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POSTTRAUMATIC STRESS DISORDER (PTSD), ACTUALPATHOLOGY, AND THE QUESTION OF REPRESENTABILITY

A Reply to "Attachment Deficits, Personality Structure, and PTSD" (J. Mills)

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Reading a reaction to one's publication is usually a good thing for one's narcissism. In the best of cases, it is a good thing for one's thinking as well, as it obliges us to reconsider critically a number of our ideas. This is the case with the paper published by J. Mills, as a reaction to our "Actual Neurosis and PTSD" (Verhaeghe & Vanheule, 2005). In the first part of our answer, we will clarify certain of our ideas in the light of Mills's critical remarks. In the second part, we want to address what we consider to be the main problem in matters of posttraumatic stress disorder (PTSD), that is, the question of representability.

The title of Mills's paper gives a good summary of his central objection to our reasoning. In his clinical experience, the predisposition to future PTSD profiles is predicated "on earlier deficits in personality structure due to developmental traumas." In his latest book (Mills, 2005) he has generalized the idea of "structural deficits in personality organization due to attachment pathology constituted as a disorder of the self and maintained on unconscious representational levels." At first sight, this seems to be a major difference with our reasoning, where the actual-neurotic structure, based on a failure of the Other during the early child–parent interactions, is put forward as the predisposition to future PTSD. Nevertheless, there are more similarities than divergences.

Indeed, in our reasoning, the failed interactions between child and Other determine what we have called here the original trauma (Verhaeghe & Vanheule, 2005, p. 502) and elsewhere even the "structural trauma" (Verhaeghe, 2004, p. 317). When writing our paper and even right now, we are very much aware of the semantic difficulties. Stating that a disorder caused by a trauma is based upon a preceding trauma sounds too circular. That is why we considered it more important to elaborate the—indeed—structural context of this original trauma, based upon a reinterpretation and enlargement of Freud's actual neurosis.

The idea of "structure" is hereby quite important. There are at least two actors involved—the infant and the Other—around one central issue: the drive arousal, experi-

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enced by the infant as coming from the outside. During the mirror stage, the infant receives representations coming from the Other, indicating not only what he or she feels, and how to handle it, but also who he or she is. Indeed, both for Lacanian theory and contemporary attachment theory, identity development and drive/arousal regulation are one process. Moreover, this development of the identity is not only a matter of content, it is also—and probably even most importantly—the instauration of a subject structure. Depending on the theory, different denominations can be used to indicate this structure. In a classic Freudian tradition, we find here the ideas of the Super-Ego and the Ego, combined with the Ego Ideal and the Ideal Ego, on top of the Id. Moreover, even in Freudian theory, these structures surpass the black-and-white opposition between the I and the other, as indicated by the processes of identification and projection (Freud, 1925/1978a). The latter terms provide the link to yet another important idea: the mechanisms of defense, which can be understood as defenses directed both against the own drive arousal as against the outside world.

This brings us back to the actual-neurotic structure and the Other. If someone gets stuck at the actual-neurotic level, this does not only mean that he or she did not properly acquire the psychological tools to process the somatic arousal; it also means that the development of subjectivity itself is hampered. Thus, in our reading, actual neurosis also implies defects in the structure of the subject, based upon the initial failure of the relationship between the Other and the subject-to-be. Obviously, this was not made clear enough in our article. This leads us to two other critical remarks, the first one about the Other, the second one about actual *neurosis*.

We have used the idea of the Lacanian Other, to indicate the other party in the process of subject formation; its meaning was briefly explained in a footnote (Verhaeghe & Vanheule, 2005, p. 495, footnote 1). Mills accentuates the agency of the M/other (sic) as "the presentation of the original love object qua primary attachment figure who simultaneously communicates as an embodied linguistic subject." In his reading, the discourse of the mother is the main informer of the unconscious structure "but this is still not a sufficient condition to account for psychic structure in its totality, a discussion that is best left for another venue." Frankly, we don't see that much difference between his reading of the M/other and our presentation of the Lacanian Other, besides the fact that the latter implies the father as well, probably as the necessary part to account for the inauguration of the psychic structure as such. Is it possible that we meet here with the remnants of a strange aspect in psychoanalytic history? We are reminded of Freud's overaccentuation of the father with an almost total neglect of the mother, prompting a necessary overcorrection by the Kleinians and the larger Anglo-Saxon school, followed in its turn by the Lacanian overcorrecting focus back onto the father. Anyhow, it is quite remarkable to read the major work in contemporary psychoanalytic attachment theory (Fonagy et al., 2002) and to see that in the conceptual and empirical parts of that work, the father is almost completely absent—in dire contrast to the case studies.

Another remark made in this respect is far more difficult to answer. As Mills correctly points out, our reasoning implies "a causal determinism that occurs as a one-way relation directed from the Other." It seems as if pathology is the sole effect of the Other, be it because he or she has offered not enough mirroring to the infant or the wrong kind of mirroring, possibly within a context of abuse. The two-way relation and the mediating aspect of the ego as such are hereby neglected. This is Freud's problem of the "Neurosenwahl" (choice of neurosis), indicating the impact of the subject in the specific development of his or her specific pathology. We are fully convinced of a bidirectional causality, but for the time being, we are not able to include this in a nuanced way. This

is a very important topic for future research, although it is hard to find the correct methods to investigate this bidirectionality.

Our most important idea is that, because of a disturbance in the early relationship between subject and Other, a number of subjects are left with a failure in their capacity for the psychological processing of both their arousal and identity, in combination with a particular stance toward the Other. We have interpreted this failure via a new reading of Freud's "actual *neurosis.*" Mills is right in pointing out that such a reduction to neurosis is indeed a reduction. We are very happy with this remark, because it gives us the opportunity to put forward our more general idea, that is indeed not present in this particular article but which was published elsewhere (Verhaeghe, 2004). It is our contention that the scope of what we prefer to call *actualpathology* goes much further than PTSD or neurosis for that matter (Verhaeghe, Vanhuele, & De Rick, 2007). Let us remind the reader of the fact that even for Freud, an actual neurosis could be present in psychosis; more particularly in hypochondria (Freud, 1914/1978b, pp. 82–85).[1] Again, our main idea concerns the failure in the possibilities to process psychologically both the arousal and identity, in combination with a particular stance toward this other. The net result is exactly the opposite of the traditionally expected symptoms and transference.[2] Indeed, the classic symptoms (conversion, phobic constructions, obsessional thoughts, hallucinations, delusions), different as they may be, testify to a representational processing of an underlying problem. That is why a classic symptom contains multilayered meanings that ask for interpretation. An ever-growing part of contemporary pathology, usually summarized in the idea of "borderline," demonstrates time and again a failure in this respect; their symptoms (somatization, self-mutilation, addiction, eating disorders, . . .) are more often than not meaningless attempts to abreact an underlying problem. In this respect, we fully agree with Mills to enlarge our reasoning beyond the neurosis. Moreover, it brings us to a major issue that he didn't miss either: the question of representability.

As this is probably one of the most difficult subjects, we can only produce the start of an answer, that is, stating the problem. We fully agree with our colleague when he summarizes his remarks on this point by stating that "the therapeutic obstacle was in the nature of representability that could not properly diffuse the anxiety attached to the memory." This is Freud's core problem as well, right from the start. In this respect, the easiest reasoning is one that opposes two series concerning a (traumatic) event. On the one hand we have representations, normal memories, consciousness, and the possibility for psychological processing; on the other hand, there are no representations, no normal memories, no consciousness, and the impossibility for psychological processing. This is the basis of Freud's first topology, where he discovered that these absent representations and memories were obviously very much present, but in an unconscious "elsewhere" from where they operated in a pathogenic way. He considered this absence as the reason for the failure of their "Abreaktion," that is, a necessary process for psychological health. Moreover, this abreaction concerned a quantum of affect that was normally associated to the representations. In case of the absence of the latter, this quantum of affect remained

[1]Let us not forget that at the time of Freud, "neurosis" was a generic term, and that for Freud, the main distinctions were those between actual neuroses versus psychoneuroses, and transference neuroses versus narcissistic neuroses.

[2]We cannot elaborate the typical differences between the actualpathological transference and the "normal" one. Suffice it to say that the accent is on separation anxiety (they need the Other) in combination with an ambivalent expectation (they did not get much good from this Other in the first place, why would it be different today?).

strangulated ("eingeklemmt") and operated in a pathogenic way, precisely because it could not be abreacted (Freud & Breuer, 1895/1978).

So, their absence in the conscious (memory) system implies a presence in an unconscious (memory) system. But what is the nature of this presence or of this memory, for that matter? Are we still talking about representations? These are questions that run through Freud's work and psychoanalysis in general. In his first topology, he formulates an answer in terms of primary repression. In the post-Freudian era, this idea has almost disappeared and we tend to forget Freud's definition. A primal repression is a primal *fixation* of certain material that is not allowed to evolve into normal psychological representations. This material has to do with trauma, and forms the kernel of the system Ucs. from which an attracting force will operate on the material that will become the object of secondary repression or "Nachdrängung" (literally: after repression) (Freud, 1915/1978d, p. 148).

The post-Freudian discussion about the nature of this unconscious kernel is exemplified by the discussion in the Kleinian schools on the (nature of the) unconscious fantasies, the discussion between Lacan and Leclaire about the presence of signifiers in the system Ucs. and between Lacan and Laplanche about the interpretation and translation of Freud's "Vorstellungsrepräsentanz" (Laplanche & Leclaire, 1966). Lacan's ideas in his seminar XI are quite close to the original Freudian system Ucs., as he reads the "Un" of Unconscious as the indication for something preontological and not realized (Lacan, 1964/1973, pp. 28–32). In this respect, he joins Freud's remarkable idea about what therapy effectuates. As there are no conscious memories to be found about the trauma, Freud hypothesizes that the treatment comes down to "the accomplishment of a psychical act which did not take place at the time [of the trauma]" (Freud, 1893/1978c, p. 39; Freud & Breuer, 1895/1978, p. 300; see our previous article, Verhaeghe & Vanheule, 2005, p. 503). This act is the translation or verbalization of unconscious "representations" into conscious ones. Again, this leaves us with the question about the "nature of consciousness" (Freud, 1895/1978, p. 300). In the post-Freudian era, this therapeutic goal has been understood too hastily as a necessity for remembering the trauma. Freud's goal is different: The verbalization will permit the disappearance of the affect via the process of association; the pathogenic effect of the trauma has to do with the fact that the normal wearing-away processes by means of abreaction and uninhibited association was impossible for lack of representations (Freud & Breuer, 1895/1978, pp. 9–11).

The opposition between the conscious and unconscious representations in matters of trauma is—as Mills points out—not a distinction between being inscribed in the psyche or not. Both of them have to be inscribed; the question is to understand the differences. A possible way is to accentuate the often-neglected differentiation made by Freud between the representation and the affect. It seems as if the representation has more to do with consciousness and that the affect has more to do with the unconscious. It is remarkable to discover the same reasoning in contemporary neural science, even with the same application on PTSD. Normal declarative memory functions mainly via the hippocampus, which is responsible for the forming of representations. This memory system is very useful, as it helps us to forget things or at least, to line them up with our contemporary situation (meaning that as a memory, it is not very trustworthy). The other memory is based upon the amygdala and keeps track of our affects—moreover, it does this by keeping the affect as it was, and reviving it whenever the system is called upon (Ledoux, 1996, pp. 198–200). Although the first hippocampus-based memory may bring us a memory of an affect, the other system brings us an emotional memory "just like it

was"—remember Freud, who said that the Unconscious does not know time, that everything is kept in its original form.

Furthermore, neurological research explains the strange fact of why a trauma, that has such a big impact on the subject, is usually very hard to remember in a normal, that is, representational, way. Research has demonstrated that high levels of stress, as induced by trauma, inhibit the normal declarative memory quite seriously, while doing the exact opposite for the amygdala-based memory of the affect (Ledoux, 1996, pp. 243–246). Basically, it means that we store the anxiety and the panic caused by the trauma and "remember" these far too well, although it is a memory that we cannot control, because we did not manage either to build representations about the trauma, build enough of them, or build them in such a way that they could have entered the normal associative chains and hence the normal wearing-away process.

In summary, the problem of representability and trauma might be presented as follows. More often than not, there are no normal representational memories about the trauma. If there are, they are not "normal", in the sense that they are not associated to their affect (see dissociation). In case of a trauma that is not representationally remembered, we meet with embodied affect "memories" that are more re-experienced than remembered (see amygdala-based memory); their representational status is very unclear. The goal of the treatment is to make it possible for the patient to construct and to handle the representations about the trauma together with its affect, in such a way that these representations enter the normal chain of associations (and its wearing-away effect) and that the affect is thereby abreacted. As every clinician knows, this is only possible within a positive and supportive working alliance, which is not that easy to install—even on the contrary.

The latter—the transferential problems—brings us to the etiology in actualpathology. In our reading, these patients start their identity formation and arousal regulation within an unsafe, structurally traumatizing environment (the Other), resulting in a deficient identity and in poor capacities to handle arousal processes (including their own drive arousal, besides arousal effects due to a trauma) in a representational way. The effect is double. On the transferential level, they won't expect much from the Other—and that is even the best scenario. On the individual level, they will not be able to produce Freud's normal "Abreaction," that is, via associative processes. Let us not forget that the classic symptoms are for Freud also faulty ways of Abreaction, but they have the advantage of being already on the representational symbolic level. This way out is not available for actualpathology, meaning that they have to handle the arousal is on the level of the real, usually the real of the body (be it the patient's own, or somebody else's).

The implications for a psychoanalytic approach are very important, and were already indicated by Freud: Classic psychoanalysis does not work, because there are no classic symptoms that might be interpreted. Instead of that, we are confronted with an immediate (i.e., not symbolically mediated) handling of the arousal. What these patients need is the possibility to process the arousal in a representational way. Instead of interpreting, we need to help them with constructions. This is all the more difficult, because the transference is quite different compared to classic psychoneurosis, and usually more negative–ambivalent than something else. As a positive relationship is the necessary condition for the presentation of constructions, this will be the first goal of the treatment. At the same time, we should not forget that the poor representational capacities of these patients are not an isolated characteristic—the very same thing goes for their identities as well.

With some exaggeration, it can be said that our work here is exactly the opposite compared to our traditional work with the traditional psychoneurosis.

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