“As these [traumatized] men are unable to process affective stimulation through ordinary channels, very few psychological options remain open. Since they react to emotional stimulation as if it threatened a recurrence of the traumatic stress, they respond to any affectively charged situation only through the rigid, primitive, and totalistic reactions appropriate to overwhelming and traumatizing situations – either with fight responses or with flight. This lack of affect tolerance interferes with the ability to grieve, and with the capacity to work through ordinary everyday conflicts and to accumulate restitutive, gratifying experiences. Hence, they are deprived of precisely those psychological mechanisms which allow people to cope with the narcissistic injuries of daily life” (van der Kolk & Ducey, 1989, p. 268).

“In people with PTSD [post-traumatic stress disorder], even minor stimuli may serve as precipitants of emergency responses. They have no awareness of the personal meaning of the stimuli that reactivate past learning. The reliving of the past occurs automatically and without reflective recognition of its historical context: Contextual stimuli directly evoke stored memories without conscious awareness of the transition (Squire, 1978). The inability to appraise new situations appropriately results in further autonomic arousal, anxiety, and . . . even disorganization of thought processes.”

“Pierre Janet, who first explored the human response to trauma in detail, believed that vehement emotions interfere with people’s capacity to cognitively integrate traumatic events into the totality of their life experiences. He thought that if an event is too upsetting for people to be able to make sense of it, it cannot be neutralized by integration into the memory system. The terrifying nature of the event results in ‘a phobia of memory’ (1919, p. 661) which prevents the integration of traumatic events and causes dissociation of the traumatic memories from ordinary consciousness (1889, 1898). Janet postulated that an experience becomes traumatic when it cannot be assimilated into existing meaning schemes, and that this lack of transformation of traumatic memories into a personal story results in recurrent intrusive nonverbal memories (1911). Memory traces of the trauma are dissociated, but linger and continue to intrude as terrifying perceptions, obsessional preoccupations or as somatic reexperiences. Janet described how traumatized individuals become ‘attached to the trauma,’ and that new emotional experiences cannot be integrated as long as a person is unable to assimilate the traumatic memories: ‘they are attached to an unsurmountable obstacle. The patient is unable to tell the story of the events as they occurred and yet, he remains confronted with the situation in which he was unable to play a satisfactory role’ (1919, p. 660). It is ‘as if their personality development has stopped at a certain point and cannot be expanded any more by the addition or assimilation of new elements’ (1911, p. 532). Eventually, Janet suggested, patients just want to get away from it all, and forget the situation: ‘complete avoidance is characterized by complete absence of allusion to sensitive objects or the anxiety associated with them. It is as if the event, or even the function never existed’ (1909, p. 352). The capacity to adapt to current reality breaks down, and the patient ends in a state of chronic helplessness expressed through both psychological and somatic symptoms (1903)
“He [Freud] proposed that the failure of the ‘stimulus barrier’ to screen out overwhelming excitation in the face of massive psychic trauma accounts for the ‘compulsion to repeat’ the trauma as a current reality, rather than process it as a memory: ‘He is obliged to repeat the repressed material as a contemporary experience instead of . . . remembering it as something belonging to the past’ (1920, p. 18).

“Freud and Janet attached crucial importance to the capacity to be able to reproduce memories into words. Freud called the inability to put experiences into words repression, and when that happens, the person, instead of remembering, acts it out: ‘He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating . . . . he cannot escape from this compulsion to repeat; and in the end we understand that this is his way of remembering’ (1914, p. 150). . . . He saw the individual’s experience of the intruding affect associated with trauma, the ‘compulsion to repeat,’ as an attempt to symbolize the mute, concrete, unsymbolized experience, and to master actively what he was initially overwhelmed by passively. Thus, while Janet emphasized the passive inability to integrate overwhelming experiences that led to the dissociation of experience, Freud asserted that active motivation to forget unacceptable memories led to repression. They both claimed that the crucial factor that determines the repetition of the trauma is the presence of mute, unsymbolized and unintegrated experiences: A sudden and passively endured trauma is relived repetitively, until the person learns to remember simultaneously the affect and the cognition associated with trauma through access to language.”

“The key elements of the psychotherapy of people with PTSD -- as perhaps for all psychotherapy -- is the integration of the alien, or, in Freud’s famous (though frequently mistranslated) dictum on the aim of psychoanalysis, ‘where it was, there shall I come to be’ (1933, p. 80). Life events initially experienced as alien, as if imposed from outside upon passive victims, must come to be ‘personalized’ affectively as integrated aspects of one’s history and life experience (Ducey, 1987, 1989). Even after having been dealt seemingly unmanageable blows by fate, people must somehow integrate those blows as aspects of their own lives, in order to maintain continuity of a sense of self.”

“The patient’s ‘repeating’ the trauma in action is the forerunner to his ‘remembering’ and symbolizing it in words, which in turn is the precursor accompaniment to his ‘working through’ in emotional experience” (van der Kolk & Ducey, 1989, p. 272).

PRIMARY REFERENCE


SECONDARY REFERENCES


