Psychic Trauma and Traumatic Object Loss

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Psychoanalysis began with the concept of psychic trauma, which was subsequently not clearly differentiated from traumatic object loss or from unconscious conflict and fantasy. Psychic trauma is investigated in relation to unconscious conflict, with and without concurrent object loss. The syndromes of PTSD, uncomplicated by object loss, of traumatic bereavement, and of relatively nontraumatic bereavement, though often interwoven and inseparable, are all different. The significance of the loss, sociocultural factors, and group process influence individual responses to trauma and traumatic bereavement. There are specific neurobiological and psychological sequelae of traumatic experience. Clinical applications are noted.

Psychoanalysis began with the study of psychic trauma, and that investigation remains altogether relevant to the contemporary scene. Traumatic alteration of the personality is associated with the threat of personal injury or death, or with threatened or actual injury or loss of loved ones. Traumatic memories concomitant with alteration of the personality persist after the immediate traumatic situation. In the aftermath of severe trauma, efforts at repair and mastery of traumatic injury and loss are prominent, but a “shattered self” is not reconstituted as the former personality. Integrating current research, this paper will elaborate the interrelation of trauma and object loss, with reference to shock, strain, and cumulative trauma. Trauma with and without object loss will be differentiated both from each other and from intrapsychic conflict. Neurobiological correlations will be discussed (Freud 1916-1917, 1917; Kris 1956; Khan 1963). I will also consider problems of discontinuity, dissociation, and disorganization. The traumatized person lives in the three worlds of before, during, and after the trauma and/or traumatic loss.

The current elastic definition of trauma has allowed a range of intensity, from transient loss of ego regulation to the regression, helplessness, disorganization, and paralyzing panic of massive trauma. The concept of psychic trauma has been both unduly compressed and stressed beyond the confines of consensual definition. Trauma may be so narrowly defined that the ego is considered to be totally overwhelmed, with no possibility of adequately registering the trauma or responding to it. At the other extreme, trauma may be loosely identified with any noxious experience or developmental interference. The classical definition of psychic trauma is that the ego has been overwhelmed and flooded by stimuli in a danger situation emanating from within or without—i.e., an internal or external danger. However, this definition refers to the immediate traumatic situation, not to the persisting pathogenic internal condition that is also designated as psychic trauma. It is important to differentiate the traumatic event, the internal traumatic situation, and posttraumatic sequelae. Concurrent with massive traumatic anxiety, the ego is reduced to primitive levels of cognition and affect, … but traumatic memories are registered in some form. There are tendencies toward either affect numbing or affect storms, and toward either freezing of motility or disorganized or frantic hyperactive motility. Freud (1916-1917) described overwhelming trauma in terms quite different from the narrow concept of seduction trauma of the preanalytic era: “It may happen, too, that a person is brought so completely to a stop by a traumatic event which shatters the foundation of his life that he abandons all interest in the present and future and remains permanently absorbed in mental concentration upon the past. A “shattered self”, i.e., disorganized personality, is a different theoretical formulation than symptoms based on ubiquitous unconscious conflict” (p. 276). Freud also indicated the enduring injury to the overwhelmed psyche and asserted of trauma that “we apply it to an experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in the normal way, and this must result in
permanent disturbances of the manner in which the energy operates” (p. 275). Freud's supposition is supported by neuro-biological findings to be referred to below. Freud (1926) later emphasized that the traumatic state is one of psychic helplessness quite different from that of anticipated danger.

The symptoms of posttraumatic stress disorder (PTSD) are not those of uncontrolled regression or total disorganization of the personality.

The symptoms are grouped as excessive, inhibited, intrusive, or avoidant reactions. In addition to obligatory regression, there is an obligatory tendency toward repetition of the trauma in thought, feeling, and behavior. The intrusion of elements of trauma occurs in flashbacks, daydreams, nightmares, somatic reactions, and conscious preoccupation with elements of the traumatic situation. Hyperarousal, vigilance, and tendencies toward startle reactions are frequent. The avoidant or inhibitory reactions include numbing of affect and sensation, as well as avoidance of stimuli, cues, and clues that might recall or reactivate the trauma. There are immediate effects of psychic trauma, but the diagnosis of PTSD cannot be made for at least one or two months after the traumatic situation. Since PTSD is posttraumatic, it does not encompass ongoing traumatic experience with no return to safety. Living in a war zone would be characterized by cumulative trauma with intermittent shock trauma and ongoing strain that could not be characterized as PTSD. Analysts have long understood that long-range effects and ramifications of trauma may not appear until there is a releasing stimulus or precipitating event. Fixation to severe trauma is typical, but in childhood such trauma may result in developmental inhibition or interference. The individual may remain developmentally retarded or deviant in areas of the personality from the time the trauma originally occurred. Such developmental fixation and retardation has been reported in patients who experienced parent loss during childhood (Fleming and Altschul 1963; Terr 1991).

I am skeptical of the highly questionable proposition of nonregistration of trauma or the idea that trauma is inevitably registered in nonverbal memory. Nonregistration of trauma can hardly be the case where there occur flashbacks and nightmares deriving from the traumatic experience. At the time that psychoanalytic theories of trauma were first formulated, the various forms of memory were not well understood. Severe trauma may indeed be registered in ways other memories are not; the overwhelmed personality may be speechless and unable to reflect, and the traumatic experience is then repressed or dissociated, in whole or in part, from full conscious awareness. Parallel to the conscious experience of trauma, psychoanalytic work supports unconscious registration of traumatic experience, not necessarily or entirely within declarative verbal memory. In my experience, such registration of traumatic experience has both verbal and nonverbal elements, the latter reflected in sensory, affective, motor, acting-out, and somatic phenomena. These memory elements, which are without semantic representation, are not usually retrieved in psychoanalytic work through linguistic verbal expression. Verbal representation and meaning may be achieved in clinical reconstruction, which may recreate a coherent analytic version of the past traumatic experience.

Dissociation, in which the traumatic experience remains in a divided or split-off consciousness, is a term that has itself existed in a segregated area of psychoanalytic thought. It is not in the lexicon of Laplanche and Pontalis (1967) or of the American Psychoanalytic Association (Moore and Fine 1990). Perhaps closer to the phenomena of isolation and denial, the dissociated state is reported to have a reality of its own but to be divested of attention and usual conscious awareness. Dissociation is not necessarily a product of trauma or found only in traumatic states. Denial is rarely complete, as some awareness of the disavowed reality remains. Dissociation is also the subject of considerable controversy, to which issues of the validity of memory are quite pertinent. Iatrogenic implanting of memories, true versus false memory, and reality versus fantasy have been periodically explored in the development of psychoanalysis. I can comment here on the reality only of the traumas under discussion, which are consequent to a terrible or horrific experience and/or to indisputable object loss. The consensual validation of the traumatic experiences of recent terrorist acts is quite different from the validation of a more private traumatic experience such as mugging or rape. An immediate, widely observed, and reported traumatic situation does not evoke the same level of skepticism as does the report of a traumatic childhood experience recalled as an adult.
Even in the immediate aftermath of trauma, its distortion and dissociation defend against overwhelming anxiety and rage. An elderly survivor may connect current nightmares and night sweats to his or her Holocaust experience. By contrast, a parent who is either a strict disciplinarian or a lax one unable to set limits may not be aware of the connection between this disturbed parenting and a history of abuse in childhood.

The effects of psychic trauma influence the way one perceives and reacts to external reality. It is stressful and confusing to live in two unintegrated worlds, before and after sudden object loss. In traumatic bereavement the object relationship before the trauma no longer exists. The world in which the patient finds him- or herself, and helps to shape after the traumatic loss, is significantly different. I have previously discussed this in terms of the splitting of the ego in relation to object loss experienced in childhood (Blum 1983), but its traumatic effect on relatives and other significant persons must also be considered. The alteration of the personality after severe trauma and object loss may entail ego splitting but may take a variety of other forms as well. There may be dissociation of areas of the personality before and after the trauma, with diminished conscious awareness. Traumatic effects may be selectively retained in consciousness, may be preconscious, or may be unconscious. The traumatic effects of object loss differ for each person in the family. The process of adaptation will be influenced by the defensive maneuvers, degree of clarification or confusion, and difficulties in adaptation of the other traumatized individuals within the transformed family. Where a spouse has been lost, for example, the surviving parent may acknowledge bitter truths while attempting to spare a child unnecessary pain and suffering. The surviving parent may thus help the child to deal with the reality of loss and to say goodbye over time, and so to mourn in an age-appropriate developmental manner. Alternatively, a surviving parent, traumatized, bereaved, and in grief, may foster psychopathology and fixation to trauma by avoiding talking about painful memories. The child may not be allowed to learn the cause and consequences of the traumatic loss. Discontinuities favor the maintenance of contradiction and confusion; e.g., a lost parent may be replaced by a child or grandparent. Object loss also affects the extra-familial social and cultural influences impinging on a newly restructured family. The changes in the personality, the discontinuities, inconsistencies, and alterations that have occurred, all contribute to ongoing cumulative and strain trauma. Complex internal and external changes are frequently associated with narcissistic disturbance, denial, distrust of others, and doubt about perceived reality.

Splitting of the ego and the object world is anchored in the divided reality situations antecedent and subsequent to traumatic loss. After the childhood loss of a parent, family life is fractured. There are changes in the surviving parent and family, as well as in the social surround, with attempts to adapt to what may be radically changed circumstances. There may be greater dependence on grandparents, housekeepers, day care and preschool, etc. When long-range adaptation is based on denial and dissociation or regression and repression, it is likely to be fragile and subject to later disturbance. Trauma and object loss tend to be aggregated, especially in disaster, and severe trauma may result in loss of one's former identity, with an associated loss of self-confidence, self-esteem, self-reliance, ideal self, and altered ego ideals. Basic trust and confidence in others may be replaced by caution, if not outright suspicion. Traumatized individuals may view and relate to their world in a very different way subsequent to the trauma, with profound doubt about the predictability and stability of the world and the self. Severe trauma may fundamentally alter one's feeling of self-regard and ability to self-regulate, control events, or plan for a future.

While doubtful that repetitive efforts at mastery of trauma could successfully repair traumatic injury to the ego, Deutsch (1966) allowed for the possibility of later personality consolidation and mastery under favorable circumstances. The damaged ego might be strengthened to deal more effectively with new traumatic situations. Traumatic disorganization might then paradoxically permit a more favorable ego reorganization. Resilient children and adults appear to function as though they have “righting reflexes,” and can change course and reverse regression. A benevolent object relationship has often provided a supportive and facilitating environment. In cases of social disaster, community support is important. Some highly traumatized children subsequently seem
extraordinarily resilient, possessing unusual capacities for the resolution of conflict and recovery from trauma. Holocaust studies have also shown that while most concentration camp survivors have been severely damaged by the massive traumatic experience, others have gone on to reconstitute their lives in remarkable ways (Klein 1974). Though tributes to the human spirit and capacity to recover from trauma, such reports may not do justice to the psychic scars and vulnerabilities, which at a particular time of life may not be visible.

No one is completely invulnerable or immune to trauma, though there is a tremendous range of coping ability and resilience, personality strengths and weaknesses. Preexisting personality strengths permit more effective use of whatever assistance and ego support may be available once the individual is no longer in the traumatic situation. Restoration of relatively benevolent object relationships, availability of empathic and sympathetic care, identification with rescuing, comforting, and nurturing objects, and social recognition and respect for the individual's identity and adaptation are very important to the gradual mastery of trauma (Pollack 1989; Blum 1987). The pathogenicity of trauma is balanced in degree by recovery and by possible creative solutions. The role of trauma in the genesis of art and literature has often been remarked, as seen, for example, in the lives and work of Eugene O'Neill and Frida Kahlo (Rose 1996).

Psychic trauma is complicated and intensified by cumulative trauma and physical trauma, as well as by object loss. Severe injury in an accident may leave the victim with psychic wounds far more enduring than the physical injuries, which may have healed. Persistent psychic and physical traumatic injury have a comorbidity that impedes recovery. The nature of trauma changes not only with the individual but also with the nature and duration of the trauma and the setting in which it has occurred. Is trauma more serious if caused by an intentional human act or by a natural disaster? There are too many internal and external variables to make a clear and general distinction. To be traumatized by an earthquake is not likely to be the same in its conscious and unconscious meanings as to be deliberately raped, mugged, or nearly murdered by a single visible assailant. There is of course tremendous overlap between the consequences of accidental trauma, self-inflicted trauma, and trauma imposed on an individual with the intent to harm or kill. An earthquake may be unconsciously experienced as deliberate persecution or punishment. The trauma may elicit intense anxiety, guilt, rage, and wishes for revenge, along with fears of retaliation. Feelings of injustice and victimization trigger demands for justice and the redress of shame, humiliation, and narcissistic mortification. Traumatic experience may be related to the realization of unconscious dangers such as oedipal transgression, castration, loss of the object's love and approval, object loss, or narcissistic mortification. A traumatic situation activates unconscious conflicts from multiple levels of development, as well as former traumatic experience. Past traumas may be telescoped into a present traumatic event. Since trauma is ubiquitous in childhood, a completely isolated single adult trauma is a theoretical abstraction. However, it is highly questionable whether a nontraumatic event of the past is transformed by “deferred action” into a new trauma. Rather, related events may be amalgamated with traumatic experience. A “screen trauma” may be employed by the ego as the “lesser evil,” which defends against the emergence and recognition of a more repressed trauma.

In the past there was little differentiation of traumatic object loss and trauma not caused or accompanied by object loss. Lindemann's classic paper (1944) on the symptoms of acute grief in survivors of the Boston Coconut Grove fire did not differentiate between psychic trauma without object loss and traumatic bereavement. Horowitz (1986) described a “stress response syndrome” in which bereavement was not regarded as different from other traumatic or stressful experience. He delineated the importance of cognitive functions in the capacity to cope, which applies to both trauma and bereavement. Currently, research interest in these syndromes has led to varied emphases on their differences, interrelation, and overlap, and on their common features (Brom and Kleber 2000; Stroebe, Schut, and Stroebe 1998).

Much severe traumatic experience may involve object loss, but object loss per se may or may not be traumatic. The loss of loved ones in terrorist attacks involves object loss associated with the
shock and horror of mass murder without any anticipation or preparation. Trauma and object loss were commingled and additive in their traumatic effects. However, object loss without trauma presents a different clinical picture. Adults expect to eventually confront the unavoidable death of an elderly parent. The death of a very elderly parent is at least inwardly anticipated, and not regarded as a shocking occurrence. It is not usually associated with terror or horror, unless there is terminal agony or a predisposition to such reactions. Concerned relatives may wish for a “good death” for the very elderly, say, to die painlessly in their sleep. The conscious attitude, so commonly expressed and socially sanctioned, is that the parent has had a long, full life, and no one lives forever. This is different than the threat of actual death or serious injury to oneself or others as a result of totally aberrant and completely unpredictable trauma. The death of an elderly parent is not usually associated with disorganized or agitated behavior. Normal mourning may ensue without pathological grief or the persisting symptoms of traumatic disorder. The death of a loved child, however, is inevitably traumatic for the parents.

Acute grief may have traumatic elements, but it presents a different picture. When death of a love object is experienced, the bereaved is preoccupied with the deceased and may, for example, carry on imaginary conversations with him or her. Struggling with separation conflicts and searching for the lost object, the bereaved experiences a potent wish for reunion and restitution. This longing stands in contrast to a dread that traumatic experience will be revived. Denial and protest coexist with depression and awareness of the loss. Sobbing, tears, pining, and yearning are commonly associated with grief. In some cultures wailing or shrieking, depending on gender role, may be common.

Disbelief buys time, facilitating a more gradual acceptance of the reality of the loss. Initial panic subsides as adaptation to the loss occurs. There is a temporal dimension to grief and mourning after object loss. Acute grief lasts from one to three months, and gradually subsides. Grief and mourning are predictable and are not ordinarily associated with melancholia, with characteristic feelings of helplessness and hopelessness, or with the relative helplessness and disorganization of acute trauma. Mourning work in adults proceeds for a year or two, during which time there is a disinvestment of the representation of the lost object, as well as enduring identifications with the object. Internalization of the object attempts to compensate for the loss of the object in external reality (Freud 1917) and promotes the acquisition of functions the object provided. The “appearance of traits of the deceased in the behavior of the bereaved” (Lindemann 1944, p. 142) is frequent, as are identifications with the interests, ideals, and values of the deceased. Narcissistic rage and anger toward the deceased for “abandonment” may be turned on the self, displaced or split off from the ambivalently loved lost object. With time and the progress of mourning, the survivor gradually accepts the reality of a life without the deceased, while identifying with the lost object and maintaining the internal relationship to the lost object. Institutionalized mourning in public memorials, religious rituals with group participation, and extended community mourning usually facilitate individual mourning.

The loved one persists in memory, and emotional disinvestment in the love object is relative. Memory is subject to editing and revision at different phases of life. Pleasurable memories of the deceased, which are gratifying and supportive, may coexist with unpleasant memories of disappointment and distress in the object relationship. The lost object may be idealized, denigrated, or both. But as mourning proceeds, the mourner no longer actively seeks reunion with the loved one in pleasant or painful preoccupation or conscious fantasy. The mourner, as time passes, is less afraid of the revival of initial grief and panic associated with the loss. These predictable and temporal phenomena of grief and mourning may overlap with the effects of psychic trauma, but are quite different. In children mourning may be absent or minimal, or may manifest itself in a way different from adult mourning. Adult psychoanalysis will likely revive a childhood loss and release a mourning process that had been long delayed. Whether this occurs spontaneously without treatment depends on the maintenance or modification of childhood defenses, such as denial and repression,
and capacities for adaptive mastery and new love objects. Trauma without object loss is a different clinical syndrome with different intrapsychic processes, though with overlap and interwoven features. The repetitive and persisting symptoms of posttraumatic stress disorder—intrusive and distressing recollections, startle responses, and hypervigilance associated with the traumatic experience and with unwanted flashbacks—are not generally found in an object loss syndrome, in which the traumatic elements are much less intense. Revival of the traumatic experience by external cues that symbolize or resemble an aspect of the event is found in trauma, but is uncommon in nontraumatic object loss. The sight of an accident, the sound of a siren or scream, the sight or smell of smoke, may precipitate a reexperiencing of the traumatic situation, as well as one's initial reactions to it. Psychic trauma is repeated in fantasy, and often acted out in reality. It follows that trauma has its own metapsychology, with genetic, dynamic, economic, and structural characteristics (Rangell 1967).

Avoidant reactions, too, can be seen to differ between traumatic disorder and the syndrome of object loss. Instead of attempting to avoid thoughts, feelings, and other reminders of the trauma, the bereaved individual is predominantly concerned with preserving, even while severing, the relationship with the lost love object. Intense arousal and avoidance responses are far less common than thoughts and feelings about the deceased. Life will not be the same without the lost spouse, parent, etc., but the rest of the object world is preserved, even though modified. Somatization reactions, sleep disturbance, nightmares, loss of appetite for food and sex, and lack of interest in once pleasurable activities may appear as part of either bereavement or posttraumatic stress syndrome. But the central affective response to bereavement is grief, while the central affect of trauma without object loss is massive anxiety. Anxiety is a variable reaction to object loss as well, but this is initially separation anxiety, with other affects also activated. Though there is overlap, anniversary reactions to trauma often involve anxiety attacks, while anniversary reactions to uncomplicated object loss are more likely to be depressive responses.

Though grief is a component of posttraumatic reactions, the absence of grief or its persistence is a pathogenic reaction primarily to object loss. But since the self is identified with the object, all traumatic injury is on some level connected to object loss, just as object loss is connected to loss of parts of the self. Thus, the conceptual boundaries between object loss syndromes and traumatic experience without object loss are blurred and permeable. Object loss may take on traumatic proportions when it is unanticipated or untimely, when there is predisposition to trauma, or when the object on whom the person has been dependent is no longer present. The meaning of the lost object relationship to the bereaved is crucial to whether the loss will be traumatic. Loss associated with horror and shock over the cause or mode of disappearance or death is also traumatic, as is the loss of several loved ones all at once. Object loss consequent to murder or suicide is always traumatic, and the catastrophe of mass murder adds a dimension of shared shock and revulsion that tends to escalate more than to diminish anxiety and grief. Violent deaths result in both trauma and bereavement in a combined syndrome of traumatic bereavement. However, despite decades of investigation, there is no universal consensual agreement about the concept of “traumatic bereavement” (Parkes 2001).

In the complex disturbance of traumatic object loss individual variations occur that are not taken into account in PTSD. For example, the survivor of an accident that had killed most of his family through smoke asphyxiation was now suffering from generalized anxiety. Apprehensive about accidents, as well as minor illness and injury, he had developed obsessive, tormenting concerns for the safety of his children. Environmental issues were very important, and he lamented, even grieved over, the lack of public attention to clean air and pure water. The air, the windows, the door—indeed, the entire environment of the analytic office—were scrupulously surveyed. The analyst's physical condition was noted, and the patient would blame himself for the analyst's rhinitis and laryngitis, as though the analyst had caught the cold from the patient. The analytic process became simultaneously a mourning process and a protracted reliving of disguised aspects of the trauma. In a period of negative transference the patient became depressed, as his rage at those who might have
avoided the accident, and at abandonment by his lost love objects, began to surface. The internalized rage had also been a major determinant of his masochistic self-torment. Survivor guilt appeared, prominently related to his obsessive concern for his children’s safety. Obsessive worries and survivor guilt may be particularly significant in some cases of traumatic bereavement.

When trauma involves an entire community, it has a public character. Group identification occurs—with victims, with rescuers, and with the perpetrators. Even those not directly traumatized are collectively and symbolically injured. Group trauma and losses result in communal grief and mourning, as well as anxiety and anger. Normally, a process of working through is set in motion after the initial shock. Each society or culture has its own expectations of grief and mourning. There are also age- and gender-related differences in affect expression and reactions to trauma and loss. In our culture, relative strangers in an acute traumatic situation may tearfully embrace. Tremulous shaking and sobbing may give way to childlike behavior and the need to be cuddled, comforted, and nurtured. The communal response may provide empathic communion and shared communication of necessary information. Communication and relationships within the larger supportive social setting relieve a sense of helplessness and horror that defines such massive traumatic loss. The numbing of affect and narrowing of thought may serve as a temporary moratorium during which the traumatized ego can begin to recover its usual organization and defensive constellation. Leadership is very important in regulating regression, restoring order amid chaos, clarifying confusion, and attenuating recurrent panic reactions. Given new identification with resourceful leaders, the traumatized and the wounded can begin to organize themselves and their families to mobilize the massive efforts needed to deal with widespread traumatic loss. Panic, grief, and mourning will run their course, but traumatic injury, scarring, and vulnerability may be more or less permanent. Only the most immune or resilient will be left relatively unscathed.

While object loss and psychic trauma are frequently interwoven, it appears that the neurobiological reactions and the psychological responses are not identical. The neurobiology of object loss and trauma remains the subject of intensive research and evaluation. The neurobiology of trauma involves alterations in the brain that are likely to have psychological correlates. These alterations are presumed to be more severe and lasting in infancy and childhood, as the immature brain is more vulnerable to trauma.

Psychoanalysts from Freud onward have connected trauma with the activation, realization, or validation of unconscious fantasy. When one’s worst nightmare of death and destruction becomes a reality, what had been a frightful fantasy may become a traumatic experience. The individual describes himself- or herself as living in a nightmare or having experienced a waking nightmare that won’t go away. The worst fears may have come true, as when a soldier suffering from “combat fatigue” or traumatic “shell shock” has unconsciously experienced the murder of an ambivalently loved sibling in the form of a fallen comrade. Similarly, child abuse or torture may be traumatic for a child witnessing it, as well as for the victim.

Trauma is much more than an intense and tenacious eruption of unconscious conflict. Unconscious psychic conflict, present before severe traumatic experience, does not appear to have the neurobiological correlates associated with psychic trauma. There is probably no psychic trauma after infancy that is not concomitant with psychic conflict, but conflict per se does not account for the psychological and neurobiological sequelae of trauma. Traumatic experience cannot currently be conceptualized solely in terms of unconscious conflict and compromise formation (Brenner 1982). Psychic trauma has differential effects on the psyche and the soma, and in infancy on the development of psychic structure and the brain.

The object world and internal representations change in the course of life, and time is the great healer given a relatively normal mourning process. However, some traumatic experience may become fixed, seemingly unchanged through later life. This fixity may be partly due to enduring traumatic memory at the core of unconscious fantasy. Subjects who had experienced traumata such as child abuse, rape, and auto accidents reported clear images connected with the trauma, as well as intrusive flashbacks decades afterward. (This does not imply that the images are undistorted literal
reproductions of traumatic experience.) Although there is mourning for the pretraumatic self- and object world, the psychology and psychobiology of severe trauma is quite different from that of “mourning and melancholia” (van der Kolk 2000; Terr 1991). Freud (1914, p. 78) presumed that our provisional ideas in psychology would someday be based on an organic substructure. Significant movement in this direction has occurred in recent years. Freud (1916-1917) proposed that psychic trauma causes permanent disturbance of mental energies; neurobiology supports the view that organic changes occur within the central nervous system consequent to trauma.

Stress and protracted strain will influence cognitive and emotional development. The infant who has been exposed to excessively high levels of negative emotional arousal, or has been insufficiently stimulated and left in states of low emotional arousal, may be left with a permanent developmental disturbance of the orbital frontal cortex. Trauma may also lead to kindling phenomena, perhaps related to over-stimulation of the sympathetic nervous system. A tiny trigger may elicit a traumatic response overreaction, noted long ago in shell shock syndrome, that Kardiner (1941, p. 94) described as a physioneurosis. In infants predisposed to anxiety, this sort of hyperreaction may ensue with primitive merging of anxiety and rage (Weil 1985). This is not typically associated with bereavement.

New evidence demonstrates that the environment influences the genes so that psychic trauma will have adverse affects on the central nervous system through genetic alterations (Kandel and Kelley 1999). The psychobiology of trauma involves forms of perception, memory, and response to danger unknown in Freud's time. Nonconscious emotional memory involves perceptions of danger that follow direct subcortical limbic system pathways through the thalamus to the amygdala, bypassing the cerebral cortex. Stress hormones are released concurrent with autonomic discharge phenomena. High levels of anxiety and stress hormones facilitate the possibly indelible registration of traumatic memories and their activation by the automatic, generalized reactions of the amygdala. In contrast, conscious evaluation of danger is associated with declarative explicit memory and involves pathways that include the neocortex, allowing for cognitive judgment and affect regulation (Schore 1994; LeDoux 1996). This suggests a neurobiological vulnerability to panic and a neurobiological impediment to transforming traumatic anxiety to signal anxiety. Damage and shrinking of the hippocampus occur as a result of trauma, which then may lead to impaired processing of memory and difficulty in placing experience in an appropriate temporal perspective. Thought, memory, and fantasy may be confused through defense, regression, and neurobiological alteration (van der Kolk 2000).

Trauma may have been registered in a form that is initially “unspeakable” for reasons that are organic but for the most part psychological. Some traumatized persons may not wish to talk about their experience, or be able to. Where there has been personality disorganization, benevolent relationships and identifications provide a foundation for reconstitution and psychotherapy. The security and safety of the analytic or therapeutic situation is necessary for concurrent attenuation of conflict and psychic trauma. Nonverbal communication is important, but the patient must eventually recover the capacity to narrate the traumatic experience in words. It is therapeutic to communicate the sensory and affective experience of trauma and to reflect on the thoughts and feelings connected with the traumatic experience (Herman 1992). Support for the patient's ego, which has been overwhelmed, will facilitate the opportunity for later analysis of the conscious and unconscious fantasies connected with the traumatic experience. Speech is a symbolic process, significantly distant from the immediate psychological and somatic accompaniments of trauma. Communication with an understanding empathic object helps to clarify affective-cognitive confusion and to abreact suppressed affects. Verbalization itself has a binding effect on affect and impulse. The traumatized person is no longer isolated in the scene of panic and terror, and affects can be named and tamed. Anxiety is alleviated and can be converted to signal anxiety. The understanding object unconsciously represents the stabilizing caregiver of childhood, the parent who comes to the child's rescue, provides comfort and stability, and promotes reorganization.
Psychoanalytic therapy is also a learning and unlearning experience, which presumably alters the neurobiological substrate, promoting not only ego mastery but the possible repair of organic brain disturbance. Psychoanalysis may prove to be an enabling treatment for the construction or reconstruction of appropriate brain pathways and processes (Slipp 2000). The trauma is never repeated, recalled, or enacted literally, as if there has been no internal response to it. There is always regression and confusion, as well as efforts, however enfeebled, at mastery and integration of the traumatic experience. To re-experience, understand, abreact, and reflect on the trauma and its terrors as past rather than present requires analytic work inside and outside the transference. Memories are inexact and can be used for defensive, self-serving, or self-tormenting purposes. Because of the screening, distortion, and fragmentation of memory, the recovery of repressed memory has been incorporated and superseded by the process of reconstruction in clinical psychoanalysis (Blum 1994). Even in brief dynamic psychotherapy for severe psychic trauma and traumatic object loss some superficial reconstruction of immediate cause and effect may be very helpful.

Antidepressive agents may reduce not only grief but anxiety, sleep disturbance, and startle reactions. Though psychopharmacological agents are helpful in the treatment of psychic trauma, in my opinion they are not substitutes for psychoanalysis or psychoanalytic psychotherapy. Drug treatment alone will not attenuate the internal traumatic state, characterized by mistrust, altered defenses and object relations, narcissistic injuries, and strangulated affects.

In conclusion, psychic trauma is not equivalent to or fully explained by conflict and compromise formation. Embedded and elaborated in unconscious fantasy, psychic trauma evokes past trauma. It has its own descriptive and theoretical features, and is differentiated from the consequences of object loss. However, much object loss is traumatic, and psychic trauma frequently is complicated and exacerbated by object loss. Psychic trauma and object loss are psychologically and neurobiologically differentiated, but clinically interweave and overlap. There is some loss, grief, and mourning with all traumatic experience, and a potential for trauma with all object loss. The combination and cumulation of psychic trauma and traumatic object loss result in a very complex coalescence of conceptual and clinical issues.

REFERENCES