

Extreme Traumatization: Conceptualization and Treatment from the Perspective of Object-Relations and Modern Research

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Introduction

In the last century civilians increasingly became targets in wars, totalitarian regimes and internal wars. This trend continues into this century. The basic unity in all societies, the family in its different forms, is thus increasingly under attack in these war zones, with serious consequences for the mental health and the development of its members.

Responses to Traumatization

The accepted use of trauma concepts is highly problematic. The word “trauma” implies something static and reified, like a “thing” in the mind, and this usage tends to divert attention towards the dynamic and reorganizing processes in the traumatized person’s mind, body and relations to others that happens after being exposed to atrocities. These are processes that depend on the level of personality organization, on past traumatizing experiences, on the circumstances during atrocities and, most importantly, on the context that meets the survivor afterwards. It is the person’s responses to atrocity as well as the responses of others and of societies as a whole that to a large degree determine the fate of the traumatized person and her group. Research has convincingly confirmed the importance of the response to the traumatized afterwards, beginning with Hans Keilson’s seminal work on Jewish children survivors after the second world war and also later researches (Gagnon and Stewart 2013; Keilson and Sarpathie 1979; Simich and Andermann 2014; Ungar 2012). Psychoanalysis is one such societal response, both in its practical therapeutic form and as a comprehensive theory for understanding the mind’s relation to the body and the general context of the trauma.

Traumatization and its Responses

Traumatized persons struggle with mental and bodily pains which are 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 behavioral tendencies and relational styles, and as ways of living. The effects of both early and later traumatization may show itself in many diagnostic categories where the symptoms characterising PTSD is only one form. Manifestations related to traumatization in the psychiatric illness picture may include depression, addiction, eating disorders, personality dysfunctions and anxiety states (Leuzinger-Bohleber 2012; Purnell 2010; Taft CT 2007; Vaage 2010; Vitriol 2009).

What is common for these manifestations will be 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 without, however, being inscribed in the mind's life narratives. They are not symbolized, or deficiently symbolized, in the sense that they cannot be expressed in narratives in such a way that meaning can emerge that can be reflected upon. The traumatic experiences remain in the mind as dissociated or encapsulated fragments that have a disturbing effect on mood and mental stability (Rosenbaum and Varvin 2007).

Experience Tends to Become Deprived of Emotional Meaning

As a rule, extreme traumatization (like rape and torture) eludes meaning when it happens and it precludes also forming an internal third position where the person can create a reflecting distance to what is happening and what has happened. The inner witnessing function, so vital for making meaning of experiences, is attacked during such extreme experiences impeding the individual from being able to experience on a symbolic level the cruelties they undergo. When the external witnessing function that can contain the pain also fails, the traumatized person is left alone. The result is often that these experiences remain as fragmented bits and pieces that can express themselves only in bodily pain, dissociated states of mind, nightmares and

relational disturbances. The traumatized person will try to organize experiences in unconscious templates or scenarios that are expressed in different more or less disguised ways in relation to others and the self. When working psychoanalytically with traumatized patients, the analyst inevitably becomes involved in these un-symbolized, fragmentary and usually strongly affective scenarios related to the patient's traumatizing experiences. This happens from the first encounter with the patient and is mostly expressed in non-verbal interaction with the patient. It may take a long time before these manifestations may be given a narrative form that in meaningful ways can be put into a historical context that relates to both the traumatic and pre-traumatic experiences. To achieve this end implies hard and painful emotional work on the patient's part, and also that of the analyst.

There is increasing evidence that psychoanalytic therapies are helpful for traumatized persons in comprehensive ways, in that this approach may help address crucial areas in the clinical presentation of complex traumatization (complex PTSD, (Herman 1992)) that are not targeted by other currently so-called empirically supported treatments. Psychoanalytic therapy has a historical perspective and works with problems related to the self and self-esteem, enhancing the person's ability to resolve reactions to trauma through improved reflective functioning. It aims at internalization of more secure inner working models of relationships. A further focus is work on improving social functioning. Finally, and this is increasingly substantiated in several studies, psychodynamic psychotherapy tends to result in continued improvement after treatment ends (Schottenbauer 2008).

Patients with complex traumatization often live in difficult social, economic and cultural situations and thus treatment needs to be integrated with rehabilitation procedures and often with complicated somatic treatments. Treatment and rehabilitation of the traumatized will therefore often need to be conducted by a team, and when and how to implement

psychoanalytic therapy has to be carefully evaluated and will furthermore need constant support from the team and social services.

Trauma and the Social Context

For these not symbolized and insufficiently symbolized experiences to approach some kind of integration and be given some meaningful place in the individual's mind, they need to be actualized and given form in a holding and containing therapeutic relationship. This implies that the analyst must accept living with the 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 this affirmation, the traumatized person's feeling of unreality and fragmentation connected with the experiences may continue. This was the case for many people after the second world war in the West, where the official slogan to a large degree was that one must go on living and put the past behind (Ettinger 1965, Askevold 1980).

One of the most difficult contributors to personal suffering in massive social traumatization as, for example, the Cultural Revolution, genocides (Rwanda, the Balkans, Kampuchea) and now in the Syrian disaster, is the helplessness when observing close family, especially children, being maltreated and killed, and not being able to help or protect them. This underlines the importance of Niederland's seminal insights on survival guilt (Niederland 1968, 1981), a theme that became very much marginalized in the trauma literature for many years.

The Dynamic and Structure of Extreme Traumatization

To sum up: how trauma affects a person depends on the severity, complexity and duration of the traumatizing event, the context, the developmental stage, the way in which traumatization

affects internal object relations—for example whether earlier traumatic relations are activated (Opaas and Varvin 2015)—and the support and the treatment offered after the event.

Phenomenology of Traumatization

Being traumatized is experienced by both children and adults as something unexpected that should not happen. It creates a situation where they feel a profound helplessness and have an experience of being abandoned by all good and helping objects. This profound feeling of helplessness and being abandoned may be carried over into the post-traumatic phase, where the survivor to a larger or lesser degree, and depending on the circumstances, may develop a deep fear of an impending catastrophe where one will be helpless and where nobody will help or care. An inner feeling of desperation and fear of psychosomatic breakdown with fear of annihilation may ensue and much of post-traumatic pathology may be seen as defense against this impending catastrophe.

This impending catastrophe reflects the early fear of breakdown experienced in infant life (Winnicott 1991). Post-traumatic anxieties are deep, comprehensive and may best be understood as annihilation anxiety (Hurvich 2003) or nameless dread (Bion 1962).

Traumatization effected by human beings influences internal object relations scenarios in different ways. Early traumas that bear some similarity to the present traumatization may be activated, causing the present trauma to be imbued with earlier losses, humiliations and traumatic experiences. Even early safe-enough relationships may be coloured by later traumatizing relationships (Varvin 2013a). Unbearable losses may bring the traumatized to eternally seek a rescuer or substitute in others (Varvin 2016).

Complicated relations to the traumatizing agent, the circumstances and other relations involved may be actualized in the transference. Identification with the aggressor is well known (Hirsch 1996), a term which was first coined by Anna Freud. In a recent work Henningsen described the phenomenon of “concrete fusion” (konkretistische Fusion), which

refers to the situation where the traumatized person internalizes the traumatizing object, and a part of the self fuses with this traumatizing object in order to keep the object inside, and in this way to avoid the complete object loss that characterized the traumatizing experience. This merged self-object relation may become split-off and kept more or less encapsulated, hidden in the personality and may appear during later crisis or traumatization, and it may be actualized in the transference relationship in therapy (Henningesen 2012). Thus the traumatized person internalizes important aspects of the traumatizing scenario in the form of a self-object relation which may be more (or often less as in concrete fusion) differentiated and/or fragmented, being self-negating in various ways. The actualization of these scenarios may take dramatic forms in the analytic process.

Relation and Symbolization

One salient task in psychotherapy with traumatized patients is to enhance a metacognitive or mentalizing 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 characterized by concreteness and lack of dimensionality.

Mental traces of traumatic experiences are “wild” in the sense that the person has no capacity to organize and deal with them; no inner container in relation to an inner empathic other that can help give meaning to experience (Laub 2005). These mental traces are presented to the mind in a way from the “outside” and experienced as alien and threatening. The ego meets an overwhelming abundance of stimuli and impressions that disturb the regulating functions of the mind. The psychic apparatus may be pushed towards states of extreme anxiety and catastrophe. (Rosenbaum and Varvin 2007).

There is thus an experience of the 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 the person of previous catastrophes. Relating to others, for example in psychoanalytic psychotherapy, may be felt as a risk of re-experiencing the original helplessness and the feeling of being left alone in utter despair. Withdrawal patterns may be the consequence, creating a negative spiral as withdrawal also means the loss of potential external support (Varvin and Rosenbaum 2011). The effects of trauma may thus be longstanding and complex. They may affect several dimensions of the person's relations with the external world and give disturbances at 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 traumatized person is living with historical experiences that are not 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 cultural and societal dimensions are thus not outside the psychic space but an integral part of ways of experiencing self and others. The intention to humiliate has often a gender based cultural background that has become part of the inner traumatic experience. This has consequences for analytic work. Raping a woman to humiliate the husband and destroy familial stability places the woman in a doubly humiliating position, but will also leave the man in an precarious situation that may be impossible to overcome. This is one dynamic behind the tendency to be silent on such atrocities. They may, however, be actualized in the therapeutic relationship as actions, unbearable countertransferential feelings, and they may become present in most disturbing ways. 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. Actualization and enactment may

thus be a possibility for these scenarios to, at least to a certain degree, be symbolized and reflected upon, which I will try to show later.

Actualization, Projective Identification and Enactment

The traumatized patient will from the start of therapy involve the analyst in an un-symbolized and unconscious relationship where the patient communicates by acting out, and in this way presents important aspects of their traumatic experiences (Varvin 2010). In this way, what is called trauma, but which in fact is the patient's reaction to and struggle with the repercussions of her experiences, will be present from the beginning of the contact. Treatment of "the trauma" is not something that comes later when a trauma narrative is told, as is believed by exposure therapists.

What the patient communicates touches the analyst and may hook on to unconscious, not worked through material on her/his side resulting in action that at first sight is not therapeutic, what is called countertransference enactment (Jacobs 1986). These enactments on the analyst's part may, however, be a starting point for a possible process of symbolization, in order to make these implicit experiences conscious (Scarfone 2011).

It should be underlined that enactment actually involves a collapse in the therapeutic dialogue where the analyst is drawn into an interaction where she/he unwittingly acts, thereby actualizing unconscious wishes of both her/him-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 be part of a prolonged process in therapy (Jacobs 1986) or both, as was the case with the clinical material presented below. Enactments appear thus as an unintentional breakdown of the analytic rule of "speech not act" and may imply a new opportunity of integration, or conversely may hinder the analytic process.

Enactments can come as a total surprise but can also be identified in, for example, fantasies and thoughts and feeling states which were there on beforehand (Jacobs 2001). Most

often it is a surprise, and it is only afterwards that it is possible to look at what happened.

Then, if things go well, there will be an understanding of the processes which were at work.

In the context of traumatization, enactments may represent a possibility for symbolizing 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).

In connection with traumatization, enactments can thus be seen as the actualization of relational scripts or scenarios where unconscious, un-symbolized material is activated both in patient and analyst. This is often 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 and Johan 1992) where analysts’ conflicts reinforce the patients' tendency to act out. 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 with material from the treatment of a severely traumatized woman.

The Body’s Unbearable Pain

A. came from a middle-class family in a large city in an Asian country. She was the only girl and had three brothers. Her mother was somewhat modern and supported her in her struggle to get an education. Her father, much older than her mother, was strictly religious and conservative. Her experience was thus to be raised in the crossfire of the conflict between her mother’s and her father’s view of what was appropriate for a girl. According to tradition, girls should not have any education and at the most attend Quran School, something A. felt to be

deeply unjust. She pursued her intention to get an education with a stubbornness that undoubtedly was inspired by father's attitude.

She experienced two episodes of sexual assaults between the ages of seven and nine years, which she described as very frightening and potentially traumatizing. She developed into a person who took care of other people's problems, and she was extremely afraid of offending or hurting others. She had few friends. After high school, she was educated as an assistant nurse, and worked in the poorer part of the city where she became aware of the enormous poverty and suffering in her country. While working in a legal social organization, she met her husband who held a leading position in a political movement. They had two children who were 11 and 13 years old respectively at the start of treatment.

Shortly after her children were born, the political climate deteriorated and mass arrests began. Her husband and several members of his extended family were arrested. Eight of them were soon executed. Her husband survived but was heavily tortured. Soon afterwards, she was arrested with her two small children, then 4 months and 2 years old. A. and her two children spent two years in prison, and some of their experiences were beyond human understanding and, for her, beyond words to describe. She was gradually able to talk about them during therapy, but she gave the impression that much was too difficult to recount. She could not talk with her husband and others in her family, as she did not want to cause them pain. Her husband had experienced too much himself in prison and suffered from prolonged periods of sleeping problems, nightmares and somatic pain. A. and her husband were separated for a long time after she was released from prison as he lived clandestinely and later fled.

Trauma Story: A Short Summary

First, they were in a prison in a small town for about a year. A. and her two children had to live in a small cell, less than one square metre in size, as she recounted. As it was impossible to stretch out when sleeping, she developed a technique of bending her legs backwards in

order to rest and to give the children more space. At the beginning of therapy (about ten years later), she was still obliged to sleep in that position to get some rest. Food was scarce and hygienic conditions were poor. At a time when her youngest child was about to die of hunger and thirst, the guard brought contaminated milk that instantly made the child extremely sick and brought him nearer to death. For extended periods, she had to stand, hooded, against the wall, not allowed to sit or take care of the children, who had to crawl on the floor. They could hear the screams of people being tortured, and the mother was hit while the children watched. They were then moved to a larger prison in a central city. Here they were placed in a large, overcrowded cell. She had to curl up to give space to the children and to her fellow prisoners. The fellow prisoners were regularly tortured, and bleeding and maltreated persons were a common sight. Many had their toes or fingers cut off, some became lame and some were killed in front of her and the children. She described one experience as follows:

And in every cell we were about 70 at the time.

And then they came,

placed themselves in the middle of the room,

turned around several times

pointing,

and then suddenly stopping,

and the finger pointed at one of us.

The rest of us had almost stopped breathing

while this man turned around,

now it will be me, just by chance..

When one person was pointed at,

the rest of us could breathe again,

but we were devastated

for the person who had been selected.

Because we did not know.

Is it torture or execution?

(pause).

And I remember my friends,

they were fetched at 4 o'clock in the night for execution

and we were not allowed to get up

and say our thanks and say goodbye

And it was like that,

if the fellow-prisoners took my children on the lap,

they got whipped..

This experience highlights the paralysing fright that became a part of her personality. She said during the follow-up interview: "Before I was afraid of everything, all the time. Now it is totally changed. I will never forget you". She added that she had not been aware it was fright.

During the five years she stayed in her home country after being released from prison, she and her family were constantly harassed. She was several times taken for "interrogation," as it was called—sometimes for days, sometimes for months—and was maltreated. She was harassed on the street and was constantly afraid of being killed. When she understood there was a real danger that her children might be taken away from her and that she herself could be put in prison for a long time, she decided to flee. After her flight, she had had numerous physical ailments: pains in different parts of her body (back, chest, stomach, legs, and headache), breathing problems, and recurrent urinary tract infections. She had also developed an intractable curvature of the spine (thoracic-kyphosis). She suffered from intrusive memories and nightmares relating to traumatic experiences, extreme anxiety and depression. Sadness seemed to inhabit her.

Treatment Process

The psychotherapy was conducted face-to-face with a total of 165 sessions. The first year of therapy was with an interpreter. The patient expressed the desire at the beginning of the therapy to “learn enough Norwegian to express myself”. When she decided to do without an interpreter this was, at least partly, motivated by mistrust.

The analyst formulated the focus of the psychotherapy in the following way in the first session:

“...to find what happens inside you when you experience pain, when you become sad or full of melancholic thoughts, and if there can be ways you can work with yourself to feel better in your body without having to take medicine” (which she didn’t want)

The instruction given at the beginning of therapy was an invitation “to try to say whatever came to your mind”, with an additional explanation of the meaning of this related to her cultural beliefs. This was, as could be expected, a rather difficult task for her. Having been interrogated numerous times, this invitation naturally evoked resistance. One main aim was to help her to talk in general and in particular about difficulties regarding both the current situation and her past experiences. She often behaved in a passive way, expecting to “get treatment”, which was related to her cultural tradition (doctors give treatment) but also her helplessness and lack of feelings of agency in relation to her pains.

She often regressed into a passive-aggressive position, demanding that her therapist “make her well”. “When will I be well, doctor?” and “When will the pains go away?”, were recurrent questions. The transference implications of this demand, putting the therapist in the difficult position of being the helpless helper and thereby preparing the ground for disappointment, were obvious, and proved difficult to clarify. She sought a variety of somatic treatments while in therapy (often when disappointed by or mistrusting the therapist). The therapeutic process could be divided in three phases:

1. The rapprochement phase (sessions 1-18): the first verbalization of traumatic memories and the establishment of a preliminary alliance. The immediate effect was a spontaneous improvement in her depression and some of her somatic problems.
2. Resistance and mistrust (sessions 19-90). In this phase, she had many somatic complaints, very often openly distrusted the therapist and she quit therapy twice.
3. Phase of autonomy (sessions 91-165). Here she was able to make mental connections on her own and work with what frightened her in her daily life, and thus gain considerable autonomy.

I will now focus on some aspects of the transference-countertransference relation. She involved the analyst in an un-symbolized relationship communicated by projective identifications, action and affective pressure (Varvin 2013b). The effects of her overwhelming experiences were in this way present from the beginning. Her way of relating and communicating was intense and this activated the analyst's own unconscious material, resulting in unintended, unconscious countertransference enactments.

I will try briefly to illustrate aspects of these processes with A. After the long period of resistance and mistrust where her fright of being humiliated yet again became a major focus, things loosened up and she began to link present terrors with her prison experiences and other atrocities. This resulted in increased inner freedom and also a more autonomous life. She began to see friends, moved around in the city more freely and even learned to drive a car. She realized that she had been frightened of almost everything at the beginning of therapy, and a process started where she could identify what made her afraid and the roots of her fears. For example, she panicked when her husband touched her ears. This she could connect with the time in prison when she was hooded and had to watch her children with her ears. She got anxiety when hearing voices from the radio, reminding her of the messages in the prison from the loudspeaker, broadcasting who should be tortured. The colour black made her almost

paralysed: the connection to the black-dressed men in the prison became clear when the analyst wore a black jacket.

An enactment episode ran as follows: she came to the session complaining of intense back pain and demanded to lie on the couch. When the analyst moved his chair closer, feeling encouraged by her increased freedom in the consulting room and hoping for a closer contact, she became stiff, full of anxiety and silent. It took some sessions to clarify that the scene represented a seduction situation reminding her of assaults she had experience in the prison. The analyst's wish for closeness, after long and frustrating resistance and aggression from the patient, represented for her a violent, sexual approach. The unconscious roots for the analyst's wish and the not very cautious way it was acted out, was material for self-analytic work.

A. brought experiences from her prolonged and complex traumatizing experiences into the consulting room and involved the analyst in scenarios of distrust and attack that were difficult to understand and emotionally hard to contain. A marked changed occurred when she was able to realize that she was indeed afraid, that something she experienced in the here and now made her stiff with fright. This was a starting point for a historicizing process where she was gradually able to make connections between present terrors and earlier experiences, as described above. This was an amazing process where she seemed to have internalized the analyst's constant efforts to contextualize her present fears. In this process, she increasingly insisted on making these connections by herself. Furthermore, she started to relate to her pre-traumatic childhood experiences. She gradually realized that she, after her prlonged traumatization, had remembered her life as through and through filled with anxieties where there were almost no "safe points" which she could relate to, none anchoring in earlier safe enough relational experiences that could have given her at least some feeling that the world could be safe. One example demonstrates this: her fear of the color black brought back memories of a strict and quite cold grandmother. When reflecting on this she realized that

these memories nachträglich, after her prison experience, were “coloured in black”. She remembered her experiences when grandmother took her for weekly baths at the village's public bath. At the end of the bathing rituals she was taken to a deep well in a rather dark place to be thoroughly washed. She remembered she had been afraid but realized that the blackness had generalized and had coloured the memories of grandmother. When this was sorted out over time, other good memories appeared and being together with grandmother at the public bath appeared in another light. Washing was seen in a different context and in that way, her grandmother emerged as a rather kind person and her childhood gradually “became better”. I think this part of her work with the past, demonstrated the retroactive (nachträglich) work of extreme traumatization, and especially how it activates early fears of breakdown. Psychoanalytic therapy thus worked retrospectively (nachträglich) to reorganize memories from early parts of her life.

[Break]

Summary

This article offers a critique of the concept of trauma as it is used to understand the extreme traumatizations of civilians, especially refugees. This concept tends to reify the psychic condition, which may result in overlooking the way the mind struggles with the consequences, and obscure the resilience involved. Extreme traumatization affects the individual and her/his relations to others, as well as the family group and its supporting structures. This has to be taken into consideration when treating and rehabilitating the severely traumatized individual.

[Break]

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