up. Hence, if some physical touching is resorted to (Kohut once offered one of his fingers for a patient to hold), the psychotherapist is responsible to monitor whether the patient is being soothed or whether the touching/hugging behavior is overstimulating the patient’s affective system and therefore risks retraumatizing the patient. Touching is generally not a therapeutic experience if it is difficult for the patient and/or the therapist to control fears of being retraumatized through the stimulation of sexual instincts. In my experience, some patients who were horribly abused in childhood, feel soothed by being understood and don’t ask for, or need physical holding. Just

being understood is enough to reduce their fears of retraumatization and their cortisol levels. There are others for whom the understanding is not sufficient.

When understanding doesn't sooth sufficiently to reduce cortisol levels, the patient may request some form of physical touch. With certain patients, the request for touching needs to be responded to if therapeutic progress is to occur. As the Sydney psychiatrist Robert Gordon suggests, holding/touching should only become a regular therapeutic procedure after a plan is openly discussed and agreed to by both parties, carefully delineating no sexual behavior, then written out and signed by both patient and therapist. This signed plan is meant to increase the patient's sense of security and to retain the psychotherapist's professional stance.

What I have shared are but a few issues of treatment, for no matter how extensive or thorough a paper may be, it is never sufficient for learning to work with self-disorders, especially difficult traumatized patients, whose treatment needs regular, experienced supervision. So let me conclude with a quote from Kohut. He says (1981),

The specific shape and content of a nuclear self ---are never the result of only wholesome experiences. On the contrary, so far as we can judge, early development is never free from traumas. The outcome of psychic development, however, is not determined only by the relative frequency and severity of traumas but by the ability of the self --- to respond to certain traumatic frustrations of its developmental needs with a renewed and vigorous search for new solutions [pp. 721-722].

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