Disruption and loss characterise the life of the person who has undergone extreme traumatisation (torture, concentration camp, etc.), especially when he/she lives in exile. This presents new challenges both in understanding trauma and massive traumatisation and in treating it. When planning and conducting treatment, it is of special importance to take into consideration the mental survival strategies that the person has developed. These are mental capacities that aim both at developing methods of avoiding the pain of re-experiencing and at achieving solutions to the dilemmas posed by the posttraumatic phase. The latter often consists of aborted attempts at mentalisation and integration of traumatic experiences.

The traumatised person will often experience the therapeutic encounter as threatening because of fear of re-experiencing and re-traumatisation, and also because having experienced atrocities disturbs or damages the capacity for developing a trusting relationship. This paper discusses the complexities of the consequences of this situation and describes a model for a psychoanalytic approach to the treatment of these patients, focusing on the disturbance of symbolisation and mentalisation caused by trauma. Treatment must address this and provide a setting where experiences that have been insufficiently symbolised (expressed in somatisation, acting, non-verbal characteristics of speech, procedural aspects of transference, etc.) can be placed in context through a process of historisation.

Key words: psychic trauma, psychotherapy, symbolisation, mentalisation, survival strategies

Sverre Varvin, M.D., Dr. Philos., Gustav Vigeland's vei 40, NO-0274 Oslo, Norway, E-mail: sverrev@ulrik.uio.no

Introduction

Psychic trauma is a blow to the mind – something external invades and transgresses a person’s internal borders, and a state of helplessness ensues. Extreme traumatisation is a special and complicated sequence of events; it is the result of an intentional, malignant act or acts committed or designed by persons, organisations or states in order to cause damage to the individual and to social organisations, in order to produce a state of fear and helplessness and to produce prolonged and long-standing destabilisation. It is implemented within a context of suppression and oppression, often with a background of state-organised terror and/or political violence aimed at specific groups such as ethnic communities, political movements or social groups. The aim is to produce fear on a mass basis and destroy or destabilise social links.

The political aim and objective may be more or less clear. Usual contexts for extreme traumatisation are concentration camps, torture, extreme conditions during imprisonment, war conditions and various forms of terrorism.

In this paper we will discuss how persons who have experienced extreme traumatisation attempt to survive mentally. This survival involves mental capacities that aim both at avoiding the pain of re-experiencing and at achieving solutions to the dilemmas posed by the posttraumatic phase. The latter often consists of aborted attempts at mentalisation and integration of traumatic experiences in an internal and/or external threatening environment.

2 Some terrorist acts may have a clear aim, for example freeing political prisoners, while others, like the Japanese sect Aum Shinrikyo’s poisoning in the Tokyo subway, have a more all-encompassing but also madder aim, poignantly expressed by Lifton in the title of his book on this sect: “Destroying the World to Save It” (35).
The traumatised person will often experience the therapeutic encounter as threatening because of fear of re-experiencing and re-traumatisation, and also because the atrocities experienced have damaged or disturbed mental capacities and the capacity for a trusting relationship that is necessary for relating intimately to another person. We will discuss some of the complex consequences of extreme traumatisation and give an outline of a model for a psychoanalytic approach to the treatment of these patients, focusing on disturbances of symbolisation and mentalisation caused by trauma. Any treatment must address these disturbances and provide a setting in which experiences that have been insufficiently symbolised and mentalised (expressed in somatisation, acting, non-verbal characteristics of speech, procedural aspects of transference, etc.) can be placed in context through a process of historisation. This implies helping the patient to perceive/understand his or her life history in a more coherent and less distorted form. Extracts of analyses of two therapies are presented to illustrate different levels of mentalisation and corresponding therapeutic work.

Extreme Traumatisation

The concept of trauma is widely used in medical and psychological literature. In medical literature it was previously generally presumed to mean a blow to the tissues of the body (1, 2), and its meaning was expanded to also signify in a meaningful way “the tissue of the mind” (3). The metaphor “the tissue of the mind” refers in part to the concept that the mind functions through associated connections of feelings and ideas, and that these are torn apart as a consequence of the trauma; in a way, the metaphor “the tissue of the mind” refers to symbol formation (4) in a broad sense.

After a traumatic injury, the capacity of the mind (in reality mind-brain functions) can be disturbed to the extent that adaptation and development may take an empirically observable pathological turn. We do not know to a sufficient degree how this damage determines the course of psychotherapy or psychoanalysis, or how they affect specific psychoanalytic functions (e.g. defence mechanisms or transference-countertransference patterns) (5). The effects of the trauma tend, however, to be quite damaging, and often long-lasting. Nevertheless, the traumas do not necessarily by nature present a permanent impediment to mature development. Whether psychic trauma bypasses the mind and results in lasting damage to the mind-brain functions, or, alternatively, whether it is possible to see post-traumatic states as “metaphors” of the traumatic event, is a matter of scientific debate at the moment, the resolution of which is impeded by, among other things, a lack of proper empirical studies. The hypothesis of a specific traumatic memory that may be imprinted in the brain (6) and be beyond representation (7) is an example of the first position, while several authors still claim that it is ultimately possible to represent traumatic experiences (5, 8–10). In connection with this, there is a discussion of what is meant by “development” and “cure” in psychoanalysis. In this paper we will argue that one salient task in psychotherapy with traumatised 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. More simply, one could say that mental traces of traumatic experiences are “wild” in the sense that the person has no capacity to organise and deal with them. They resemble thoughts without a thinker in Bion’s sense (11). These experiences are presented to the mind as traces from an alienated world, as images, sensations, behavioural traits, etc. They may also at the same time be defined as what we would call “dry” narratives, which can be told in a detached manner. When the affective component emerges, the narrative will usually be fragmented and breakdown.

The psychoanalytic enterprise with persons exposed to traumas is thus partly grounded on the idea that the traumas can be symbolised and worked through, or alternatively, that the effects of an encapsulation of the signifiers of the experiences can be counteracted through psychoanalytic treatment. The Freudian basis for the viewpoint outlined above is Freud’s original formulation concerning the traumatic experience as something that overwhelms the ego (the psycho-economic perspective) (12). The person is experiencing helplessness because the mental apparatus is not able to deal with experience “in the ordinary way”. In this model, the ego is presented with an overwhelming abundance of stimuli and impressions. As a result, the processes of the psychic apparatus are pushed towards states of catastrophe.
Thus, different apperceptions, which are usually organized and related through bonds or associations, become unstable and fused. Instead of forming the basis of thought-formation, these apperceptions are invaded by anxiety, fears and painfulness, and hence the cognitive functions are less able to process the emotional meaning of the experiences.

In other words, something alien, “the traumatic event”, forces its way into the individual, smashing through whatever barriers the mind has set up as a line of defence (13). It invades the mind, and becomes a dominating feature of the mind’s interior landscape (14,15). It takes control of major aspects of the person’s life, resulting in “the posttraumatic condition or process”. From this perspective, posttraumatic symptoms may be seen as various attempts to avoid a mental catastrophe.

From an object-relation perspective, the trauma is the result of the loss of internal protection related to the internal other – primarily the loss of the necessary feelings of basic trust and mastery. However, it also affects infantile omnipotence and self-idealisation. This may be experienced as loss of the protective and empathic other, or as damaged relations to internalised others who in other circumstances give meaning to thoughts and actions (8,16). When this internal linking is broken, damaged or destroyed, attachment to others may be perceived as dangerous. Relating to the (external and internal) other, for example in psychotherapy, may then imply an even greater risk of re-experiencing the original helplessness and the re-emergence of a feeling of being left alone in utter despair. Withdrawal patterns may be the consequence, creating a negative spiral since withdrawal at the same time means the loss of potential support.

A traumatised mind clings to specific moments, which may gradually or suddenly loosen their grip on the subjectively felt flow of time, thus preventing the mind from organising a correct sense of chronology in which “past” precedes, and is distinguished from, “present” and “future”. In a traumatic condition, this chronology (the deictic anchorage of time) is undermined, and is often “converted” into an inchoative (fragmented), existential time experience, known from dreams states and fantasy, where the past-present-future distinctions become blurred. Since deictic anchorage of person, space and time is basic to the integration of perceptions, feelings and thoughts in symbol formation, changes in this anchorage may be dramatic. At their best, the perceptions may be judged according to symmetry, condensation and contiguity, i.e. any sign that bears some likeness to signs of the earlier perceived danger is evaluated as a signal of danger (17). This way of perceiving the environment, based on symmetry, is characterised as imaginary reasoning and may be described as a “time-collapse” (18). At worst, the trauma turns the experience of time into a fragmented experience, totally disconnected from the framework of biographical time. Under these conditions, the perceptions and sensations of the body and environment are not even linked by means of imaginary modes of thinking. Instead, they may be said to be of an indexical nature (19), i.e. immediate, perceptual, non-symbolic intrusions on the mind.

In the traumatic condition, the process of symbolisation is distorted to the extent that thoughts in the dissociated areas of the mind cannot be given a temporally meaningful place in the emotional autobiographical narrative, and/or in the actual description of one’s present state of mind, e.g. vis-à-vis the psychotherapist, family, friends or others in the environment. This temporal fragmentation allows the emotions of anxiety, aggression and depression to dominate, and to a certain extent destroy, the meaning-making (20) and symbol-formation efforts (5). The meeting with the other person becomes potentially frightening and may be felt as complicated, confusing or as an immersion in an internal power struggle.

The blow felt to the self and the feeling of self-worth further complicates the consequences. The effect of dehumanisation may be lasting and may imply a profound feeling of shame. This may be perceived as a result of being treated as a non-human or as a human of lesser worth, or may be due to the necessity of acting according to primitive standards that are incompatible with the

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3 Deixis means “to point at”. It concerns how elements in speech organise time, place and space for that which the utterance refers to. It orients communications in an “I-here-you” perspective, and gives the uttered sentence subjectivity at the same time as the sentence then refers to something outside language (Rosenbaum, 2000). Deixis refers thus to a function in language but presupposes the existence of certain mental functions that ascertain the subject’s anchorage in the present (“I am talking to you here and now”) and specifies this present as different from past and future.
person’s usual ego ideals and super-ego standards in order to ensure survival in extreme circumstances (21).

The effects of trauma may thus be longstanding and complex. They may affect several dimensions of the person’s relations with the external world. These can be summarised as follows:

1. 

   **Subject/body-other relations.** This dimension concerns the individual’s relationship to the other on a dyadic level. This is the level of emotional bodily-mediated regulation of affective states. Emotional withdrawal will diminish the possibility of using others in the process of modulating negative affect. In disordered states, the person may be unable to concretise or symbolize sensations. Within this dimension, important nonverbal emotional regulatory processes occur between the self and others, and there is a self-soothing reliance on internalised object relations. Research on affective self-regulatory processes (22) and interpersonal regulatory interactions has demonstrated key processes in maintaining safety. This concerns especially the regulation of negative or unpleasant arousal, and is dependent on safe early attachment relationships and good-enough early containment by the mother/caregiver (4, 23). These, in turn, are dependent on a growth-promoting cultural and social context (24), including the family and social network support (25). Krause and Lütolf have demonstrated the importance of such processes in psychotherapy (26).

2. 

   **The individual’s relationship to the group.** This is the level of identity formation where one finds one’s identity both as a member of a family, group, community and nation, and as different and unique. The salient questions are related to belonging to a group (including the family) and sensing what others want one to be or do. One learns from the group and its members and acquires the ability to empathize and see things from others’ points of view. In the distorted or disordered subject-group dimension, the self and the group cannot cognitively act as foreground and background for each other. Empathy is reduced to egocentricity, intimacy is perverted to intrusion or exploitation, and care is turned to neglect. The community feeling may be abandoned and transformed into physiological dis-ease. One is no longer a part of a group and may experience a loss of the aspect of personal identity related to the group or the family. Developmentally this relates to the establishment of a sense of we (27). In societies where the family and the group (clan, tribe) are the most important organising units of society, and where belonging to such a group is of fundamental importance for both personal and social identity, disturbances in this dimension may have grave disorganising effects.

3. 

   **Subject discourse dimension.** This dimension relates to the individual’s relations with the culture at large, that is, to religion, cultural narratives such as folktales, philosophical texts, moral codes, norms and so forth. This is the level where meaning is established, and is the source for finding ways of understanding existential themes, life crises, developmental challenges, rites de passage, etc. This concerns the discourse level, which in principle consists of written, temporized and memorized signs of living in a culture. These signs are not particularly stable over long periods of time, but are stable enough to produce converging and diverging myths, narratives, ideologies and paradigms of beliefs and argumentations. (Elaboration of this model is given in (28)).

Our brains seem “inherently suited to” carrying out the functions of the two first-mentioned dimensions. They require a language-supported sign-system only to a limited degree, but they do rely heavily on mimetic representation. The latter dimension, however, requires symbolic inventions, the invention of rules for their use as well as mythic/narrative integration of symbolic inventions and written language as an external symbolic storage system (29).

When a person is speaking, the three dimensions – body-world, subject-group, and subject-discourse dimensions – display individual characteristics that can be traced in the person’s expressions. However, the dimensions may also be functioning in an interdependent way. Each dimension relates dynamically to the latent or manifest expressions in the other dimensions. The dimensions influence each other in speech. The background feelings of the body-world dimension affect the subject’s feelings of being accepted or rejected by the group to which he/she wants to be attached (subject-
group dimension). The temperaments of the body-world may also affect the adherence to one or more theories about human relationships, and to the constructing and deconstructing lines of argumentation.

At each dimensional level, the subject is under the influence of attracting and repelling forces – notably forces involving emotions such as anxiety, anger, dependence, isolation, and shame – that drive the subject into a state of conflict or dilemma that the symbolising mind is more or less ready to resolve. This means that conflict and dilemmas are basic to the human mind – a trait that may distinguish our minds from those of the rest of the animal world – in so far as they are preconditions for being able to choose and take responsibility. These conflicts do not vanish completely, but are resolved by giving priority to one stream of thoughts or actions instead of another, which may then be repressed until it seems useful in a future situation. The ability to hold ambivalences in the mind and reflect upon them is, moreover, characteristic of maturity.

In human beings the meeting with the other, the others or otherness as such always carries both positive and negative values, attracting and repelling forces, as judged by, or experienced by, the subject in action. The subject is attracted to or repelled by opposite representations of otherness. This dynamic between subject and otherness is the core of the function of each of the three dimensions in the above model. Each dimension has its own psychodynamic patterns. One could imagine the psychodynamic of each dimension as consisting of opposing forces where the subject may be attracted by positive or negative forces on each level. In the meetings of persons, there may be more or less space for the interplay between the negative and the positive, a variable transitional space for the creation of symbols and protosymbols referring to opposing forces. The less space there is, the greater is the chance of a catastrophic fusion. What the severely traumatised person fears the most is the fusion between these opposing forces. This would result in a chaotic situation in which there is no possibility of distinguishing the good from the bad. The catastrophic fusion may imply either chaos or psychic death.

The different strategies inherent in posttraumatic symptoms aim at avoiding this fusion and/or chaos, and withdrawal and blocking of emotion and involvement are attempts to create distance from anything that may intrude upon the mind: emotion, impulse or image. This implies the risk of psychic death. Intrusions, on the other hand, can be seen as attempts to control the danger, but entail the risk of chaos. Posttraumatic conditions are thus really a balance between Scylla and Charybdes.

Levels of Mental Survival Strategies

From the above it is obvious that mental survival after extreme traumatisation involves intrapsychic as well as relational measures. This is a consequence of the fact that trauma not only causes damage to psychic apparatus at the level of psychic economy (the "too much" or the overwhelming – and the helplessness-producing aspect of traumatisation), but also has effects on the internal relationship to an empathic other. The latter affects the ability to trust and establish close emotionally helpful relationships with others, a relationship with the group (concerning identity issues) and creative relationships to cultural discourses in the process of making meaning of experience.

On the mind-brain level, the central processes affected are those concerned with symbolisation and mentalisation. Symbolisation concerns the transformation of “raw experience” into mental signs at different levels in an increasing level of organisation (30, 31). Mentalisation refers to the processes underlying the organisation of the mind. It concerns self-object differentiation, the ability to see things from the other’s perspective and the ability to conceptualise and understand mental states in general, both one’s own and those of others (32, 33).

Extreme traumatisation may produce defects or deficits in the ability to symbolise and think or reflect about later experiences, that is, affect the mentalising capacity. Not only the trauma-related events but also experiences not related to the original traumatic experience can be affected, creating a generalised instability in the network of mental representations. From this perspective, the significant problem after extreme traumatisation is not only the experiences in themselves, but the deficient or non-existent ability to symbolise and mentalise both these and later experiences. In other words, it is the lack of the capacity for integration that becomes the most important ongoing problem. Furthermore, a continuous defect
may arise in the ability to deal with emotional experiences that are related to the traumatic events (by, for example, mnemonic traits such as smell, visual impressions, internal images, etc.) at the same time as other features in the environment and related phenomena in the internal world may be associated with the traumatic experiences. This may cause a tendency towards mental confusion and an urgent need for some way of ordering the diversity of mental representations and impulses that may be evoked. The plethora of symptoms, signs and personality features associated with posttraumatic conditions described in different diagnostic systems and phenomenological descriptions is an expression of attempts to rescue oneself from this mental confusion (above referred to as attempts to avoid chaos or psychic death).

This is what we define as mental survival strategies. For example, somatisation uses the body as an arena for built-up tensions caused by non-metabolised affects. Acting may provide a means of dealing with aggression, either through acts of violence or by mere hyperactivity. Other strategies are avoidance, different forms of dissociation, encapsulation, creation of false selves, etc. Re-experiences may be seen partly as a deficit-avoiding strategy, and partly as the ego’s attempt to revert to the original helplessness by returning to “the scene of the crime”, so to speak.

Mental survival strategies tend to be organised as mental schemata and may express themselves in internal relational scenarios, that is, more or less organised patterns of relating to others, especially in situations of perceived danger. A confluence with patterns derived from earlier problematic experiences in relation to significant others may ensue, which makes these internal scenarios complex constructions relating both to traumatic and other earlier experiences.

We will in the following present two examples of ways of dealing with extreme experiences. First, an example of what we will call a low-level strategy of mental survival, where danger was experienced as acute most of the time. We will refer to the three-dimensional model described above.

Living in Three Worlds

When Hassan came to Norway, he had undergone a long journey from his homeland. As an UN quota refugee, he had been selected for acceptance to Norway from a desert refugee camp in a country neighbouring his own. He had been there for almost four years, and he equated this experience with the inhuman treatment he had received in prison in his home country. Before his flight, he had undergone a long period of persecution, terror (among others things, he had been nearly fatally shot while walking on the street) and imprisonment with the harshest torture, including mock executions and the murder of people close to him. He was exhausted and was suffering from serious psychic distress as well as physical disabilities and sequels after being maltreated for prolonged periods.

One of Hassan’s core problems could be described as “an experience of being killed”, the feeling of being unprotected and living in a state of persistent terror and insecurity. This feeling of facing death at any moment continued to torment him. His mind structured these experiences by creating three partly separated (or dissociated) experiential modes, three “worlds”, as he said:

1. The world of his past. This was the experiential world before the period of trauma resulting from torture. This world revolved around his relationship with his father, his mother and the rest of his family. It was an idyllic picture with an almost delusional character, especially regarding his relationship with his father, which he in reality had experienced as complicated and at times frightening.

2. The imaginary world. This was the world of persecution in which he could be killed at any moment and had to take all sorts of precautions. This world dominated at the beginning of therapy, and for prolonged periods during therapy. He had re-experiences of his traumatic experiences, he hallucinated about his persecutors and had concrete delusional experiences of being persecuted and threatened with death. He had to take all kinds of precautions in order “to avoid being assassinated”, such as hiding in his flat, wearing a disguise when he went out, and so forth.

3. The world “in between”, a relatively superficial experience of trying to live a normal daily life, which consisted of a mental state in which he attempted to deal with economic and other practical matters. This state of mind was not
very stable, especially at the beginning of therapy.

His life could be described as a precarious balance “on the edge”. At any moment, he could “tip over” and experience the world in terms of the second perspective or world. This situation improved markedly during therapy. We will illustrate, through some excerpts from his therapy, how his mind was affected in relation to the above-mentioned dimensions; that is, what problems he had to deal with as a result of year-long terror and persecution.

Because he belonged to a minority group, persecution of him and his family began early in his childhood. He became politically active, and the first blow came when his fiancée was arrested and raped, and then committed suicide as a consequence of this.

This represented a clash between his relation to the culture (dimension 3) and his relation to others on a dyadic level (dimension 1). He was unable to protect his fiancée and thereby lost an emotional relation. This had a severely disorganising effect.

He was subjected to inconceivable torture, both physically and mentally. He was shot through his arm in order to make it impossible for him to practice sport again, and received no medical help afterwards. He was shot through his chest in an attempt at assassination.

Neither his group belonging (dimension 2) nor his culturally designated position (dimension 3) could offer him protection. He was treated as a non-human. This may have reinforced an idealisation of the past.

Very early in the therapeutic process, he described a feeling of being alienated. It appeared that it was extremely difficult for him to trust people, and he lived much of his life alone, with only a few friends.

In exile, his relationship with his group was dominated by withdrawal. He felt he had failed to accomplish his assigned task and felt shame. During a major part of the therapy he worked in “splendid isolation”, contemplating how to solve the problems in his country. Later he started participating in practical, goal-oriented human rights work and became the leader of a human rights organisation, thus reversing his alienation in relation to the group.

One of his “worlds” was, as mentioned, the abundant re-experiencing and dreaming (nightmares) of the traumatisation.

This implied a withdrawal to the negative pole of his relations in all dimensions (body-other, group and culture). This withdrawal diminished clearly during therapy, as shown by a decrease in nightmares and re-experiencing.

The “real world” of his daily existence was an intermediate level.

He gradually increased this territory. He established lasting intimate relationships that gave him emotional support, and managed to become a part of a new group while in exile: a Norwegian family. This implied a step towards a gradual reorganisation of his relationship with discourse and culture in that he established more realistic goals regarding what he was able to achieve as the designated leader of his clan, and also gradually achieved a more secure position as an exile belonging to two cultures.

The first “world” was that of his childhood. As mentioned, this was an idealised version, but nevertheless a retreat to a position of an idealised self with idealised parents.

This represented an imaginary solution that brought the three dimensions “in order”. Needless to say, this was a brittle construction. It provided him with a safe haven, which he needed when the second world, the prison world, threatened to take over.

For long periods of time his second “world” dominated. In this world there were persecutors everywhere. When he walked down the street, people followed him everywhere. Therefore, he could only go out when it was absolutely necessary and often had to take detours (which sometimes made his arrival at sessions quite irregular).

This may be seen as an extreme example of being rejected by the group and isolated. Both his relationship with the culture and his emotional relationship with others were affected negatively. This aspect improved during therapy and his ideation lost its paranoid quality. He was, however, constantly afraid of deadly attacks although the intensity of this fear diminished towards the
end of therapy. At follow-up, he reported having long periods when this fear was absent. This way of experiencing was, of course, rooted in his past traumas; once you have experienced a catastrophe, you can never be sure that it will not happen again. However, it was also associated with real and present fears, as the dictator’s agents were a part of the exile milieu.

Hassan had thus been severely affected by a traumatising environment where his group belonging and his culturally assigned position were of no help. He struggled to survive mentally by dissociating, splitting up and projecting. The border between inner and outer reality was, however, blurred both because of his traumatisation and because he felt there was a real danger “out there”. The transitional space in his mind became increasingly privatised and dominated by restricted, concrete representations of persecutors.

At the beginning of therapy this represented a level of mental survival that can only be described as very demanding energy-intensive and time-consuming and that activated, at times, the entire range of his mental capacities. More mature strategies evolved during therapy even though he was never freed from the feeling that the catastrophe might occur again.

Fear of Helplessness

For the next patient, the traumatic effect had been painful for many years, but the effects had not been as all-encompassing as in the previous example.

Anna came from a South American country. She was married and worked in the school system when, fifteen years before therapy, she was arrested while participating in a political group that pursued its aims by peaceful means. She spent three months in prison and two years in a concentration camp. During this time she underwent severe torture. A later experience of not being respected during a close relationship with a man, and of being made a helpless victim of this man’s inconsiderate negligence, reactivated feelings related to the torture she had been subjected to while in prison and the concentration camp. She had then often been placed in a position of total helplessness without having any means of avoiding the experience of utter pain and degradation. It was significant that a medical doctor had participated actively in the torture.

She suffered from repeated depression and chronic bodily pain. She had disturbed sleeping patterns and posttraumatic symptoms (re-experiencing, nightmares). She had nevertheless managed to create an acceptable life in exile. She had a steady job and lived with her son at the time of the therapy.

Early in therapy, it was possible to detect her ambivalent attitude to therapy and to the doctor-therapist, which was related to a deep fear of being made helpless, as she had been during the torture. This experience had led to serious problems, including deterioration in her ability to establish intimate relationships. Her ambivalent attitude and relational problems, however, also had roots in relational patterns established in childhood.

Her problems were more circumscribed than Hassan’s. She had managed to maintain relationships with her original family and friends and also establish new relationships when in exile. Her identity as belonging to an exiled group, her identity as a professional woman and her identity as belonging to her family of origin (dimension 2) were complicated and conflict-ridden, but were never questioned in a basic sense as they were in Hassan’s case. She was well able to use both her culture of origin and her new culture as sources for establishing meaning of experience (dimension 3). However, having been exposed to atrocities and maltreatment inflicted by other human beings delivered a serious blow to her belief in others, to her feeling of being protected, and to her identification with cultural values and norms (dimensions 2 and 3). Her problems were recurrent, and included severe depressions and a pervading tendency to somatisation, mostly in the form of muscular pain reflecting problems in intimate relationships (dimension 1). She had repeatedly sought treatment by different doctors and physiotherapists with a consistently negative outcome, which on closer examination could be described as negative therapeutic reactions. Her central problems could be described as situated in a specific relational domain, the meaning of which was revealed, at least partly, during therapy. Whereas Hassan’s problems were visible at the surface of his existence, the riddle of Anna’s pains and depression had to be revealed during therapy.
This was related to a more comprehensive symbolisation of her original traumatic experience that made it possible for her to apply more mature defences towards their derivatives. Her central problematic experience was thus both desymbolised and expressed in somatisation and also, to some extent, repressed, especially as it was related to earlier conflicts from childhood. Due to limited space, only part of this story can be discussed.

Very early in therapy, several themes became evident. It was possible to detect these in the following passage from session 3:

T4: (. . .) Yes, I don’t know if you have any comments to our last meeting.
P5: Yes I think it was last Thursday / afterwards that I tried really to find explanations, why I had come here.

*But I did not.*

I feel that I in way try to find explanation which is based in my mental condition, but the way I experience it so eh, it is not like eh, (small laugh) this thing about normal and abnormal is very much discussed but . . .

But is has not been such terrible things or such, which may be like, . . .

*That I have been afraid of being crazy*, to say it like that, **but more like sorrow and depression, and more a feeling like of, eh, hopelessness, but not so much because of the mental condition but because of physical pains.**

(Session 3)

The following positions could be described using Dialogic Sequence Analysis (5, 34).

1. Achieving/anxious girl vs. demanding authority: *Underlined*
2. Childlike/help-seeking vs. a possible empathic object: *Bold*
3. Complaining/defensive vs. dangerous other: *Underlined and bold.*

These positions reflect dilemmas she was facing when she began therapy. Position 1 expresses her desire to seek help and her belief that it might be possible, and, at the same time, her fear that she would discover after all that she was mad or irreparably damaged, that is, made permanently helpless (as the torturers had “promised”). Even though she had many mental symptoms and problems, she tried to persuade herself and the therapist that they had not been “such terrible things” that would have driven her mad or damaged her permanently.

Only in the small interjection “**but I did not**” did she present a more uncomplicated help-seeking behaviour. This represents position 2.

The third position was expressed in a defensive way and with the complaining voice, signalling the later markedly developed negative transference.

The complaining/defensive and the achieving/anxious voice came to dominate more and more as she approached a key session in the last part of the therapy as her anxiety rose and her main problematic experience increasingly emerged in relation to the therapist, expressing a marked negative transference.

The therapy developed through several crises and came to focus more and more on her relationship to the therapist. The whole course of psychotherapy could be viewed as a repetition of an important aspect of her original trauma in the following sense: she had sought the help of a doctor as she had done many times before with complex motives and hopes. On the one hand, she wanted to achieve resolution of the feeling of betrayal she had felt when being tortured by a doctor, but on the other, she also wanted to achieve revenge by making him helpless. The latter had “succeeded” on many occasions before when treatment attempts had failed. This therapy nearly “achieved” the same outcome. By focussing the work in the transference, it was possible, however, to understand her actions in relation to a compulsion to repeat.

The following is a brief description of the process leading towards a key session where a main transference theme emerged⁴. Before a holiday break, she became increasingly depressive and harboured suicidal thoughts. She “persuaded” the therapist to give her antidepressants to which she immediately reacted with bodily pains and fear. She vehemently accused the therapist of having harmed her, and expressed a feeling of having been

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⁴ The therapy process was analysed longitudinally using Assimilation Analysis. This analysis tracks the development of problematic experiences throughout therapy by means of a qualitative procedure using narrative and procedural aspects of the therapeutic dialogue (36).
betrayed. Memories from the torture emerged and the role of the doctor was focused increasingly sharp. Through a complex process she achieved the insight that she had, as she said, “just connected these things”. She had unconsciously experienced the therapist’s attempt to help her with antidepressants in terms of the torturing doctor’s attempt to make her weak and to force her to reveal information through the use of hypnosis and medication. She said in the key session:

P258. (crying, 48-sec. pause) (sobs)
I have problems with forgiving that / because / on misuse of power (cries)
by the help of a doctor
who just stands there and says // but she can stand a bit more.
(cries, 17-sec. pause) because it was a doctor who was there
in // torture which was / with electricity
which / standing by the door like (incomprehensible)
bent like an arch,
and come and make an examination and saying;
“yes, it is possible a bit more” (crying).

The process that led to this point could then be understood as:

- An actualisation of an inner scenario where she now tried to mend a damaging chain of events.
- She sought help, expected to be placed in a helpless position, and then became afraid, rejected the other or behaved in way that provoked rejection and ended up as lonely as before. The actualisation of this scenario was repetitive, but in the therapy context the outcome was positive in that she could establish a relationship with the therapist as a good object who was different from the torturer.
- Even though the therapist was led into the actualisation when interrupting the psychological treatment and their common project of understanding by prescribing medication, he nevertheless managed to interpret at an important moment, which led Anna to realise how she “had connected these things”.

Needless to say, this insight needed repeated working through. The outcome was, however, a marked improvement in her bodily pains and tendency towards depression.

Conclusion

Extreme traumatisation has potentially devastating effects and involves complex chains of events. We know only part of the underlying mental processes at work. The following may, however, serve as preliminary conclusions:

1. The main problem is the mental apparatus’ inability to deal with the experiences or the traces of these experiences in the mind. This appears as deficits in the processes of symbolisation and mentalisation.
2. The effects tend to be organised in mental schemata and relational scenarios which are complex organisations of ways of dealing with internal affect states and relational challenges.
3. The effects are on the mind-brain level as well as on a social relational level. Three dimensions must be taken into consideration: the relationship to the singular other, the relationship to the group and the relationship to culture.
4. Psychotherapeutic work must take all dimensions into consideration. That is, the therapist must understand how identity issues as well as emotional states are interdependent and regulated by complex meaning-producing discourses. The latter are heavily affected by the traumatising violence of, for example, state-organised terror in that the inherent values and basic schemas for “the meaning of life” are attacked.
5. Working through of the “here-and now” of the therapeutic relationship may repair the time-collapse seen in traumatisation and thus achieve a historisation of the traumatic experiences. The effect is that they no longer, or to a lesser degree, colour and disturb present relations and reality.
6. Psychoanalytic psychotherapy must thus work with present reality and actualised relational scenarios in order to mend an internal world fragmented by the “too much” of the traumatic influence and by the disruption of relational and empathic capacity.

References

Summaries in German and Spanish

Varvin S. Extremtraumatisierung – Strategien psychischen Überlebens.

Beziehungsabbrüche und Verluste charakterisieren das Leben jener Menschen, die extreme Traumata (Folter, Konzentrationslager etc.) erlebt haben, besonders wenn sie im Exil leben. Damit stellen sich neue Herausforderungen hinsichtlich des Traumas, der massiven Traumatisierung und der Behandlung. Von besonderer Wichtigkeit ist, die vom Traumatisierten entwickelte seelische Überlebensstrategie zu beachten, wenn man eine Behandlung beginnt. Damit sind seelische Fähigkeiten gemeint, die darauf zielen, eine erneute Traumaexposition zu vermeiden als auch Versuche, die eigene Erfahrung zu verstehen und zu integrieren. Der Traumatisierte erfährt die therapeutische Situation oft als bedrohlich aus Angst, dem Trauma erneut ausgesetzt zu werden und auch, weil die Erfahrung der Verwundung die Fähigkeit zum Vertrauen in einer solchen Beziehung stört oder zerstört. In diesem Aufsatz werden die komplexen Folgen einer solchen Situation diskutiert und ein Modell der psychoanalytischen Annäherung an eine Behandlung für solche Patienten beschrieben. Der Fokus liegt auf der Störung der Symbolisierung und der Mentalisation, die das Trauma verursacht. Die Behandlung muß das ansprechen und ein setting anbieten, wo eine unzureichend symbolisierte Erfahrung (ausgedrückt in Somatisierungen, Agieren, non-verbalen Charakteristika des Sprechens, prozeduralen Aspekten der Übertragung etc.) in einen Kontext der Historisierung gestellt werden kann.

Varvin S. Traumatización extrema: estrategias para una supervivencia mental.

Interrupción y perdida caracterizan la vida de la persona que ha sufrido un trauma extremo, (tortura, campo de concentración etc.), especialmente cuando el/ella viven el exilio. Esto representa desafíos nuevo sobre el entendimiento del trauma y traumatizacion masiva así como su tratamiento. Es de especial importancia el considerar las estrategias mentales que esa persona ha desarrollado cuando ha planeado llevar a cabo un tratamiento. Estas son capacidades mentales que intentan evitar el dolor de re-experimentar así como lograr soluciones a los dilemas que representa la fase posttraumática. A menudo esta última representa intentos abortados de mentalización e integración de experiencias traumáticas. La persona traumatizada experimentará el encuentro terapéutico como amenazador debido al temor de poder re-experimentar otra vez y también porque la atrocidad distumba o daña la capacidad para una relación de confianza. Este artículo discute las complejidades de las consecuencias de esta situación y describe un modelo para una aproximación psicoanalítica al tratamiento de estos pacientes. Se focaliza sobre el trastorno de simbolización y mentalización causado por el trauma. El tratamiento tiene que dirigirse a esto y proveer un setting donde las experiencias que no fueron simbolizadas (expresas en somatizaciones, acting, características de un discurso no-verbal, aspectos de la transferencia etc.) puedan transformarse en un contexto a través del proceso de historización.