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"Psychoanalysis with the Traumatized Patient: Helping to survive extreme experiences and complicated loss."

Sverre Varvin, MD, Dr. Philos*

*Professor, Oslo and Akershus University College of Applied Sciences (OAUC)
Faculty of Health Sciences, Institute of Nursing

Corresponding author:

Sverre Varvin

Professor, Oslo and Akershus University College of Applied Sciences (OAUC)

Faculty of Health Sciences, Institute of Nursing

Address: Postboks 4 St. Olavs plass

0130 Oslo

Tlf.: 67 23 50 00

E-mail: sverre.varvin@hioa.no

Abstract

Extreme and complex traumatization represents a severe problem in today's world. Many traumatized persons and their families live under difficult conditions in refugee camps, shelters and in exile. Treatment and rehabilitation approaches need to take social and cultural conditions into consideration. The paper will discuss how psychoanalytic therapy may be helpful for severely traumatized patients and what are the mechanisms of change in the therapeutic process. A focus is on how traumatic experiences are actualized in the transference and brings the analyst in a situation where enactments inevitably occur. It will be demonstrated how these processes may lead to symbolization of non-symbolized reminiscences of traumatic experiences. Psychoanalytic therapy with patient with complicated loss experiences will be analyzed and some conclusions based on this and others researched therapies will be discussed. The advantages of working with trauma-related material in the transference will be focused.

Keywords: Traumatization, loss, psychoanalytic psychotherapy, enactment

Introduction

Traumatized persons struggle with mental and bodily pains difficult to understand and difficult to put into words. The pains may be expressed as dissociated states of mind, as bodily pains and other somatic experiences and dysfunctions, as overwhelming thoughts and feelings, as behavioural tendencies and relational styles, as ways of living and so forth. The effects of both early and later traumatization may show itself in many diagnostic categories where the symptoms characterising PTSD is only one form.

Traumatization may be a causative and/or disposing factor in many psychopathological manifestations: depression, addiction, eating disorders, personality dysfunctions and anxiety states (Leuzinger-Bohleber, 2012; Purnell, 2010; Taft et al., 2007; Vitriol, 2009; Vaage, 2010).

What is common for these manifestations of traumas are deficiencies in the representational system related to the traumatic experiences; the traumatic experiences are painfully felt and set their marks on the body and the mind but are poorly contained in words. They are not or deficiently symbolised in the sense that they cannot be expressed in narratives in a way where meaning can emerge that can be reflected upon. They remain in the mind as dissociated or encapsulated fragments that have a disturbing effect on mood and mental stability (Rosenbaum & Varvin, 2007).

As a rule, extreme traumas (like rape, torture) eludes meaning *when* it happens and it precludes also forming an internal third position where the person, in his or hers own mind, can create a reflecting distance to what is happening. The inner witnessing function, so vital for making meaning of experiences, is attacked during such extreme experiences hindering the individual from being able to experience on a symbolic level the cruelties they undergo.

Psychodynamic treatment approaches

In this paper I will discuss how people may live through extreme and prolonged traumatisations and also how they try organising their lives in the aftermath and how their way of struggling and coping may manifest itself in the therapeutic or analytic process. A main point is that the analyst, when taking on the task of treating such traumatised patients, inevitably becomes involved in the not-symbolised, fragmentary and as a rule strongly affective scenarios related to the patient's traumatic experiences. This happens from the first encounter with the patient and is mostly expressed in the non-verbal interaction between the patient and the analyst. It may take long time before these manifestations may be given a narrative form that in meaningful ways relates to traumatic and pre-traumatic experiences, and it implies hard and painful emotional work from the patient, and also from the analyst to achieve this end.

There are several therapeutic approaches at present for the treatment of the serious or extreme traumatised persons. There is, however, a lack of research on outcome, on how different approaches works for which patients in what situation a certain therapy may help. In this presentation I will focus on psychoanalytic treatment. I have in my own research and clinical practice seen good results of this approach an example of which I will demonstrate in this article. It is perhaps a paradox that many traumatized persons prefer psychoanalytic treatments in spite of recommendations for many evidence-based, often exposure oriented or trauma focused, therapies (B. A. van der Kolk, McFarlane, & Weisaeth, 1996). This user-based view on the advantages of psychoanalytic approaches was, moreover, confirmed by Schottenbauer and co-workers who demonstrated essential beneficiary aspects of this approach. Firstly they found in metastudies that evidence-based treatments had high drop-out and non-responder rates (M. A. Schottenbauer, Glass, C. R., Arnkoff, D. B. Tendick, V., Gray, Sheila, H., 2008). They argued further eloquently for psychodynamic therapies as suitable for the treatment of traumatised persons for the following reasons (M. Schottenbauer, Glass, CR, Arnkoff, DB, Gray, SH., 2008):

- Psychodynamic approaches address crucial areas in the clinical presentation of PTSD and the sequels of trauma that are not targeted by currently empirically supported treatments.
- They may be particularly helpful for complex PTSD as they target problems related to the self and self-esteem, ability to resolve reactions to trauma through improved reflective functioning and aim at the internalization of more secure inner working models of relationships.
- They work on improving social functioning.
- Psychodynamic psychotherapy tends to result in continued improvement after treatment ends.

Patients with complex trauma often live in difficult social, economic and cultural situations and treatment needs thus to be integrated with rehabilitation procedures and often with complicated somatic treatments. This holds true for many traumatized refugees but also for complex family based traumatization. Treatment and rehabilitation need therefore often to be conducted by a team and when and how to implement psychoanalytic therapy, has to be carefully evaluated and will need constant support from the team and social services.

Trauma and the social context

For these not symbolised and insufficient symbolised experiences to approach some integration and given some meaningful place in the individual's mind, they need to be actualised and given form in a holding and containing therapeutic relationship. This implies that the analyst must accept living with patient in areas of the mind that are painfully absent of meaning and at times filled with horror.

As a rule, however, this is not sufficient: without acknowledgement of the traumatic events at the societal, cultural and political level, the individual and the group's work with traumatic experiences may be extremely difficult.

Without affirmation on the social and cultural level, the traumatised person's feeling of unreality and fragmentation connected with the experiences may continue.

This was the case for many after the second-world war in the West, where the official attitude to a large degree was that one must go on living and put the past behind. In Norway this had devastating and often fatal consequences for

many warship sailors who had endured extreme traumatisations and hardships while being constantly attacked and torpedoed by German submarines. (Askevold, 1980).

One should remember also that what may contribute most to the personal suffering of survivors seem to be to observe others being maltreated and killed and not being able to help or protect. This underlines the importance of Nederland's seminal papers on survival guilt (Nederland, 1968, 1981), a theme that came in the background in the trauma literature for many years, but was highlighted clearly by the youth surviving the Utøya massacre 22 of July 2011 in Norway.

The dynamic and structure of extreme traumatisation

How trauma affects a person depends on the severity, complexity and duration of the traumatising event, the context, whether intrafamilial or external and the developmental stage. Central is the way in which traumatisation affects internal object relations; for example whether earlier traumatic relations are activated and the perceived support after the event and the treatment offered.

I will here concentrate on adult onset trauma and give one example from a traumatised refugee in psychoanalytic therapy.

I. Phenomenology of traumatisation

Being traumatised is an experience of something unexpected that should not happen. It creates an internal situation of profound helplessness and an experience of being abandoned by all good and helping persons and internal objects. The feeling of helplessness and being abandoned may be carried over into the posttraumatic phase. A deep fear of an impending catastrophe of helplessness where nobody will help or care may develop. An inner feeling of desperation and fear of psychosomatic breakdown with fear of annihilation may ensue and much of posttraumatic pathology may be seen as defence against and an attempt to cope with this impending catastrophe, which in fact already has happened (Winnicott, 1991)

Human made traumatisations influence internal object relations scenarios in different ways. Early traumas that bear more or less similarity to the present traumatisation may be activated making the present trauma imbued with earlier losses, humiliations and traumatic experiences. Even early safe-enough relationship may be coloured by the later traumatising relationships when for example a too authoritarian father may be fused with a torturer thus almost deleting the good enough aspects of this relation. Unbearable losses may bring the traumatised to forever seek a rescuer or substitute in others, as happened with Fatima, to be presented later.

Complicated relations to the traumatising agent/person, the circumstances and other relations involved may thus ensue and these may be actualised in the transference. Identification with aggressor is well known.

The traumatised person internalises important aspects of the traumatising scenario in the form of self-object relation which may be more or often less differentiated and/or fragmented and in different ways self-negating. As we shall see, the actualisation of these may in the analytic process take dramatic forms.

II. Relation and symbolisation

One salient task in psychotherapy with traumatized patients is to enhance a metacognitive or mentalising capacity that can enable the patient to deal more effectively with traces and derivatives of the traumatic experience. This implies helping the patient out of mental states characterised by concreteness and lack of dimensionality.

During traumatization the ego meets an overwhelming abundance of stimuli and impressions. The regulating functions of the mind breaks down and the processes of the psychic apparatus are pushed towards states of extreme anxiety and catastrophe (Rosenbaum & Varvin, 2007). Mental traces of such traumatic experiences are “wild” in the sense that the person has no capacity to organize and deal with them; no inner container in a relation to an inner empathic other that can help give meaning to experience (Laub, 2005).

There is an experience of loss of internal protection related to the internal other – primarily the loss of the necessary feelings of basic trust and mastery.

An empathic internal other is no longer functioning as a protective shield and the functions that gives meaning to experience may no longer work.

Attachment to and trust in others may be perceived as dangerous reminding of previous catastrophes. Relating to others, for example in psychoanalytic psychotherapy, may be felt as a risk of re-experiencing the original helplessness and a feeling of being left alone in utter despair. Withdrawal patterns may be the consequence, creating a negative spiral as withdrawal at the same time means the loss of potential external support (Varvin & Rosenbaum, 2011).

The effects of trauma may thus affect several dimensions of the person's relations with the external world and give disturbances on the bodily-affective level, on the capacity to form relations to others and the group and family and on the ability to give meaning to experience. The last is dependent on the social and cultural meaning-giving functions which under normal circumstances provide affirmative narratives; e.g. stories told by elders, scientific explanations; e.g. psychological theories and political acknowledgement; e.g. leaders' acknowledging the historical circumstances of the atrocity.

The traumatised person is living with historical experiences that are not or poorly formulated but painfully and non-verbally represented in the body and in the mind. The task of therapy is to allow these experiences to emerge in the transference relationship so that words and meaning can be co-created even if the experiences themselves by all human standards are cruel and devoid of meaning.

The traumatic experiences must thus become actual in the therapeutic relationship. This may happen when the analyst is drawn into relational scenarios where he/she becomes part of the emerging trauma related scenes that the patient hitherto has struggled with alone.

I will in the following demonstrate one aspect of psychoanalytic therapy that may be an important step in this symbolising process

III. Actualization, projective identification and enactment

The traumatised patient will from the start of therapy involve the analyst in not symbolised and unconscious relationship where the patient communicates by acting out and in this way present important aspects of their traumatic experiences (Varvin, 2013). In this way, trauma is present from the beginning of the contact. "Trauma" is not something that comes later when a trauma narrative is told.

What the patient communicates touches the analyst and may hook on to unconscious, not worked through material on his /her side resulting in action that at first sight is not therapeutic, therefore named countertransference enactment (Jacobs, 1986).

Such enactments on the analyst side may, however, be a starting point for a possible process of symbolisation and making conscious of these implicit experiences (Scarfone, 2011).

It should be underlined that an enactment actually involves a collapse in the therapeutic dialogue where the analyst is drawn into an interaction where she/he unwittingly acts thereby actualising unconscious wishes of both him/her-self and the patient. It may be a definable episode in a process with more or less clear distinctions between the pre-phase, the actual moment and the post-phase but may also be part of a prolonged process in therapy (Jacobs, 1986). Enactment appears thus as an unintentional breakdown of the analytic rule of "speech not act", and this may imply a new opportunity of integration or it may hinder the analytic process when it goes unnoticed or unanalysed.

Enactments may come as a total surprise but can also be identified in for example fantasies and thoughts and feeling states on beforehand (Jacobs, 2001). Most often it is a surprise and the analyst suddenly finds himself doing something that is out of the ordinary and not in accordance with the usual practice of psychoanalytic psychotherapy. It is only afterwards that it is possible to look at what happened and then, if things goes well, be able to understand which processes were at work.

In the context of trauma, enactments may represent a possibility for symbolising material related to traumatic experiences. Scarfone holds that “remembering is not, when it works, a simple act of “recalling” or “evoking”. It implies the transmutation of some material into a new form in order to be brought into the psychic field where the functions of remembering and integration can occur (Scarfone, 2011).

Enactments can thus in connection with trauma be seen as actualization of relational scripts or scenarios where unconscious, not symbolized material are activated both in the patient and in the analyst. This is seen as an unavoidable part of the analytic interaction and outcome depends on the analytic couple’s ability to bring the enactment into the psychic field.

The pressure is usually understood as starting from the patient, although mutual or reciprocal pressure may be seen (Mc Laughlin, 1991; McLaughlin, 1992) where analysts conflicts reinforces the patients tendency to act. An unconscious fantasy is actualized in the transference, the pressure is mediated via projective identification and the analyst “acts in” due to unresolved countertransference problems.

I will try briefly to illustrate aspects of these processes.

Loss and trauma – a case story

Fatima, a woman in her late thirties, came to Norway as a refugee from a country in the Middle East 9 years prior to treatment. She was in psychoanalytic psychotherapy face-to-face, 2-3 times a week, for one and half year.

She reported a relatively happy childhood, being loved both by father and mother and her siblings, and she had managed to get an education as well in spite of a culture that did not favour women's education. She was married and was working as clerk when she was arrested because of participating in a non-violent political organization together with her husband. At the time of her arrest she was pregnant in the last trimester. She was maltreated physically (including beatings on her pregnant womb) and

psychically (threats, seclusion etc.) and suffered from malnutrition and lack of proper medical care when she became ill. Her husband was arrested at the same time and was tortured to death some months later. She was allowed to go to a public hospital to give birth, and an escape was arranged for her shortly thereafter. While she was living clandestinely, her child died of an unknown disease, probably caused by the torture, maltreatment, and lack of adequate medical care during her stay in prison.

After the death of her child and husband, she lived clandestinely for about one year before she fled from her country under difficult circumstances. During this time, she experienced additional serious traumas. When she arrived in Norway she was not believed by the authorities. She was put in prison and sent back to a third country where she had to live under very poor conditions for some time before she again was allowed entrance to Norway.

She arrived in Norway severely depressed and suicidal and had serious eating problems in addition to post-traumatic symptoms and psychosomatic symptoms. In the years in Norway she suffered almost continuously from nightmares, re-experiencing, avoidance behaviour, somatisation, and psychosomatic illness and recurrent depressions. In spite of this, she managed to settle and achieve a considerable degree of integration in the community. She lived alone and had friends but no intimate contact with men. High levels of activity, lots of helping others, and little time for herself, seemingly reflecting a need to act rather than feel, characterized her life in exile.

Fatima had to a large extent mourned her husband, for example, performing grief-rituals on his birthday. The loss of her child was not a problem she presented when seeking therapy and it remained silent during the first part until it emerged in a quite dramatic way in a session after a week's break in the treatment.

She arrived on time at the session, out of breath as she had been running believing she was late. Her first remark was. **"I lost the bus"** (A common expression in Norwegian when coming late for the bus, and here

also indicating the theme of loss). In the first part of the session she spoke in staccato manner evoking a strong need in the analyst to help and support her.

She talked about her loneliness during the break, the need to have someone to lean on, to trust and who could be close. The analyst affirmed her feeling of loneliness; something that set in a counter movement where she referred to a progressive friend who maintained that one could easily do without the support of a family. Her own family and her close relations to them and also her ambivalent feelings towards them had been a theme throughout the therapy. In this section of the session the analyst's interventions also became intellectual with lack of affective resonance. The analyst did in this way join the patient in an enactment attempting to ward off painful material.

Then a shift occurred when the analyst remarked, remembering her earlier clearly stated affection for her family, that they, her family, surely would have liked her to get a family. She then became silent for some minutes and said crying:

“Yes, I have been thinking if I had my son, he would have been 13 years old and .. “

She cried a lot and seemed distant, obviously re-experiencing scenes from the past. She then haltingly in short sentences, and after encouragement, told about the birth of her child, how happy she had been when she heard the child cry. It was felt like a victory. Also the dangers came to her mind and she was frightened and desperate in the session. She did not manage to stop crying as she left.

This was a breakthrough of memories, or rather memory-fragments, which came as surprise for the patient (and for the analyst). It was a re-experiencing “like a film” of the trauma-scenario, a broken narrative.

She was physically ill during the night and when she came the next day she was still quite affected and it gradually became clear what had happened before and during the previous sessions, which in fact represented an actualisation of the drama when she lost her child.

Three consecutive nights before the key session she had had the following dream, which she told, realising the connection with her child's death:

“And then suddenly I get all; I feel I, I got like; I had / I did not tell you,

I dreamt for three nights [before the key session] that I cried..., I was very narrow in my throat and, and had like saliva around my mouth. It's like a; then I thought like, what is it that makes me feel. I don't get enough oxygen and (heavy breathing), when I, eh, was in the middle of crying, when I woke up”.

She then could narrate how her child died:

She was living clandestinely under poor conditions. Her child got fever and had increasingly difficulties in breathing. In the end the baby died in her arms of lack of air (asphyxia). Her despair and grief were abruptly interrupted by the dangerous circumstances, which demanded that she moved on. Her baby was buried in haste and the harsh tone among her comrades stopped any attempt of her for emotional reactions.

We can now reconstruct aspects of what happened in her therapy¹. She had a markedly positive, almost idealising transference towards the analyst. In the break she had felt utmost lonely and this had evoked in her unconscious memories of her child, as well as other persons she had lost (her husband and also her father when she was in exile). In the session she came out of breath with a feeling of loss (expressed in her first remark: “I lost the bus”). The countertransference was characterised by a desperate wish to help but then a felt helplessness, which resulted in distancing and intellectualisation on the analyst's side.

In hindsight it was possible to identify several episodes earlier in the therapy where the theme of loss had come up and also where dead children had been mentioned. This had obviously been small attempts by the patient to

¹ The therapy process was analysed longitudinally using Assimilation Analysis. This analysis tracks the development of problematic experiences throughout therapy through a qualitative procedure using narrative and procedural aspects of the therapeutic dialogue ((Varvin, 2003)

bring maybe her most painful experience into the therapy but she then backed away and either intellectualised or dropped the theme. The analyst had colluded with this and also avoided the theme of loss, which had connection with the analyst's own problems and some unresolved issues concerning his own losses. These countertransference problems were possible to identify, understand and reflect on only when analysing the sessions afterwards.

The theme of loss became, however, more acute for her in the break preceding this key-session. She had obviously during this time, partly unconsciously, lived through and been occupied with her tragic loss and identified with her dead child and, by projective identification, the analyst got the role of the helpless helper pushing him to act according to the role assigned to this part. This interpretation was supported by analyst's subjective counter-transference reactions (i.e., feeling solicitous but helpless)

The relative abstinence in the session allowed her to start symbolising her traumatic loss. The dreams was obviously a signal of an unconscious preparation for re-experiencing the death of her child, in which she gave voice to the part of herself identified with the child trying to survive.

As the loss theme was elaborated, Fatima began to integrate the loss of her child with her other losses -- her husband's death, her father death some years ago, and also other deaths. Thus, the emergence of the loss of her child brought with it memories of other losses, which she then worked to integrate and mourn during the rest of the therapy. She also had to face her guilt for not having been able to help her child, which may be interpreted as a survivor guilt.

Needless to say, this was a hard and labours process also for the analyst who had to work on his own unresolved issues. The work was completed but the treatment did make a difference in her life; she was no longer depressed and had less somatic pain and, more important, she started a new way of life. She was no longer the tireless helper, she took time to care for herself and relax and she managed to establish a relationship with a man.

Discussion

Fatima's experiences in her therapeutic process reflect complex interactions on a verbal and nonverbal level. Traumatic experiences are present in the mind and body of the traumatised in different ways, all seeking expression in communicative styles and ways of being in relation to the analyst. They may dramatically involve the analyst in processes that touch the analyst's own unresolved or partly resolved issues and draw him into a process of acting instead of thinking and reflecting. The transference- countertransference situation may push the analyst to become involved in a relational scenario that as a rule is possible to understand and interpret only after the fact. In the sequence presented from Fatima's treatment, the analyst became the "helpless helper" in the transference and defended against this feeling by joining the patient's intellectualization. The transference situations varies of course, and different personas from the patient's internal world may appear in the transference as for example the perpetrator, the dehumanised victim and so forth.

It is argued that countertransference enactment may be a central vehicle for unsymbolized trauma related material to emerge and that when this happens, an opportunity may appear for the "unthought known" to be heard and contained in a common created narrative that relates present suffering to past misery. A time-dimension can then be established in this area of the psyche, which also makes reflection possible. The precondition is attention to countertransference reactions and fantasies and the analyst's capacity for containment and gradual reflection and working through of the personal part of his reactions.

What happens is a mostly unconscious "mis en scene", which may happen over longer time in therapy. What we saw in this example was a more acute reaction of the analyst, but also that avoiding the loss theme probably had been going on for a prolonged part of the treatment.

One may speculate that similar processes are at stake in so-called trauma - focus therapies (Kruse, 2009). These do not, however, reflect on transference

and countertransference processes. It is an open question then whether psychoanalytic therapies may have more lasting effects, as claimed by Schottenbauer et al (2008), due to the working through of traumatizations in the transference. This may focus trauma-related experiences in their rootedness in the personality, which implies work both with personality functions and relational aspects..

This may especially relate to the work nonverbal aspects of communication, as the most important aspects of relational traumas are non-verbal and only partly symbolised (Packard, Rodríguez-Fornells, Stein, Nicolás, & Fuentemilla, 2014). Traumatized persons experiences represents a partial foreclosure where parts of the symbolic function is undermined. This contrasts with the almost total undermining of the symbolic function in many psychotic conditions. Foreclosed signifiers are not integrated in the subject's unconscious so they tend to re-emerge from outside, in "the Real" (Lacan, 1977). Another way of saying this is that they appear as beta-elements and sometimes also as bizarre objects experiences as coming from the outside through for example hallucinations (Bion, 1977). These mechanisms may also be reflected in traumatized persons' attention- and concentration problems and their difficulties in organising impressions in thoughts (B. van der Kolk, 2014). Many traumatized persons have, moreover, the experience that language was perverted during torture and other atrocity situations which have the consequence that they to a large degree have learned to rely on non-verbal communication. In torture, for example, everyday-day expressions are often used for the most gruesome torture practices, confusing communications are used to break down people and so forth.

The fact that so much of the focus in interpersonal relations with severely traumatized patients relies on the non-verbal dimensions may explain to a certain extent why many traumatized patients feel safe in "psychoanalytic context" and also why psychoanalytic therapy works when patient and analyst have different cultural background and different native languages. As Erik Homburger Erikson stated poignantly many years ago regarding communication with exiled and immigrants: "They do not "hear what you say, but "hang on" to your eyes and your tone of voice" (Erikson,

1964)p.95). Apart from this, one must underline that psychoanalytic therapy is in itself a culture sensitive approach in that utmost care is done to understand patients on their background of their personal and cultural contexts.

Massive traumatisations create destabilisation of the basic structures of human relationships:

- on the level of intimate relationships where intrapsychic and interpersonal functions concern regulations of emotions, primary care functions and basic identity issues
- on the level of the individual relations to the group where personal identity and developmental task are negotiated
- on the cultural or discourse level, where narratives are established that give meaning to and stabilises relations and developments on the individual and group levels (Rosenbaum & Varvin, 2007).

Any approach to patients who have been traumatised in a violent social context, such as wars, mass persecution and genocides, must therefore be sensitive to, and take into consideration the dimensions of social and cultural influences on development, psychopathology and health-sickness behaviour. The last hundred years of history has moreover shown that social forces repeatedly have neglected traumatised persons and groups and even treated them as malingerers as was seen during World-War I. This lack of social support and recognitions has for many been devastating. Treatment of traumatised patients can therefore only with great difficulties work in a social/cultural setting where traumatisations are not acknowledged and worked with at other levels in society.

Askevold, F. (1980). The war sailor syndrome. *Danish Medical Bulletin*, 27(5), 220-224.

Bion, W. (1977). *Seven servants*. New York: Aronson.

Erikson, E.H. (1964). Identity and Uprootedness in Our Time. In *Insight and Responsibility* (pp. 81-107). New York: Norton.

Jacobs, T. (1986). On countertransference enactments. *J Amer Psychoanal Assn*, 34, 289-307.

- Jacobs, T. (2001). On misreading and misleading patients: some reflections on communications, miscommunications and countertransference enactments. *Int J Psychoanal.*, 82, 653-669.
- Kruse, J., Jokosimovic, L., Cavka, M., Wöller, W., Schmitz, N. (2009). Effects of trauma-focused psychotherapy upon war refugees. *J Trauma Stress*, 22(6), 585-592.
- Lacan, J. (1977). *Écrits*. Hammondsworth: Penguin Books.
- Laub, D. (2005). Traumatic shutdown of narrative and symbolization: A death instinct derivative? *Contemporary Psychoanalysis*, 41(2), 307-326.
- Leuzinger-Bohleber, M. (2012). Changes in dreams—From a psychoanalysis with a traumatised, chronic depressed patient. In Horst Kächele Peter Fonagy, Marianne Leuzinger-Bohleber and David Taylor (Ed.), *The significance of dreams* (pp. 49-88). London: Karnac.
- Mc Laughlin, J.T. (1991). Clinical and theoretical aspects of enactment. *J Amer. Psychoanal Assn.*, 39, 595-614.
- McLaughlin, J.T. & Johan, M. (1992). Enactments in psychoanalysis (Panel report). *J Amer Psychoanal Assn.*, 40, 827-841.
- Niederland, W.G. (1968). Clinical observations on the "survivor syndrome". *Int.J Psychoanal.*, 49(2), 313-315.
- Niederland, W.G. (1981). The survivor syndrome: further observations and dimensions. *J Am.Psychoanal.Assoc.*, 29(2), 413-425.
- Packard, PA., Rodríguez-Fornells, A., Stein, LM., Nicolás, B., & Fuentemilla, L. (2014). Tracking explicit and implicit long-lasting traces of fearful memories in humans. *Neurobiol Learn Mem.*, 116, 96-104. doi: 10.1016/
- Purnell, C. (2010). Childhood trauma and adult attachment. *Healthcare Counselling and Psychotherapy Journal*, 20(2).
- Rosenbaum, B., & Varvin, S. (2007). The influence of extreme traumatisation on body, mind and social relations. *Int J of Psychoanal*, 88, 1527-1542.
- Scarfone, D. (2011). Repetition: Between presence and meaning. *Canadian Journal of Psychoanalysis/Revue canadienne de psychoanalyse*, 19(1), 70-86.
- Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B. Tendick, V., Gray, Sheila, H. (2008). Nonresponse and Dropout Rates in Outcome Studies on PTSD: Review and Methodological Considerations. *Psychiatry*, 71(2), 134-168.
- Schottenbauer, MA, Glass, CR, Arnkoff, DB, Gray, SH. (2008). Contributions of psychodynamic approaches to treatment of PTSD and trauma: a review of the empirical treatment and psychopathology literature. *Psychiatry*, 71(1), 13-34.
- Taft, CT., Kaloupek, DG., Schumm, JA., Marshall, AD., Panuzio, J., King, DW., & Keane, TM. (2007). Posttraumatic stress disorder symptoms, physiological reactivity, alcohol problems, and aggression among military veterans. *J Abnorm Psychol.*, 116(3), 498-507.
- van der Kolk, B. (2014). *The Body Keeps the Score. Mind, Brain and Body in Transformation of Trauma*. London: Allen Lane, and imprint of Penguin Books.
- van der Kolk, B.A., McFarlane, A.C., & Weisaeth, L. (1996). *Traumatic Stress*. New York London: The Guilford Press.

- Varvin, S. (2003). *Mental Survival Strategies after extreme Traumatization*. Copenhagen: Multivers.
- Varvin, S. (2013). Trauma als Nonverbaler Kommunikation. *Zeitschrift für psychoanalytische Theorie und Praxis*, 28, 114-130.
- Varvin, S., & Rosenbaum, B. (2011). Severely traumatized patients' attempts at reorganizing their relations to others in psychotherapy: An enunciation analysis In N. Freedman & M. Hurvich, Ward, R. (Eds.), *Another kind of evidence. Studies on Internalization, Annihilation Anxiety, and Progressive Symbolization in the Psychoanalytic Process* (pp. 226-243). London: Karnac.
- Vitriol, VG. Ballesteros, st., Florenzano, ru., Weil,kp., Benadof, df. . (2009). Evaluation of an Outpatient Intervention for Women With Severe Depression and a History of Childhood Trauma. *Psychiatr Serv*, 60, 936-942.
- Vaage, A.B. (2010). Long-term mental health of Vietnamese refugees in the aftermath of trauma. *The British Journal of Psychiatry* (2010) 196: 122-125, 196, 122-125.
- Winnicott, D.W. (1991). [Fear of breakdown]. *Psyche*, 45(12), 1116-1126.