Freud's Unfortunates:

Reflections on Haunted Beings Who Know the Disaster of Severe Trauma

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I try to make the ghosts within me speak. (1, p. 143)

The forms of dissociation are multiplex and must include a type of dissociation that represents human beings' fundamental inability to process and represent severe trauma. This article posits a form of dissociation—resulting from trauma—linked to disastrous knowledge, signifying a person's incapacity to use language and symbol to organize the core of the traumatic experience in terms of semantically structured self-in-relation. Catastrophic knowledge of severe trauma is unexperienced experience that paradoxically stands for an indescribable core of an event that undermines self-in-relation and the concomitant capacities for language, narrative, and knowledge. This irretrievable unexperienced experience continues to haunt despite a person's recovery. This perspective points to the limits of therapy and the necessity to establish and maintain a relationship of trust and loyalty in the face of an event that annihilates self-in-relation. Included in this work are the therapeutic tasks of serving as a witness and a container of the unnamable horror.

In a person's telling of a trauma "what remains to be said is the disaster. Ruin of words, demise of writing" (2, p. 33) for both the speaker and listener. This ruin of words, this sense of being defeated by the disaster is embedded, paradoxically, in the very act of speaking. It is the catastrophe of trauma that undercuts our attempts to organize and communicate experience through our stories, theories, and models. Therapist and patient struggle to understand, though there "is no reaching the disaster" (2, p. 1). And yet the very act of speaking and responding intends, affirms, and confirms continuity and community that, to use Blanchot's phrase, the very "knowledge of the disaster" undercuts. This is to say that the efforts to narrate experiences of severe trauma move listener and narrator to the edge of the abyss of a disaster that is "unexperienced experience" — experiences lost to, and outside of, connmunion and community. It is this

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paradoxically "known" unexperienced experience of trauma that haunts the afflicted person and, at least in some ways, haunts those who listen.

This article focuses on those people who speak about, and are haunted by, their experiences of severe trauma – *violent, overwhelming, and humiliating experiences perpetrated by other human beings*. These traumatic experiences are neither repressed nor *defensively* dissociated, in the sense that the trauma is defensively unformulated or formulated and sequestered outside the realm of consciousness and self-reflection (3). They do not defensively dissociate behavior, affect, sensation, or knowledge (4). These people are aware of the event and are able to speak about the trauma, often with great eloquence and emotional impact (5). They remember and speak about the trauma, yet the trauma continues to haunt them for the rest of their lives, though not necessarily by sensory fragments that overwhelm them. Listening to their stories and struggles provides clues to questions that rightly continue to capture the attention of those interested in helping and understanding people who have undergone severe trauma. Why is it that remembered traumatic experiences continue to plague or haunt a person throughout his/her life? How do persons process and handle traumatic experiences? What can be offered to a person who suffers from past traumas? What does this eternal presence of traumatic memory reveal about the process of dissociation, the limits of language, and, more broadly, about being human?

I suggest that this group of people, which Freud called unfortunates, can tell us something about the nature of violent trauma, the limits of personal and communal self-reflection and of symbolic capacities to process extremely violent human trauma, and the idea of dissociation. Briefly, my claim is that severe trauma results in a form of knowing that is disastrous and consequently haunting to persons who continue to remember and speak affectively about their experiences.[1] This knowledge of disaster is unexperienced experience and *a type* of nondefensive dissociation—unformulated experience or unexperienced experience—present in the midst of remembered and formulated experience. Defensive dissociation suggests a tool unconsciously used to survive trauma, while nondefensive dissociation refers to a human incapacity to process severe trauma.

I argue that unexperienced experience is haunting because the core experiences of severe trauma threaten to disrupt the very foundations and

[1]The argument here is that the core of severe trauma is unformulated experience, whether that is found in those who develop particular symptoms and defenses or those unfortunates who remember and articulate their experience of the trauma. I focus on the unfortunates because their articulations point to the incomprehensible core of severe trauma.

process of organizing experience as a self-in-relation-with-other selves. In other words, the development of preverbal and verbal organizations of a stable and vital self is contingent upon being in relation to trustworthy and loyal others (cf. 6-8). Even after the emergence of object constancy and a cohesive-self, violence threatens to disrupt a sense of self and the very process of organizing the experience symbolically because the emergence of symbolization and sense of self is dependent on interactions characterized by trust, loyalty, and hope. Severe trauma is a violent eclipse of trust and loyalty necessary for a stable and vital sense of self. We might think of this moment as a hole in the fabric of a cohesive self or object constancy, and this hole represents a moment of the annihilation of trust, loyalty, and, consequently, self-in-relation. The annihilation of trust and loyalty in the moment of severe trauma means that these experiences, in part, lie forever outside a person's capacity to grasp them through the use of language and yet, paradoxically, the victim can and needs to speak about the trauma. Incomprehensibility is linked to the unexperienced experience of the disastrous annihilation of trust and fidelity in human relations. In short, the *core* of severe trauma is fundamentally beyond the reach of self and community and the symbols, language, and rituals that establish and maintain self and relatedness.

Questions and concerns about traumatic experiences, along with related interest about psychological defenses, the formation of symptoms, and the ensuing "inhibitions upon life" (9, p. 75) have in many ways always been at the center of the development of psychoanalytic theories and treatment of defenses. What follows is a brief sketch of Freud's answers to the questions regarding the experience of trauma and more recent psychoanalytic formulations and discussions about defensive dissociation. I begin with Freud because his formulations regarding trauma may be interpreted, in part, as a response to disastrous knowledge and also because the idea of repression may be considered a subset of defensive dissociation (10, p. 118). In addition, while Freud's and more current notions of symptom formation differ (11-14), there is a similarity between Freud's theories of trauma and more recent psychoanalytic depictions of defensive dissociation as unformulated experience. This similarity is a relative neglect of the paradox and implications of the incomprehensible at the center of violent trauma. This lays the groundwork for addressing and adding to the idea of dissociation, how it relates to severe trauma, and the limits of psychotherapy as a talking cure.

DISASTROUS EXPERIENCE AND PSYCHOANALYSIS: FREUD'S MODELS OF TRAUMA

Freud (15) initially proposed, in his traumatic theory of hysteria, that "*one or more occurrences of premature sexual experience*" (p. 203) proved "suitability as a determinant" and the "necessary traumatic force" in the formation of hysterical symptoms. The hysteric's symptoms "*are derivatives of memories which are operating unconsciously*" (p. 212) and which were, for the most part, rooted in the patient's childhood traumatic experiences. Hence, the therapeutic task was to bring these unconscious memories to consciousness. While Freud apparently abandoned the unbearable model of experience for a theory and model that viewed hysteria as the repression of conflict-laden sexual and aggressive impulses of children (16), he was not one to give up a good idea. Thus, Freud never entirely discarded the insights of this early work, even though he tended to emphasize that neurotic symptoms emerged only as a result of unacceptable sexual and aggressive impulses and fantasies (9).

The conflict or "unacceptable impulse" model of trauma (14, p. 55) replaced, for the most part, Freud's early hypotheses about the etiology of trauma. Yet, this new model contained his initial view of the formation of symptoms, the importance of the unconscious in neurosis, and the challenge and necessity of making unconscious experience conscious in order for symptoms to be removed. The diagnosed hysteric in the unacceptable impulse model developed symptoms as a result of intolerable childhood wishes, which were safely held in the unconscious awaiting the psychoanalyst's or analysand's timely interpretations.

Years later, Freud's impulse and developmental model of trauma collided with the traumas of war and other similar catastrophic events (17, 18). Childhood sexual and aggressive fantasies could not explain the neuroses and fixations that formed as a result of overwhelming experiences of warfare. Freud noted that these "traumatic neuroses give clear indication that a fixation to the moment of the traumatic accident lies at their root" (p. 274). The fixation and symptoms were the result of an overwhelming experience and not of unacceptable wishes. The seemingly abandoned beliefs of the unbearable model of trauma found in Freud's *Aetiology of Hysteria* returned, though they were to remain in the shadows of his conflict-impulse models of symptom formation (e.g., 17, pp. 358-377; 19). Twenty years after *Aetiology of Hysteria* Freud wrote that

> It is as though these patients had not finished with the traumatic situation, as though they were still faced by it as an immediate task which has not been

> dealt with; and we take this view seriously. . . . (A)n experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in a normal way, and this must result in permanent disturbances of the manner in which the energy operates. . . . Neurosis could then be equated with a traumatic illness and would come about *owing to inability to deal with an experience* whose affective coloring was excessively powerful. (p. 275 emphasis added)

According to Freud, the development of a symptom as a result of traumatic experience was due to "[s]ome particular mental processes [that] should have developed to a point at which consciousness received information of them" (17, p. 280). The experience was not processed in the conscious system leaving the "true basis and historical origin [to be] forgotten" (9, p. 75).

Given the evidence of those returning from war, Freud also came back to his earlier claim of 1896 that traumatic experiences, which lead to fixation, did not necessarily result in the construction of neurotic symptoms. Freud believed, in other words, that a person's traumatic experience can "shatter(s) the foundations of his life [such] that he abandons all interest in the present and future. . . But *an unfortunate* such as this *need not on that account become neurotic*" (15, p. 276; emphasis mine). Freud recognized that some people did not develop symptoms even though they continued to be haunted by their experiences. Naturally, this group of unfortunates did not come under Freud's considerable critical scrutiny precisely because they were not neurotic.

Those who did develop neurotic symptoms as a result of traumatic experiences, however, fell into two categories. For some the "historical origin" of the event was forgotten through the process of repression (9). The patient's symptoms, fixations, and compulsions kept the patient from remembering and reliving the event. Other patients possessed symptoms and remembered the trauma but the "connection between the two was hidden" (17, p. 277). For example, one patient of Freud's "had never once noticed its (obsessive behavior) resemblance to her experience on her wedding night" (17, p. 283). Neurotic symptoms deflected her from making the connection between the remembered traumatic experience of the past and her present dilemma. In either case, trauma frequently resulted in the development of neurotic symptoms and consequently some form of amnesia or disconnection.

Freud was primarily interested, not surprisingly, in the group of people who developed and were plagued by symptoms resulting from the trauma. The focus was on the relation between symptoms (and their formation)

and unconscious experience. He did not pursue those who continued to be "fixated" on the traumatic experience, but who had not developed symptoms. As a result, he did not address how an "experience which within a short period of time presents the mind with an increase of stimulus too powerful to be dealt with or worked off in a normal way" (17, p. 275) continued to operate for those who did not develop symptoms or forget or disconnect the trauma from their daily lives. Apparently, only those who developed symptoms and whose experiences remained forgotten or disconnected from their present behaviors exhibited "abnormal" mental processes. What were the mental processes of those nonneurotics who remembered and continued to know the event in their daily lives?

I pause here briefly to wonder if Freud's focus on neurotics (not the unfortunates) and his building a theory and models of trauma parallels the very process he outlines with regard to symptom formation in the face of overwhelming experience. Is there, in other words, a hint of the incomprehensible in the formation of comprehensible theory? Similarly, the construction of his models, I believe, points to the analyst's and patient's paradoxical dilemma when confronted with severe trauma. Consider that for Freud neurotic symptoms keep the repressed experience from returning. Symptoms deflect one's consciousness from focusing on the painful experiences buried in the unconscious. Neurotic persons are preoccupied with their symptoms. They know their symptoms but do not know the experience that lies at their root. The symptom represents something the neurotic confidently knows as well as a troubling sense of not knowing. The familiarity and concreteness of neurotic symptoms, though unpleasant, give them something to understand or grasp and something to do rather than face unconscious overwhelming experiences. These symptoms, neurotics unconsciously believe, enable them to survive the trauma by keeping it from themselves.

We could say that the formation of symptoms and repression protects neurotics from an experience embedded in severe trauma: an experience found in Elie Wiesel's (1) lament and Jankiel Wiernik's (20) frustration. Wiesel cries out that "I no longer know anything, I no longer understand anything; they have taken away my certainties, no one will give them back to me" (p. 137). Symptoms are derivatives of this incomprehensible horror, which defy capacities to know and communicate. Wiernik (20) states that "No imagination, no matter how daring could possibly conceive of anything like what I have seen and experienced. Nor could any pen, no matter how facile, describe it properly" (p. 18). In the face of incomprehensible violence, a person constructs a symptom in order to survive and

know and, at the same time, not experience helplessness associated with ungraspable violence.

Notwithstanding the importance and helpfulness of Freud's work, imagine the construction of Freud's theory and models as somehow a symptom that represses or keeps hidden an incomprehensible experience. The theory and model enable Freud to understand, to know, while "repressing" the sense of no longer knowing or understanding anything and the concomitant experiences of isolation and disconnection. Freud's models of trauma and techniques gave him confidence in knowing what to do, hiding the experience of complete uncertainty, incomprehensibility, and indescribability of trauma from both listener and speaker. Perhaps our theories and models, while necessary, parallel the neurotic's formation of symptoms and defenses in that they may deflect attention from an experience that disrupts all knowledge, understanding, and certainties. At least our theories provide us something we do know and reassure us that we can do something. We can use them to understand, to comprehend with some certainty, and to manage a connection in the face of catastrophic loneliness.

Another aspect of Freud's theory tends to gloss over the incomprehensible. Freud believed that people "experience" reality. A person's memory of an event is constructed in relation to the external incident, despite the fact that fantasy or intolerable impulses can distort and in some cases lead to false memories that screen the real event. More specifically, in his "unbearable experience" model, Freud did not question the construction of experience in relation to the traumatic event. Neurotics develop or construct symptoms because they could not deal with the actual traumatic experience. Thus, Freud's analytic interest and focus was on understanding and explaining how the experience was forgotten or disconnected from present actions. Moreover, he assumed that the patient could eventually speak about what was hidden. Freud did not consider that some forms of human "knowledge" and experience—known and spoken—leave us helpless and haunted even in our very attempts to corral it through language. In my view, Freud's construction of models and his inattention to the unfortunates were, in part, responses to something that could not be grasped by language and theory or resolved by self-reflection, reason, and awareness.

DISSOCIATION AND SEVERE TRAUMA

Freud was not alone in his search to understand and treat persons who struggled as a result of trauma. Jean-Martin Charcot was the first to argue

that hysterics suffered from dissociated experiences, which were the result of unbearable experiences in childhood (12, 14). It was Charcot's colleague Pierre Janet who studied and described the relation between dissociation and memory, as well as its presence in normal human development (21). However, with the exception of a small number of thinkers (22-26), the concept of dissociation, multiple self-states, and its relation to trauma were largely eclipsed in psychoanalytic circles by Freud's theory of repression until the late 1980s and 1990s. Since then, there has been increased interest in exploring the clinical and theoretical implications of dissociation (27-35).

Dissociation is an exquisitely complex and continually debated human cognitive phenomenon. I very briefly touch on several aspects of dissociation and its relation to trauma before focusing primarily on the relation between violent trauma and a type of dissociation—unformulated experience. From a physiological perspective, it is believed that dissociation results from overwhelming emotional experience that may be processed nonverbally. Intense arousal, van der Kolk (36) hypothesizes, is processed by the thalamus and amygdala and not by the hippocampus and prefrontal cortex. The traumatic event is neither assigned meaning nor constructed in terms of declarative (episodic and semantic) memory (21). Instead, the traumatic experience is organized and stored at "somatosensory or iconic levels" or as sensory fragments and kept from semantic and episodic memory systems (37, p. 287). These sensory fragments appear as flashbacks or intrusive situations, which van der Kolk notes may persist "even after the construction of a narrative" (p. 289). Indeed, his research indicates that victims of trauma are eventually able to talk *about* the trauma and construct narratives that "explain" the fragmentary sensory experiences. However, unlike normal narrative construction, these sensory elements do not appear to be fully integrated into a personal narrative.

The biological-cognitive mechanisms, however, are not completely understood because defensive dissociation may also lead to experience that is formulated but segregated from consciousness, such as amnesia, fugue states, and dissociative identity (38). These formulated experiences are sequestered from consciousness and thus are not subject to self-reflection. As a result, these organizations of experience are difficult to change and often are revealed in a person's symptomatic behavior.

Since I am addressing people who remember and reflect on some aspects of their experiences of trauma, I will not consider these particular types of dissociation (amnesia, fugue states, etc.). Instead, I first discuss a type of defensive dissociation, which refers to experience that is not

formulated linguistically, as an entrée into suggesting that violent trauma, remembered and formulated, continues to haunt persons because there is a core of the experience that cannot be formulated—a type of nondefensive dissociation. Put another way, the paradoxical presence of formulated experience and unformulated nonexperience, both of which are linked to a traumatic event, reveals the limitations of language, consciousness, and therapy.

One response to severe trauma is to turn away from the event by not attributing meaning to it. The person does not formulate the experience and it is an unthought known (39). This "unexperienced experience," in other words, is not organized within the framework of the person's narrative and consequently is not an object of reflection. The result is a split between claimed (me) experiences organized in terms of personal narratives and connected to semantic and episodic memories and disclaimed (not-me) experiences that are organized in sensory-somatic fragments and linked to procedural memories (40, p. 317; 28, p. 215). Thus, dissociation, which is a form of organizing traumatic experience, enables the victim to continue to negotiate interactions in the social world by holding onto, and making use of, a semantically structured self while at the same time keeping the overwhelming sensory experiences from totally disrupting self and relationships. Of course, this is not a happy solution because the sensory fragments continue to plague the person.

Defensive dissociation suggests mental operations that lie outside of a person's conscious control. However, Donnel Stern (35) proposes that this type of defensive dissociation involves an unconscious decision by the victim, a decision emerging by virtue of an unconscious (anxious) feeling tendency associated with the overwhelming experience or situation long before it makes its way to consciousness. The victim unconsciously chooses not to remember or not to formulate the experience, bringing it within his/her narrative (pp. 126-128). Traumatic memory, in other words, is composed of dissociated anxiety linked to not-me experiences "that would disrupt our stories so thoroughly that we would be forced to ask the most basic questions about our identities, and even about what kind of place the world is and how safe it is for us to live in it" (p. 124). Janoff-Bulman (41) makes a similar claim when arguing that trauma is overwhelming because it shatters the assumptions that are linked to the very structure of the self-in-relation to others. It is psychologically and, at times, interpersonally safer not "to spell out," remember or formulate the event(s) in terms of one's story. Having said this, the trauma and consequently the unformulated experience makes its appearance by intrusive sensory-based images

and disturbing behavior. In short, dissociation or unformulated experience "is the consolidation of experience in the mode of action" (35, p. 159) that keeps a person from remembering but does not protect the person from being plagued by the past horror.

Unformulated experience that results from trauma frequently leads to disruptions in self-organization and relationships. Disruption of self-organization occurs in an experience that challenges the very basic trust and safety needed to organize experience linguistically or integrate it into one's self-narrative (12, 41, 42). Similarly, the ability of a person to form intimate attachments is compromised because the assumption of safety and trust is unconsciously always in doubt. The traumatized person "has to prepare for almost any conceivable emergency that would startle one into becoming aware of the dissociated system" (29, p. 66), and the consequences are found in the victim's diminished ability to form secure attachments.

Dissociation is an intrapsychic defense and an interhuman process. Unformulated experience as an interhuman process results from two sources. The first is simply those experiences that simply lie outside a community's stereotyped and rigid narratives and rituals—what Stern (35) calls dissociation in the weak sense (pp. 129-145; also 21, p. 80). Dissociation in the weak sense may contribute to a victim's being unable to formulate the experience, which means there is no shareable discourse regarding his/her experience (21, pp. 108-111). Clearly the suffering of victims of sexual abuse was for many years exacerbated by the social process of weak dissociation.

I would add here that in weak dissociation, there is an underlying and often unconscious motivation for disclaiming or avoiding recognition of trauma experiences. The abyss of trauma threatens to disrupt the listener's "assumptive world" and threatens the listener's narrative sense of self. This will be discussed in greater detail below.

Another aspect of dissociation, as an interhuman process, resides in the very action of trauma. In the action of severe trauma, both victimizer and victim possess motives for keeping the event unformulated. The victimizer is motivated to disclaim and "not spell out" the violations committed. This may be the result of the victimizer's own history of trauma and his or her desire not to face the guilt and shame associated with the actions. In situations of incest, the victim or child, because she is dependent and in need of her attachment, will also be unconsciously motivated to agree to not bring the experience to language. Of course, in many instances, the child does not have the linguistic or semantic capability to formulate the experience and so it remains unexperienced. Later, not spelling out the

event protects the child from the horror of betrayal and the anxiety of psychological disruption. Defensive dissociation in this view becomes a way of organizing experience for the sake of maintaining an attachment and avoiding the pain of violation.

Dissociation as a response to unbearable experience and as a mode of action is a defense against knowing. Each type of dissociation represents a kind of "amnesia" that protects the person from being overwhelmed and unable to function (40, pp. 311-314). Therapeutic strategies involve establishing relationships of trust, safety, and security for the sake of the person formulating her experience into shareable narrative frameworks (12), which are similar to Freud's strategies of care. The result is less of a need for dissociation, greater ability to differentiate emotions and contexts, transformation of traumatic memory, and reduction in symptoms. Or as Jennifer Freyd (21) states, "Through communication—integration within ourselves and connection between individuals—we can become whole: embodied, aware, vital, powerful" (p. 192). I am a bit less sanguine about this outlook.

While there are significant differences between Freud's concept of repression and recent psychoanalytic perspectives regarding repression and dissociation, there are also similarities. Both are attempts to account for experiences that are kept from consciousness, yet present in the patient's behaviors, dreams, and sensory fragments. Both assume that the patient does not "know" the "truth," which is hidden, though shown, in the person's symptoms and behavior. The therapeutic hope is that in an atmosphere of trust and safety the unconscious will be made conscious through a process of interpersonal self-reflection and the discovery of words that will formulate the previously unformulated or find new meaning for repressed experience. The unthought known will become known, freeing the person from the bondage of unspoken trauma.

Yet, there are people who know and speak about their trauma with great eloquence and power. Some have not sought therapy, and others have in the process of therapy found words and stories to talk about the trauma. In either case, there are those who "even after acquiring a personal narrative for the traumatic experience" discover that "these experiences continued to come back as sensory perceptions and affective states" (37, p. 289). While the return of sensory perceptions and affective states are indeed troubling, there are other reasons for being haunted by remembered trauma. In my view, both Freud and many others tend to overlook those unfortunates who live productive and rich lives, yet continue to be

haunted by the disastrous experience linked to well-formulated and articulated memories.

DISASTROUS EXPERIENCE: NONDEFENSIVE DISSOCIATION AND DYSCOMMUNION

It is not entirely convincing that people who remember and talk about trauma continue to be haunted because of the tendency to retain in memory aversive events or because sensory, perceptual, and affective memory fragments continue returning to awareness. Nor is it wholly persuasive that being unable to integrate or linguistically capture an experience is itself disturbing, though clearly the attempt may be troubling. Similarly, the sense of possessing an experience that is "not-me" (unformulated) can lead to a sense of conflict; yet to me it does not fully account for one's being haunted. Even those who have worked to integrate not-me experiences and articulate their traumas are not redeemed from the traumatic event. The disaster not only lingers once it has been brought to consciousness, language, and narrative, but also haunts. In short, repression and defensive dissociation represent processes that allow a person to survive—usually by virtue of "amnesia"—but they do not fully explain the struggle of persons who no longer depend on these defenses.

The ideas that overwhelming experience shatters one's assumptive world (41), disrupts the sense of self, and "defeats our capacity to organise it" (42) explain, in part, the intensity of the experience, the sense of incomprehensibility, and uncertainty that continue to plague the person. Consider the testimonies about severe trauma by Elie Wiesel, Jean Amery, and Bruno Bettelheim. Paradoxically embedded in their stories is a type of nondefensive dissociation (unformulated experience) present at the very moment of speaking and writing about trauma. This type of dissociation involves an awareness that even while the trauma is represented, the very *core* of severe trauma defies symbolic representation (42, 43). Persons continue to struggle to represent what is incomprehensible. This paradox or conflict may be troubling, perhaps even challenging, but it is not what disturbs or haunts them. The unformulatable and unrepresentable core of severe trauma and what it "represents" is what haunts and horrifies speaker and listener. The disastrous knowledge, the unexperienced experience of severe trauma is dyscommunion and non-being. There is no reaching the alienated disaster by language, story, or other human beings.

Let me begin with Elie Wiesel who writes:

> I see them transformed into ashes. I hear their cries turn into silence, and I no longer know anything, I no longer understand anything; they have taken away

> my certainties, no one will give them back to me. . . . A member of the *Sonderkommando* of Treblinka asked himself if one day he would laugh again; another, of Birkenau, wondered if one day he would cry again. I didn't laugh, I didn't cry. I was silent, and I knew that never would I know how to translate the silence that I carried within myself; again I found myself in the ghetto. In a sense I am still there. It's natural. I can do nothing about it: the ghetto is in me, in us. It will never leave us. We are its prisoners. And yet, there has been a change in our behavior. First of all, we express ourselves. I force myself to share the secret that consumes me. I try to make the ghosts within me speak. Does that mean the wound has healed over? It still burns. I still cannot speak of it. But I can *speak*—that's the change. (1, pp. 137, 143)

In his essay, "Torture," Jean Amery echoes Wiesel's thoughts.

> But with the first blow from a policeman's fist, against which there can be no defense and which no helping hand will ward off, a part of our life ends and it can never be revived. . . . If from the experience of torture any knowledge at all remains that goes beyond the plain nightmarish, it is that of great amazement and a foreignness in the world that cannot be compensated by any sort of human communication. . . . Whoever has succumbed to torture can no longer feel at home in the world. (44, pp. 127, 135, 136)

Psychoanalyst Bruno Bettelheim writes:

> My desire to make people understand received much impetus from my need to comprehend better what had happened to me in the camps, so I could gain intellectual mastery over the experience. I did not realize then that unconsciously my efforts were attempts to master this shattering experience not just intellectually but also emotionally, because *it continued to keep me in a thrall*, and much more seriously than I wished to accept consciously. . . . I wished to believe that there would be no long lasting psychological effect of having been a concentration camp prisoner. . . . But these writings did not attempt to shed light on the second crucial problem, that of survivorship: on how to live with an existential predicament which does not permit of any solution. (45, pp. 16, 27)

Incomprehensibility, not feeling at home in the world, a sense of foreignness in the midst of community, having to live with a predicament that has no solution, a wound that cannot be healed are all aspects of severe trauma that contribute to the sense of being haunted by it. Beneath these statements are clues for understanding (not experiencing) the disaster of trauma, disastrous knowledge, and the presence of nondefensive dissociation in the very midst of talking about the traumatic experience.

Each of these testimonies reflects the struggle to construct experience out of an event that defies symbolic constructions. At the core is "known" unexperienced experience, and it continues to haunt them for two related

reasons. First, the very construction of human experience is initially yoked to a sense of self and identity that is dependent on an other. As Edith Balint remarks "to be conscious there has to be an 'I' and a 'you': a relationship in a setting" (46, p. 95). Before the emergence of an "I," the infant's sense of self develops alongside the necessary physical and emotional ministrations of his caregiver. Cumulative good enough interactions provide the infant with the necessary global and unified confidence and trust to organize his experience and experience this organization in terms of a sense of a "true" self and later identity. Put another way, the caregiver's dependable recognitions of, and appropriate responses to, the infant's expectancies and assertions confer both trust and a sense of self (47, 48).

The absence of trust due to deprivation and impingement lead to annihilation anxiety and impaired potential to construct experience symbolically. Winnicott's (49) notion of the false self may be understood as the child's attempt to secure some measure of attachment in order to construct experience and to possess some sense of organization while being attached. These early organizations of experience-in-relation are foundational for, and transformed by, subsequent verbal and symbolic organizations. In short, the early construction of experience (verbal and preverbal) and concomitant sense of self and identity depend on interactions with a good-enough and loyal or obliged caregiver who recognizes and confirms the assertions and expectancies of the child. These organizations become the background of subsequent subjective organizations.

Jean Amery's account of torture reveals the loss of a global sense of trust and confidence, which continually disrupts his sense of self and place in the world. The experience of torture, in other words, is the antithesis of trust and relationship and not simply the presence of an unempathic person. He writes that "with the first blow that descends on him he loses something we will perhaps temporarily call 'trust in the world'" (44, p. 126). This loss of global trust is connected, in part, to the absence of an obliged and trustworthy other; an other who recognizes and responds to one's assertions and expectancies. Amery continues: "The expectation of help is as much a constitutional psychic element as is the struggle for existence. . . . If no help can be expected, this physical overwhelming by the other then becomes an existential consummation of destruction" (p. 127). Thus, one could not even call "the first blow" the experience of distrust because distrust presupposes trust or the possibility of distrust getting repaired. Neither is this simply a momentary loss of an empathic

other. The policeman's fist annihilates the very notion and experience of empathy.

Jean Amery's story of torture reveals the absence of trust, which includes the absence and, hence, negation of recognition and confirmation of self-assertions that are necessary for self-organization. In this moment of double absence there is no self and with no self there is no-thing to experience. Blanchot (2) expresses this when writing about disaster:

> The disaster does not put me into question, but annuls the question, makes it disappear—as if along with the question, "I" too disappeared in the disaster which never appears. The fact of disappearing is, precisely, not a fact, not an event; it does not happen, not only because there is no "I" to undergo the experience, but because, since the disaster always takes place after having taken place, there cannot possibly be any experience of it. (p. 28)

So, how is it that this nonexperience continued to haunt Jean Amery? He possessed a memory of the torture and quite likely had moments where these sensory fragments painfully appeared – no doubt troubling enough. Clearly, Jean Amery and other survivors experience powerlessness and physical pain associated with the trauma. This experience, however, is haunting because in the moment of severe trauma there is no self and no identity through which to organize the experience and communicate to another person the event of torture. A sense of self and identity cannot be organized in relation to an event that obliterates both trust and the obligation to respond. The memory of torture by its very presence continually reveals the absence (and real possibility of absence) of self and identity and thus is a continual reminder and threat of the possibility of surviving without self-in-relation. Because one's sense of self (or identity) "is so fundamental to the essence of being human that it is in those rare instances when it is lost or altered in a central way, the experience is almost incomprehensible to others (and to the survivor)" (28, p. 174). The unexperienced experience of severe trauma, in other words, leaves the survivor with a sense of a socially and semantically structured self (ordinary memory) that is continually confronted by the memory of an experience of no-self. Charlotte Delbo writes that to survive "was so improbable that it seems to me that I was never there at all. . . . So separate from one another are this deep-lying memory and ordinary memory" (50, p. 78). I would add, it is "known" by victims but also found incomprehensible. Amery, Wiesel, and Bettelheim experienced this loss, this unexperienced experience, which at its core is impossible to imagine or convey linguistically.

A second and related aspect of severe trauma and nondefensive dissociation is revealed in the paradox of language and narration. Wiesel,

Amery, and Bettelheim are very articulate in speaking about their traumatic experiences and yet each recognizes the limits of language. These limits are not the ordinary limits of language, i.e., in constructing experience symbolically we partially distort the experience (51, 52, p. 10; 53, p. 182). Language and symbols, then, cannot fully capture, understand, and communicate harrowing subjective experience. The ordinary limits of language and knowing, however, continue to preserve the person's sense of self, one's experience, and one's understanding of experience even in situations of mystery. The testimonies of severe trauma victims reveal this relation between language, self, knowledge, and community by shattering the relation. Amery, then, does not merely encounter the quotidian limits of language. Rather, he, like Wiesel and Bettelheim, face the very absence of language and discourse, self and other, and hence knowledge and community.

Human beings rely heavily on language and stories for grasping reality and for constructing and communicating experiences. These essential human capacities for symbolization, language, narrative, and self-reflexiveness (knowing) first emerge from the interaction of a child's constitutional structures and the caregiver's appropriate and timely recognitions and affirmations (54, 55). The earlier nonverbal self and concomitant presymbolic experiences are, in part, transformed by the arrival of these new capacities in relation to a dependable and devoted caregiver. Hence, the emergence of a verbal and later narrative self or identity is contingent to a large degree on a secure relationship that provides the child the necessary confidence and trust to make use of language to construct, understand, and communicate his/her experience (34). There is evidence that disruptions in this relationship influence the child's ability to use language and narrative to construct, understand, and communicate experience (55-58). Along with the child's use of language and narrative, then, are his or her sense of identity and more broadly sense of self. That is to say: present in the child's use of language is the belief, even if mistaken, that there is someone who recognizes and affirms his identity and knowledge. Even in disruptions in recognition there is a hope and belief in an empathic other.

To return to Winnicott's notion of false self, a child or adult uses language and symbols to construct a false sense of self or identity, and this provides one with some knowledge and understanding of oneself and others. What undergirds one's use of language and narrative is the belief that a listener's devotion, recognition, and affirmation can only be secured through a person's resort to false expressions. For a child, even a phony or

distorted recognition, affirmation, and understanding are better than their absence.

Language, symbol, and narrative are used, for the most part, to grasp, connect, and understand subjective and intersubjective experience and in this very process there is a sense of identity-in-relation-to-another "I." Events of severe trauma, like Wiesel's experiences in the concentration camps, cannot, at their core, be grasped linguistically. The core of severe trauma forever lies outside the realm of symbol and knowing. The reason why a "language for Auschwitz has never emerged" (59, p. 8) is because language, symbol, and narrative are predicated on self-in-relation, on a social or intersubjective world. The very absence of a trustworthy and loyal other, because of violence, erases the person's ability to make use of language to construct experience in the moment of severe trauma. In the moment of torture, there is no self, no language for the experience, and no knowing—only the disaster. Wiesel points to this in his lament: "I no longer know anything, I no longer understand anything; they have taken away my certainties." Blanchot (2) makes a similar comment in saying that "The wish of all, in the camps, the last wish: know what has happened, do not forget, and at the same time never will you know" (p. 82). The survivors' known experience is incomprehensible to them and their listeners.

Severe trauma makes a hole in the very ability to make use of language in constructing self-experience and communicating this to others. The experience of severe trauma haunts not simply because it is related to feelings of powerlessness and physical pain: surely reasons enough for distressing remembrances. It haunts because it is a memory that continually reminds the victims that the certainties they unconsciously, and of necessity, hold with regard to constructing, understanding, and communicating their experiences as well as knowing/possessing themselves, are fragile and can be, and have been, annihilated. In other words, the survivor's sense of self and identity is preserved by language and narrative, providing shared discourse as well as subjective and intersubjective knowledge and understanding. This embodied-narrative-socially structured self, however, is haunted and disrupted by the trauma that threatens to negate self, intersubjectivity, and knowing by destroying the necessary foundations of trust and fidelity in human relations.

Disastrous experience at its core represents unformulatable experience. It can be known, and yet it is never known in the sense of being understandable and communicable. Indeed, the communication of disastrous experience leaves listeners bewildered, anxious, and speechless. It is

not only that the listener experiences the deep powerlessness associated with the traumatic experience. That is difficult enough. Rather, it is that the absence of trust and the very negation of self-experience and identity evokes horror. Speaking about the disaster is a form of communication that leads to the edge of the black hole of trauma, which disfigures language, defies narrative, annihilates representations, destroys community, and threatens the very structures of being human.

DISASTROUS KNOWLEDGE AND THERAPY

Cataclysmic knowledge is a form of nondefensive dissociation that afflicts both patient and therapist. This nondefensive dissociation is present in the experience of speechlessness and incomprehensibility when both therapist and patient face the event of severe trauma. This does not deny the importance and necessity of the "talking cure." Rather, it points to the fundamental need for speaking and listening, because both affirm and confirm a sense of self-in-relation to trust and loyalty. Even in the silence after listening to the patient's testimony of the event and before a verbal response, the act of listening affirms self and community in the face of an event that starkly negates both.

The presence of nondefensive dissociation is manifested in countertransference. Not surprisingly, testimonies of trauma evoke experiences in the listener, which are connected to the speaker's experiences of the trauma. The therapist's experience of speechlessness is a countertransferential response to the patient's own speechlessness in the face of the event of severe trauma. I understand this to mean that the therapist experiences a degree of powerlessness, self-disruption, and incomprehensibility, as well as a motivation or craving not to know or not to know too much. For example, there are times, moments before the person begins his or her story, when the thought "Oh no, here it comes" emerges. We want to turn away (which includes rushing to explanations), and it is the asceticism of the therapist that contains his/her horror in order to listen. At the same time, there is also a desire to respond to the story. Of course, there are occasions when the desire to respond is an attempt to mitigate the sense of incomprehensibility or to move the patient to something else. But at a more basic level, the motivation to respond emerges from a desire to establish a connection with the person that will affirm his or her humanity and the presence of trust and community between the therapist and victim.

Disastrous knowledge is also revealed in the sense of inescapability or being haunted. After having listened to the testimony, there comes a sense that one cannot escape the experience. It sticks with us. The trauma is like

a stain that cannot be washed clean. In a much smaller degree, the patient's story of the trauma continues to haunt the therapist, which discloses the patient's dilemma of having to live with "it."

In confronting disastrous knowledge through the patient's story, there is a certain amount of humility that comes with the recognition of the limits of our therapy. While therapy provides numerous benefits, it is not a "cure" for the experience of disruption and incomprehensibility associated with severe trauma. Some realities in human life cannot be formulated, and not all brokenness can be fully repaired. Hope, then, is not for cure but for life and community in the face of hideous experiences that undermine both.

CONCLUSION

The unfortunates whom Freud referred to were those who experienced and remembered the trauma without developing neurotic symptoms. The resulting "fixation" that occurs in the face of unbearable experience points to the ongoing struggle to make sense of the incomprehensible. Fixation or being haunted by the trauma reveals a type of nondefensive dissociation that is present in the midst of speaking about, and listening to, the traumatic story. More specifically, severe trauma points to those core experiences that undermine a person's ability to organize the experience linguistically, which in turn defies his ability to integrate the event into his self-narrative and communicate this to others. The experience remains unformulated despite efforts to remember, tell the story, and listen to the story of trauma. The unformulated experience represents an event that annihilates trust, recognition, and loyalty that are foundational for persons' ability to organize experience and obtain a sense of self and identity. Whether speaker or listener, the haunting effect of disastrous knowledge is in its threat to disrupt the certainties that are necessary for a semantically structured self and community. Therapy, in part, is walking with the patient to the abyss of severe trauma, all the while recognizing, confirming, and affirming self and community.

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