Early psychological trauma and adolescence: 
a psychodynamic approach.

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ABSTRACT: After a brief historical review of the notion of “trauma” in Psychiatry and Psychoanalysis the various definitions and aspects of the concept of trauma are discussed (epidemiological, clinical, and therapeutic). It suggests that there should be no confusion between the various aspects and their function (research or therapy). In the clinical work with adolescents trauma should be considered as a basically therapeutic tool. Trauma is an active giving of sense to an accumulation of events in the family history. Recognizing trauma early on, especially in our work with adolescents, transforms our therapies.

Key Words: Psychological trauma, Adolescence, Transitional space, Psychotherapy.

INTRODUCTION
Discussing psychological trauma in Psychiatry leads directly to an urgent need of its definition. This kind of discussion already has a long history. The concept of psychological trauma seems to have been introduced to the 20th century Psychiatry via Psychoanalysis. From an epistemological point of view, it’s worth asking the following question: how a rigorously medical concept like trauma inspired Freud and how, by way of Psychoanalysis, it entered the field of Psychiatry. This adventurous trajectory of trauma, not only in the fields of Psychoanalysis and Psychiatry, but also in Social Pediatrics, Art or public discourse, deserves to be studied and could teach us a lot about the notion of trauma1,2. In any case, there is a point about trauma nowadays, the plasticity of the concept: narrow or broad, focused or decentred, it can be case specific. This plasticity is not unrelated to multiple points of view and a degree of confusion about trauma. Maybe the data obtained by a specific methodology in one discipline are often exported unchanged to other disciplines, where a different methodology would obtain different results. In other words, what does “trauma” mean in psychotherapy and what does it mean in epidemiology? It may be we are not talking about the same “trauma”, not even the same data.

A brief historical review of the notion of “trauma” in Psychiatry and Psychoanalysis.

We can probably recognize in Charcot’s association of “event - idea - symptom” in the case of hysteria3, the earliest notion of psychological trauma. But it is basically Freud who first consolidated this notion as an operational concept with a problematic future.

Freud analyzed sexual trauma in 1895 into two separate periods: The child is at first stage victim of sexual seduction from an adult and at a second stage, a non sexual scene, through association, rekindles repressed mnemonic traces. The initial fact of seduction really exists, but it becomes traumatic later through this rekindling. Since 1897, when Freud distinguished between the reality of events and the psychic reality, considering as creations of fantasy whatever till then he considered as real scenes of seduction, the discussion on the relations of fantasy and (traumatic) reality has been waged with passion.

Freud gradually abandoned the notion of a real event in his conception of trauma, and in 1920 he ad-
opted an “economic” thesis, wherein trauma, as excessive internal or external stimulation, provokes a wide breakdown in the protective shield. He uses the despair of the baby as model case.

Later on, Freud seems to return to the reality of the event and his conception becomes all the more complex, as if he is “chased” by the idea of the discovery (research) of an initial, concrete and repressed event, that would explain the symptoms. He did not refuse the economic conception, but he tended to recognize again the real event, talking about denial of parts of reality that come back as symptoms: aggressive or sexual impressions, early narcissistic wounds of the young child that have been forgotten, become later traumatic because of a quantitative factor during the period of child amnesia.

Ferenczi in 1932 discussed real trauma again: it consists in a passionate response of an adult to the tenderness of a child, and this event causes a splitting of the child’s Ego. The child feels innocent regarding the event, but at the same time introjects the guilty feelings of the adult. Finally, the child prefers to think that reality is a creation of its imagination, because he/she wants to keep a good image of the adult. The child “prefers” not to trust its memory. In Ferenczi’s conception, the hypocrisy of the adult is central. In the same line of thinking the therapist’s sincerity should also be central.

Viderman (1970) has an innovative proposal to lead this discussion about fantasy versus reality beyond its dead end. He proposes another way of thinking: it is impossible to uncover the real event in psychoanalysis, because the depth of repression, constitutive of the unconscious, does not permit a distinction between fantasy and history. The analyst recreates (“fabricates”) an hypothetical scene with its own coherence, he makes something exist by announcing it, he discovers an unknown beginning (origin). Finally, it is of little interest if the scene is real, as long as it appears real. This condition makes the scene true in the context (framework) of psychoanalysis.

The discussion following Viderman’s book tends to combine the views, so that history becomes at the same time restitution and creation. Viderman comes back proposing a very interesting metaphor: around a grain of sand (the event) develops a pearl (the fantasies). This metaphor can be considered as a very subtle compromise. But in the last thirty years, “reality” seems to take its revenge after a period of domination of the theory of “fantasy”. We can understand this line of evolution if we consider the importance given to the syndrome of child abuse or to the historical research concerning Freud’s biography (the “events” of his life modelling his theories and of course all the public fantasies around all these “revelations”).

Defining trauma

In a discussion about psychological trauma, emphasis may be placed on the violent and rare character of an event or on the “subterranean” nearly invisible accumulation of small events; arguments may be focused on the quality of the event or on the psychological elaboration of events that may appear insignificant. Declared or not declared theoretical views may influence this debate and push it to opposite directions. So dialogue is sometimes impossible.

Defining psychological trauma seems to be a very complex epistemological necessity, even though the concept of trauma is so evident in Medicine. But this medical evidence can complicate things even more in Psychiatry. Trauma is visible in Medicine; one can automatically obtain its image. This automatic possibility of an image draws us, without even knowing it, to a conception or a conviction about trauma; to an effort to render visible something mostly invisible. This is the great paradox in Psychiatry: we can represent psychological trauma only if we listen to it.

We use a metaphor in the place of an image. Historians base their research on the material traces of the past: for the therapist the only material traces are words, or the design - game of a child, which is also discourse. In the case of a psychiatric interview there is no “pure” diagnostic process, regardless of a therapeutic or inter - relational content. (Of course there is no “pure” institutional or other care in Psychiatry, no abstract application of rules regardless of the context of care giving).

Trauma reveals itself to the therapists - and for them - through hearing, always related to a therapeutic context or process. Trauma starts existing as an image due to the words of patients and due to the therapeutic framework that permits the words to exist. A thera-
pist learns about trauma through his therapies, but he learns mostly about trauma as it appears into therapy and during therapy. He learns about personal trauma through hearing a life history, but he learns much less about trauma in general. Clinical approach is the basic condition of the existence of trauma in Psychiatry. The conditions of clinical approach are also an object of analysis, as trauma itself.

There are two ways to render trauma visible in Psychiatry: either due to the “volume” or “weight” of the event itself, or due to the very evident psychological consequences of the event - and their supposed causal associations. In fact, discovering an evident causality may sometimes appear as a simple way of thinking, but it may also prove simplistic. In some cases, however, the “evident” way may prove useful, for example when post-traumatic insurance compensations have to be decided, violent behaviors to be condemned or epidemiological research to be conducted. In these cases, the classical medical model of trauma becomes nearly a necessity: the external event and the trauma itself should both be visible. This situation becomes problematic (from an epistemological point of view among others) when this model of trauma becomes over generalized and consequently arbitrary. Therapists may thus forget how little they see and how much they hear and be misled in their comprehension. They may also forget how the therapeutic framework (or setting) influences not only the production of the patient’s words and memories but also how a therapist hears and what he listens to.

A pure medical position may be necessary for reasons of research: then childhood trauma can be defined as an external blow or a series of blows that push temporarily a child into a state of helplessness and break the existing defense mechanisms. Trauma is then considered (and defined) as something that comes from the outside and provokes internal changes that last: that’s why medical examples (or metaphors) are useful to illustrate this case or point of view: for example Terr (1991) uses the paradigm of rheumatic fever to describe this kind of trauma. Some researchers defend a rigorously limited definition of trauma, that refers only to massive extraordinary events, like those initially described by Freud. They propose to find other terms for different kinds of psychological damage.

The medical model gives to the concept of trauma a necessary coherence, but it leaves out the psychological complexity. This model fits better in cases of massive trauma: a trauma that becomes massive either by intensity and violence or by its long-term somatic consequences (traces on the body). Intention could also be considered as an aggravating factor in massive traumatic situations: then a child is overtly a victim (abuse, torture etc).

Another question arises: Is the definition of massive trauma (a trauma that sometimes may be considered “beyond the reality principle”) a duty or a competence of psychiatry or psychotherapy? Is therapeutic experience with children (or adults) indispensable in the definition of obviously destructive or unacceptable situations as traumatic? Another argument may also be developed, concerning the scientific attitude as an approach that is free from every predefinition of possible consequences of an event, or even the psychological integration (or functioning) of an event. Otherwise events may be charged in advance (and sometimes ideologically) with traumatic potentialities.

This is the kind of dilemma we are confronted with every time we have to deal with serious or massive traumatic situations: as if what is to be proven happens to be known to start with, a priori. That’s why specialists seem sometimes so “helpless” regarding the prevention of trauma: because the traumatic events don’t depend on them. There is no psychiatrist, psychologist or psychotherapist that can foresee, anticipate or prevent a war or an earthquake (and only in few cases they can really feel they have prevented incest or abuse in a family). On the other side there is no therapy that can discover the exact traumatic “weight” of an external event.

In a therapeutic point of view it may seem more prudent to speak of events or life, events that may (or may not) be integrated in one’s mental state (or psychic apparatus) and some of them virtually (or most possibly) may have a traumatic functioning. But also, some events that appear traumatic from a common sense point of view, may function in an opposite way in some cases (due to one’s history, personal conditions etc.). For example difficult social conditions may sometimes “save” a child from a violent, abusing family: thus the child that is separated from his family
is the one who proves to be lucky, comparing to its brothers or sisters.

The above argument does not annul the social definition or social condemnation of traumatic events, but pleads mostly for their non-psychiatric or non-psychological definition. Definition of traumatic events seems more to be a competence or a duty of social, legal or ethic instances. Wars, natural or social catastrophes, torture, child abuse etc. are traumatic by definition with social or ethic criteria. How these events function (or disorganize) in every “private” psychological world or destiny is a competence of psychiatry or psychotherapy. The concept of trauma - especially concerning massive trauma - does not need a psychiatric caution to prove its negative effects or to lead to its social condemnation or plead for its prevention. The catastrophic effects of a war on a society (or on children) do not need the proofs of psychotherapies. In some cases such “proofs” may lead to regrettable confusions that alleviate the injustice, so they are also counter-indicated from an ethical point of view.

Simplified views about trauma can lead to two problematic directions: a) everything, even the slightest frustration in the life and development of a child may be considered as traumatic. This notion leads to a continuous ortho-pedagogical “prevention” of trauma that finally becomes an obstacle to normal development as it annuls every desire from the part of the child. From an epistemological point of view confusion is created, where trauma and every day life events become mixed up: finally this “traumatological” point of view ends up to concepts with no meaning. b) events that are simply characteristic of transformation of modern societies (or are simply facts of life in society) are defined as traumatic in general. In a second time they are hastily correlated in a linear causal way to every modification of child behavior that follows them, even modifications that have to do with the process of development. Divorce can be an example, when it is being considered by specialists as a de facto traumatic situation: the specialist’s attitudes (just like the parent’s attitudes), interfere with the process of divorcing and may render it more traumatic than if it was left to its “natural” evolution. At the same time we should not easily forget how traumatic may be for a child pathological and violent parental couples that do not divorce.

Distinguishing trauma from the general categories of “pathological” or pathogenic situations may prove very fecund, as well as its inner differentiation between trauma and traumatic process, or even linear and indirect causality. In such a case the correlation of trauma and therapy appears to be indispensable in any psychiatric approach; otherwise there is a risk of creating an “awkward” psychiatric sociology of trauma. In short, there should be something specific about definition and therapy, whenever we speak of trauma in psychiatry.

Our common scientific conception of trauma is strongly influenced by the model of neurosis, either in the form of seduction or in the form of castration. This conception permits what J. Cournot (1988) calls “the good use of trauma”. However we have to shift to another level of understanding when we approach the archaic trauma of psychosis, a trauma that overflows not only the history but also the prehistory of the subject (person): in this case the basic danger for the Ego is the id and not the super-Ego. In other cases, the level of understanding refers to stimuli that break through the protective shield (membrane) between the outside and the inside, as in cases of psychosomatic states where energy diffuses into the body or in situations of extreme abandonment or of massive external blow where the Ego is crushed by reality. In other situations there is a minimal possibility of investment of the mental apparatus, for example in cases of severe depression or autism.

**CLINICAL VIEW**

Charging the concept of trauma in negative way is not in itself sufficient to lead to the required clinical categorical distinctions. It simply leads to a tautology of the traumatic with the pathogenic and thus to an insufficient discussion with regards to therapy. How can this discussion about trauma become heuristic, that is, how can it lead to those questions that will lead to a better understanding and a better therapeutic approach? Why do we discuss trauma? Do we need this concept on a clinical - therapeutic - level and how do we need it?

Trauma should be considered as a basically clinical therapeutic concept, so that we avoid associating external events and mental life in a simplified way. Trauma may thus be transformed into a shared ex-
Early Psychological Trauma and Adolescence: A Psychodynamic Approach

The concept of trauma leads us directly to childhood, with a growing tendency to locate it the earliest possible in life. The childhood trauma constitutes then a traumatic “uterus” that may under certain circumstances find a renewed vigor later in life. There still remains a paradox: The outside world is a necessity for a child’s existence, but at the same time this necessity is potentially transformed to a traumatic experience for the child. The maternal care may be extremely intense and over stimulating, or absent and abandoning. The dialectical interactive relationship between presence and absence is no more balanced; what supports mental life becomes its own danger. We may suppose that this is a way to understand an early model of the traumatic: something excessive in intensity and duration that leaves its traces for the rest of a person’s life. It will be on the basis of the memory of this traumatic nucleus that adolescence will enact itself.

At this point of the discussion we can come back to the metaphor of the grain and the pearl, as commented by Janin (1995). He argues that many grains get lost, but those grains that have a symbolic value persist and these are the ones that show the traumatic core (nucleus) of all mental processes; the “good trauma”. The first internal object may exist, just because the real object may be absent and create frustration. Another way to put it would be what Laplanche says: “a mother who cares normally for her child addresses to him/her messages charged with sexual meaning”. Reality itself or basic needs of the child create a primordial/primal “good” trauma. Janin (1995) uses the metaphors of hot and cold to defend that extreme stimulation or not enough stimulation end being experienced in the same way; that is as an excessive stimulation. He proposes an effort of a very attentive elaboration of the patients’ history in order to analyze how this extreme stimulation was not integrated (processed) by the patient’s Ego. This difficulty in integration or comprehension consists also a basic form of a psychological trauma (that is the difficulty to recognize the properties and the quality of inner mental experiences). Another form of trauma has to do with what Janin (following A. Green) calls the “unlucky meetings” of a fantasy with a real event: in this case the mental apparatus cannot contain its inner world and is led to an inner collapse, a loss of the reality feeling. If we accept the collapse hypothesis, then we can also presume the existence of a functional splitting as an effort to recreate a psychic envelope (Bayle, 1991). The subject tries through splitting to protect itself from a reality that disorganizes its mental apparatus. In the same functional way we can also understand in some cases the autistic retreat, operational or utilitarian thinking (the “pensée opératoire” defined by the French authors) or pathological repetition.

Tracing back to early childhood and its interactions with parental excessive presence or absence constitute the necessary but not sufficient presuppositions of trauma.

Clinical experience teaches us that what is more violent is not necessarily the most traumatic, that what is called traumatic by the patient is not forever (at least for the duration of therapy) the trauma, that one trauma is hidden behind another trauma and that following the trauma we pass from the child to its family and from the family to previous generations. Trauma moves, it is “transported” (carried out) on the line of one’s history, on the narration of this history, from one generation to another. Traumatic meaning follows these movements of trauma.

Seeking sense in trauma

A sudden serious illness may be very traumatic for a child. After discovering this first trauma we pass to the traumatic experience of its mother, who lives the agony of losing her child. Later we pass to the mother’s adolescence, marked by the anxiety of being separated from her parents. To discover many months later a memory of her violent separation from her own parents in her early childhood. Every time during this therapy, trauma changes places, because its meaning is displaced elsewhere. So every time trauma appears during therapy, it constitutes a creation between patient and therapist.
Trauma is an active giving of sense to an event of the past: so a future may be created by (through) therapy and the creation of this future constitutes the therapy of trauma. Giving sense to the past gives sense to the present and opens up a way to future. There can exist no trauma out of a symbolic inscription in a chain of facts. This chain of facts stops being a destiny in the evolution of a therapy, if we are able to listen to someone narrating his trauma. Because what is more important is not the “reality” (factual-ity) of trauma itself, but the belonging of a trauma to someone and the recognition of this belonging. Which means the therapist’s acceptance (and “permission”) of the patient’s feelings of guilt, that is his/her feelings of responsibility, feelings of being a subject of one’s destiny. (Cournut, 1988). This acceptance permits the patient to proceed to a distinction of the outside and the inside world. This distinction is anti-traumatic because it comes on the opposite side of the “model” traumatic situation, where the inside and the outside world stop being perceived as separate, where the inner world of fantasies gets “equalized” completely with the outer world of reality, thus creating a collapse of the inner world (Janin, 1995). The world of trauma is a world of confusion: inside/outside, parents/child, one generation/another generation; therapy of trauma contains the effort to make distinctions between these categories.

The concept of trauma should perhaps be maintained in a transitional state (following the ideas of Winnicott), in a state intermediate, between the two: the inside and the outside. This transitional state of the therapeutic meeting is necessary; as everything happens in the interior of the therapy, nobody really asks if something comes from the inside or the outside, in the same way that nobody asks a child if it found its transitional object alone or somebody else found it for him.

Therapeutic approaches

What during our therapeutic work with children or adolescents makes us think of trauma? Something that comes from the children or something that comes from us? This is a difficult question to be answered. Maybe this question arises the necessity of creating another transitional space between therapist and patient, where nobody has to ask who brings what. A space where trauma may “freely” move, without touching in a dangerous way either of the protagonists. It is possibly sufficient in this case for a therapist to feel that something “moves” inside him, something that has to do with an endless traumatized childhood, with an open trauma that does not heal.

Dealing with trauma, especially in our work with adolescents, may push us to the “breaking” of a very rigid therapeutic framework. This often transforms our therapies to more human therapies. Recognizing trauma may push the therapist to offer some more acts, some more “satisfactions”, some more “presents”. It may push the therapist to want to take care of, to move further more than the comfortable place (and seat) of the therapeutic setting. Trauma may also push the therapist to be in a hurry, not to tolerate the slow time of healing.

That’s when new dangers may reappear: to cure trauma therapists have to become parents. But parents how and how much? Maybe more than what is needed and then, because this is intolerable, less than we should. Parents that lie for the benefit of their children, parents that reveal truths because they have to, when they shouldn’t. Parents trying to protect their child from an initial trauma and then thus they will protect it from every trauma, that is from the whole world.

To recognize trauma we have mostly to listen - to cure it we sometimes need also to act. This is a dangerous equilibrium that can traumatize (us) in return.
Πρώιμο ψυχολογικό τραύμα και εφηβεία. Ψυχοδυναμική προσέγγιση.
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ΠΕΡΙΛΗΨΗ: Στο παρόν άρθρο εξετάζονται οι διαφορές όψεις της έννοιας του τραύματος στην ψυχιατρική και στην ψυχοθεραπεία. Είναι σημαντικό να μην υπάρχει σύγχυση μεταξύ των διαφορετικών ορισμών (επιδημιολογικών, κλινικών, θεραπευτικών). Η αναγνώριση και η νοηματοδότηση του τραύματος στην οικογενειακή ιστορία αποτελεί βασικό εργαλείο στη θεραπευτική εργασία με τους εφήβους.

Λέξεις Κλειδιά: Τραύμα, Εφηβεία, Μεταβατικός χώρος, Ψυχοθεραπεία.

REFERENCES
