The concept of psychical trauma: A bridge in interdisciplinary space

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The concept of trauma currently occupies a central position in interdisciplinary dialogue. Using the concept of psychical trauma as a bridge, the author attempts an interdisciplinary dialogue with psychiatry, biology and neuroscience. Beginning with the concept of psychical trauma in Freud, the author reviews the evolution of Freud's thinking, and links it with the ideas of Ferenczi and post-Freudian psychoanalytical authors. From a different framework, he considers the present state of research on post-traumatic stress disorder in current psychiatric nosography and attempts an interdisciplinary approximation to the concept of psychical trauma. Interesting ideas like the traumatic situation, trauma spectrum and psychopathological spectrum emerge, which enable a better understanding of the concept of psychical trauma through its relatedness, as a bridge connecting a broad psychopathological range extending from normality to psychosis. The ensuing possible relative loss of nosographical rigour is more than compensated by the resulting increased understanding and enlarged therapeutic possibilities. In the second part of the paper, the author attempts a dialogue with neuroscience, taking into account new advances in current research on emotion and memory, and making them compatible with the psychoanalytical concept of trauma. In this sense, the paper underlines the importance of emotion and crucially of memory, regarded as a fundamental axis of the subject explored in this paper. Here a substantial distinction which is pertinent for analytical work appears: declarative memories versus non-declarative or procedural memories. In a concluding discussion the author argues that, taking into account the implications of these current notions regarding a number of theoretical and technical aspects, psychoanalysis currently holds a privileged position, both in its potential for prevention and regarding the treatment of patients, in so far as, through interdisciplinary dialogue, psychoanalysis can be receptive to and be enriched by the contributions of other disciplines, just as it enriches them with its own contributions.

Keywords: trauma, psychical trauma, traumatic neuroses, psychopathological spectrum, post-traumatic stress disorder, neuroscience, memory, technique, interdisciplinary dialogue

Introduction

The world is becoming increasingly traumatic for humankind, a truth that became evident once more following the tragic events of 11 September 2001 and their devastating consequences. Interest in the effects of this kind of event is not new.
Nearly a century ago, the ‘war neuroses’ of the First World War led psychoanalysts to direct their attention to traumatic experiences as triggers of neurosis. However, such traumatic experiences pose questions that have yet to receive satisfactory answers: can events, by their magnitude alone, cause disruption of psychical equilibrium? Is it possible to think about a traumatic situation from a purely economic point of view? If so, can we expect all subjects to react to it in an identical way?

Psychical trauma always involves an interaction between the ‘outside’ and the subject’s internal world. We cannot conceive of psychical trauma occurring exclusively on the basis of an external current event, no matter how violent this may be; such a conceptualisation would be tantamount to denying the personal—the individual ‘baggage’ underlying each person’s reaction—and ultimately to denying the participation of the unconscious. The concept of psychical trauma implies a continuous, oscillating interaction between the external and the internal worlds, or, more specifically, what is recognised as the traumatic consequential outcome of a specific interaction between the external facts and the way they are psychically experienced. Psychoanalysts must therefore use concepts referring to the unique relationship between each person’s internal and external worlds. Let us always keep in mind, then, the complex intersection of these two imposing realities which, from both ‘outside’ and ‘inside’, beleaguer the subject. To conceive, as Freud does, of a psychopathological entity—traumatic neurosis—operating entirely independently of the unconscious system and of psychical conflict poses no small problem for the theory of psychoanalysis.

Freud’s own preoccupation with this led him to classify traumatic neuroses as ‘an exception [for] their relations to the determinants in childhood have hitherto eluded investigation’ (1938, p. 184). Certainly these words, among the last he wrote in a lifetime’s work, bear witness to Freud’s ambiguity regarding this topic. Let us remember that psychical trauma, which appeared in the early days of psychoanalysis as the factor triggering neurotic symptoms, soon became the portal and the pathway to new discoveries. From this point of view, the theory of trauma became for Freud a trauma in his theory—something he was unable to elaborate on properly.

Thus far, we have the first part of an intellectual exercise which left to its own devices could progress to a discussion exclusively located within the analytical sphere. However, to go down that route would be to run the unfortunate risk of hiding ourselves away in our institutions and seeking the solipsistic achievement of a pure analytical method, isolated from other contributions. An alternative possibility is to attempt to follow the undeniable advances external reality sets before us; for, as a theory, a discipline, an Institution, we are confronted by the challenge of a continuous dialogue with other schools of knowledge: indeed, the advance of analytical theory and technique must occur at the ‘frontiers’ of psychoanalysis. Thus, taking up the theme of the 43rd IPA Congress in New Orleans, ‘Working at the frontiers’, it seems right to be contemplating an interdisciplinary approach which will attempt to confront psychoanalytical theorising about psychical trauma with the concept of post-traumatic stress disorder, a fundamentally important idea from a psychopathological standpoint.

I am aware that the concept of stress is not part of the basic conceptual universe of psychoanalysis; but I chose to use it in order to establish a more open exchange...
with like disciplines and to avoid the pitfalls of endogamous dialogue. Thus, this paper’s aim is to attempt an interdisciplinary dialogue, using the concept of psychical trauma as a ‘bridge’. The first part of the paper highlights the vicissitudes of the concept of psychical trauma in Freud’s thinking, followed by a discussion of post-Freudian thinking on the same topic. From the juxtaposition of, and dialogue between, these ideas and the notion of post-traumatic stress disorder in psychiatry, interesting notions arise about the concepts of trauma, the traumatic situation and the pathological spectrum. In the second and main part of this paper I will attempt to conduct a dialogue between psychoanalysis on the one hand and psychiatry and neuroscience on the other, with reference to the present state of interdisciplinary ideas about trauma, emotion and memory. In the final discussion I will consider the possible implications of all this on psychoanalytical theory and practice.

This approach does not seek to deny the special validity of a given concept within the confines of its original discipline; rather, it advocates accepting the invitation each discipline can and should extend to the others, to search from inside its own field for anything external to it that might assist in advancing its own body of knowledge. It does not advocate the wholesale adoption of the methods of other disciplines; instead, it calls each discipline to consider different concepts alongside its own methods. I fully appreciate that not all psychoanalysts will be approving and willing to partake of the ideas engendered by such an approach.

Some years ago, hoping to encourage communication with parallel and contiguous fields, the *IJP* created a space for brief articles informing psychoanalysts of accumulated basic scientific knowledge in disciplines which might at first sight appear to be entirely unconnected to ours. Olds and Cooper (1997, p. 219) used the term ‘cross-fertilisation’ to describe what can occur in the interdisciplinary field, alluding to creative ideas frequently encountered at the crossroads of mutual interactions, where one discipline can be reinforced by discoveries and contributions from contiguous fields. Both authors quote a growing number of psychoanalysts who have made fruitful contacts with neighbouring disciplines, either scientific or humanistic, because ‘it is our job to help to build those bridges’ (p. 220).

To return to my original theme, in my understanding the concept of trauma is perfectly placed for such an attempt at interdisciplinary dialogue. Theories do not just lie there, waiting to be discovered; as researchers, we must build bridges, using those links we consider relevant to the phenomena we are studying, even if it then proves difficult to live with the uncertainties this bridging might produce. The question, to echo Eizirik (2000, p. 52), is ‘Is psychoanalysis still relevant for our culture?’ In my view, the answer will largely depend on psychoanalysis’ ability to receive and become enriched by contributions from other disciplines and likewise to contribute to their enrichment through its own findings.

**Part I: The vicissitudes of the concept of psychical trauma in Freud’s thought**

Given the great number of authors who have written on this topic, I will attempt only a brief review, noting the principal aspects of Freud’s forays into and reassessments of the concept of psychical trauma. Before 1900, Freud (1893–5) gave an essentially
economic metapsychological definition of trauma—as an excess of excitation which cannot be discharged through a motor channel or integrated through association. The subsequent ‘abandonment’ of the seduction theory ushered in an increased interest in the importance of fantasy life and internal reality, and a gradual attempt to redefine external and internal reality. Thus, while maintaining an economic definition, Freud began to see an intersection of these two realities which besiege the subject from within and from without: ‘If they have occurred in reality, so much to the good; but if they have been withheld by reality, they are put together from hints and supplemented by phantasy’ (1917, Lecture XVIII, p. 370).

Later, trauma reclaimed its important position in Freud’s thinking (Freud, 1920). There was certainly a return to the old notion of trauma, though it now had a more complex character following the elaborations which had been generated by the conceptual shifts implicit in the second topographical model and the new instinct theory—the ideas of ‘link’ and ‘repetition’. The concept of psychical trauma as something created by a breach appeared to reclaim its place, though enriched by the addition of another concept of fundamental theoretical importance: the death instinct and the repetition compulsion.

In Inhibition, symptoms and anxiety (1926) the concept appeared restructured for a last time, now related to anxiety and psychical conflict and also to alterations of the ego and the interstructural character of all traumatic situations. In Moses and monotheism, Freud recognised that the neuroses are evidently the consequences of experiences and impressions that we rightly see as etiological traumas, and that these experiences are ‘impressions of a sexual and aggressive nature, and no doubt also to early injuries to the ego (narcissistic mortifications)’ (1939, p. 74)—concepts that do not at all exclude the economic factor.

Freud oscillated between a definition of trauma as merely economically derived and another definition in which what matters is conflict, which is gradually superimposed and eventually predominates, resulting in the integration of the economic and the dynamic dimensions. In what follows, I note certain fundamental ideas as nodal points which inject and limit the economic aspect of trauma as it evolved in Freud’s thinking—ideas which the reader should keep in mind throughout this paper.

A posteriori

This concept not only retains its relevance but also has now been deepened, enabling us to maintain Freud’s idea of the need for two scenes or two moments in the constitution of a trauma (and in working through).

As explained by Laplanche and Pontalis (1973, p. 111), who underlined its primordial importance, this concept does not allude simply to deferred action—i.e. to a cause which remains latent until it finds the opportunity for presenting itself—but to a retroaction, from the present back to the past, rupturing chronological time and mechanical causality in favour of a concept of dialectical causality and a model of time where past and future are mutually conditioned and reciprocally inflected as to their meaning, in the act of structuring the present.
Complementary series
This idea, expounded by Freud in his *Introductory lectures* (1917), is still relevant though complicated to use because it implicitly locates trauma at two different points in the series: both at the infantile level (through constitution or experience) and at the level of subsequent—including adult—happenstance which produces the trauma retroactively, decentralizing the action from a purely single economic and mechanical moment and propelling it towards a construction that gives new meaning to childhood experience.

Death instinct
The need to understand the relation between childhood psychical traumas and psychical traumas capable of triggering war neuroses, in conjunction with other ideas he was exploring at the time, led Freud to introduce a concept which was destined to modify the theoretical edifice of psychoanalysis in general and of trauma theory in particular: the death instinct and the compulsion to repeat.

It is very difficult to conceive of a traumatic situation in which this instinct is not involved, despite the controversy the notion of the death instinct generated among psychoanalysts. The fact is that through this concept Freud introduced ideas which are crucial for understanding the traumatic situation and its possible working through—such as the concepts of binding (*Bindung*) and psychical working out (*Verarbeitung*), operating as an interactive set.

The archaic
I am interested in considering as archaic that which, having failed to be processed psychically early on, subsequently persisted and remained in the deepest unconscious strata of the psychical apparatus, un-worked through, as cysts, marks, foreign bodies. Marks or cysts have been defined in equivalent terms as ‘a hole with no historical account’ (Baranger et al., 1987, p. 768), ‘a basic fault’ (Balint, 1969), related to ‘the negative’ (Green, 1979) or, as Bion (1962) prefers, ‘vestiges’. Uriarte de Pantazoglu (1991) speaks of ‘broken threads that do not compose a weave’ and Schkolnik (1995) of ‘the archaic’. The number of authors that have been engaged with this topic attests to its present relevance.

In my understanding, which is also reflected in my use of the term here, the archaic refers to early impressions which cannot be processed through normal ego functioning because the immature and helpless ego is unable to integrate them, as it does not understand their meaning. Thus, they remain in the unconscious as something operative but unrepresentable, which it has been impossible to work through completely or in part, in unstable equilibrium, prone to subsequent disorganization and, precisely because of all these factors, acquiring a potentially traumatic character. It is a concept referring to a strictly non-verbal phenomenon, to something which has erupted in the mind, bequeathing it with a profound deficit in the capacity for representation. Because of the importance of this archaic dimension as something decontextualized in the process of structuring the psychical apparatus, I will attempt later to examine and integrate this concept in the course of developing some of the ideas which I am trying to elucidate here.
Freud–Ferenczi and post-Freudian authors

The theory of generalised trauma, or ‘broader trauma’ (Freud, 1926), comes to mind. In psychoanalytical terms, trauma is always a traumatic situation from childhood, an always complex situation which involves both the external and internal worlds, activates fantasy and essentially not only puts the subject on the spot and induces a breach of his anti-stimulus barrier, but also crucially engenders helplessness (Hilflosigkeit).

It is possibly this essential characteristic of helplessness and vulnerability at birth that has led many psychoanalysts reviewing the clinical facts over the past 50 years to reflect on the importance of this traumatic helplessness in the first stages of the infant’s life, where the need to depend on another person constitutes an essential element in the structuring of the mind. However, the importance that Freud almost always attributed to the subject’s individuality and fundamentally to intrapsychical space became perhaps the nugget of his disagreement with Ferenczi, who was to insist that in any psychopathological situation there was a real traumatic factor operating as a trigger. Thus in 1933 Ferenczi wrote to Freud that the latter had ‘underestimated the real traumatic experiences of the entire period of early infancy, granting a privileged position to fantasy and intra-psychical conflict’ (cited in Muñoz, 1996, p. 73).

The well-known Freud–Ferenczi controversy, positing the terrifying possibility that Freud might retreat to his old 1897 theory of trauma, was unnecessary. Indeed, Ferenczi’s proposed hypothesis was a direct continuation of Freudian thinking, just as some of Ferenczi’s own ideas were to have a tremendous impact on contemporary psychoanalysis. In one of his most emblematic writings, ‘Confusion of the tongues between the adults and the child’, Ferenczi (1949) attributed a determining role to external objects in the structuring of the child’s psychical apparatus, emphasising how the other’s psychical reality can generate trauma when he holds the power of giving (or imposing) his own meanings, not only on the traumatic event but on the subject’s entire life. For Ferenczi, trauma was the expression of a disturbance in communication between child and adult, that is, a ‘confusion of tongues’ (1949, p. 229) in the sense of mutual misunderstanding and faulty communication. It becomes clear, then, that his ideas, far from being retrogressive, form part of contemporary psychoanalytic thinking. At the end of the day, Ferenczi’s ideas are embedded in many lines of current psychoanalytical thought: in Mahler, Winnicott, Balint, Bowlby, Spitz, Kohut, Aulagnier, and in many of the underlying ideas in couple and family therapy. They also have an important presence in Lacan, Laplanche and post-Kleinian authors like Bion, Meltzer and Bick—authors who recognise the input of the mother figure and stimulate our thinking about precocious traumatic situations. Integrating what Freud proposed with the ideas of these and other authors who explored different aspects of this problem paves the way to a reformulation of both the metapsychology of trauma theory and of related clinical practice.

I would like to describe now the series of traumas children experience during their first years, and their relation not only with the mother but also with the father and the environment in general. I am referring to all those lines of analytical thought.
that attach more importance to the role of the external dimension, the other, language and environment. Many vicissitudes generate trauma in childhood: maltreatment; not being understood; violence from parents, siblings or carers; a lack of connection with the child’s needs; excessive sexual stimulation, and extreme poverty, misery, hunger, and so on. All these circumstances and many other similar ones constitute current traumatic situations, which in most cases occur every day and are repeated for years on end in the early stages of life, leaving an indelible mark. So, when we speak of trauma, are we thinking of one or many traumas?

In the psychoanalytical conceptualisation, the model of one predominant event can pave the way for a succession of events, especially during the early years of life, this being the period of the greatest psychical vulnerability. Pertinent here is Khan’s idea of ‘cumulative trauma’ as the result of:

the breaches in the mother’s role as a protective shield over the whole course of the child’s development, from infancy to adolescence … these breaches over the course of time and through the developmental process cumulate silently and invisibly … the use of the word trauma in the concept of cumulative trauma should not mislead us into considering such breaches in the mother’s role as a protective shield as traumatic at the time or in the context in which they happen. They achieve the value of trauma only cumulatively and in retrospect (1963, pp. 290–1).

However, we have been referring exclusively to the mother. What about the father? And the environment? Acevedo de Mendilharsu highlights the father’s role in this process: ‘the child must not fully take up the mother’s libidinal organisation or be her exclusive libidinal object; instead, behind the child, and beyond, the father must stand as a pivotal element, and third in the mother’s libidinal economy’ (1988, p. 318). Balint’s (1969) hypothesis of the basic fault refers to a deficit in empathy between mother and child; the origin of the basic fault is the child’s defective adjustment with the people in his environment. For Balint, trauma involves the child’s closest figures, and this environment becomes part of the structure of his ego. García Reynoso asks what happens when, in situations of extreme social abandonment, parents are unable to act as life supports for their children. He affirms that ‘an external traumatic situation, when it cannot be symbolised, becomes an internal trauma by being internalised, will acquire the value of trauma if it proves impossible to metabolise, symbolise and be transformed into thought and action’ (1992, p. 6, translator’s version). Bernardi, alluding among other things to ‘social support’, defined ‘as a function of the degree of emotional, material and informational support the subject finds through insertion into the social network’ (1988, p. 19ff), has shown how deprivation caused by poverty affects the child’s development.

The psychopathological spectrum: I

All psychopathological formations, as well as normal control techniques, aim to prevent the appearance of extreme forms of anxiety—anxiety so primitive that can only be described in economic terms. ‘We can only characterise this form of automatic anxiety as the initial trauma, pure trauma, meaningless, totally disruptive’
(Baranger et al., 1987, p. 766). This ‘traumatic experience’, in the words of Benyakar, ‘flooded by automatic anxiety, bereft of representation, is the psychical gap that makes it impossible for the subject to think about or derive meaning from an event that has occurred’ (1988, p. 22). However, as we have seen, trauma always involves the closest persons. This is the environment which, from the beginning, becomes part of the ego’s very structure and will play a fundamental role in the process of development and psychical structuring.

Lichtman (2000) mentions ‘primary structural deficiencies’ in this process of working through, and Stern (quoted in Altmann de Litvan, 1995) refers to primary traumas that are normal in development, distinguishing between ‘normal primary traumas’ and ‘secondary pathogenic traumas’: primary traumas can be transformed into secondary ones as a result of the interaction of negative environmental influences and constitutional factors. Green has called these narcissistic scars ‘adherences’, that is, vulnerable, sensitive zones that ‘create a narcissistic, protective and preventative carapace against traumas; but at the price of a mortifying sclerosis which undermines the pleasure of living’ (1979, p. 115). Considering these alterations of the ego, it is likely that we are all exposed to such ‘early constituent trauma’ (Aduriz Ugarte, 1996). This leads to the recovery, from the different referential schemes, of the idea of ‘traumatic situation’, differentiated from that of ‘trauma’ as a pathogenic situation. In my view, this clarification leads to a more precise understanding of what is essentially traumatic in the clinical domain of psychoanalysis.

In the traumatic situation, a trauma can be understood to be necessary because, by separating the child from maternal fusion, it facilitates the child’s adequate organisation of the mind and its inscription into a symbolic order. In the case of a trauma, all evidence indicates that in such situations the said process, which structures and organises the child’s fantasy, failed, giving rise to more or less substantial psychical spaces in which sense cannot be made, and which refer to the above-mentioned archaic forms. This experience is traumatic because it is flooded with affect and lacks a scenario, creating a marked deficit in the capacity for representation.

It may be useful to introduce here the concept of the pathological spectrum, to account for a situation where, at one extreme, we have disorganising, invasive and paralysing traumas and, at the other extreme, traumas constructed in open historical time. Between one extreme and the other there are, as one can readily understand, all sorts of intermediate situations producing greater or lesser psychical harm, from ‘more or less light states that form symptoms in the organisation of neurosis, to what become veritable gaps of symbolisation which can extend to the psychical silence of the psychoses’ (Casas de Pereda, 1996, p. 40). As I understand it, Casas de Pereda’s eloquent description alludes to a phenomenon covering a broad spectrum, from the most benign psychopathological situations to those attesting to a veritable psychical collapse, where the mental apparatus generally fails to process the traumatic event. Muñoz has rightly described this situation as ‘the thousand faces of early trauma’ (1996, p. 74) alluding to the different ways psychopathology deploys itself in the context of the multiplicity of individual existences.
Part II: Post-traumatic stress disorder

I will now consider post-traumatic stress disorder, which *DSM IV* (1994), aiming to establish a standard general terminology, identifies as an anxiety disorder.

**Diagnostic criteria**

I will attempt a brief summary of the important diagnostic pointers according to *DSM IV* (p. 424):

1) The *clear antecedent* of having been exposed to an intense traumatic event, characterised by death or threats to the physical integrity of the subject or others. Faced with this, the person *responds* with reactions of intense fear, despair or horror.

2) *Characteristic symptoms* include re-experiencing the traumatic event, either through painful, invasive and recurrent memories, during day-dreaming, or as a nightmare. States of dissociation can also occur, lasting from a few minutes to days. Psychical numbness or affective anaesthesia and the activation of the autonomous nervous system (hyperactivity, irritability and dream alterations) may accompany the symptoms.

3) Situations reminiscent of the original trauma are systematically avoided.

4) Other symptoms may occur, with feelings of guilt, depression, anxiety, anxiety attacks, shame and anger, substance abuse, self-harming conduct or suicide attempts.

**Etiology**

Alongside the clinical aspects it is interesting to note also certain etiological considerations. Our first port of call is *American Psychiatric Press textbook of psychiatry* which states: ‘this relationship between the severity of the stressor and the type of subsequent symptomatology is not always predictable’ (Hales et al., 1999, p. 546). This leads inexorably to consideration of the notion of reactivity, that is the inter-relation between a triggering factor with a predisposing one; the person always reacts in an individual way—an idea totally opposed to the notion that identical causes will produce identical effects.

For Kaplan and Sadock (1998), while the presence of a stressor is necessary, it is not sufficient to provoke the disorder; clinicians must also consider pre-existing biological or psychological factors. These authors also consider that recent research has placed more emphasis on each person’s subjective response, alluding to the predisposing factors that indicate vulnerability. They also take into account the permanent interplay between the internal and the external worlds, emphasising that what is traumatic is the consequence of a specific interaction between the facts and the way they are psychically experienced. Thus, a war, an accident, or the death of a loved one will be traumatic for some and not for others. This may be why Benyakar (1998), referring us to the facts, insists that we use the concept of disruptive situations, indicating that, because of their characteristics, these act as threats to the psyche; he uses this concept to establish an operational paradigm.

Gabbard’s (2000) appreciation is that recent research is in line with the growing consensus that post-traumatic stress disorder probably depends more on subjective
factors than on the gravity of the stressor. Now, at first sight the *DSM IV* does not appear to emphasise the individual’s subjective response to the event. However, upon careful reading the two diagnostic criteria for the stressor seem to reflect the importance of painstaking psychodynamic research on the meanings the patient assigns to the event, and of the patient’s specific vulnerabilities to the event when several environmental triggers are evaluated. Thus, it is possible to conclude that ‘a personal predisposition to develop post-traumatic stress disorder was necessary for the symptoms to emerge’ (Gabbard, 2000, p. 253). Furthermore, we know that most people do not develop post-traumatic stress disorder even when faced with a terrible trauma, and conversely that events that may not seem so serious can trigger the disorder in certain individuals because of the subjective meaning they assigned to the event. According to Gabbard, the modern psychodynamic vision of disorder has been substantially influenced by Krystal’s work, for whom ‘psychic trauma in childhood results in an arrest of affective development, whereas trauma in adulthood leads to a regression in affective development’ (p. 254). Even according to *DSM IV*, it is important to differentiate each diagnosis because together they display the entire range of mental disorders, from the major disorders to the adaptive disorder, reflecting the stress-vulnerability ratios of individuals. In this sense it is worth noting that Hollander et al. point out that increasing attention is being paid to: ‘a concept of “trauma-spectrum” disorders, which result primarily from chronic childhood intrafamilial abuse and encompass diverse manifestations such as borderline personality disorder and multiple personality disorder’ (1999, p. 610).

**The psychopathological spectrum—II**

At the end of this first part of the paper, it is important to try to establish points of contact between these current concepts of psychiatry and the psychoanalytical ideas set forth at the beginning. With this in mind, I will take a point in the dialogue that will surely serve as a bridge: I will try to relate the idea of the trauma spectrum that appears in the *Textbook of psychiatry* (Hales et al., 1999) to what I have called the psychopathological spectrum.

What do we understand by trauma spectrum? Hales et al. (1999) mention chronic intrafamily abuse from infancy, accompanied by a variety of manifestations like borderline disorder and multiple identity disorder. If we look at the various diagnoses which may be confused with post-traumatic stress disorder the panorama becomes even broader, with brief reactive psychosis at one extreme; with acute stress disorder, mourning that has not been worked through and mood and anxiety disorders in mid-range; and at the other extreme the adaptive disorders, defined as non-adaptive reactions to an identifiable social stress, ultimately being different in that ‘the stressor in adjustment disorder is usually less severe and within the range of common experiences and the characteristic symptoms of post-traumatic stress disorder, such as re-experiencing the trauma, are absent’ (Hollander et al., 1999, p. 617). Kaplan and Sadock (1998) quote ICD-10 which places adaptive disorders in the same category as serious stress reactions, and places post-traumatic stress disorder in the same category. This shows that individual variations play a role in the appearance and seriousness of these disorders, as does the extreme variability of stressors.
Adaptive disorder, on the other hand, is a borderline diagnosis with considerable
taxonomic and diagnostic problems. This indicates that disorders located in a
diffuse diagnostic area, between normal behaviour and the major disorders, are
not well defined, overlap with other diagnostic groups, are recognised through
imprecise presenting symptoms and are, finally, problematic as regards reliability
and validity. The etiological and dynamic characteristics of the adaptive disorder
make it a fascinating diagnostic category, a key area between normality and illness.
We must also take into account the ‘significance’ of events for an individual,
which leads to the issue of describing and locating the threshold beyond which an
individual is considered a patient. In other aspects, DSM IV does not offer criteria,
or it offers guidelines too imprecise to quantify stressor agents in an adaptive
disorder, or evaluate their effect or the meaning they have for an individual at a
particular time. Though stress has been described as the etiological agent for this
disorder, diverse modifiers and variables are implicated. For Kaplan and Sadock,
relevant psychodynamic factors are, amongst others, ‘the nature of the stressor, the
conscious and unconscious meanings of the stressor, and the patient’s pre-existing

Research of the current construct of stress has been delineated thus because the
idea of ‘stressor’ is complex; it combines intensity, quantity, duration, reversibility,
environment and personal context. Though the upper limit has been established for
the major syndromes, the lower limit of adaptive disorder has not; and the issue of
what is ‘normal’ has not been provided with operational criteria. This illustrates the
problem with ‘limits’, a challenge for future editors of DSM.

Case studies

The above-mentioned disorders, which Kaplan and Sadock believe ‘a lay person
would call a personal calamity’ (p. 770), should, I believe, be placed in the range
of what is classically known as neurotic personalities, where there is a history of
conflicts that are maintained in a state of more or less compensation with regard
to vital events that could act as triggers of suffering or pathology, depending on
circumstance. I would like to illustrate these ideas with a series of clinical vignettes
adjusted to a strictly psychiatric nosography.

Case 1

The patient, a 31-year-old man, was hospitalised in Vilardebó Hospital in the
prisoners’ ward in 1980, a time during the military dictatorship, when the population
lived in fear. He was picked up by the police while robbing a tyre depot, and was
taken to a police station where he was threatened with torture and murder. Hours
later, he was diagnosed as psychotic and was remanded to the psychiatric hospital.
When I arrived, I found a totally disoriented young man, his face a mask of terror,
looking around mistrustfully. He had delusions of persecution and believed that he
was to be executed, though he did not know by whom, or why. He did not know
where he was and remembered absolutely nothing of the circumstances which had
brought him there. He had been receiving treatment with neuroleptics for two days
and was beginning a micronarcosis series. I began talking to him, trying to calm
him, and explained to him the circumstances of his arrest which he heard with great
difficulty. I managed to help him reorganise his experiences and to diminish his
intense feelings of terror. Gradually the patient calmed down, remembered the details
of how and when he had been picked up, organised his thoughts and memories, and
at length totally recovered a clear awareness and full reconstruction of the events in
question. The diagnosis of acute psychotic episode was offered, motivated by the
clear antecedent of being exposed to a situation of terror.

Case 2
Gabriela, aged 56, married with three children and a grandchild, began her
transformation after she and her husband were attacked. Her husband was shot twice
and left for dead; she was beaten brutally by the assailants, who finally tried to run
over her unconscious body with their car to ‘finish her off’, as she believed she
heard them say. The couple was hospitalised and treated; both of them recovered
physically. The episode occurred three months before the consultation, which her
children compelled her to attend, alarmed by profound changes in their mother’s
behaviour. Previously a happily married housewife, Gabriella now felt that the
violent episode had established a ‘before’ and ‘after’ in her life; she felt that it was
impossible for her to return to the life she had before. After the attack, which had
occurred at a place relatively close to her home, she became a recluse. She surrounded
her house and garden with a metal fence and took to living behind closed doors,
refusing even to go into the garden which she had previously cultivated with great
care. She became self-absorbed, lying in an armchair, not answering calls, and only
occasionally doing some housework. When she watched television, she did so mostly
without really taking anything in, and not being able to tolerate any programme
with even minimal violence. In the interview, I encountered a depressed, anguished
woman who did not want to speak, cried at times and declared that the assailants
should have killed her because, in fact, her life had been transformed into hell and
was no longer worth living. Even so, as the interview proceeded she began to feel
freer and was able to describe just what that hell she had experienced was like. She
lived in terror, constantly dreading re-encountering the individuals who had harmed
her so much; because they had robbed her and got all her details in their hands, she
believed it would be easy for them to find her. She was also tormented by flashbacks
of the incident; sometimes she found temporary relief in some manual activity, but
suddenly the images would assault her; she had even shouted out when alone, as if
reliving the original episode. When she managed to fall asleep she had nightmares
in which the episode or some part of it would be repeated, or else she experienced
being in situations of physical or psychological threat, awakening suddenly in a
sweat, screaming. She had thought of killing herself, though this had not taken any
precise form; in the interview she repeated several times in a whisper: ‘It would be
better to be dead’.

Case 3
This was a 41-year-old woman. She had got out of her car to walk to the front
doors of her house when she was accosted by a stranger who put a gun to her head,
threatened to kill her and told her that he was going to rape her. After a brief struggle, she managed to escape and get into her house, terrorised and having suffered minor wounds. Over the following days, she had anxiety attacks accompanied by flashbacks in which the traumatic scene was repeated. She began to feel physically ill, with dizziness, nausea and near-fainting spells. Other marked disturbances for a time were forgetting significant events of the day, and waking up suddenly from nightmares in which either the actual episode or some other threatening situation was reproduced. There was no disturbance in her working or intellectual life. These symptoms persisted over the following three months, accompanied by phobias, especially agoraphobia and the avoidance of violent scenes on television. The patient was initially medicated but in light of the persistence of the clinical symptoms she began psychoanalytical treatment. The more evident symptoms disappeared shortly afterwards; the phobias persisted for a further period. In analysis, a fundamentally neurotic conflict became apparent. She remembered two traumatic situations of physical abuse in childhood, and had to work though her feelings of vulnerability and of anxiety about death and the passage of time.

These three clinical vignettes illustrate well the point I made earlier: in the first case, a patient reacted to a situation of deep stress with acute psychotic disorganisation; in the second case, considering the traumatic situation, the clinical presentation falls into the range of depression; in the third case the patient’s presentation places it in the region of the neuroses. We thus have a range from psychosis to neurosis, what the *Textbook of psychiatry* (Hales et al., 1999) calls the trauma spectrum. Could this not be superimposed on what I have called the *psychopathological spectrum*?

I would like to return now to the archaic. Those primary defects in psychical structure, those remnants which had not been worked through or made into history, as initial markers, would be predisposing factors for triggering future illness in the course of life’s happenstance. There is a range, *from supposed normality to the more serious forms of mental disease*. If we adopt this view, we will risk *losing* some nosographical detail but, on the other hand, we will *gain* an enlarged potential for understanding, and will thus be better placed to help our patients. This is not an attempt to differentiate entities rather it is an attempt to emphasise the broad range of a spectrum where individuality and personal history cannot be dismissed.

**Part III—An attempt at interdisciplinary dialogue**

The systematisation of knowledge cannot proceed in hermetic compartments (Whitehead, quoted by Biebel, 1999).

I will begin with a quote from a paper by Biebel on psychoanalysis and science:

> the interaction between psychoanalysis and other disciplines and professions like biology, ethology, linguistics, semiotics, sociology, ethics, cognitive psychology, poetics, rhetoric and neuroscience is at a moment of fertile communicative possibility, but for this to come true, we must work on those factors that approximate the concepts, cognitive strategies, modalities of thought, and smooth out problems in communication, problems which are not only of theoretical order but also of biological, psychosocial and sociological orders (1999).
One approach would be to say, ‘Well, I believe psychoanalysis is this and not that’—something we psychoanalysts often do: it is frequently heard in discussions, and is a preamble to the taking of irreconcilable positions and of ensuing misunderstandings. The discussion is closed before it has happened, according to some definition made on the basis of a particular criterion regarding what is and what is not psychoanalysis, even among those who say they practise it (Biebel, 1999). To test whether the explosion of knowledge in neuroscience, psychiatry and cognitive science is relevant to psychoanalysis, we must first be aware of the work which is being done, and then be able to transfer the discourse of these disciplines into the domain that concerns us, while accepting, with respect, that not all psychoanalysts will be interested in such approximations.

Kandel posits that, as a result of failing to develop objective methods for testing important ideas it had formulated, psychoanalysis entered the 21st century with declining influence; which he deplores, ‘since psychoanalysis still represents the most coherent and intellectually satisfying view of the mind’ (1999, p. 505). For his part, Panksepp holds that:

We should now seek a new consilience … among the many disciplines that are honestly seeking to reveal the deeper layers of human nature. There should be a major scientific role for psychoanalytic approaches in such endeavors, for the currents of mind run deeper and in more complex patterns than any one of our methodologies can adequately probe (1999, p. 35).

Based on the preceding considerations, I will attempt an approximation to a dialogue between psychoanalysis, psychiatry, biology and neuroscience, taking as a bridge the notion of *psychical trauma*, and establishing a link with post-traumatic stress disorder. From the standpoint of clinical and diagnostic criteria, and keeping to simple definitions of symptoms, I believe that a broad view enables us to connect the ideas of post-traumatic stress disorder with the concept of war neurosis or traumatic neurosis, to which Freud alluded in *Beyond the pleasure principle* (1920). At the beginning of the 20th century, the important influence of psychoanalysis, especially in the USA, led clinicians to label this disturbance a traumatic neurosis.

**Advances in memory, emotion and the psychoanalytical notion of trauma**

The strongest point, and the one I shall discuss, is constituted by useful considerations on stress, and present findings on the encephalic structures that are linked to emotion and memory. Psychoanalysts cannot but be surprised at the contributions made in this field by neurophysiology, psychoneuroendocrinology (Yehuda, 1998), psychoneuroimmunology (Dantzer and Mormede, 1995), neuroanatomy and neuropsychology. For the present dialogue, however, the most useful recent findings come from neuroscience on encephalic structures, linking trauma and stress with emotion and memory. The inter-relation of factors like the operation of the autonomous nervous system, the cerebral and extra-cerebral regulation of internal secretions, their action in specific brain areas which fundamentally involve the limbic circuits (amygdala and hippocampus), the orbito-frontal cortex system,
the hypothalamus and the hypothalamus–hipophysis–suprarenal axis, and likewise discoveries in neuroanatomy and neurophysiology, testify to advances made in this field.

With regard to this research, where the functioning and processing of memory and emotion occupy an important and relevant place, I turn to recent psychoanalytic thinking found in psychoanalytical literature. I begin with Pally’s (1998) concepts in ‘Emotional processing: The mind–body connection’, and with Recovered memories of abuse, edited by Sandler et al. (1997), where fundamental questions concerning present scientific knowledge of the mechanisms of memory are discussed, both in the editors’ papers and at the papers given at the conference (at University College, London, June 1994) on the validity of recovered memories of abuse. This conference brought together psychoanalysts, child psychiatrists, cognitive psychologists specialising in memory, forensic psychiatrists, students of early parent–child relations and researchers in neuropsychology, and focused on key psychoanalytical concepts like repression, early psychical trauma, infantile amnesia, the idea of the unconscious, historical truth and unconscious fantasy, splitting and denial etc.

Regarding memory, a fundamental axis in this issue, it is worth noting that there are several different memory systems, as the excellent review by Davis (2001) points out. Davis reports recent research describing memory in terms of separate and multiple systems, highlighting a difference which is pertinent for analytical work, namely the difference between declarative memory and non-declarative or procedural memory. These systems differ in their underlying neurological structures, operational principles and the type of information they process. The forms of memory we call declarative are represented by a system which first processes or codifies them, then files them in some accessible form for future use, and finally retrieves them on demand, through verbal processing, in more or less detailed form. In contrast, Davis uses the term ‘procedural memory’ to refer to non-declarative memories. While it is true that these two concepts cannot be superimposed in a strict sense, there is no disputing today that there is a sharp difference between what can be thought of, represented in images or put into words and what is inscribed in terms of affect-charged procedures, or affect-motor schemes.

What is of interest to psychoanalysts from the preceding discussion is the form in which links become inscribed, in particular the automatic affective reactions a baby may have in its relating to the significant other; these are linked to emotional experiences ‘learned’ through early, repeated experiences, accumulated through time in the course of a lifetime. It may be in this sense that Davis (2001) introduces concepts of Stern et al. (1988, p. 903) which are related to ‘implicit relational knowledge’. These refer specifically to the influence implicit or non-declarative memories have on each individual’s characteristic ‘ways of being with others’ and even of relating to oneself; they originate in early infancy, becoming more mature and complex as the brain matures and the mastery of intersubjectivity expands. These psychical ways of being are also unconscious, and, as Davis states, ‘they operate outside of an individual’s awareness, but are not repressed or otherwise dynamically unconscious’ (2001, p. 449). In other words, they cannot be explicitly declared.
By contrast, the so-called procedural memories, at present considered an area ripe for exploration, are highly relevant because they may be the repositories of forms of precocious traumas which are not amenable to verbal memory. Basic characteristic, non-declarative or procedural memories are specifically notable for being impossible to remember; no conscious experience of the memory is possible, though it is demonstrable that past experiences are retained there. Thus, an unconscious may exist which is not the result of the repression of an affect but which is, as many authors suggest (cf. Westen, 1999), organised in the form of automated procedures on how to relate to the other and to the world, inscribed as procedural memory. Memories appear as if decontextualised, dissociated or split, in the sense that they remain intact but not worked through, though influencing both behaviour and emotional disposition. Thus, the evidence suggests that procedural memories from a very early age tend to persist in the forms of patterns of behaviour, destined to be repeated later in life; and that they become manifest in the patient’s relation with the analyst in the transference.

That is why in the course of analytical treatment such memories are not recovered as declarative memories, nor can they be decoded from the patient’s narrative, but appear only in the form of acting out within the relationship, or enactment. This is not to do with a memory censoriously repressed, but with something that exists in the form of procedures about how to be with and react to the other. Consequently, it is possible to infer with a high degree of probability that children might store much experience which they are subsequently incapable of evoking. What is noteworthy here is that early trauma can alter the normal operation of the memory system.

Fonagy quotes Allen’s view that ‘implicit memory may have a key role to play in mediating symptoms of post-traumatic stress disorder’ (Fonagy, 1997, p. 187); he cites psychological evidence in support of this argument and suggests that relatively primitive parts of the nervous system like the amygdala and the hippocampus may be involved in mediating the memories of these experiences. In this model, traumatic memories would return principally through the sensory system, in the form of synesthetic sensations, smells, tastes or visual images, decontextualised and with no apparent meaning. The relatively simple properties of this memory system suggest that inscriptions (what is stored) return in the same mode in which they were codified (i.e. what was smelled returns as a smell etc.). This brings to mind the words of Botella and Botella:

> if there is memory in traumatic neuroses, this can only be conceived as ‘sensory memory or perceptual traces’ that have not acquired the representation status of mnemonic footprints. The same occurs with childhood traumas that cannot be integrated into the representation network of childhood neurosis (1997, p. 26).

According to Allen (1995) the return of the memory is accompanied by intense emotional reactions (fear and rage) as well as by images (flashbacks and nightmares) in those individuals who suffered intensely traumatic experiences.

Pally (1998) agrees with some of these ideas, fundamentally as regards emotional reactions. In her article ‘Emotional processing: The mind–body connection’, she
attempts to shed light on the circuits of emotion in the mind and to show how these circuits are applied to a large variety of relevant clinical matters: anxiety, psychosomatic conditions, and even attachment and non-verbal communication. As regards the brain structures involved, Pally notes that, besides its role in memory, the hippocampus also regulates emotional arousal: ‘it appears most likely that what is referred to by analysts as “affect” is not just a mental state but a complex psychobiological state’ (p. 352). The amygdala and the prefrontal cortex also play important roles. Pally suggests that the amygdala is also quite probably the centre of human anxiety; she notes that during stress the hippocampus can be altered or even damaged, while the amygdala’s activity can increase. The cells of the hippocampus may show diminished activity and even become atrophied during stress, leading to disturbances in attention and memory.

In the same field, Olds and Cooper (1997) briefly review research on the functioning of the hippocampus and the effects of stress in this area of the brain, and assess the importance of this information for analysts, whom are able to understand better the role constructs play in processes that can never be represented precisely because memory operated under trauma and stress. The human hippocampus is immature in the first two years of life, whereas the amygdala is completely developed. Certain researchers suggest that as a result, when severe stress results in damage to the hippocampus in an adult, very early childhood fears, which were retained in the emotional memory of the amygdala’s circuits, can surface.

Returning to Fonagy’s paper, we read that

the concepts of Bowlby (1973) concerning the models of the internal functioning of attachment, constructed on the basis of the carer’s expectations of behaviour and which are believed to organise the individual’s behaviour in all significant relations, could be seen as an example of implicit memory (1997, pp. 187–9).

According to Kandel (1999) the work of Anna Freud and Harlow was extended by Bowlby, who began to think about the interaction of the infant and his carers in biological terms.

Concluding the discussion on this aspect of memory, it is interesting to note its relation with the concept of splitting; for there is agreement with certain concepts presented in Part I above, regarding the considerable body of evidence relating splitting to trauma. In her discussion of L. Weiskrantz’s paper ‘Memories of abuse or the abuse of memories’ (presented at the 1994 London conference, mentioned above), Judith Trowell, a child and adolescent psychoanalyst, remarks that because of the intervention of early mechanisms like splitting, projection, projective identification and denial, what happened remained profoundly unconscious as experience impervious to thought, as if what was split off were encapsulated ‘like a denied bubble of experience’ (1997, p. 24), which remained unintegrated. Split-off memories are decontextualised in the sense of remaining intact but without being worked through, influencing both behaviour and emotional disposition. Decontextualisation can be of fundamental importance in preventing appropriate symbolic coding of traumatic events. Yet dissociated memories are not lost to consciousness. Christopher Bollas (quoted by Fonagy, 1997, p. 198) characterised
them as ‘not unknown thought but the unthought known’—basically, what is known but somehow remains outside thought.

**Discussion and final thoughts**

After this attempt to ‘forge links’, as Solms (1998) puts it, and frankly uncertain as to whether I have really tackled the questions set out in the introduction, I turn to another issue: Is psychoanalysis relevant today?

In my view, psychoanalysis is relevant in two ways—as prevention and as therapy. As prevention because, by treating our patients (wherever they might be found on the *psychopathological spectrum*, and while being aware of the inherent limitations of any intervention) we can attempt to prevent or attenuate the appearance of new forms of disorganisation prompted by life’s ever-changing vicissitudes. Discussing the treatment of adaptive disorders, Kaplan and Sadock suggest that individual psychotherapy offers the opportunity to explore the significance of the stressor for the individual patient, and thus confront old traumatic events. They then remark that ‘after successful therapy, patients sometimes emerge from adjustment disorder stronger than in the premorbid period, although no pathology was evident during that period’ (1998, pp. 773–4). Psychoanalysis can also be psychoprophylactic through *education* and *dissemination* of better knowledge and better management of the early relations that give rise to infant trauma, opening up the possibility of taking measures with parents or even with the general environment.

I have left the therapeutic value of psychoanalysis to last because, beyond the relief of symptoms through drugs (for we should not deny the usefulness of the judicious administration of drugs on certain occasions), I believe that the main way of *dissolving anxiety* continues to be the spoken word, as long as it is used in a proper and not arbitrary therapeutic framework; for it is of course not a question of saying just anything, or allowing just anything to be said, or doing just anything. Psychoanalysis is a process where the facts emerge in a dynamic situation, with constant oscillating play between reality and fantasy, subjectivity and objectivity—and sometimes it does look impossible to sort out which is which.

Maturana refers to the analytical process as framed in the dialectic between fantasy and reality, and alludes to ‘those moments where psychoanalytical identity is tested, especially in a quite subtle manner, from what cannot be questioned to what is evident’ (1996, p. 169). He then continues,

> Trauma for a psychoanalyst must be what, following the classical definition, is constituted as an economic plus over the ego’s capacity, but taking place in the internal world and not exclusively in the real world. In a kind of retroactivity, things have no meaning in themselves, but only when included in the internal scenario (p. 169).

It follows that this ability to ‘read’ what is narrated with a different attitude is much harder to sustain when the symptoms the subject presents with are the result of an *event which is indisputably, objectively traumatic*—yet it is at precisely this point that the psychoanalytical stance must be sustained in such a way that we can ‘hear’
whatever is meaningful to the patient without being guided only by considerations of external reality.

When the objective facts are so dramatic that they tempt us away from our analytic stance, our ability to resist the temptation is tested to its limits. If we succeed, it becomes possible to endow the patient with subjectivity, so that he can possess an absolutely personal point of view about his life, above and/or in addition to what really happened. However, patient and analyst must not withdraw to an ‘island’ where the only thing that counts is their own subjective realities. The affirmation I talked about earlier will only be valid if it maintains an equilibrium, upholding the analytical attitude without entirely discounting external reality. In this way the analytical encounter can occur, ultimately leading to working through and establishing a history. As previously stated, the analytical process tries to make it possible for the person to inscribe himself in an individual history. Analysis will make possible ‘the transition of precocious impressions into testimonies that can be fantasised about and thus made into history (Uriarte de Pantazoglu, 1995, p. 271). The aim then is to achieve psychical change, whereby ‘the enrichment in the ambit of meaning is added to enrichment also occurring in the ambit of affects, in reordering defensive processes, as also in the consequences of the new processes of identification and de-identification’ (Schkolnik, 2001, p. 50), ultimately in restructuring the psychical apparatus.

I would now like to look at the application of these formulations to clinical work, regarding the aim of mental restructuring leading to psychical change. What do the new concepts presented here imply when applied to treatment? Based on currently available knowledge about different types of memory, they imply a conceptualisation of unconscious processes beyond their reduction to the repressed unconscious, requiring also the use of interventions beyond classical interpretation. From the point of view of praxis, the issue of how non-declarative memories are changed constitutes an important problem for technique. It implies a profound commitment by both participants in the analytical scenario and a deep emotional involvement on the analyst’s part, if he is to be able to modify what, as procedural memory, is manifested only through ways of acting and feeling that were not repressed.

The emphasis on this aspect of deep emotional commitment on the analyst's part is not intended to demean important concepts such as neutrality and abstinence, but rather to attempt to rethink and relocate them in a new context of technique, for which there is currently a great need. Otherwise, the analyst might engage in ‘acting out’ non-declarative processes with his patient, but remain severely limited in his capacity to recognise and thus analyse them, that is, to bring to the patient’s awareness all the implications these unconscious influences have for the patient’s experience and behaviour.

Such a reformulation of the Freudian project of making conscious what was unconscious is not about making Freud say what he never said or attributing something to him to create conceptual confusion (here I agree with Bleichmar, 2001); it is rather a matter of trying to integrate Freud’s thinking in a broader framework which acknowledges developments proceeding from his work, and especially the consequential implications of contemporary knowledge about different types of memories—all with a view to developing more specific forms of therapeutic
interventions. Hence the questioning (Bleichmar, 2001) of the false dichotomy between those who hold that it is interpretation that produces change, versus those who believe that the transforming factor is the therapeutic relationship. In fact, both these types of intervention may be necessary, depending on the type of unconscious process or inscription being addressed—declarative memory or procedural memory. It would be a step forward to have a model encompassing a technique predicated on it, and replacing a fragmented, disjointed technique extolling any one of a number of perceived ‘universal formulas’, such as reviving experience, or remembering, or putting into words.

Regarding this project of psychical change and restructuring, I would like to add a further point, related to recent findings on memory structure. The theory of memory known today by researchers as ‘re-consolidation theory’, based on concepts like ‘memory in a labile state’ and ‘affectively dependent memory’ (Bleichmar, 2001), is, in fact, in agreement with the Freudian concept of après coup: both describe present experience restructuring past experience and giving it a meaning it did not have previously, and which is not a mere additional element. Thus, the interrelating of concepts located in adjacent areas has fundamental consequences for technique. We gain a more detailed conceptualisation of the structure of the mind, of different types of memory, of the relations between thought, affect and act; and we open up possibilities for new types of intervention according to an enriched model of how the mind operates and how psychopathology is generated. Even though the aspiration is to change and restructure the mind, it may not be possible to achieve this completely. Limits exist, a ‘but’ or a ‘however’ will always surface—but then this is true not only for psychoanalysis but also for all of life’s activities; we must learn to accept it and live with it.

In psychoanalysis, limits are set by an ‘unbreachable wall’ of understanding within the subject who is struggling to tell the story of certain aspects of his existence: ‘it would be a question of a part of the pure trauma that in him may have remained present and impossible to assimilate’ (Baranger et al., 1987, p. 768). However, distances can become shorter. For example, the classical psychoanalytical view of resistance as a contrary force representing an impediment to remembering does not take into account a different type of resistance, related to what cannot be put into words because it does not refer to symbolic knowledge but to information which, procedurally codified, does not exist in the shape of representation of some other thing. The patient is unable to narrate, either by allusion or by any type of symbolisation, what is an operational item, a procedural memory of his way of relating, which in analysis cannot be recovered as a declarative memory or by decoding the narration, but only through being acted out in the analytic relationship. This is resistance, then, not only to a thematic content which is turned away from, but also to an established mode of relating with the other. This therefore belies the myth of the neutral analyst as mere reader of the patient’s unconscious. Instead, the therapeutic relation is understood as an encounter of two subjectivities within a very significant transference–countertransference movement.

None of this implies that translating acted-out knowledge into words is not a significant tool or does not constitute an important part of the therapeutic process,
though it is important to keep in mind that the retranscription of non-declarative relational knowledge into symbolic knowledge is painstaking and never fully achieved (Bleichmar, 2001); for, while the different memory systems influence one another through many transsystemic connections, we now know that these influences are necessarily incomplete.

To conclude, I am aware that the ideas presented here are not original; my intention was to demonstrate that a better understanding of the broad range of traumatic interhuman situations can be obtained by relating psychoanalytical concepts to those of other interdisciplinary fields. Today, the concept of trauma occupies a central position in interdisciplinary dialogue. It is also related to the notion of stress. These facts highlight the many difficulties that exist in this field and the many challenges that must be met. The point is to replace a fanatical defence of Freudian theory—the argument that Freud has said everything there is to be said—with an attempt to revive interest in those Freudian concepts that truly remain relevant today. Such interdisciplinary dialogue enriches and serves the advancement of psychoanalysis; contemporary concepts about traumatic factors and the contributions of different disciplines can be made compatible, making possible an enriched understanding of what Freud called ‘complementary series’. In this sense, this paper could be seen as a preliminary communication about topics of current research interest, presenting a number of ideas that could be replicated and subsequently tested by different disciplines.

Translations of summary

El concepto de trauma psíquico: un puente en el espacio interdisciplinario. El concepto de trauma ocupa hoy una posición central para el diálogo interdisciplinario. El autor toma como “puente” el concepto de trauma psíquico e intenta un diálogo interdisciplinario con la psiquiatría, la biología y las neurociencias. Tutté parte del concepto de trauma psíquico en Freud, y hace un recorrido por la evolución del pensamiento de este autor, articulándolo con las ideas de Ferenczi y los autores psicoanalíticos postfreudianos. Desde un marco referencial diferente, el autor examina el estado actual de los estudios sobre el trastorno por estrés postraumático de la nosografía psiquiátrica, y luego intenta una aproximación interdisciplinaria al concepto de trauma psíquico. Surge ideas interesantes como la de situación traumática, la de espectro de trauma y la de espectro psicopatológico, que permiten entender mejor el concepto de trauma psíquico en su condición de articulador, como un puente que vincula un amplio abanico psicopatológico que se extiende desde la normalidad hasta la psicosis. Si bien esto presenta el riesgo de perder rigor nosográfico, asegura una ganancia en comprensión y posibilidades terapéuticas. En una segunda parte se intenta un diálogo con las neurociencias, en el que se toma en cuenta los nuevos avances en las investigaciones sobre la emoción y la memoria, haciéndolas compatibles con el concepto psicoanalítico de trauma. A este respecto, el autor destaca el funcionamiento de la emoción y primordialmente de la memoria, eje fundamental en esta problemática. Aquí aparece una sustantiva diferenciación que es pertinente para el trabajo analítico: las memorias declarativas versus las memorias no declarativas o procedurales. En una discusión final, el autor concluye que si se toma en cuenta lo que implican estas nociones actuales sobre algunos de sus aspectos teóricos y técnicos, el psicoanálisis se ubica en un lugar privilegiado tanto por su potencial para prevenir como para tratar a los pacientes en la actualidad, en la medida que, a través del diálogo interdisciplinario, estas nociones le permite recibir y enriquecerse con las aportaciones de otras disciplinas, mientras contribuye al enriquecimiento de éstas con sus propias aportaciones.

Le concept de traumatisme psychique: un pont dans l’espace interdisciplinaire. Le concept de traumatisme se situe aujourd’hui en position centrale pour un dialogue interdisciplinaire. Considérant le concept de traumatisme psychique comme un « pont », l’auteur tente un dialogue interdisciplinaire avec la psychiatrie, la biologie et les neurosciences. Partant du concept de traumatisme psychique chez Freud, l’article examine l’évolution de la pensée de cet auteur, la reliant avec les idées de Ferenczi et des auteurs psychanalytiques post-freudiens. À partir d’un cadre différent, l’auteur examine l’état actuel de la recherche sur le trouble « stress post-traumatique » dans la nosographie psychiatrique actuelle, puis tente une approche interdisciplinaire du concept de traumatisme psychique. Des idées intéressantes, comme la situation traumatique, le spectre traumatique et le spectre psychopathologique émergent et rendent possible une meilleure compréhension du concept de traumatisme psychique et de ses interrelations en tant que pont reliant un large éventail psychopathologique allant de la normalité à la psychose. Même si cette approche court le risque d’une moindre rigueur nosographique, elle permet de gagner en compréhension et en possibilités thérapeutiques. Dans la deuxième partie de l’article, l’auteur tente un dialogue avec les neurosciences, en prenant en compte les nouvelles avancées de la recherche actuelle sur l’émotion et la mémoire, qui les rendent compatibles avec le concept psychanalytique du traumatisme. En ce sens, l’article souligne l’importance de l’émotion et la place essentielle de la mémoire, notamment en tant qu’axe fondamental de cette question. Ici émerge une distinction essentielle, pertinente pour le travail analytique : la mémoire déclarative dans son opposition à la mémoire non déclarative ou procédurale. Dans la discussion finale, l’article conclut que, lorsque nous prenons en considération les implications de ces notions actuelles dans certains de leurs aspects théoriques et techniques, la psychanalyse se trouve occuper une place privilégiée par son potentiel à la fois de prévention et de traitement de ces patients, à la condition que, à travers le dialogue interdisciplinaire, ces notions la rendent capable de recevoir et d’être enrichie par les contributions d’autres disciplines, tout comme la psychanalyse continue de les enrichir avec ses propres contributions.

Il concetto di trauma psichico: un ponte di collegamento nello spazio interdisciplinare. Oggi l’idea di trauma occupa una posizione centrale nel dialogo interdisciplinare. Utilizzando come ponte il concetto di trauma psichico, l’autore tenta d’instaurare un dialogo interdisciplinare con la psichiatria, la biologia e le neuroscienze. Prendendo avvio dal concetto di trauma psichico in Freud, egli passa in rassegna l’evolversi del pensiero in questo autore, collegandolo alle idee di Ferenczi e degli psicoanalisti postfreudiani. L’autore esamina quindi lo stato attuale della ricerca sul disturbo da stress post-traumatico nella nosografia psichiatrica corrente partendo da uno schema referenziale diverso e tentando poi un approccio interdisciplinare al concetto di trauma psichico. Emergono così idee interessanti come la situazione traumaatica, lo spettro di trauma e lo spettro psicopatologico che rendono possibile una miglior comprensione del concetto di trauma psichico e delle sue interconnessioni, come di un ponte che collega un ampio spettro psicopatologico che va dalla normalità alla psicosi. Pur presentando un rischio di perdita di rigore nosografico, ciò consente una migliore...
comprensione e maggiori possibilità terapeutiche. Nella seconda parte è avviato un tentativo di dialogo
con le neuroscienze, dove sono presi in considerazione gli attuali progressi della ricerca su emozione e
memoria, rendendoli compatibili con l’idea psicoanalitica di trauma. In questo senso l’articolo sottolinea
l’importanza dell’emozione e soprattutto della memoria quale asse fondamentale del problema. Qui compare
una distinzione fondamentale pertinente al lavoro psicoanalitico: memoria dichiarativa versus memoria non
dichiarativa o procedurale. Nella discussione finale l’articolo perviene alla conclusione che, esaminando le
implicazioni di questi concetti attuali e prendendone in considerazione una serie di aspetti teorici e tecnici,
a psicoanalisi occupa un posto privilegiato, sia per le sue possibilità nell’ambito della prevenzione sia
per il trattamento dei pazienti, nella misura in cui, attraverso il dialogo interdisciplinare, queste nozioni le
permettono di ricevere gli apporti delle altre discipline e di esserne arricchita, così come essa contribuisce
ad arricchirle.

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