

Trauma, Autobiographical Sharing and the Experience of Time¹

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PART 1: Trauma and acknowledging/witnessing truth

You have stolen my ocean, my swiftness, my soar,

Delivered me to the clutch of uprupturing earth

And for what?

The mouth still moves though the man cannot.

- Osip Mandelstam

All extreme trauma survivors share this experience of being unrecognized...disbelieved. We therapists know it as "failed witnessing," what Ferenczi (1932) called the "double shock;" (p. 182) the child is betrayed by the parent, who then rejects and repudiates his/her attempt to bring this betrayal to the parent's attention.

In my preparation for this paper (which is actually part of a series of papers), I read Primo Levi's book, *The Drowned and the Saved* (1989) in which he describes the despair of the concentration camp inmates, their fear that they would not be

¹ This paper is a part of a series of papers based upon my IFPE presentations over the past few years and my experiences in IFPE's Autobiographical Dialogues moderated by Gersh Molad and Judy Vida. If the reader would like a copy of the full paper, it is available upon request.

believed, and their hope it might be otherwise. Virtually all described recurrent dreams with the same theme,

... "they had returned home, and with passion and relief were describing their past sufferings, addressing themselves to a loved one, and were not believed, indeed, were not even listened to. In the most typical (and cruelest) form, the interlocutor turned and left in silence." (1989, pg. 12).

No one could bear their truth.

Despite obvious differences between the experiences of survivors of mass atrocities and survivors of extreme early family trauma, all are continually re-traumatized by being disbelieved—incarcerated alone in unbearable anguish. With each experience of failed witnessing, their shame and isolation is compounded by the anticipation of further disbelief the next time their truth is broached.

Both Gerson (2007) and Benjamin (2015) stress the importance of speaking one's truth in the aftermath of atrocity. "Psychological survival requires that the impossibility of life be spoken" (Gerson, 2007, p. 14). To paraphrase Gerson, for the survivor of extreme family trauma, psychological survival depends on speaking their inconceivable truth.

As therapists, there are many possible impediments to our ability to hear our patients' truth, as well as our own (Searles,1975; Miller, 2005). I'd like to consider a few of them.

The survivor of extreme early family trauma cannot speak a truth of that they cannot even conceive! The "truth" in my own family, for instance, was inconceivable. (I don't mean inconceivably bad or terrible which it certainly was)...It was not knowable; the truth completely eluded me. ...Too terrible to be known. The perpetrators of such trauma, our parents, were those we loved beyond words, but at whose hands we suffered what Dubois (2015) calls "developmental death" Living in a state of daily terror and annihilation precludes thought and reflection. My mind was not my own.

Our most traumatized patients come to us not knowing their truth....I could not recognize, until after my parents had died several years ago (and despite years of my own therapy with several analysts since age 18), that I had been sexually abused by my father, with my mother's collusion from early childhood. I had to come to my own realization that my parents, whom I had still continued to idealize somewhat over years, were actually narcissistic sociopaths, and that, as an unconscious act of loyalty to them, I had given up my own creativity, my ability to think, and, my writing in particular. I refer to this period of my life as my free-fall like the opening

credits of "Mad Men," the popular television show, falling through space as everything around me collapsed.

The survivor of early family trauma requires the ongoing experience of witnessing his or her inconceivable truth (to be believed with love, compassion deep understanding and insight), an experience extending over years. These qualities create a safe-enough "relational home" (R. Stolorow, 2007, p. 9; with the other for both the initial registration of trauma, holding, and the metabolizing-over-a-lifetime... Mourning. I want to underline the words' initial registration. To order to witness such inconceivable truth in their patients, therapists must have the capacity to face such truth in their own lives as well as in their patients' lives. The extent of her trauma is most often entirely unconscious and embodied. First, there must be recognition on the part of the therapist of the possibility of murderous or parasitic parents; secondly, the terror and betrayal endured by the trauma survivor must be received "without recoil" (Gerson, 2007, p. 19). Otherwise, the inconceivable truth cannot emerge.

In *The Prisoners of Childhood* (1979), Alice Miller developed the thesis that therapists hone empathic skill as children in their relationships with their vulnerable parents. Atwood (2012) emphasizes that our job now is to help patients find their truth, not to remove pain as we may have done as children for our parents. In fact,

the truth may be more painful, but necessary. Atwood cautions that dangerous unconscious collusions will inevitably occur between therapist and patient, in the service of lessening both patient's and therapist's pain, but avoiding the truth. When this collusion does occur, neither the patient nor the therapist will be able to perceive/experience the catastrophe such a patient has barely survived. When failed by a therapist in this way, a patient is sentenced to years, if not decades, alone in a hell of self-hatred, terror, and self-blame.

As therapists, we need an acutely-honed sensitivity to the unconscious meanings of the experience of trauma survivors. For example, psychic agony is often dissociated and embodied in chronic illness and fatigue, body pain, eating disorders, and other forms of self-injury. The patient's lifelong terror may be represented by states of constant dread, panic, and preoccupation with death, or, the terror may lie buried under workaholism as well as alcohol and/or substance use. We need to see our patients' shame and self-blame as an aspect of what Atwood (2012) calls profound annihilation states. We need to recognize our patients' relentless experience of isolation, alienation, of not belonging anywhere. We need to understand that the extreme trauma survivors' idealization of their parents may be the enslavement to a lie, an aspect of what Dubois (2014) calls "family terrorism." We need to see that a mind, body and spirit which have been appropriated, a mind not recognized as one's own, but colonized from birth (Silverman, 2015), represents Dubois' (2015)

"developmental death." States of panic and terror about present and/or imminent breakdown need to be seen as evidence of a psychic near-death already survived, but unknowable in childhood (Winnicott, 1974).

Severe family trauma patients are particularly vulnerable to a therapist's unconscious projections, since their very survival as a child was dependent on absorbing their parent's projections (Zinner and Shapiro, 1972). For example, these patients readily and unconsciously volunteer to be the "sick" one or the "angry" one in relation to the therapist, deeply uncomfortable with their own disturbing emotions and disavowed vulnerability. This seems a repetition of their enslavement as a child and a hoping that this servitude might be seen and understood by the therapist. A family trauma survivor must internalize the projections of all significant others in order to survive. We, as therapists, are more likely to project when unaware of the extent of our own trauma and/or shame (and related omnipotence) as wounded healers. Such a survivor, who also surrendered their individuality, their creativity, their mind, in their efforts to heal their parents, will inevitably repeat this pattern with the therapist; they will unconsciously offer themselves to the point of perilous depletion in an effort to heal the therapist (Searles, 1975).

Very importantly, Searles, in his paper, "The Patient as Therapist to his Therapist" (1975) sees the child's efforts to heal a parent, and the vicissitudes in these efforts

(e.g., severe frustration, no acknowledgement, blame and rejection) as the most significant factor in psychological trouble of all kinds, and a key hidden issue in therapy impasses.

Christopher Bollas (1987) describes an unconscious process, which he sees as complementary to projective identification between parent and child, in which the parent takes, or appropriates for their own use, important aspects of the child's mind. Bollas calls this process "extractive identification" (p. 158). Searles' emphasis on what is "offered" by the child unconsciously in the interest of healing a parent, both the introjection of the parent's illness as well as giving via projection of the healthy aspects of the child's mind (so they might be better able to parent the child), may well occur alongside the more aggressive stealing process described by Bollas.

I also want to consider the effect of our Western-cultural beliefs. In *The Body Never Lies* (2005), Alice Miller describes the powerful Judeo-Christian ethic, embedded in Western culture, to love and honor our parents without question, which she believes undermines our ability to perceive our individual truth. For Miller, a therapist or a patient under the spell of these cultural strictures, cannot see their own or our trauma because to do so would be an unconscionable act of disloyalty to their/our parents. The survivor of early family trauma inevitably blames herself (as other

family members also often do) in order to spare their parents. A child can much more readily accept that she is inherently evil than that she is surrounded by evil, emanating from her parents (Fairbairn, 1952). By continuing to idealize her parents, the trauma survivor sacrifices the chance to know her truth, and thus reclaim her life. Idealization of parents alongside symptoms of trauma such as those described above is very likely indicative of a person who has been enslaved to "love" their parent by totally surrendering any claim on a mind or body of their own, or to be loved for themselves.

In *The Body Never Lies* (2005), Miller attributes her own ability to experience her truth more deeply in mid-life to having been in treatment with an analyst that was freed of the "love and honor thy parents" injunction. At a recent case conference I attended, a senior analyst said she "wasn't accustomed to thinking of parents as monsters," a profound example of Alice Miller's thesis.

A further obstacle to the therapist's ability to witness her patient's trauma is discussed by Jessica Benjamin in her essay, "The Discarded and the Dignified" (2014). Although Benjamin is addressing geopolitical trauma, her observations are pertinent here as well. She explores the psychological conditions that both enhance and undermine our ability to witness trauma. She identifies unconscious splitting whereby we render ourselves safe by appropriating the illusion of being better, not-

so-damaged, better-analyzed, while effectively othering and pathologizing the suffering person by projecting our own unbearable "not-me" experience into them. This splitting process precludes any possibility of identification with the sufferer, according to Benjamin, which is the basis of empathy. Splitting, then, inevitably results in failed witnessing in her view.

Benjamin suggests the concept of the moral third as a means of holding both sides of this good/bad split, provides "acknowledgement of violation by those who serve as witnesses ...by expressing condemnation and indignation over injustice and injury, trauma and agony endured by the victims" (2014, Part 3, pg. 1) whereby this suffering is dignified. In treating the trauma survivor, we must be mindful of the inevitability of splitting; of course, this happens among us as colleagues and friends as well. I would like to emphasize the need for a particular sensitivity to our vulnerability to splitting, as therapists with our own trauma histories, in light of the trauma survivor's family history of internalizing and embodying whatever splits were required for their parent's equilibrium.

I would also like to speak about a related topic, mourning our "lost childhood." Psychoanalysts such as Searles and Atwood, who've devoted their life work to treating severely-abused patients, emphasize the inevitability of significant trauma in all our backgrounds, deserving of a lifetime of reflection and mourning. Atwood

(2012) describes two likely childhood traumas (most often in reality a mixture of both, I expect) that co-opt our childhoods, and compel us to become therapists as adults. One is effectively a role-reversal in which we care for a chronically-depressed parent, as I tried to do for my mother; in the second, we suffer a very significant sudden loss of a parent through death, illness, or other serious disappointment wherein we cope by identification with the idealized lost parent, perhaps providing our family what we imagine that parent might have furnished. Atwood sees this idealization and identification in lieu of mourning as problematic.

I think it is potentially disastrous for us all, patient and therapist alike when the depths of the losses initiated at our parents' hands is not being continually plumbed. Our "lost childhood" must be dwelt in, recognized by others, and mourned over a lifetime. The monstrous nature of what has happened to us during our childhoods (as survivors of extreme early trauma), as well as what has not happened in the form of love and parental devotion must be recognized (witnessed) and grieved. A therapist who isn't actively engaged in this work of mourning his own losses, or who has become defensively-stalled in a more palatable narrative, will have limited ability to help similarly traumatized patients; they may unconsciously sabotage the work with their own denial, projections and blame of the patient. Further. I certainly hope the reader has understood that, for the trauma survivor, speaking her inconceivable truth is also the most dangerous thing of all, but when

spoken to, and heard by, an empathic witness, it's also a transformative event in the arduous process of reclaiming her life.

PART II: Immersion in the subjective world of trauma

All journeys have secret destinations of which the traveler is unaware.

- Martin Buber

Today is all black, little yellow hell

Pecking, pecking at my stone brain....

Black warships inching distance as through oil.

Black wakes like waves of sound that never sounded.

And here between the boat slips, icy emaciations

Past blackness somehow, the color of plummet...

- Osip Mandelstam

1. Terror

Terror is a word not often heard in case consultations, nor is it often written about although there are important exceptions (e.g., Atwood, 2012; Dubois, 2015).

Winnicott, using extreme language in order to match the extremity of the experience he addresses and referred to severe traumatic circumstances in childhood as "primitive agonies" (1974, p. 103). When we speak to one another as therapists about traumatized patients or, when we speak to them directly using a less dramatic

language, we refer to "anxiety," for example rather than to "terror," we may have failed to understand, and this empathic failure may in turn result in an unseen abandonment of the patient. One aspect of this emotional desertion rests in the impossibility of our patient ever being able to "know the terrible things" without our deeply-felt presence. Another feature of the abandonment pertains to the patient's utter aloneness, which so often has been life-long, and that is extended unbearably by such an unseen empathic rupture.

A patient whose present experience of dread is engulfing, may be confusing feelings which are rooted in childhood disaster for present or imminently-felt catastrophe, including a fear of breakdown, death, and/or illness. An understanding of this fusion of past and present is of critical importance in our clinical work.

Just as my analyst and friends have been vigilant about reminding me regularly that I am always, and already, in the grip of Susie's world (shorthand for my childhood experience), so too must we remind our patients about the grip of their childhood traumas upon them. I can now speak gently to Susie, remind her that she belongs on the planet, she has a right to be alive, and she is safe and loved now in the present.

There will invariably be somatic signs of terror in the form of a hyper-aroused autonomic nervous system, which requires attention. I have a yoga and meditation practice and pranayama (breathing exercises) that help address these issues. Like many who have suffered trauma, I have regularly had a symptom of breathlessness that I have come to understand as related to variations on the theme of "Do I have a right to be alive?" Trauma survivors are in a battle for life itself. Another symptom, not being able to think or speak clearly, has been understood as also connected with terror, with aspects of what Dubois (2015) refers to as "family terrorism."

2. Alienation, Isolation, and Aloneness

In addition to terror, the trauma survivor's daily experience is enshrouded in multiple, unseen, and inchoate experiences of alienation, isolation and aloneness. George Atwood and Robert Stolorow write movingly and brilliantly about the centrality and depth of these emotions for the trauma patient. In *Trauma and Human Existence* (2007), Stolorow says there is

"(A) profound despair about having one's experience be understood which lies at the heart of emotional trauma" (p. 15); he continues, "I was certain that the horizons of their experience could never encompass mine, and this conviction was the source of my alienation and solitude, of the unbridgeable gulf separating me from their understanding. It is not just that the

traumatized ones and the normals live in different worlds; it is that these discrepant worlds are felt to be essentially and ineradicably incommensurable." (p.15)

He highlights the "shattering of the absolutisms of everyday life," such as the belief that partners have that they will see one another in the morning, or love one another forever, the things we take for granted and find necessary to carry on with life. He continues, "it is in the essence of emotional trauma that it shatters these absolutisms, a catastrophic loss of innocence that permanently alters one's sense of being-in-the-world. Massive deconstruction of the absolutisms of everyday life exposes the inescapable contingency of existence in a universe that is random and unpredictable, and in which no safety or continuity of being can be assured. Trauma thereby exposes the 'unbearable embeddedness of being'" (Stolorow and Atwood, 1992, p. 22). As a result, "the traumatized person cannot help but perceive aspects of existence that lie well outside the absolutized horizons of normal everydayness. It is in this sense that the worlds of traumatized persons are fundamentally incommensurable with those of others, the deep chasm in which an anguished sense of estrangement and solitude takes form" (Stolorow, 2007, p.16).

The vast differences between an adult and a small child exposed to trauma often comes down to the fact that the suffering is at the hands of the very people the

child needs and with whom the child should feel safe, and from whom there is no possibility of receiving reliable care. Where Stolorow states the traumatized person "cannot help but *perceive* aspects of existence that lie well outside the absolutized horizons of normal everydayness," (2007, p. 16) the child is engulfed by such aberrations. This attack on a child's innocence is unfathomable. What life-long impact will it have if these absolutisms of "normal everydayness" can never form in the first place?

In his book, *The Abyss of Madness*, Atwood (2012) writes regarding "the theme of infinite isolation...the loneliness of the trauma victim is of the most extreme kind that one can imagine. It has as its essential feature that it is felt as absolute, never to be relieved. The loneliness is cosmic, rather than terrestrial. It extends through the universe, and seems to the person suffering it, to be eternal. It is not conceivable that it can ever be addressed, diminished, soothed, or escaped. It is damnation" (pp. 128-129).

3. Trauma's Decimation of Temporality

I will touch upon the relationship of trauma and time briefly in this section and at length in the final section of this paper that focuses on the aspect of time. For now, I will just note that family trauma decimates the person's sense of time or temporality. Trauma's impact on temporality is considered by Stolorow to be

another aspect of the shattering of "what is needed to experience ones world as safe, stable and predictable" and therefore a further elaboration of the abject alienation of the traumatized persons experiential world.... The "breaking up of the unifying thread of temporality"...a sense of continuity over time from birth to death, unifying the 3-dimensions of past, present and future (2007, p. 20).

The trauma patient's subjective experience often includes a sense of there being an impending, imminent disaster. This distortion in the experience of time is understood brilliantly by Winnicott in his paper "Fear of Breakdown" (1974) as a catastrophe from the patient's childhood that she couldn't know, but has barely survived. The loss, sustained then, needs to be experienced now, with a therapist capable of receiving and holding this trauma along with the patient, and then in helping metabolize and integrate it, mourning all the implications and related losses that followed from the original trauma. This apparent paradox of then and now, related to the patient's experience of time, is critical for the therapist and patient to understand.

4. A Child has been Murdered

Severe childhood trauma often includes a sense of having been killed or otherwise of having died. This is an emotional death, a killing off of innocence, and it brings about the loss of the capacity to hope for a better future. The murder of the child

means the end of all feeling of going-on-being (Winnicott, 1960), and may obliterate the experience of the mine-ness of mind and body. If the analyst fails to empathically grasp the felt-finality of this killing, there is little hope for a healing therapeutic bond to form.

5. Denial of Death and the Illusion about Childhood Possibilities Restored

One of the unconscious ways a survivor of early family trauma has attempted to bear what has happened is a subtle denial of death, which makes possible a related and likely unconscious illusion about redoing childhood. There is a strange faith that there will always be time available to undo the losses of the past. This precludes or obstructs the necessary mourning process that makes possible the vital engagement with life's creative possibilities that remain in the present. This illusion about lost childhood possibilities being restored (perhaps by the therapist) are unseen and may undergird collusions to avoid facing the grim truths of their (our) lives, both the therapist's and the patient's.

6. Invalidation, Erasure of Subjectivity, and the Erasure of the Erasure

Failed witnessing and the devastating, re-traumatizing effects of not being believed are critical themes when discussing trauma. Ferenczi (1932) writes about the "double shock" (p. 182) suffered in childhood wherein the child is first neglected and abused, unseen in their distress, and, secondly, the child's attempt to alert the parent is

rebuffed, rejected, and often the child is blamed. In my experience both personal and professional, these traumas can be followed by the triple shock effect of a therapists' failures to hear, believe, and hold the possibility of a annihilating trauma in their patient's early life. If the therapist cannot hold this possibility long enough, the patients may not begin to "know the terrible things" that have befallen them. It is this latter capacity" to hold the possibility of annihilating trauma in their patient's early life that Winnicott discusses in his paper *Fear of Breakdown* (1974) as a foundational element for the therapist seeking to accompany her patient into her "primitive agonies" (p. 103).

As I am able to settle further into the relational home my present analyst and I have made possible, a foundation of trust has been established between us whereby I can journey further into my own "knowing of the terrible things." The "inconceivable truth" that my sole reason for being was to meet all my parents' needs is fully believed without reservation, allowing for a thorough and searching exploration of these needs and the results of such a profound eradication of birthright, the love and protection of parents devoted to nurturing my/our going-on-being. My very personhood was stolen, and those generative possibilities supplanted by a toxic sense of myself as the "selfish thief", as bad, repulsive, and to blame for all family difficulties. One of the most devastating consequences of such identity erasures for

me alongside other trauma survivors is that the reality of the losses itself is also erased along with subjective experience of the self.

Mourning cannot take place in a vacuum without a sense of this reality; my parents' erasures have been memorialized by one of my own symptoms (never before appreciated as a symptom of trauma) of ongoing memory problems, and my continued questioning of my perceptions and truths, a well-known problem of family trauma survivors. In response to the obstruction of mourning just mentioned, my analyst encourages me to "stay with the violence of the erasure, and the double violence of the erasure of the erasure -- if we do this, the mourning will come."

THE NARCISSISTIC ANALYST

Narcissistically-impaired therapists who are caught in a ravenous need for affirmation of the corrective emotional experience they believe that they are offering, cannot face the despair and rage inevitably connected with the end of childhood, either for their patient, or for themselves. The betrayals of childhood for them both are absolute and done. Childhood is over. There may often be a shared, unconscious fantasy/delusion of re-parenting to avoid the agony of grief, the therapist "rescuing" the patient, needing to dispel her patient's pain. This is passed along inter-generationally from analyst to patient, and analyst to analyst. The fantasy that childhood is still a possibility led to a devastating re-enactment in my treatment

of my childhood experience, in which I was hated and loathed although this was completely denied. My subjective experience was continually attacked, and the narcissistic practitioner attempted to supplant my truths with the therapist's reality, and then, after doing so, implicitly blaming me for not "recovering." I had to finally leave that "treatment" relationship, initially believing that the failure was my own. Of course, this was exactly as I had left home, believing all my difficulties were my fault alone.

As is expected where a therapist cannot hold the patient's early trauma of annihilation experience, nothing of the catastrophe of my early life was ever seen, including its reenactment via my slavish devotion to meeting the analyst's needs above all, and what this meant for me as repetition of my early family life. What occurs then is a complete failure to recognize the annihilating and murderous circumstances of the patient's early life, the associated costs to psychic development, and collusive use of the patient to avoid their own grief. This is commonly-seen treatment impasse, sometimes lasting decades in which the patient is literally unable to leave, even when that patient hasn't been helped to see the repetition, let alone the original trauma. At such times, the traumatized patient blames himself and is repudiated by the therapist (Searles, 1975). Dubois (2015b) echoes these observations in a paper on the tragic "mismatch" between early family trauma survivors and narcissistic therapists.

Dori Laub (2005), in an article entitled "Traumatic Shutdown of Narrative and Symbolization," reflects on the difficulties, 30 years earlier, a training analyst and his supervisor had had in hearing the deepest concerns of his first control case. The phrase "traumatic shutdown" refers to the profound, unconscious unavailability he sees now, retrospectively, in both the analyst and his supervisor based on their own unaddressed trauma. Such a shutdown, which I believe is not an uncommon occurrence in the treatments of trauma survivors, impeded his capacity to explore widely and deeply with his patient, and collapsed symbolic play, among other problems. Laub does not mention the candidate's analyst in this article, and the important role s/he might have played in colluding with this blindness, or, under very different circumstances, how she might have helped both Laub, his patient, and his supervisor. Such assistance, rather than the collusion he describes, would surely have altered the course of the analyst's and his patient's work together, and hence, the quality of both their lives.

An important problem not explored by Laub is the predominance of concrete thinking for any therapist in the grip of a traumatic shutdown. This severely hampers his/her serious creative play with the metaphoric meanings of a patient's symptoms.

Searles' paper, "Efforts to Drive the Other Crazy" (1965), has been so important in validating some of the familial origins of my own psychic troubles, as well as

impossible and dangerous limitations in two of my own previous treatments. For Searles, one important protective measure for us as therapists in this regard is to be engaged in ongoing vigilance and study of our own use of reaction formation in our work, which he cites as a frequent and elusive defense of those with obsessive-compulsive characters. His interest in the connections between our early life, the origins of this defense, and this choice of profession is clear in this paper as well as in "The Therapist as Therapist to his Analyst "(1975). Here, he is particularly interested in the notion that a common underlying problem in patients' early-life histories (our histories!) as well as in therapy impasses is the patient's unacknowledged, and perhaps spurned efforts to heal something in the therapist, a spurned "gift" from the patient.

Atwood (2012) writes,

"The analyst is captive to his mother and/or father, in the sense that he or she, unconsciously, is always drawn to alleviating the parents' (and patients') pain, and the grip of this mission is an imprisoning death camp for the analyst's soul. If the child, fated to become a psychotherapist later in life, breaks away from the role of soothing and otherwise supporting the parent, he or she catapults the parent into an agony state, and is attacked or emotionally abandoned. This theme then plays out in the psychotherapy practice, where the real power of analysis - to address the truth of a life -

becomes subverted by the ancient agenda of relieving parental pain. All kinds of collusions and evasions then begin to structure the analytic dialogue, defeating its potential to achieve its most important goals." (2012, pp. 116-117).

SOMATIZATION AND SYMBOLIZATION

Several psychoanalytic writers have emphasized the devastating consequences to physical health of early family trauma, including Ferenczi (1929), Krystal (1974), Miller (2005) and Winnicott (1974). In his paper, "Fear of Breakdown," Winnicott mentions several "primitive agonies," (p. 103) or annihilation states, manifested by patients surviving childhood trauma such as "falling forever," "loss of the sense of real," and the disconnection of mind and body, which he calls a "loss of psychosomatic collusion, a failure of indwelling" (p. 103). While he does not elaborate further here, we might speculate that his fear of breakdown idea, extended somewhat elliptically to the fear of death, and experiences of non-being, might also be pertinent to similar fears and preoccupations regarding physical illness and disease, chronic fatigue and body pain. This possibility would be worthy of further study and writing.

Ferenczi (1929), in a paper entitled "The Unwelcome Child and His Death Instinct," described the susceptibility to poor health and "aversion to life" typical of children who "had observed the conscious and unconscious signs of aversion or impatience

on the part of the mother, and that their desire to live had been weakened by these. In later life, relatively slight occasions were then sufficient motivation for a desire to die, even if this was resisted by a strong will to live" (p. 104). Ferenczi goes on to emphasize that "the child has to be induced by an immense expenditure of love, tenderness and care to forgive his parents for having brought him into the world without any intention on his part; otherwise the destructive urges begin to stir immediately. And this is not really surprising, since the infant is still much closer to individual nonbeing... slipping back into this nonbeing might therefore come more easily to children" (p. 105).

In Alice Miller's book, *The Body Never Lies* (2005), she articulates her thesis that therapists under the unconscious influence of the Judeo-Christian ethic to love and honor parents, would be unable to help their patients find the truth of their traumatic childhood experience vis-a-vis their parents, and that such therapists would, for the same reason, be unable to tell their own life story. Miller cites as examples a number of well-known writers in the 19th and 20th centuries with significant family trauma who developed various life-threatening physical illnesses, as if they would sooner perish not knowing their truth, than be disloyal to their parents.

Children subjected to protracted early family trauma almost invariably develop a variety of somatic symptoms since none of their emotions is validated, and any expression of emotion is usually dangerous. As a consequence, a critically-important focus for the therapist is his/her immersion in which the symbolic meanings of these experiences are thoroughly explored. As analysts we must search for the unseen significance of pain, fatigue, breathlessness, blurred vision, migraine headache, immunologic collapse, dysmenorrhea etc. This is the path of transmuting somatic symptoms into emotional truth. As mentioned earlier, the therapist's own traumatic shutdown, manifested in concrete thinking regarding these symptoms, precludes or truncates this journey.

THE NEED FOR COMMUNITY

"We wish to believe that life can be enabled, and even vitalized by bringing the deadliness up from the netherworld in which it is neither buried nor fully alive. And that this painful reckoning could alter the endless immersion in the half-life of a stillborn existence where life is attempted, desired even, but is missing some essential property that would imbue activity with the potential for growth... We have all come to recognize that the most basic necessity for psychic aliveness in the aftermath of atrocity is the active witnessing presence of an other" (Gerson, 2007, p. 14-17).

In this same paper (2007), Gerson writes about his understanding of the essence of Primo Levi's poem, "Unfinished Business," that, "Psychological survival requires that the impossibility of life be spoken" (p.14). For Gerson, this 'active witnessing presence' is required for both the initial "registration" of trauma, as well as for the lifelong mourning process. One critical element of witnessing is the ability to receive "without recoil." A colleague of Gerson's in London, reporting on an interview she had conducted with an aid worker regarding her work with newly-released inmates from concentration camps, stated that "the act of rocking together and receiving their pain without recoil (*italics added*) was essential" (p.19). In trauma therapy, the inevitable moments of recoil whatever their form, must be non-defensively acknowledged and repaired.

PART III: Reflections on the Impact of Trauma on Our Experience of Time²

"You have stolen my ocean, my swiftiness, my soar...."

-O. Mandelstam³

² **Based on my IFPE 2017 conference presentation**

³ The latest translation of Osip Mandelstam's poetry is titled *Stolen Air*. Since I have been exploring over many months in my therapy the meanings of my own experience of breathlessness, alongside all the other things stolen from me over decades, this title, *Stolen Air*, spoke to me.

In this final section of my paper, I want to explore the complex interplay between trauma and our experience of time. Extreme family trauma leaves the survivor with an "inconceivable truth" (Burland, 2015), and what Dubois calls "trauma of the unimaginable" (2016): I am speaking of the loss, the theft of birthrights such as love, protection, innocence and safety. Trauma ravages the experience of time. One is haunted and held captive by the constant, savage, and invisible force and swirl of the past invading all present and future experience. Although sometimes difficult to perceive, and even more challenging to experience, we as therapists must see this "time distortion" that our patients experience. Failure to do so, and to dwell deeply, dooms them.

G. Atwood (2012) writes, "The loneliness of the trauma victim is of the most extreme kind that one can imagine. It has as its essential feature that it is felt as absolute, never to be relieved. The loneliness is cosmic, rather than terrestrial. It extends through the universe, and seems to the person suffering it, to be eternal. It is not conceivable that it can ever be addressed, diminished, soothed, or escaped. It is damnation." (p. 128-129)

D.W. Winnicott, in his seminal paper, *Fear of Breakdown* (1974), described how one's fear of an imminent psychological catastrophe may embody a memory of traumatic emotional disaster from long ago, which is projected into the future. I will discuss

Winnicott's idea, and extend his understanding to other disturbances of time experience:

"This past and future thing then becomes a matter of the here and now, and become experienced by the patient for the first time" (p. 104).

Referring, in *Fear of Breakdown*, to the failure of a defense organization, Winnicott states, "...We need to use the word 'breakdown' to describe the unthinkable state of affairs that underlies the defense organization (emphasis added)...It is a breakdown of the establishment of the unit self that is indicated" (Winnicott, pg. 103). He goes on to list several unbearable early states-of-being which he names '**primitive agonies**' (emphasis added), specifically stating, "anxiety is not a strong enough word here" (p. 104). In his list of primitive agonies, Winnicott includes:

- A. Returning to an unintegrated state...
- B. Falling forever...
- C. Loss of psychosomatic collusion; failure of indwelling...
- D. Loss of the sense of real...

Winnicott describes the elements of a fear of breakdown, and its concomitant agonies as follows:

1. "Clinical fear of breakdown is the fear of a breakdown that has already [occurred]. A fear of the original agony that caused the defense organization the patient displays... There are moments when a patient needs to be told that the breakdown, a fear of which destroys his life, has already been" (p. 104).

2. "...The patient needs to 'remember' (the catastrophe) near the beginning of his life but it is not possible to 'remember' something that has not yet happened, and this thing of the past has not yet happened, because the patient was not there for it to happen to... this past and future thing then becomes a matter of the here and now, and becomes experienced by the patient for the first time" (p. 105).

3. "If the patient can accept this queer kind of truth, that what is not yet experienced did nevertheless happen in the past, then the way is open for the agony to be experienced in the transference... All this is very difficult, time-consuming... but not futile. What is futile is the alternative" (p. 105).

Winnicott goes on to apply these thoughts to the fear of death, suicidal ideation, as well as the experience of emptiness and non-existence. I would add that such matters are also linked to physical illnesses and disease, chronic fatigue and body pain, as well as to a preoccupation with immunological difficulties including autoimmune disease.

This posthumously-published paper by Winnicott is important in several ways. First, he apprehends the heart of the trouble for trauma patients, which lies in the original "agony," the unseen shattering of the "unit self," or more likely, the unseen protracted annihilation experience with care-givers that allowed minimal development of a unit self. He appreciates the absolute necessity of the false-self adaptation for earlier survival, while wasting no time getting to the underlying "unthinkable state of affairs." To do otherwise, to avoid or erase, for Winnicott, would be "futile" (p.105). There would seem to be an implicit awareness in this way of working, that the only greater agony for such patients would be the betrayal that results when such wounds remain unrecognized by the clinician (as I described in previous sections of this paper).

While Winnicott clearly understands that "anxiety is not a strong enough word here" (p. 103) for what he correctly names "primitive agonies," he still seems to under emphasize this point when he uses the term "fear" in his title, *Fear of Breakdown*. In my opinion, the word "terror" seems more apt than "fear" and more consistent with an underlying "agony" which he describes as "unthinkable."

TIME DISTORTION

In addition to his critical appreciation of the "agonies" at the heart of early annihilation experiences, the more subtle contributions of this work lie in Winnicott's

appreciation of the complex distortions in the traumatized person's experience of time. An emotional catastrophe from long ago, experienced as a present and/or imminent event, is already ruining the patient's life, and is threatening to ruin his or her life forevermore.

This paradoxical 'past and future thing' points again to the minimal development or obliteration of a nascent self-experience, to an arrest in any further development of the patient's "unit self." This would include the disruption of the sense of going-on-being, and such a disruption collapses past, present, and future. Such catastrophe can only emerge into the past tense as a memory—through the painstaking, abiding emotional dwelling of the clinician, in the present tense over a long period of time. The profound disturbance in the sense of temporality, Winnicott describes can create an unbearable "eternal now" (Atwood, 2012, p. 12) for the patient. If the analyst herself cannot recognize the meaning of these preoccupations with imminent disaster, the therapeutic dialogue is subverted, and the stage is set for the inevitable re-traumatization of the patient, who "must go on fearing to find what is being compulsively looked for in the future" (Winnicott, p. 104).

My own interest in Winnicott's "Fear of Breakdown" is deeply personal. I find myself suddenly in the grip of, or even a stranglehold, of an "agony" or terror which feels unequivocally about now, casting a hopeless despair over my future, until I can right

myself, and experience that temporarily-paralyzing affect as a flashback-into-the-future belonging to the terror of my early days. This work is often a daily practice both for myself and with my patients until they, too, can right themselves.

TRAUMA AND TEMPORALITY: Absence of an abiding sense of "I am"

Severe childhood trauma often includes a sense of having been killed or otherwise of having died. This is an emotional death, a killing off of innocence, and it brings about the loss of the capacity to hope for a better future. The murder of the child means the end of all feeling of going-on-being (Winnicott,1960), and obliterates the possibility of the essential experience of mine-ness of mind and body.

Clare Winnicott (Winnicott,1980) published a report of a treatment illustrating her husband's ideas from Fear of Breakdown. Her patient is a 40-year-old musician suffering from a persistent amnesia. Two dreams from this treatment highlight the centrality of D.W. Winnicott's ideas. The first dream mentioned by the musician patient was a recurring nightmare:

"She dreams she is in a desert which is a vast empty sandy space. There are animals but no people...The animals don't seem real, although they are familiar. Some are two-dimensional, made of wood or cardboard. They all begin to sink into the sand until they have completely disappeared and she is alone and very frightened (p. 352)."

This dream profoundly seems to reflect D.W. Winnicott's unthinkable "agony"—Clare Winnicott's patient is expressing the terrifying experience of annihilation and erasure, the animals symbolizing shattered aspects of the unit self, her vast, eternal isolation, and imminent slipping away into nothingness. Nothing is real. Past, present and future are thereby collapsed.

In a second later dream, the patient finds on the right side of her bed a slowly disappearing pile of coal; opposite to where the coal had been, there is a camel that the patient is pleased to see, and that she recognizes as her analyst, "a special camel mother who had enough food stored up to take her across the desert" (p. 353), an allusion to their journey together in the present through a vast desert, hopefully allowing the patient to shift her engulfing catastrophe slowly into the past tense. C. Winnicott viewed the shrinking pile of coal as related to her own presence or absence in the patient's psyche, "if I am not there, she is left with the broken-up bits of coal which are like the broken-up bits of me" (p.354).

Another possibility is that the broken-up bits of coal symbolize the patient's utterly-decimated "unit self," easily crumbling in the therapist's absence leaving her with the horror of the past agonies invading the present (a growing pile of black coal). That the patient's terror in the face of such profound vulnerability catapults her into non-being (upon her analyst's absence) would be wise to keep in the forefront of every

clinician's mind. The imagery in both these dreams of fragility, collapse, terror, and erasure reflects an annihilation of the felt reality of "I am," without which there can be no steady discrimination between past, present, and future. Winnicott's agonies of falling forever, disintegration, and loss of the sense of real, come immediately to mind.

Whereas Clare Winnicott optimistically interprets the dream as a healing consolidation of the positive transference, I wonder whether, at the same time, the disappearance of the coal reflects a further annihilation experience in which the patient's fragmented emotional experiences are lost, buried, and erased once again.

There is no possibility of any continuity of past through the present to the future without an abiding sense of "I am" that serves as the contiguous factor and, without which, there can be no enduring felt-"mine-ness" associated with one's body and mind. In addition to the terror of erasure, the trauma survivor's daily experience is enshrouded in continuous, inchoate experience of alienation, everlasting aloneness, and hopeless despair about being understood. Without a secure sense of going-on-being, Stolorow (2011) writes there is a collapse of past, present and future, "experiences of emotional trauma become freeze-framed into an eternal present in which one remains forever trapped, or to which one is forever condemned to be perpetually returned through the port-keys supplied by life's slings and arrows" (p.

55). Key to the relationship between trauma and time, is that one's identity may be splintered along the axis of time.

KAFKA'S COUNTRY DOCTOR AND THE WOUND OF TRAUMA

There was a missed opportunity that occurred in the early stages of a very destructive psychotherapy I experienced decades ago. It concerned my encounter with a short story written by Franz Kafka, "A Country Doctor," which has haunted me all these years since that time. I mentioned the story to my analyst, but he turned away from it and from me, showing no interest in what it symbolized about my own buried horrors. Sadly, at the time, I was unable at the time to resist the power of his denial.

Kafka's story embodies an example of the "eternal now" nightmare of a chronic annihilation state and the concomitant temporal disintegration that tends to go along with that (personal communication, G. Atwood, 2017). In the story, a doctor is summoned to see a very ill young boy, and must travel by horse-drawn gig across a vast, snowy landscape—"a thick blizzard of snow filled all the wide spaces between him and me" (between he and his patient), perhaps foreshadowing the dissociative impossibility of understanding and connection between them. The doctor is "deafened and blinded by a storming rush that steadily buffeted all [his] senses." In a distortion of time, he is instantaneously transported to the boy's house and the

blizzard stops. Completely unaffected by the suffering, "gaunt boy with vacant eyes" or his immediate gesture of throwing his arms around the doctor, imploring him to let him die, the doctor dismisses him, accusing him of malingering, and needing nothing other than to be kicked out of bed. Just as the doctor is preparing to leave, exclaiming to himself with contempt about the expectations of his patients, the patient's sister is holding a "blood-soaked towel" and the doctor concedes the boy may be more ill than he had thought. The doctor is stripped of his clothes by a chorus of villagers, and forced to lie in bed beside the boy and his open wound. Their lying naked alongside each other can be interpreted as though they have become one. The story is riddled with images of violent attack, brutality, and forceful entry through windows and doors, suggestive of imminent murder and death.

I'm going to quote a very disturbing passage describing the horrific wound that the doctor uncovers:

"In his right side, near the hip, was a open wound as big as the palm of my hand. Rose-red, in many variations of shade, dark in the hollows, lighter at the edges, softly granulated, with irregular clots of blood, open as a surface mine to the daylight. That was how it looked from a distance. But on closer inspection, I could not help a low whistle of surprise. Worms, as thick and as long as my little finger, themselves rose-red and blood-spotted as well, were wriggling from their fastness in the interior of the wound toward the light,

with small white heads and many little legs. Poor boy, you were past helping. I had discovered your great wound; this blossom in your side was destroying you.”

This extraordinarily-disturbing description was the ugliest and most horrifying thing I had ever read, in light of all it has symbolized for me as a trauma survivor. Much later, I realized that I had been alone, all these years, with this very sense of horror and dread, with the help of an epically-different analyst. The boy’s wound and its worms, Kafka’s wound, and my own wound, are the result of an infection from the outside—the wound, is an apt metaphor for the disfiguring impact of trauma itself that attacks and obliterates the integrity of the “unit self.” In fact, there can be no mine-ness of a sustaining kind in the presence of terror that threatens psychological murder and death. In addition, everything seems to be occurring at the same time, collapsing past, present, and future. These thoughts regarding “A Country Doctor” evoke, of course, Winnicott’s ideas about “primitive agonies” and the past engulfing the present and future, collapsing any possibility of self-constancy and going-on-being in a safe surround.

Kafka’s nightmarish imagery symbolizes the disruption and disintegration of a unitary sense of “I am,” occurring in consequence to the vast early trauma in his own life. Deep insight into the specific features of this trauma is provided in Kafka’s

"Letter to The Father," which I also discovered 35 years ago. Franz Kafka's father was a destroyer of souls rather than a true parent, someone so absorbed in himself as to deny reality and validity to anyone's experiences but his own.

Kafka is a kindred spirit, a brother-in-darkness. When I first read "A Country Doctor" and "Letter to The Father," I had an immediate, inchoate sense of deep identification which I needed to immediately gut and erase as an act of obedience to the "law of the land" (Dubois, personal communication, 2015) required by my parents and my analyst for survival. I saw the effect of my parents' psychic rape of my life in Kafka's horrifying image of the boy's worm-infested wound, and also in Winnicott's formulations of the "primitive agonies:" a lifelong, buried terror of annihilation stemming from the disastrous hold of the past catastrophe on our present and future.

Let me close this paper on a more hopeful note, one looking toward the possibility of real understanding and healing in a psychotherapy process that recognizes the full scope of early trauma and its associated agonies. Out of such a lengthy process, the past can become past in the Winnicottian sense, transformed into painful memory, freeing the present and the future from everlasting captivity.

... "This is the use of memory:
For liberation - not less of love but expanding
Of love beyond desire, and so liberation
From the future as well as the past...
History may be servitude,
History may be freedom. See, now they vanish,
The faces and the places, with the self which, as it could, loved
them,
To become renewed transfigured, in another pattern

T.S. Eliot, "Little Gidding," from Four Quartets (1942)

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