Experiences of Trauma and Dissociation in France

Jean-Michel Darves-Bornoz

SUMMARY. In France, trauma was identified as a cause of mental illness as early as the middle of the nineteenth century. Physical, sexual, or emotional abuse are the most frequent events. Interpersonal trauma, such as assault, abuse, confinement, or war, lead much more often to severe traumatic responses. In the aftermath of trauma, several traumatic syndromes exist. I discriminated especially *the dissociation and phobia traumatic syndromes*, *the reliving traumatic syndromes*, and *the narcissistic regression traumatic syndromes*. For us, posttraumatic clinics do not fundamentally differ from country to country. French mainstream psychotherapy still remains psychoanalysis. Maybe, the most significant research contribution in France lay in creating, many decades ago now, the first *medical Non-Governmental Organizations* as a therapeutic answer to mass trauma. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2005 by The Haworth Press, Inc. All rights reserved.]*

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Paul Briquet[1] stated as early as 1859 that he found determining causes of "hysteria" in certain events experienced by his patients. Even before, in 1857, Edouard-Adolphe Duchesne reported some traumatic illnesses in railway men that he named "*maladies des mécaniciens*."[2] Then, in France, trauma was identified as a cause of certain types of mental distress in the studies on railway accidents by Duchesne and de Martinet, and on several kinds of overwhelming private events in childhood or adulthood by Briquet.

At the same time, long-ignored scientific interest in the observation and theorization of the division of the mind was arising together with literary plays on interacting states of mind. This led to notions of the *double* in literature and *personnalité alternante* in psychopathology. Such ideas circulated loosely for some time before becoming organized in Jean-Martin Charcot and Pierre Janet's categorization of "traumatic hysteria."

The framework of knowledge accumulated over some decades in the nineteenth century in France became so impressive that even such an experienced doctor as Sigmund Freud visited Charcot's La Salpêtrière Hospital in Paris. In 1885, he had the opportunity to approach the field of trauma and dissociation in Paris, and even attended the very specialized activities on sexual crimes on children conducted by Brouardel, a professor in forensic medicine. Unfortunately, the followers of Charcot in La Salpêtrière left this stream of thinking and covered this knowledge over with a veil of so-called doubt and mistrust concerning the actual suffering of these patients.

However, other inspired clinicians revived the field. Among them were Alfred and Françoise Brauner, who went to Spain in 1936, and who imagined new techniques of psychiatric care for children in war conditions, including drawing techniques. They still remain a reference in France (Brauner, 1946). Such personalities maintained a creative stream of knowledge for trauma in some French circles.

A new wave of interest in France for mass trauma started in the early seventies with the foundation of Non-Governmental Organizations (NGO) such as *Médecins Sans Frontières* and afterwards *Médecins du Monde*. The founding doctors of these organizations wanted to speak out against human rights abuses around the world. One of them, Bernard Kouchner, once summarized their approach by saying: "*mankind's suffering belongs to all men*." Together with ideas for the respect of women's rights, and also fears of violent nationalist struggle reaching France in the 1980s, interest in trauma was definitely re-established in a significant sector of the French population.

TYPES OF TRAUMA

In order to appreciate the types of trauma that nowadays affect the French population, I present here, as an example, the description of my own outpatient department in the University Hospital in Tours. This consulting room was essentially oriented towards people exposed to traumatic events. More than half of them suffered from lasting *Post Traumatic Stress Disorder (PTSD)*.[3] We used the description of these patients for one of my resident student's master memoir. Its methodology was reported elsewhere (El Hage, Darves-Bornoz, Allilaire, & Gaillard, 2002).

All my outpatients older than sixteen were systematically approached for consent. They covered the whole range of ages from adolescence to elderly. The resulting sample over-represented women by five percent, but the mean ages of men and women did not appear significantly different.

Using the *Clinician-Administered PTSD Scale (CAPS)* developed by Blake and his colleagues (Blake et al., 1995) to assess *PTSD*, it was possible to gather which types of potentially traumatic events the patients experienced, through their rating of the exhaustive list of overwhelming incidents included in this instrument.

During the study, one hundred and sixteen subjects reporting one or several overwhelming incidents in their lives were interviewed. All together, these subjects had to face 491 potentially traumatic events, which meant an average of four to five experiences of that type for each person. This fact is crucial when thinking of treatment. Indeed, when such a person consults, it is not necessarily obvious which event was the key event in the process of traumatization. We ordered the overwhelming incidents reported by the patients, sometimes as witnesses, in four classes: physical, sexual or emotional abuse (37.5%), threat on health (31.9%), accidents (16.1%), disasters (10.8%), and war (or civil war) experiences (3.7%). The details of these events are shown in Table 1.

TABLE 1. Types of overwhelming events reported by French psychiatric outpatients (N = 116)

Overwhelming events	N = 491	
	n	%
Physical, sexual or emotional abuse	**184**	**37.5**
Physical assaults (physical maltreatment in childhood, assaults whether by the spouse, an acquaintance or a stranger, sometimes during a burglary)	54	11.0
Weapon assault (knife or sometimes firearms) seldom followed by a confinement	44	9.0
Sexual assaults (non-consensual sexual relations with the spouse, rape attempts or actual rapes, repeated or not, in childhood or adulthood; child abuse with sexual contact)	62	12.6
Severe emotional abuse or neglect	24	4.9
Threat on health	**157**	**31.9**
Illness or physical wound threatening life	30	6.1
Severe human suffering due to an illness	24	4.9
Witnessing a severe wound or personal damage	7	1.4
Sudden and violent death of one's nearest and dearest	28	5.7
Sudden and unexpected death of one's nearest and dearest	68	13.8
Accidents	**79**	**16.1**
Transport accident	50	10.2
Severe accident at work or in the home (with burn, cut, fall and then fracture, crush, or blast)	25	5.1
Exposure to dangerous toxic substance	4	0.8
Disasters	**53**	**10.8**
Natural disasters (earthquake, flood, storm)	23	4.7
Conflagration, explosion	30	6.1
War	**18**	**3.7**
Combat or exposure to a war zone	16	3.3
Captivity in a war (or civil war) context	2	0.4

THE DISSOCIATIVE RESPONSE TO TRAUMA

In our patients, these difficult experiences did not appear equally harmful for two main reasons. First, the repetition of certain incidents or their mix with other types of unfavourable contexts or chronic neglect deepened the traumatic wound as other authors have noted (Gold, 2000): it is not equivalent to undergo a car accident followed by immediate comfort from a warm family, and to experience the hard daily life of a prisoner of war for years subsequent to war combat; it is not equivalent to be raped once at twenty-five by a stranger, and repeatedly from five to ten by one's father (Darves-Bornoz, 1998a,b). Second, events by themselves do not equally overwhelm subjects: in our observations, experiences with an interpersonal dimension, like assault, abuse, confinement or war, lead much more often to severe traumatic responses whether in the traumatic reliving field, or in the traumatic withdrawal and numbing field. In order to fit the broadest range of traumatic syndromes, our clinical outcome studies were then undertaken among one of these groups, rape survivors, where subjects seldom remain non-traumatized (Darves-Bornoz, Lépine, Choquet, Berger, Degiovanni, & Gaillard, 1998). However, we must not forget that any type of overwhelming experience can lead, though more sporadically, to the same extensive clinics in some subjects.

In previous writings (e.g., Darves-Bornoz, Pierre, Berger, Lansac, Degiovanni, & Gaillard, 1997), I stated that in the aftermath of trauma, several traumatic syndromes exist. I discriminated especially three types of syndromes, distinct in their semiotics and independent in their outcome, whose occurrence follows each other: *the dissociation and phobia traumatic syndromes*, *the reliving traumatic syndromes*, and *the narcissistic regression traumatic syndromes*. Their onsets, in general, were hardly or not at all delayed from each other.

The patients let us know, often loudly, their traumatic reliving symptoms, but in many ways, the two other types of syndromes preoccupied us much more, especially as far as children and adolescents were concerned, because of the major psychic development disorders they induced in them (Darves-Bornoz, Berger, Degiovanni, Soutoul, & Gaillard, 1994c; Darves-Bornoz, Degiovanni, Berger, & Soutoul, 1995; Darves-Bornoz, 1995).

The *dissociation and phobia traumatic syndromes* represented the subject's defence mechanisms during the traumatic experience, and afterwards their attempt at processing, on the one hand, an identity wound by fragmenting the memories and the mind, and on the other hand, a traumatic reliving of trauma by avoiding the world. When using the term of dissociation, we meant a soma-psyche as well as purely intrapsyche splitting.

The intrapsychic dissociations included disorders such as psychogenic amnesias (related to the traumatic event or not), depersonalisations (espe-

cially with out of the body experiences), derealizations (for instance, feeling of watching one's own life like a movie), identity fragmentations (at worst, feeling one is two different persons), and automations (especially in fugues). To different degrees, they gave an answer to the subject's psychic pain when unprepared for the emergence of a representation of the world which was contradictory with the one he thought appropriate until that event.

The European psychiatric tradition used to speak of conversions when speaking of soma-psyche dissociation, for example non-epileptic seizures or anaesthesia. For us, these phenomena, as well as purely intra-psyche ones, also gave an answer to a pain, related in this case to the body, experienced before as safe and which was shown not to be so. These oppose the somatic reliving of the traumatic event as confirmed by daily physiological observations (Leroi, 2000).

Table 2 illustrates the close association of psychic dissociation, conversions and phobias to the experiencing of trauma. As for phobias, let us mention agoraphobia as the most specific, and social phobia as the least. Indeed, social phobia may result as much from the complication of a temperament, in other respects not very able to avoid adverse situations, as a traumatic consequence. Although the *reliving traumatic syndromes* had disappeared, we sometimes noticed that the only disorder which persisted was a psychogenetic amnesia or a panic disorder with agoraphobia. This clinical remark tallied with the current theorizations on panic attacks. Indeed, in order to understand the onset of the first attacks, the specialists needed to locate an environmental wound among the factors involved (Gorman, 2000).

The *dissociation and phobia traumatic syndromes* were the first traumatic syndromes occurring after the traumatic event. In some patients, they become recurrent. In that case, the clinical situation developed as if the experience of this defence during the traumatic event induced more frequent subsequent recourse to the same mechanisms in adverse events–but not necessarily traumatic–whereas other people would have reacted in a different way. Their persistency was shown to be a relevant alert sign for the dreaded long lasting *reliving traumatic syndromes* (Darves-Bornoz, 1996).

The clinics of the *reliving traumatic syndromes* consisted in reminiscences, nightmares or what we called trigger-associations which launched the reliving of the pain suffered in the traumatic experience or even the illusion of the traumatic experience itself (for example, a white car for someone who was assaulted in a white car). They formed the most specific and

TABLE 2. Definite psychiatric disorders (*) and their link to trauma experience *[in a six month outcome study of rape survivors]*

	Trauma experience:		
	if lasting at six months %	**if vanished** at six months %	**frequencies comparison** in lasting/vanishing groups p
Dissociation	84	38	< 0.0001
Conversions	75	42	< 0.01
Agoraphobia	70	20	< 0.0001
Specific phobia	56	25	< 0.02
Social phobia	49	29	ns
Panic disorder	18	0	< 0.03
Depressions	53	8	< 0.001
Gender identity disorder	41	4	< 0.001
Alcohol abuse	29	8	< 0.05
Drugs use	14	8	ns
Obsessional compulsive	12	0	ns
Generalized anxiety	7	17	ns
Psychotic or Bipolar	7	13	ns
Anorexia or Bulimia	20	8	ns

(*) Only the disorders occurring early and persistent in one form or another during the six months were taken into account in the table.

Reference. Darves-Bornoz, J.-M.(1997). Rape-related psychotraumatic syndromes. *European Journal Obstetrics & Gynaecology and Reproductive Biology, 71*, 59-65.

sensitive set of traumatic symptoms. Even though the American classification of mental disorders does not adopt such a cluster of symptoms as a sufficient criterion for diagnosing such *PTSD*, in practice when subjects suffered from painful traumatic reliving, these generally fulfilled the other clusters of symptoms required for this category, i.e., traumatic numbing or withdrawal, and traumatic hyper-arousal. In addition, the strength of the reliving was on a par with the strength of *PTSD* as a whole. The painful reliving was massive in physically or sexually assaulted subjects (Darves-Bornoz, Berger, Degiovanni, Lépine, Soutoul, Grateau, & Gaillard, 1994a). For the majority of rape survivors, the diagnosis was still present one year after the trauma (Darves-Bornoz, Pierre, Berger, Lansac, Degiovanni, & Gaillard, 1997) and is posed chronologically as one of the first therapeutic questions. Reliving occurred when the patient recalled an elementary sensory representation (for example, the image of the perpetrator's eyes), through

reminiscences, nightmares, or trigger-associations. This proto-representation figured the whole trauma, and activated the emotion related to the traumatic experience. The traumatic reliving appeared to us then, as a disorder of the representation of the past.

In spite of its frequency in traumatized people–one in two–highlighting depression of the traumatized could lead to thinking that treating traumatized people is no more difficult than treating an isolated depression. It is not even of much use to qualify this as resistant depression. Let us mention, however, that the British professor of psychiatry Sir David Goldberg, after a whole life dedicated to the vulnerability factors in affective disorders, did not hesitate to present child abuse as the first etiological factor of depression (Goldberg, 1998).

In some cases or moments, the *narcissistic regression traumatic syndromes* came to light rather through psychic manifestations and, in others, rather through behavioural manifestations. At first, "the identity uncertainty" assumed the shape of a narcissistic depression (low self-esteem, shame, guiltiness, feelings of abandonment, emptiness or devitalisation) sometimes so severe that it could evoke melancholia if its traumatic aetiology had not been recognized. The identity disorder often became complicated afterwards, early on in some cases, especially in children and adolescents, by an impairing of the psychic development. Indeed, a peculiar "identity reconstruction" then appeared, including outbursts of paranoid omnipotence and acting. These features, well known in patients with a so-called borderline personality, were quite specific to the interpersonal character of trauma. They were infiltrated to such an extent by elements of dissociation, that the question arose as to whether the diagnoses of borderline personality and major dissociation states were redundant, as was suggested by another author (Sar, Yargic, & Tutkun, 1996). The impairing of relationships to other people and the world resulted from that interpersonal traumatic experience which promoted alienating identifications (in particular to the aggressor). In order to protect the psyche, the survivor paradoxically experiences masochism behaviours often described as "traumatophilia." The recurrence and severity of traumatic exposures increased the onsets of these *narcissistic regression traumatic syndromes*. In this manner, in Table 3, the narcissistic regression features were over-represented in incestuous rapes when compared to non-incestuous ones, especially in the fields of low self-esteem and feelings of abandonment, emptiness or devitalisation (Darves-Bornoz, 1998a,b). One must keep in mind that in the most severely traumatized, these syndromes were often the last ones to resist therapy long after any *reliving traumatic syndrome* had stopped.

TABLE 3. Link of narcissistic regression psychic and behavioral features (*) to event severity *[in a six month outcome study of rape victims]*

	Rapes	
	incestuous	non-incestuous
Low self-esteem	68%	37%
Recurrent fear of abandonment	64%	57%
Dissociative episodes	84%	60%
Affective disorder of the depressive type	49%	31%
Persistent feeling of emptiness	76%	56%
Idealization (versus devaluation) of one's nearest and dearest	28%	44%
Suicide attempts	33%	26%
Impulsive fugues	33%	21%
Rage leading to violence	54%	42%
At least five features out of the nine	58%	38%
Mean number of features	4.8	3.7

(*) Only the disorders occurring early and persistent under one form or another during the six months were taken into account in the table.

Reference. Darves-Bornoz, J.-M.(2000). *Problématique féminine en psychiatrie.* Paris : Masson, 270 pp.

They affected the subject's expectations and ideals for himself. As a consequence, we must not be surprised that they showed a more deleterious effect than the other types of traumatic syndromes on children and adolescents. In that way, the *narcissistic regression traumatic syndromes* could be seen as a failure of the representation of the future.

IS THERE A FRENCH SPECIFICITY IN CLINICS OR TREATMENTS?

As for the clinical expression of trauma in France, all the attempts to find major differences with other cultures or countries failed. For instance, many think that "Charcot's type of hysteria" disappeared in France a long time ago and remained present only in "Mediterranean countries." However, when working with a French department of neurology on supposed refractory epileptics recorded in video-EEG sessions,[4] we confirmed that some of them exhibited non-epileptic seizures, and

that all of them had experienced severe trauma in their history. This finding showed once more that phenomena are discovered if they are looked for. Non-epileptic seizures exist in France as in the times of Charcot and as in other countries (Bowman & Coons, 2000). Our thesis lies in the idea that post-traumatic clinical manifestations do not fundamentally differ from country to country.

As for treatment, this is another story because, indeed, there is a French specificity for ways to treat traumatized people. In France, the mainstream psychotherapy still remains psychoanalysis. Actually, even though it seems strange to many colleagues elsewhere, some therapists in France even think that trauma could be a future for psychoanalysis. The example of American psychoanalysts such as Jean Goodwin could indeed show that such a statement does not arise from a new utopia.

Some psychoanalysts from the *Société Psychanalytique de Paris (SPP)*[5] in France became involved in the treatment of mass trauma survivors (Pérel Wilgowicz or Eva Weil); others approached the somatic expression of mental distress (with historical figures such as Joyce McDougall or Pierre Marty, and more recently Claude Smadja and Marilia Aisenstein). In my opinion, the main ability of psychoanalysis in these situations might lie in the actual reexperiencing of fragments of traumatic experiences in the sessions, but this time, in not alone and associative reexperiencing, instead of alone and dissociative reliving. As a matter of fact, the psychoanalytical therapies of borderline cases, well studied by the *SPP* members, differ radically from any spontaneous traumatic reliving. In my view, they allow the patient's psyche to internalise a new protective envelope which could be an image of his calming analyst. During an *SPP* seminar dedicated to that question in La Baule, France, in June 2003, Danielle Kaswin-Bonnefond nicely explored the personal effort to be made by the psychoanalyst with such patients around her report of a borderline case, and with Dolnald W. Winnicott as a permanent reference in her mind. Incidentally, Pierre Chauvel evoked in one of his case presentations the patient's expectation from the analyst, "of an ability to keep emotions as in a safe." Further, André Green, focusing on certain survivors whose development became too chaotic with so many traumatic exposures, stated that finally, one must consider them as if a "paranoia of destiny" preyed upon their lives. He would then incite the psychoanalyst to find new psychoanalytical therapies in these extreme cases.

When physicians do not believe in the usefulness of psychoanalysis, they then mainly centre their hopes on medication, mostly oriented, unfortunately, on unspecific diagnoses such as depression, or on the specific target of reliving. As a consequence, they leave aside all the other specific, but negative or regressive symptoms, such as numbing and narcissistic withdrawal. Such attitudes often disappoint the patients' expectations from a therapy: not only the vanishing of symptoms, albeit upsetting, but above all a restructuring of their internal world on new bases.

RESEARCH ON DISSOCIATIVE PHENOMENA AND TRAUMA

Pierre Janet noted that what was amazing in traumatic disorders lay in the coincidence of amnesia and hypermnesia. Many usual psychiatric symptoms seen in traumatic disorders, like psychogenetic memory disorders, can be referred to dissociation phenomena, and they are not infrequently identified as such in France, whether the traumatic cause is put forward or not. We are not surprised then, to observe interest in France on this topic whatever the point of view taken: today generally the point of view is psychoanalytical (studies on repression or splitting) even though the underlying phenomenon does not differ from Janet's (referred as to passive dissociation). Finally, one cannot say that French psychiatrists ignore the field of dissociation, rather they must be seen as processing them usually in a meta-psychological way.

There has been research on trauma and dissociation in France, but most, it is true, was not conducted in such a way as to allow publication in English language journals, because the interest for the current techniques of clinical epidemiologists, here, remained low. Nevertheless, certain French academicians do not ignore foreign scholars' research who have long since been attracted to this way of studying, whether from countries very close to France such as B.P.R. Gersons, O. van der Hart, S.O. Hoffmann, J.T.V.M. de Jong, J. Modestin, E. Nijenhuis, or U. Schnyder, or from further afield such as J. Chu, P. Fink, M.P. Koss, F.W. Putnam, D. Spiegel, or E. Witztum. So, one can say that French research has been in semi-captivity, although some knew what was going on abroad. This does not mean that the French researchers' findings were of no value for the development of the field. In several areas, studies have been extremely thorough: violence on women, mass trauma, disasters and terrorist attacks, psycho-somatic reactions, psychoanalytic meta-psychology, and some aspects of epidemiological clinics.

In the sphere of psychoanalysis, some refined the studies on meta-psychological concepts related to trauma even though this relation did

not mobilize their interest much. For example, Claude Le Guen, studying repression, did not hesitate to state that research on this concept was over. The usefulness of meta-psychology in the understanding of eating disorders as a psychosomatic disorder continued to be explored by Philippe Jeammet. To my mind, indeed, Spitz's category of anaclitic depression, which is rarely lacking in the early history of a patient with anorexia, is in fact a trauma category.

As far as violence on women is concerned, one must not forget Eva Thomas's text entitled *Le viol du silence*. One could say this book is not research properly speaking, but everybody must be aware that her contribution went beyond the status of a narrative. Eva Thomas founded a survivors' association named *SOS Inceste*. Each year, they all meet for a *Research Meeting* and invite a guest to talk with them. I was that guest once, and I would like to say that I will never forget it. It was moving to see these people converging in Grenoble, France, from all over Europe, and to see how friendly they were toward those who tried to help. With emotion but accuracy, probably because they were the most lucid among these survivors, they all taught me a great deal, through our exchange of ideas: I proposed a theory which they echoed in their survivor feelings; I then suggested ways to get out of the trap, and they responded with brotherhood as a philosophy of existence. This is not the usual standardized research, but as theorization and communication of knowledge, it is definitely human research.

In this field, Catherine Bonnet's studies on sexually abused babies should also be mentioned. Gérard Lopez also stands as one of the first French male psychiatrists who expressed ideas on rape issuing from his consultations in the Hôtel-Dieu forensic centre in Paris. As far as perpetrators are concerned, great psychopathological work by Claude Balier and his pupils (Balier, 1996; Balier, Ciavaldini, & Girard-Khayat, 1996) must be noted, so much so that a French consensus conference was held in 2001 on the initiative of Jacques Fortineau, the president of the *Fédération Française de Psychiatrie*.

Mass trauma studies have mobilized much professional energy all over the world since World War II, and have spread to all kinds of collective violent conflicts (Albeck, 1981). Indeed, a theory has to be made on practitioners who respond to the exacerbation of community conflicts and violent ways of practicing politics by non-violent practices, and then work through mass trauma. This tendency was noticeable in the way the new South Africa processed the crimes of the past, or the way the mothers of the disappeared in Argentina quietly persisted. Now, the recommendation by the Iraqi branch of the NGO *Human Rights Watch* to set up a *Truth Commission* for second rank citizens responsible for the past genocide crimes in Iraq is also planting some seeds of that nature. In France, Haydée Faimberg and Pérel Wilgowicz contributed greatly to the understanding of the alienating processes of intergenerational identifications in survivors and their offspring. In the nineteenth century, it was stated that Germany influenced Europe through the genius of its theoreticians, and France through the talent of its practitioners. Maybe this opinion still applies. Indeed, on the side of treatment, one can say that the French movement leading to the creation of the first *medical NGO* many decades ago now also represents a practical French answer to mass trauma in the sphere of therapeutics (Darves-Bornoz, Berger, Degiovanni, Soutoul, & Gaillard, 1994b).

As far as trauma through disasters or terrorist attacks is concerned, there has been a recent interest in two directions: early treatment and some aspects of epidemiological clinics. A network for early treatment of such traumas started to be established by the French government a decade ago. It consisted of one hundred psychiatrists, one responsible for each French administrative area, assisted by volunteers (nurses, psychologists, psychiatrists) and prepared for early interventions. Some of them had other experiences in the trauma field: for instance, Darves-Bornoz (assaults), Katz (firemen), and Vila (children). Until now, the assessment of its efficiency could not be made. Epidemiological studies of terrorists attacks have also been the subject of interesting publications (Jehel, Paterniti, Brunet, Duchet, & Guelfi, 2003).

In the sphere of psycho-somatic reactions, the French theoretical effort was important. The salient authors came from the *SPP*. Though they all refer somatization to some kind of trauma, their interest in the field, as mentioned above, lies in the will to understand the functioning of any subject rather than patients with definite disorders from a psychiatric point of view. Two different approaches to conceptualising these phenomena currently prevail. The first one, including Marty's followers (Smadja and Aisenstein), is centred on the category of "pensée opératoire," which is close to Sifneos's alexithymia, resulting from the loss of ability to associate and fantasize. The second one, represented by Joyce McDougall, who accomplished a part of her career in Paris and a part in New York, considers the psychosomatic phenomenon rather as a continuum of phenomena including slight daily manifestations, the so-called "hysterical conversions," up to severe illnesses with the reputation of comprising a strong psychosomatic component. She considers somatization as an archaic body language and a way to survive psychically for those who cannot find usual words for their trauma.

To my mind, any effort for theorizing trauma is useless if not founded on valid observations. I have therefore found it essential to lead clinical investigations using epidemiological techniques that are as modern as possible. Since the end of the eighties (Choquet, Darves-Bornoz, Ledoux, Manfredi, & Hassler, 1997; Darves-Bornoz, 1990; Darves-Bornoz, & Lempérière 1992; Lépine & Darves-Bornoz, 1993), we have tried to do so with Marie Choquet, Jean-Pierre Lépine, Thérèse Lempérière and Andrée Degiovanni, and now we are planning to combine other approaches with Hervé Le Louet. Our outcome studies of assault victims allowed us to discriminate early predictive factors of long lasting trauma. For instance, observing early and persistently a set of symptoms composed of low self esteem, permanent feelings of emptiness and fears unrelated to trauma such as agoraphobia, was found to be a strong predicting model of the persistency of *PTSD* one year later (Darves-Bornoz, 1998b). One could say this in another way: the more the narcissism or identity regress after the event, the longer the trauma will last. Moreover, we could also state that severity of trauma is on a par with the intensity of such psychic movements, including dissociation manifestations (Darves-Bornoz, 1996; Darves-Bornoz, Berger, Degiovanni, Gaillard, & Lépine, 1998b). For us, these findings fuel our opinion that narcissism or identity regressions subsequent to overwhelming incidents signal the most preoccupying change in traumatized populations.

CONCLUSIONS

In summary, in France, the subjects whose trauma refers to an interpersonal relationship with a third party in a sadistic position, suffer the most. They suffer without any doubt from traumatic reliving, but they also resort to intra-psyche or soma-psyche dissociations, and to phobic avoidances of the world in order to prevent the pain felt in their panics. At the same time, they transform, negatively or not, their identity and their narcissistic equilibrium.

A constituted trauma alters the usual activity of representing the past. In the *reliving traumatic syndromes*, the traumatic memory is reduced to a proto-representation–in our previous example, the sole image of the aggressor's eyes–and the pain felt in the whole overwhelming experience is attached entirely attached to this.

A constituted trauma alters the usual activity of representing the future. With the *narcissistic regression traumatic syndromes*, survivors wounded in their being aim at a neo-identity for the future implying new

ways of thinking and behaving, for example in identifying with the aggressor, the lost object, or the damaged object.

The way in which the subject passes from the first register to the second is determined by the defences used during the overwhelming experience and combined what we called *dissociation and phobia traumatic syndromes*. Indeed, on one hand the phobic avoidance actualises the traumatic past again and again. Paradoxically, at the same time, the phobia carries its own projection into the future, the counter-phobic attitude of challenge. Thus, amnesia, and also conversion, through the fragmentation of the being, especially enable the past to be ignored. However, these dissociations also promote the emergence of neo-identities underpinned by new ideals and expectations for the future. With these jumps into the future, the survivor attempts to tune his being to the world as constituted after the trauma.

NOTES

1. In his "*Traité clinique et thérapeutique de l'hystérie.*"
2. In a book entitled: "*Des chemins de fer et de leur influence sur la santé des mécaniciens et des chauffeurs.*"
3. We will refer from here, as to PTSD, this psychotraumatic category within the current *American Psychiatric Association*'s classification of mental disorders.
4. During one week periods with a coupled electroencephalograph recording.
5. The French founding society of the *International Psychoanalytic Association.*

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