The concept of psychological trauma in psychodynamic French theory: From metaphor to clinical usefulness

Erik de Soir
Royal Higher Institute for Defence, Avenue de la Renaissance, 30, 1000 Brussels, Belgium

ARTICLE INFO

Article history:
Received 9 January 2018
Received in revised form 17 April 2018
Accepted 22 April 2018

Keywords:
PTSD
DSM-5
Traumatic neurosis
Repetition syndrome
Effroi de la mort

ABSTRACT

This article examines the hermeneutical conceptualization of psychological trauma in contemporary French psychodynamic theory and the clinical importance this approach still holds beyond the community of English-speaking trauma clinicians. Starting with the historical background of the psychodynamic French trauma concept, it investigates the potential contribution to the current knowledge on psychotraumatology internationally and aims to clarify differences and similarities between these approaches in the light of the leading paradigms of today. The position of the psychodynamic contemporary French authors is that stress and trauma do not necessarily fit into the same concept. The French classical and psychodynamic description of psychological trauma is based concepts such as the effroi de la mort (frozen fright of death) and the repetition syndrome (syndrome de répétition). A better understanding of these clinically relevant theories sheds another light on the currently used concepts in mainstream literature and the discussion on PTSD in DSM-5. The comparison of trauma concepts in different cultures and/or language groups, in a context of globalization of trauma societies, could be useful in bridging the existing conceptual gaps, understanding critical differences in clinical practice and offering a more integrative view of psychological trauma.

© 2018 Published by Elsevier Masson SAS.

1. Introduction

Scientific research in recent decades has provided a clear description of the serious consequences of trauma-related experiences (Breslau & Davis, 1992; Carlson, Furby, Armstrong, & Shlaes, 1997; Foa & Rothbaum, 1998; Horowitz, 1986). Various concepts have been developed to explicate the consequences of these experiences (Gersons & Carlier, 1992; Kinzie & Goetz, 1996; Wilson, 1989, 1994). Post-Traumatic Stress Disorder (PTSD) and other mental disorders (including anxiety, depression, substance abuse, dissociative disorders and psychosomatic disorders) can result from psychological trauma (Brewin et al., 2000). Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) are described in DSM-IV-TR (APA, 2000) as mental disorders, which may occur after traumatic experiences such as severe accidents, rape, torture, violence and war. The risk for PTSD increases with the degree of exposure to trauma and both the frequency and the severity of the traumatic events (e.g. Bramsen, 1995). This is better known as the dose-response relationship.

Over the years, a scientific consensus has appeared in the Anglo-American scientific literature about the symptoms of both acute and posttraumatic stress – i.e. intrusive recollections of the traumatic event, a profound sense of numhness, avoidance, increased arousal and hyperactivity and/or exaggerated startle response and dissociative reactions (Foa, Riggs, & Gershuny, 1995). If these reactions – intrusive reexperience, avoidance and hyperarousal – persist (at least for one month) – causing significant distress or loss of function, PTSD can be diagnosed according to the DSM-IV-TR (APA, 2000).

In DSM-5, PTSD was included in a new section on trauma- and stressor-related disorders. This move from DSM-IV-TR, which addressed PTSD as an anxiety disorder, is among several changes approved for this condition that is increasingly at the centre of public as well as professional attention (APA, 2013). In PTSD (APA, 2013), the trigger is exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual: directly experiences the traumatic event, witnesses the traumatic event in person, learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures or movies unless work-related). The disturbance, regardless of its trigger, is supposed to cause clinically
significant distress or impairment in the individual’s social interactions, capacity to work or other important areas of functioning and was not the result of another medical condition, medication, drugs or alcohol. As compared to DSM-IV, the diagnostic criteria for DSM-5 draw a clearer line when detailing what constitutes a traumatic event. The Acute Stress Disorder (ASD) and PTSD A2-criterion stipulating an individual’s response to the event – intense fear, helplessness or horror – has been deleted from the DSM-5.

DSM-5 pays more attention to the behavioural symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three. They are described as re-experiencing, avoidance, negative cognitions and mood, and arousal. DSM-5 requires that a disturbance continues for more than a month and eliminated the distinction between acute and chronic phases of PTSD. It includes two subtypes: PTSD Preschool Subtype and PTSD Dissociative Subtype (APA, 2013).

Significantly different perspectives, largely dependent on historical and cultural differences, exist in the international trauma literature. Among these, the classical French conceptualization remains largely unknown to the Anglo-Saxon field of traumatic stress studies because most of the authors representing this classical psychodynamic school do not seem to publish easily in English. While the mainstream literature often serves as the reference point for young non-English speaking researchers, the viewpoints of the classical French-language authors continue to provide an important basis of clinical practice for trauma clinicians in France, Belgium, Québec and Switzerland. Moreover, these psychoanalytic concepts also remain highly influential in Latin countries across Europe and South-America. Clinicians and researchers in non-English speaking countries continue to be inspired by classical hermeneutical interpretations, psychodynamic theories and clinical experience. The depth and breadth of the theoretical and conceptual gap which exists between trauma concepts in different language groups is striking. While the existing professional societies for traumatic stress studies struggle to create greater openness to cultural diversity, our knowledge no attempt has been undertaken to define or integrate these very different descriptive and conceptual views or investigate their relative usefulness for clinical practice.

We consider it important to rethink the potential importance of these classical trauma theories along with the conceptual terminology used by some of the psychodynamic (French) authors along with a brief review of the historical background from which these ideas arose. The international trauma community is currently adapting to the revised status of PTSD in DSM-5 and the Global Initiative Committee within the International Study for Traumatic Stress Studies is meant to bridge key differences among trauma experts worldwide. Therefore, the objective of this article is to explore how classical psychodynamic theories might contribute to a more integrative view on the variety of terminologies and concepts used by trauma practitioners in different language groups.

2. Historical background

2.1. From ancient history to the traumatic neurosis

The history of the classical French trauma theory goes back to the concept of traumatic neurosis as originally defined by the German psychiatrist Oppenheim (1884). Oppenheim was one of the first to identify this posttraumatic disorder as an independent entity in a study on the psychological sequelae caused by fear experienced during train accidents. The theory which Oppenheim formulated, posited that posttraumatic nervous symptoms constituted a distinct diagnostic entity and resulted from the direct – anatomical or psychic – effects of traumatic experiences. His suggestion was opposed by Charcot (1887) who saw ‘traumatic neurosis’ as nothing more than a particular etiologic form of hysteria, or – at the most – of ‘hystereoneurasthenia’ and prompted his students to write a number of theses defending his views. Charcot (1825–1893) studied trauma during the second half of his career, from the later 1870s through to his death in the early 1890s. By this time, he had already completed his major clinical and scientific work in neurology and was a figure of international fame throughout the world of Western medicine and arguably the best-known physician in France. Included among Charcot’s voluminous clinical publications are approximately twenty detailed case studies that carry the primary diagnoses of “névrose traumatique”, “hystérie traumatique”, “hystéro-traumatisme”, or “hystéro-neurasthénie traumatique” (Micale & Lerner, 2001). Clinically, what Charcot observed in his practice during the 1880s were curious syndromes following a diversity of (sometimes minor) bodily injuries, marked by disabling physical and psychological features but in the complete absence of any indication of structural damage. The most common symptoms seemed to be motoric and sensory disturbances – anesthesias, hyperestesias, paralyses, and contractions of all kinds. Fatigue, headache, back pain, heart palpitations, chest pain, irregular pulse rate, constipation, dizziness and fainting spells, and the trembling of the hands and legs also occurred frequently. Emotional troubles could be part of the symptom profile as well: depressive states, sleep disorders (including insomnia and nightmares), phobias, mental confusion, and lowered intellectual efficiency. At times, these symptoms disappeared suddenly and spontaneously, in a matter of hours. At other times, they persisted for months or even years (Micale & Lerner, 2011).

From Graeco-Roman times onward, conversion hysteria has been well documented. A well-known example is the case of the Athenian warrior who fought the Marathon battle – mentioned by Herodote – and became ‘blind’ for the rest of his life because he had been frightened by the sudden sight of a colossal enemy whom he had taken for a spectre (Crocq, 1999). Another famous case, mentioned by Pinel (1798), is that of the philosopher Pascal, who – after being nearly thrown with his coach into the Seine river by his runaway horses – suffered from repetition nightmares and could fall asleep only after placing a chair near his bed to reassure himself that he was not on the brink of void.

The cases of ‘nostalgia’ in campaigning armies during the 18th century and the syndromes of ‘cannonball wind’ exhibited by Napoleon’s armies probably included a large number of (post)-traumatic stress reactions, named ‘traumatic neurosis’ in classical literature. Pierre Janet (1889), and then Freud (1893), looked into the pathogenic role of psychological trauma and memories ‘forgotten by consciousness’ of traumatic events and ‘moral emotions’, and each contributed to the discovery of the unconscious and of the ‘cathartic’ method for curing these disorders. For Freud, Charcot’s cases opened the way toward the possibility of a purely psychological explanation of physical symptoms, that is, a theory of conversion, and, beyond this, to a general psychological theory of the neuroses based on Charcot’s clinical writings on hysteron-traumatic paralyses (Freud & Breuer, 1893).

Etiological, Charcot believed that his cases resulted from the combined action of a hereditary diathèse, or constitutional predisposition to nervous degeneration, and an environmental provoking agent (agent provocateur). Throughout the second half of the nineteenth century, a doctrine of hereditary determination dominated French mental medicine (Dowbiggin, 1985). According to this view, which Charcot endorsed unreservedly, nervous and neurological diseases manifested a latent flaw or defect of the nervous system – a tare nerveuse – that at all times was waiting to be activated by appropriate circumstances. In Charcot’s medical
thinking, traumatic stimuli acted on this prior constitutional
susceptibility, and the fact that some individuals developed
elaborate neurotic symptoms following a trauma while others
did not was explained by the presence or absence of this
background (Bertrand, 1990).

According to Freud’s initial psychoanalytic theory, hysteresia has
traumatic origins (Freud, 1956). Hysteresia is seen as a neurotic state
in which an experience cannot be admitted into consciousness and is
instead expressed in a body part. This is what Freud (1956) referred to as
derfed effect or Nachträglichkeit; that is an event is not experienced as traumatic at the time at which it occurs but
becomes so later once it is given a meaning within the frame of
mental representations. This experience cannot be admitted into
consciousness and is only expressed in a symptom. In his two most
important early works, L’Automatisme psychologique (1889) and
l’Etat mental des hystériques (1893), Pierre Janet (one of Charcot’s
most influential students) focuses on the mental, rather than the
neurological, stigmata of the neuroses, including phobias, abasias,
obsessions, and states of “dual” or “double consciousness”. Many
of these symptoms result from emotional trauma the memory of
which became unconsciously fixed in the patient’s mind causing a
weakening of the ability for mental and emotional synthesis. The
vocabulary (obnubilation of consciousness, dissociation of the ego)
used by Charcot in the case of “Le Log” – a 29-year-old Breton who
had been crossing the Pont des Invalides in Paris and sideswiped
with a wheelbarrow by a passing horse-drawn carriage – is close to
the language of early Janetian psychology.

2.2. War neurosis

Actually, the two World Wars were the most instrumental
events in establishing the existence of traumatic neurosis, in its
etiologic form of ‘war neurosis’ (névrose de guerre), underlining the
role of a ‘shock-emotion’ and emphasizing the ‘post-emotional’
(i.e. after having lived through vehement emotions) as opposed to
the ‘post-commotional’ (i.e. due to the commotomological effects
of explosions or train accidents) etiology or the ‘war psychoneurosis’
(psychonévrose de guerre) as described by Roussy and Lhermitte
(1919). French medical writing about la neurologie de guerre (war
neurology) during World War I was largely inspired by Charcot’s
ideas on the neurology of human trauma. Suddenly confronted
with outbreaks of psychogenic paralysis, blindness, and amnesia
among soldiers at the front lines, French physicians returned to the
ideas of Charcot. Publications in military psychiatry medicine in
France between 1914 and 1918 repeated the fin-de-siècle debate
about the origins of the traumatic neuroses. Neurophysicians
during World War I increasingly came to acknowledge that so-
called shell-shocked soldiers suffered not from the direct concus-
sive effects of exploding shells and poisonous gas but from extreme
levels of fear, anxiety and fatigue. The war seemed to illustrate on a
huge scale Charcot’s emphasis on the terribly pathogenic potency
of fear (Cygellstrøm, 1916). Many wartime doctors openly
categorized shellshock as hystérie de guerre (Lefebvre & Barbes,
1984). The ‘infantile’ or ‘regressive’ attitude of the war neurosis
patients was also mentioned (Charpentier, 1917; Ferenczi,
Abraham, Simmel, & Jones, 1921), and Freud (1918) as well as the
American authors of World War II (Kardiner & Spiegel, 1947)
revealed the ‘conflictual’ interweavings (war superego against
peacetime superego, fight or flight) entwined with the ‘fright’ and
‘surprise’ dimensions of the trauma.

Conflictual etiologies and the guilt these conflicts generate,
were again identified in subsequent studies of post-1945 wars and
guerrillas, including the French campaigns in Indochina and
Algeria (Crocq, 1999), the Vietnam War (Jones, 1982) and the
Middle-East conflicts (Belenky, 1987). Renewed interest in
traumatic neurosis and related disorders was generated by the
development of victim psychopathology – in victims of the
Holocaust, rape, accidents or abduction and disaster psychiatry
(immediate and delayed sequelae of accidents and disasters)
(Wilson et al., 1988).

This historical background makes clear that the classical ideas
on trauma differ from the psychiatric concept as described in the
Diagnostic and Statistical Manual of Mental Disorders (DSM) (APA,
overwhelming event can only be traumatizing when it is
observable by others and directly and causally linked to the
disorder. In contrast to the latter, the psychoanalytic idea
proclaims that events not directly observable by others may also
be traumatic.

3. Psychological trauma from a contemporary psychodynamic
point of view

3.1. Traumatic neurosis in contemporary French psychodynamic
literature

Louis Crocq, who was the recipient of the 2006 Lifetime
Achievement Award of the International Society for Traumatic
Stress Studies, should be considered as one of the most influential
contemporary French trauma theoreticians, closely followed by his
colleagues François Lebigot and Claude Barrois. Crocq (1999) tried
to fulfill a bridging role between the psychodynamic trauma
interpretation and the current view on psychological trauma in
mainstream literature. He pointed out that posttraumatic stress
disorder (PTSD, APA, 1994, 2000), except in some etiological
differences, corresponds closely to the former ‘traumatic neurosis’
in the classification of neuroses. Freud, who devoted memorable
pages to this condition as early as 1893–95 (Studies on Hysteria),
then shortly after World War I, in 1921 (Beyond the Pleasure
Principle), never disclaimed its existence since he recognized –
towards the end of his life – in 1938, that traumatic neuroses had
always eluded the infantile conflict hypothesis. In his writings, he
elevated the medical idea of trauma from secondary to primary
etiological status and linked trauma to the notions of psychosexual
motivation and unconscious repression (Micale and Lerner, 2001).

Traumatic neurosis is recognized by Crocq (1999) as an
independent neurosis, i.e. as a structured and lasting neurotic
disorder, including both specific symptoms (symptoms of repeti-
tion) and general neurotic symptoms such as anxiety and asthenia,
and involving a typical organization (which in this case is a
reorganization) of the personality which produces and perpetuates
symptoms.

Crocq (1999) presents the traumatic neurosis as a persistent
residual state that should not be mistaken for an immediate stress
reaction. It develops after a latent period that varies across
situations and individuals (from several days to several months).
This latent period, previously called ‘incubation’, ‘meditation’,
‘rumination’ or ‘contemplation’ by trauma clinicians, corresponds
to a psychodynamic readjustment of personality, which must
elaborate new defences in order to cope with the intrusion of an
event that the subject was unable to control at the time of its
occurrence. During this latency period, which is apparently silent,
the knowledgeable observer can nevertheless detect various signs
or symptoms including self-isolation, solitary mental rumination,
depressive withdrawal, or, on the contrary, paradoxical and
valuable euphoria predicting subsequent problems.

3.2. The repetition syndrome in traumatic neurosis

Every neurosis is characterized by its constellation of symp-
toms: anxiety attacks in anxiety neurosis, specific fears in phobic
neurosis, conversion and/or dissociation in hystera, rites and
obsession in obsessive-compulsive neurosis. In traumatic neurosis, the characteristic finding is a set of symptoms related to what is called the ‘repetition syndrome’.

Crocq (1999) describes the repetition nightmare as the most important feature in the disturbances after a traumatic experience. The repetition nightmare is experienced rather than contemplated: the traumatized subject relives – under the original form or as a transposition developed to the dream-formation rules of displacement, condensation, and symbolization – the inaugural traumatic scene that overwhelmed his defences. The repetition nightmare is experienced intensely; the subject screams, struggles, occasionally falls out of bed and wakes up, terrified and covered with sweat.

The repetition syndrome also includes other forms of repetition, including resurgence of irresistible thoughts recalling the traumatic scene, mental ruminations, fleeting, near-hallucinatory visions, an irresistible tendency to look for and contemplate scenes of violence in real life or in visual reproductions, impulsive motor behaviours improvising motions of defence or aggression, and, last but not least, startle reactions – either in response to minimal stimuli or spontaneously – that may be considered as the most archaic form of repetition.

3.3. The traumato-neurotic personality

Every neurosis is defined not only by its symptoms but also by the pattern of the underlying personality: an anxious personality in anxiety neurosis, and, phobic, histrionic and autistic personalities in phobic, hysterical, and obsessive neuroses. Crocq (1999) argues that, in the traumatic neurosis, the underlying personality pattern is not ‘constitutional’ or acquired during childhood, but rather what the personality has become after the impact of trauma; fearful, inhibited, regressive, dependent, but also contentious and demanding attention and rehabilitation.

Fenichel (1945) is the author who has best defined this ‘traumato-neurotic’ personality, which he characterizes by the blocking of three ego functions: function of filtration of stimuli, function of presence and activity in the world, and ‘libidinal’ function, all the sources of love for other beings diverted towards the reparation of self-love which lacked support at the critical time of traumatization.

4. Psychological trauma in contemporary psychodynamic French literature: the use of a clinical terminology

Contemporary French psychoanalytic authors (Barrois, 1998; Crocq, 1992, 1999, 2001; Lebigot, 2001, 2002, 2005) have questioned the terminology of ‘(post)traumatic stress’ used by anglophone authors, claiming that stress and trauma are two distinct concepts and that the most immediate human reaction to a traumatizing stimulus is a typical state of petrified shock or dread. These authors (ibid) refer to a prototypical state of effroi, close to Kraepelin’s old concept of Shreck (1899). According to this view, intense fear and stress reactions only follow after this first and basic reaction of shivering tremor. In his clinical cases, Charcot conjectured that such a state induced a kind of “sonambulism” or “hypnotic trance” in which there is an increased psychological suggestibility which leads to a reproduction or imprinting of the traumatic sensation as a mental representation. A “traumatic idea” or idée fixe is then lodged in the mind of the individual. It is interesting to note that, according to the Oxford English Dictionary, the word “trance” derives from a Middle French word for “being frightened to death”.

In line with this view, these French authors have proposed a clinical uncoupling of psychotraumatic syndromes – i.e. syndromes directly linked to the potentially traumatizing impact of a sudden, massive and/or brutal confrontation with death – and the psycho-emotional consequences of disturbing events and life crises (Crocq, 1992, 2001). The accent is put on the unique personal truth of the traumatic experience, which can never be reduced to merely experiencing an overwhelming event and a consecutive biophysical reality of extreme stress (Crocq, 2001; De Clercq & Lebigot, 2001; Lebigot, 2001). In this view, the immediate, post-immediate and delayed stages of the reaction to a potentially traumatizing event are clearly distinguished and therefore a disorder (previously described as ‘traumatic neurosis’), for which the repetition syndrome (syndrome de répétition) is the pathognomonic expression, can be clearly identified. This interpretation is strongly inspired by psychoanalytic theories based on concepts such as the traumatic unconscious ( inconscient traumatique), psychological automatism (automatisme psychologique) and the reality of death (reé de la mort), respectively inspired by the theories of Freud (1895), Janet (1889, 1904) and Lacan (1973).

4.1. François Lebigot and l’effroi de la mort

In this classical Lacanian theoretical approach of stress and trauma, the core of a potentially traumatizing event is the confrontation with the ‘reality of death’ (le réel de la mort). Due to the sudden and unexpected confrontation with death, the subject enters into a temporary state of petrified shock – i.e. seems to turn into a stone as numerous soldiers in the old Greek Medusa tale (Crocq, 1999). In the state of effroi de la mort (frozen state of shock in the face of death), the subject encounters the complete and absolute emptiness and nothingness of death, and experiences it as being totally abandoned by the world of the living.

This interpretation is well documented by numerous clinical vignettes in the work of Lebigot (2005). The notion of effroi de la mort is essential in this approach: it describes the impact of an event which involves extreme anxiety, horror, total abandonment and powerlessness, which also appears in DSM-IV under the A2 criterion of PTSD (APA, 2000) but which has since been dropped in DSM-5 on the basis of statistical studies of its predictive power in assessing PTSD. This hermeneutical trauma interpretation is inspired by the early Freudian viewpoints on trauma in which the psyche is represented by a restricted volume in which there is a network of representations, between which small amounts of energy (affect) can freely circulate (Fig. 1). This restricted volume is surrounded by a membrane, which is seen as a stimulus barrier, protecting the psyche from being overwhelmed by over-stimulation and being charged with positive energy. The metaphorical view on the psyche is used to explain the difference between stress and trauma. The stimulus barrier protects the psyche from excessive stimulation which could, from the outside, influence the psychological equilibrium on the inside and deform the shape of the stimulus barrier. The tension on the outside of the stimulus barrier can be seen as a kind of strain (‘to stress’ literally means ‘to increase the strain’) which will have a negative impact on the free circulation of energy between the representations within the psychological system. The anxiety which results from this specific state will lead to an increase of energy on the outside of the stimulus barrier (i.e. the subject will draw on its own resources and react). The psyche defends itself against the aggression coming from the outside. When the tension from the outside decreases or disappears, the stimulus barrier takes its previous shape again. In this interpretation, the subject defends itself against a threat from the outside and manages to recover from stress: an apt metaphor for psychological resilience.

In the case of a traumatic impact, the story becomes different. Trauma is seen as the vital threat, life threatening and striking unexpectedly and very suddenly. It is an overwhelming amount of energy coming from the outside which abruptly penetrates the
In this metaphorical interpretation, the psyche is considered as a restricted volume surrounding a network of representations, separated from the outside world by a membrane. This view illustrates the difference between vital – i.e. threats for the integrity – and non-vital aggressions on the psyche. The way in which the psyche remains affected by a (potentially) vital aggression from the outside and/or tries to recover from it, as a function of time, is determined by the possibilities of symbolizing or representing the experience. The inability to symbolize the traumatic experience through verbal expression and language excludes the traumatized subject from the world of those who are able to speak and renders integration within the network of mental representations impossible. Social relations and all of the internal and external networks based on that world of internal representations are profoundly disrupted resulting in loss of the ability to relate to self or others.

Stress involves a psychological suffering which persists for as long as the external pressure (strain) lasts; when the ‘stress’ disappears, the membrane or stimulus barrier slowly takes back its previous shape and the system recovers. The internal functioning of the psyche can continue, even in the light of small internal changes which might have occurred due to the losses provoked by the external aggression. On the other hand, trauma leaves – potentially forever – an internal source of disruption, an indigestible strange corpus (corps étranger) within the psyche: this disruption will persist, even when the threat is over. But stress and trauma often go hand in hand: in these cases, there is first the crushing and transforming impact due to the strain from the outside of the membrane, and then the penetration by the strange, disrupting element. In the case of trauma, the protective function of the stimulus barrier fails and is penetrated: the psychic apparatus becomes the subject of an effraction, which literally means break-in or brutal impact. Once penetrated, the psychic apparatus will do everything it can to assimilate or reject the new source of excessive stimuli but these attempts fail. It appears impossible to metabolize the pathogenic nucleus of trauma. On the clinical level, first symptoms of severe stress will appear before the appearance of the repetition syndrome (syndrome de répétition) which may begin much later. In this syndrome, there will always be the re-appearance of the strange nucleus (corps étranger) under its various forms, like a testimony of the effraction of the psychic apparatus.

The hermeneutic aspect of this metaphorical trauma view, which is proposed by the French authors mentioned above (Barrois, 1998; Crocq, 1999, 2001; Lebigot, 2001, 2005), indicates that a potentially traumatizing event, simply called le trauma in French, is experienced subjectively. But what is traumatizing for one survivor, will not necessarily be traumatic for the other. The essence of trauma has to be seen as an encounter between an event and a subject. From this angle of incidence, each event could be seen as potentially traumatizing, but a subject with sufficient defensive resources (i.e. a strong enough stimulus barrier) will be able to formulate an adapted response to it.

4.2. The specificity of psychological traumatization: From the close encounter with death to the repetition syndrome (syndrome de répétition)

Barrois (1998) presented psychological trauma as a disruption in the connection with the external world. The subject is confronted with the unthinkable, namely his own death. This confrontation, for which one can never be fully prepared, triggers a reaction of effroi (frozen fright or dread) in the individual, in which death of the self is announced as the ultimate truth. Trauma is experienced as a disruption in the continuity of one’s existence. And even if we all know that death is the inescapable end for every
human being, we do not have a (mental) representation of death in our psyche. We live our lives as if we all know that we will die, but without believing that this will actually happen. We all know what a dead body is, but we do not know what death in itself is really about. The real cognition of death (I will die) suddenly appears as a consequence of an intimate encounter with death; our own death or the death of another human being who matters to us.

According to this theoretical approach, the psychological trauma response will be an answer, a syndrome of adaptation, to the disruption of the continuity of life: there will also be a disruption between the life prior to the trauma, on the one hand, and the post-trauma life, on the other hand. But in the light of a potentially traumatizing event, not everyone will be traumatized. If the subject can resist/prove resilient and find a way to cope with the confrontation with death and complete the necessary series of survival reactions in the face of the confrontation with the reality of death, the neurobiological symptoms will dissolve and disappear. In the psyche, there will still be a conscious memory of the potentially traumatizing event, but this memory will become less intense and more vague over time. The opposite is also true: when there is no fulfillment or completion of coping with the potentially traumatic event, there will be no final narrative to insert the traumatic memory into the personal life story and symptoms of psychological trauma will tend to coalesce and persist.

As already mentioned, the concept of a repetition syndrome through which the traumatic experience, containing the ‘irrepresentable nucleus’ in the original event, reappears over and over again, still plays an essential role in the clinical work of these influential authors (Andreoli & Damsa, 2005; Barrios, 1998; Crocq, 1999, 2001; Lebigot, 2001, 2005). Symptoms of intrusion are described as repeated involuntary reminiscences with distinct manifestations, expression registers and circumstantial appearances (Crocq, 1999). Beyond the automatic replication of the experience of frozen fright (effroi) and petrification (sidération), this approach also highlights the memory and personality disturbances which often develop after some time (cf. the delayed onset of symptoms as described in DSM) and involves psychological functions which are both complex and independent from the direct effects of overwhelming stress (Crocq, 1999; Crocq, 2002; Lebigot, 2002).

Through the repetition syndrome, these authors describe how the traumatizing event instantly stops or freezes the time in the psyche and installs itself, instantly or after a given amount of time, as a strange object which creates a permanent reiteration of the traumatic experience, accompanied by exactly the same somatosensory and psychological phenomena as those present at the time of the original event. The nature of the alterations in memory and consciousness occurring during the repetition syndrome have been described by Crocq (1999, 2001), and Crocq and De Verbizier (1989) with the use of the concepts of ‘traumatic unconscious (inconscient traumatique)’, dissociation from consciousness and catharsis. These ideas are based on the contributions of classical authors such as Janet (1904), Breuer and Freud (1895) and Freud (1895).

The ‘black hole’ of the traumatic memory is considered as the characteristic trait of posttraumatic pathology. The French psychodynamic authors describe the concept of ‘traumatic unconscious’ as a result from the close encounter with the reality of death (‘réel de la mort’). The experience of perplexity, absurdity and annihilation, which typically appears in clinical descriptions of trauma survivors, constitutes a ‘short circuit’ of symbolic function i.e. the cognitive action responsible for the symbolization of experience is suspended, rendering the subject without words or mental representation of the experience. In this view, psychological traumatization is brought back to disruption in ‘signifiers’ – i.e. the Lacanian concept for meaningful representation carriers, words, which are needed to structure knowledge – due to the sudden confrontation with the unthinkable and the inconceivable. In line with this view, trauma means a disruption between the ‘signified’ (i.e. death) and the ‘signifier’ (i.e. the representation or symbolisation of death in the network of representations in the psyche). What really happens is that the previously symbolic references to death prove insufficient in the face of the réel de la mort which then leaves a break between the signified and the signifier. Thus, the psychological disturbances occurring in the repetition syndrome are not the direct consequences of the stress created by the apperception of an event, but of the psychic impact of this same apperception and its total inconceivable (irrepresentable) or unthinkable aspect. It should be noted that the ‘réel de la mort’ does not exactly equate with the ‘reality of death’ even if that is the closest literal translation available in English. Réel de la mort more specifically refers to a fundamental confrontation with the wordless shadow of life, the ‘nothingness’, the ‘hole’ left by trauma in the current psychological functioning of the stricken subject and the annihilating effect which will continue over time, upon each automatic reiteration of this experience through the repetition compulsion.

These metaphorical French trauma interpretations, influenced by the terminology and the clinical concepts of Freudian and Lacanian psychoanalytic theories, lead to a phenomenological approach which is clinically relevant for the interpretation of trauma-related accounts of survivors. They illustrate the specific meanings and position on stress and trauma concepts in the non-English speaking trauma community (i.e. France, Belgium, Switzerland, Spain, Italy, Portugal and the South-American countries). Clinically, these interpretations may allow us to better understand the accounts of trauma survivors who always repeat the fact that their experience is impossible to express in words while clinicians are always in search for the right therapy protocol or technique which make the expression of trauma-related experiences possible.

5. Discussion and conclusion

The classical and psychodynamic French authors should be credited for their important descriptive clinical contribution to the field of psychological trauma. This article explored how contemporary psychodynamic French authors, inspired by classical psychoanalytical theories, have contributed to a more integrative clinical view on a broad range of terms and concepts used by trauma practitioners in different language groups. A problem with the French terminology is that le trauma (the trauma) is used both as a trauma-eliciting event and as a chronic state of psychological trauma thus conflating cause and origin. Furthermore, these theoretical viewpoints are clinically interesting but should be bridged with the results from empirical research regarding the efficacy of therapeutic treatment programs. This work is still to be done and therefore these insights remain largely unknown to the mainstream Anglo-Saxon literature.

Contemporary French psychodynamic trauma theory separates the clinical pattern of psychological trauma on two distinct levels: the level of posttraumatic symptoms and the level of the underlying personality which creates and sustains the explicit symptoms. The lack of filtration of stimuli, the loss of interest in former activities and emotional withdrawal are in fact only expressions of this alteration of the personality in the wake of a traumatizing event. Instead of focusing on the biological, behavioural and cognitive aspects of psychological trauma, French theories focus on the phenomenological variety and the underlying meaning of trauma symptoms.
One of the weak points in the mainstream Anglophone literature is its considerable variation in terminology, while there is a huge amount of research on the determinants and predictors of (both neurobiological and psychological) pre-, peri- and posttraumatic symptoms. The translation of the empirical results into relevant clinical concepts or therapeutic approaches seems sometimes difficult. In DSM-IV, DSM-IV-TR and DSM-5 (APA, 1994, 2000, 2013), PTSD is essentially approached from a quantitative point of view as defined by a set of symptoms, belonging to different clusters, and by time-related criteria of dysfunction. A bridge toward the psychodynamic trauma interpretation was previously perceived in the split of the stressor criterion of PTSD into two parts (in DSM-IV-TR); Criterion A1 and Criterion A2. Criterion A1 referred to the objective elements of the trauma (e.g., physical threat of the event to self and others), and Criterion A2 related to the subjective components (e.g., the individual’s response): intense fear, helplessness, and/or horror (APA, 1994; 2000) but this potential crosswalk between theoretical approaches has been lost following the redefinition of the Stresstor Criterion in DSM-5. The subjective aspect of the trauma diagnosis, focusing on the meaning that a potentially event had for its survivor, could still receive more attention since recovering from trauma should not only be reduced to showing less symptoms or a reduction in the intensity (severity) of the trauma symptoms listed in the typical symptom clusters. The phenomenon of the trauma, as it appears in the psychodynamic trauma theories exposed in this article, insists on the adaptive ability to reach a level of integration of the traumatic experience into one’s psychic existence by transforming the ‘traumatizing experience’ into a narrative, accompanied by a catharsis of affects and the cessation of the compulsive repetition syndrome (‘syndrome de répétition’). This is in line with the opinion of Van der Hart, Nijenhuis, & Steele (2006) who consider failed integration on the perceptual, cognitive and somatic levels as essential features of psychological trauma and of Krystal (1988) who described psychological trauma in terms of alexithymia.

The psychodynamic (French) trauma theories, exposed in this article, may lead clinicians to a better understanding of the accounts of trauma survivors and offer insights which go beyond the descriptive approach of psychological trauma in the diagnostic nomenclature.

It would be meaningful to integrate these different approaches within a more holistic trauma view and bridge the gap between the quantitative (empirical) trauma approach, on the one hand, and more qualitative (clinical) interpretations, on the other hand. There should also be a search for a more restrictive terminology in the field of psychotraumatology, aiming at what psychological trauma really is: a close encounter with the inconceivable, the irrepresentable, which leads to a loss of integration of the various levels of the personality.

DSM-5 (APA, 2013) lists symptoms which are essentially applicable in the stress and HPA-activation paradigm, while the persisting symptoms of trauma survivors appear to be of psychodynamic origin. In the light of the contemporary psychodynamic theories, the following question might be raised: Should the new stressor criterion of DSM V, i.e. the exposure to actual or threatened death, serious injury or sexual violation, remain in the definition of PTSD? The current nosography of posttraumatic stress disorder suffers from a lack of conceptual richness or of words which fit with the actual experience of trauma survivors. While the psychodynamic interpretation of psychological trauma might be the unspeakable experience of the confrontation with the ‘reality of death’, a confrontation with an aspect of life which one cannot fully integrate, associated with manifest neurobiological correlates and a typical constellation of stress and anxiety symptoms. Therefore, from a classical hermeneutical and clinical point of view, it would make more sense to broaden the A2 criterion for PTSD instead of eliminating it from the set of diagnostic criteria. The scientific evidence in neurosciences and behavioural sciences which have appeared over the past two decades, should make it possible to bridge the phenomenological and psychodynamic description of trauma with DSM-5 criteria: intrusion symptoms, persistent avoidance, negative alternations in cognitions and mood, alteration in arousal and reactivity, duration of these symptoms and the distress or impairment in social, occupational, or other important areas of functioning. The increase of cross cultural and ‘cross conceptual’ research, in a context of global integration of trauma societies, will hopefully lead to the development and further improvement of evidence-based clinical treatment for trauma survivors which should show more respect for cultural and transglobal diversity.

Disclosure of interest

The author declares that he has no competing interest.

References


