Psychoanalytic Psychotherapy with Torture Victims

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Abstract

Psychotherapy of people traumatised by war, especially people who have been exposed to torture, as well as their specific emotional and cognitive response to the experience of extreme horror, set many challenges before both participants in the therapeutic dyad and at the same time face them with many delicate questions. Besides usual issues that have been dealt with in this article, such as the issue of criteria for including patients and choice of the type of psychotherapy, followed by the issues of indications and contraindications for using psychoanalytic psychotherapy, as well as the motivation of patients for such treatment, we have also elaborated on the issue of the technique itself in the given context, i.e. specific nature of the patient-therapist relationship, specific features of the setting, adaptation of the technique itself and the particular characteristics of the course and ending of therapy. We have tried to answer what it is that helps torture victims who have been treated in this way, but we also discussed the possible causes of unsuccessful therapeutic outcomes.

PSYCHOANALYTIC ASPECTS OF TRAUMA

After having abandoned the theory of historic, real seduction and real trauma in childhood as the root cause of neurotic problems of his hysterical patients (Blass & Simon, 1994), Freud shifted towards discovering other models for understanding a traumatic event and its effects in the forming of psychopathology. Through the analysis of patients, as well as through self-analysis, Freud discovers the Oedipus complex, the significance of fantasy and subjective experience of the patient. Fantasy is given predominant importance in terms that fantasy of an event could be effective, and the subjective experience of a real event is more important than its objective nature: "… in the world of neuroses the psychic reality is the one that has decisive influence" (Freud, 1916-17). Recognised in such way, traumatic reaction and neurotic disorder most often occur as a consequence of internal instinctual tensions. Such high valuation of participation of fantasy in the traumatic would for a long while shield and render relative the importance of real sexual and physical abuse in childhood in the genesis of psychopathological enactments.

Possibly the horrific consequences of the WWI and certain personal tragic experiences have again led Freud to turn to the importance of real external occurrences. New experiences with war related neuroses bring him back to the psycho-economic model, i.e. issues of intensity of psychic energy and ways in which the mental apparatus manages it. Here Freud develops the *protective membrane and stimulus theory*. When the stimulus is sufficiently strong to breach the protective membrane or when the membrane is too weak, or when there is a specific combination of membrane weakness and stimulus force, the breach of protective membrane occurs, followed by a breakdown of defences and the psychic balance that strives for constancy. The excitation of mental apparatus becomes such that it cannot be processed or linked, so the psychic apparatus regresses to lower, more primitive development levels. Thereby the traumatic experience, as an alien body, remains encapsulated in the mental apparatus. The organism defends itself by way of forced repetition aimed at attempting to discharge the excitation or by way of abreaction or its psychic linking. Freud uses the forced repetition also to explain the phenomena of traumatic dreams and intrusion symptoms. The Ego, which normally produces signalling anxiety, now becomes completely helpless because it is overwhelmed by automatic anxiety.

The issue of importance of internal instinctual life and the event itself is resolved by Freud through a wide compromise definition in which he says that the traumatic reaction could arise as a consequence of interplay between the excessive, unacceptable instinctual need on one side and the external experience on the other (Freud, 1920). Freud, however, gave neither a more precise determination of the quality and quantity nor of the relationship between external and internal, nor of the decisive factor that would define when the trauma occurs.

We could say that Freud's disciples, while continuing the development of the trauma theory, have developed further concepts by putting more emphasis on the importance of internal or external factor, i.e. the nature of the event itself.

Fenichel (1945) further develops Freud's theory of the excessiveness of unprocessed stimulus and introduces elements of suddenness of event as a decisive factor in the genesis of traumatic neurosis. Consequently, the less prepared the person or the more sudden the traumatic event, the higher the possibility for development of traumatic reaction.

By applying a different technical approach and relation to patients (more open, sincere, less neutral and less formal) Ferenczi also develops a different view on the origin or traumatic experience. According to him, the relationship between the child and significant objects is extremely important both for the development of trauma and for the treatment of its consequences (Ferenczi, 1933). Balint and others have continued Ferenczi's theory towards a higher emphasis on object-relationship and relative decrease in importance of the traumatic event itself. Such approach has been substantially corroborated by later research on sexual abuse of children, where the severity of trauma as a consequence was linked mainly to the closeness and trust that the abused child had towards the abuser.

The schools on object relations and schools that have studied deficits in the relationship between mother and child have to some extent supported this position by placing in the foreground the child's inner objects and their importance for the child.

Emphasising the importance of relations towards objects, Simel introduced the term *war Superego* that replaces the peacetime one. Unit commanders thus replace the images of parents, and warriors show strong inclination to regress to the child-parent relationship with a high degree of dependence. Kardiner (1947) who worked with war related neuroses claimed that war neurosis is in fact psychoneurosis.

Therapists who have worked with Vietnam veterans noticed how much influence in Vietnam War the bond with the group, support or isolation, had on the development of posttraumatic stress disorder (PTSD) in Vietnam veterans, which also spoke in favour of the thesis that it is the inner situation that enables a difficult external situation to become traumatic.

Solnit and Kris (1967) make a distinction between the *strain trauma* and *shock trauma*, emphasising that not only does the strain trauma make the defences more rigid, but also it makes the person less resilient and more susceptible to social trauma. Consequently the acute trauma is aggravated because the person does not have an adequate repertoire of defences and manoeuvres for adaptation to new challenges directed at him/her both from the environment and from inside, in terms of existence of intensive unsatisfied inner needs.

Tragic experience of the Holocaust contributes to recognising the importance of the trauma itself and understanding the complexity and seriousness of this phenomenon. It has turned out that the clinical picture of survivors is very similar, regardless of the type of experience and type of pre-traumatic personality; Bergmann (1996). Besides, this was no longer one single trauma, however extreme, but a prolonged traumatic experience. A new term is developed - *survivors' syndrome*. Dominating in it is the exceptionally strong presence of anxiety and depression, excessive aggressiveness, sleeping disorders, reduced imagination and symbolic function together with inability to verbalise, numbness, overwhelming sense of guilt and rage and general significant dysfunction. It became

obvious that basic personality structures were at risk and that entire personality was being affected.

Based on these experiences Krystal (1978) criticises the stimulus membrane theory as insufficient, stating his conviction that the basic element in trauma dynamics is the experience that the situation could be escaped or not. Consequently, according to him, trauma would be the consequence of an experience of extreme helplessness, breakdown and psychic surrender. He describes the robotisation of personality, catatonia and psychic death. Krystal understands the sense of numbness and blocking of affective life as a paradoxical way of protecting the individual from the painful feeling of helplessness. With the aim of surviving, Ego separates into the observing part and the indifferent part. The indifferent part represents the body that Ego sacrifices. Mental and imaginative processes become extremely impoverished and narrowed. Even once the traumatic situation is gone, the traumatic reaction persists. The cognitive-affective constriction remains and catatonia is transformed into depression or loss of interest. Stimuli linked to the traumatic situation in any way are avoided as far as the state of pseudophobia. Most often present are also nightmares, aggression and anhedonia. These, as well as other phenomena of the realistically high presence of psychosomatic diseases, disturbed immunological balance and alexithymia, greatly resemble the characteristics of psychosomatic patients. Psychic suffering is thereby transformed into physical.

British psychoanalytic school gives its contribution to the understanding of these phenomena through Bion (1967) and the *theory of containment* and the *theory of thinking* as well as through Hannah Segal and the *theory of symbolic function*. For Bion the early relationship and exchange that a child has with the mother is of crucial importance for his/her entire future development, i.e. for his/her capability for defence or assimilation from internal or external attacks. The child projects into the mother his/her own horrific experiences that he/she is unable to think about and needs to be liberated from. These experiences are in the area of extreme paranoia, sense of danger and overwhelming anxiety that a child does not experience on a whole, but rather through fragments of unbearable events and anxieties leading to internal chaos and complete helplessness. These fragments Bion has named beta particles. In the positive case the mother could accept them, contain them, process and return them to the child in a metabolised state as information and pure affect that the child can now build into the Ego and empower its growth. Repetition of these positive experiences strengthens the good inner object, Ego, mentalisation, thinking and symbolisation. The developed alpha function is linked with the developed symbolic function. The symbol represents a replacement for what it symbolises. If the symbolic function is not developed or has regressed to the level of symbolic equalisation, the subject is not capable of making a difference and a distance between I and non-I, the real event and its perception. Thus the symbols of the traumatic event, even the words themselves, do not lead the person to recollection but to re-experiencing. Because he/she is unable to think symbolically or verbalise the horrific event, the traumatised person experiences the flashback as real and present. In order to avoid this terrible experience, the traumatised person develops avoidance behaviour, while verbalisation, symbolisation and imaginative creative processes in the mental apparatus are reduced to the minimum.

Bion links what a mother can do for the child with what a therapist can do for the patient, and that is to translate the unbearable and unthinkable into something that could be thought about. Thereby in a protected atmosphere of the therapeutic situation, with a therapist able to contain, think and return to the traumatised his horrific experiences in a metabolised form, the traumatised patient can come in contact with terrifying feelings experienced in the traumatic situation, but in a way in which they are no longer overwhelming and threatening and therefore preventing him/her to keep thinking about the traumatic experience.

Horovitz (1976) differentiates between child trauma and the adult trauma based on the level of damage of cognitive functions. He introduces *mental models* and *pre-existing schematisations*. Extreme traumatic experiences cannot fit into the pre-existing schematisations (perceptions of self, others and the world). Awaiting the attempt of integration into already established schemes or the creation of new ones, traumatic memory places itself in special parts of the mental apparatus and expects to be encoded. However, it is only when a new schematisation is established that the traumatic experience could be forgotten or stored in the overall experience. Important parts of this process are the effacement and intrusion. An overly high level of control leads to effacement and numbness, whereas the loss of control leads to intrusion. Alternation of these processes, according to him, is a normal physiological process of establishing a new equilibrium and healing. Horowitz was also the first to empirically demonstrate the existence of link between pre-traumatic deficits in personality structure and higher inclination towards developing increased susceptibility to trauma. This, however, is not always the case and it does not have any predictive effect.

TORTURE VICTIM SYNDROME AS A SPECIAL ENTITY - YES OR NO?

Most of the leading contemporary researchers of PTSD do not distinguish torture victims nor recognise the syndrome of the tortured as a special entity (van der Kolk, 1987). None of the contemporary classifications of psychiatric disorders separate this syndrome as a special nosological entity, apart from the possibility to place this syndrome to a certain extent under the category of "Permanent personality changes following a catastrophic experience" (F62.0 in the ICD-10).

While communicating his experiences of working with Holocaust survivors, Niederland (1968) talks about typical psychopathological picture of the survivors with pervasive anxiety depression, sleeping disorders combined with nightmares, physical discomfort, withdrawal from society, chronic apathy, occasional outbursts of rage, emotional numbness and inability to verbalise. What he recognises as the key characteristic is the guilt for having survived, with insoluble feelings of grief and mourning.

However, several experts who refer primarily to their own clinical experience distinguish some particular characteristics of torture victims and advocate for the establishing of torture syndrome as a special one. Torture is not an isolated, powerful and

exceptionally severe traumatic event, but by definition a series of traumatic events and therefore similar to the syndrome of Holocaust survivor. Torture is highly focused on the individual and directed towards crushing and annihilating his/her personality by way of cruel, systematic and deliberate infliction of psychic or physical violence, most often combined, perpetrated by the torturer.

Many authors with experience in working with victims of torture agree that PTSD does not encompass all phenomena of the clinical picture of torture victims. Although the majority of torture victims suffer from PTSD, certain number of syndromes does not fit into the PTSD scope (Reeler, 1994).

Lansen and Herman (1992) talk about the complex PTSD syndrome that could include extremely traumatised clients.

Clinicians (Ramsay, Gorst-Unsworth & Turner, 1993) distinguish four basic dimensions in torture victims: incomplete emotional processing, depressive reaction, somatoform reaction and existential dilemma. While working with these clients we have seen on countless occasions the well known fact that apart from somatic symptoms torture victims often complain about physical symptoms as real consequences of torture (chronic pain in various parts of the body, particularly in the back, chronic headaches, etc.). Another regular occurrence is the weakened response of the body due to disrupted regulation of immune defence system. The most frequent psychological sequelae of torture that we have encountered in our work are the strong feeling of the torture victim that he/she has changed, that his/her identity has changed, the loss of self-esteem and confidence in others, feeling of senselessness, alienation, loneliness, shame and isolation.

Although we share the opinion of experts who advocate for recognising the torture victim syndrome and separating it as a special entity, unfortunately we still do not possess valid empirical studies that would either support or discard such observations.

PSYCHOANALYTIC PSYCHOTHERAPY WITH TORTURE VICTIMS

The Centre for Rehabilitation of Torture Victims – IAN Belgrade (CRTV IAN) employs several therapists from various psychotherapeutic orientations, as well as several therapists who use psychoanalytic psychotherapy or its basic elements in their work. Understandably, they are all different in terms of their previous experience and working style, but also in terms of varying respect for the importance of certain concepts or theoretical systems that we have discussed earlier in this paper. It is difficult to define to what extent these differences affect the specific characteristics of treatment, i.e. the establishing of psychotherapeutic relationship, its course and outcome. Nevertheless, in the following text we shall attempt to extract some common denominators, as well as to define certain specificities of the work done in CRTV. Firstly, these specificities are determined by external characteristics to a significant extent. This primarily refers to the socio-political context of work, especially the work of CRTV during Milosevic regime, with constant pressure and fear of political or physical attacks, and work after the overthrow of Milosevic

and following political changes. The other specificity relates to the general sociodemographic characteristics of our clients, which are dealt with more comprehensively in other parts of this monograph. Here it is sufficient to emphasise that a vast majority of our clients has been detained and tortured by the then enemy armies or paramilitary formations during wars in former Yugoslavia in the nineties. Most of them are men, almost all of them also refugees.

INDICATIONS FOR PSYCHOANALYTIC PSYCHOTHERAPY

The issue of indications for psychoanalytic psychotherapy should always be approached very carefully, and is especially important when it concerns torture victims. Generally speaking, indications for torture victims are the same as for other clients. From the therapist's side, the aim is to obtain a sufficiently strong impression about the quality of mental functioning of the client, the degree to which his/her relationship capacity has been preserved, preservation of Ego functions, motivation (to be discussed later more comprehensively, given the high importance of this issue), level of sensibility for psychic processes, preservation of the ability to symbolise, ability to verbalise, quality of reality testing, level of frustration tolerance, etc. Certainly special attention is paid to the impression of the premorbid personality structure as well as to the impression of the quality of overall personality functioning prior to torture experience. This is done primarily because we should not loose sight of the fact that clinical picture and behaviour of torture victims, our clients, especially during first contacts, appears as borderline functioning with prominent use of primitive defence mechanisms organised around splitting and projective identification. However, such picture is usually the consequence of torture, because the later work showed that prior to torture experience most of our clients behaved in a way indicating the average distribution of psychic structure and maturity characteristic of general population. Understanding from the very outset of treatment, inasmuch as possible, the nature and scope of influence that the mutual interaction between predmorbid structure and torture experience had on the development of patient's current state often means also recognising the area and capacities for recovery.

Analysing the quality of these characteristics provides the therapist with necessary information for rendering conclusions and deciding on whether the psychoanalytic psychotherapy would be the best option for the client who is a torture victim. Our experience is that a relatively small number of clients actually satisfied these criteria. Others have been recommended a different and more adequate form of treatment (supportive psychotherapy combined with or without pharmacotherapy, EMDR, etc.)

Great number of similar centres throughout the world dealing with torture victims are reporting potential difficulties on this level of working with their clients. This and other similar centres have been founded with the aim of assisting this population. In addition, a prevailing majority if not all people who work in the Centre are inspired by the need to advocate for and protect the rights of these clients. But this specific motivation and susceptibility to the difficulties of these severely injured clients could bring about the urge

of Centre staff to help "at any cost", even when the client does not want or does not clearly understand what kind of psychological assistance is offered, or to base their work on the "any kind of help is better than none" principle that could lead, most often at the unconscious level, to weakening of professional standards and earlier internalised and adopted models and procedures. Thereby, the aim of "giving the most we can" could in turn contribute to the decrease in expert and scientific objectivity.

We have not excluded this as a potential phenomenon in our Centre. Because of that we have approached this problem on the Centre organisational level in terms of prepared procedures. Consequently, when registering new clients in the initial phase of working with them and only with their express consent, well trained psychologists present them with a comprehensive battery of tests ensuring substantial amount of information in the field of diagnostics, clinical picture and personality characteristics, which greatly helps the therapist in his/her better understanding of the client, supplementing own impression and reaching an adequate decision and recommendation about the treatment. On the other hand, initial procedures have been designed in such a way that they are often used as psycho educational (by psychologists, physicians, legal counsellors and later by psychotherapists) in order to instruct clients about the type of their discomforts, legitimacy of needed assistance and potential sensitisation for psychotherapeutic work. Ideally, on one side the Centre's psychologists who are well trained in elements of psychoanalytic counselling perform the triage of clients who later incline to various therapists for initiating and receiving the most adequate treatment, and on the other they provide clients with enough basic information and space to explore by themselves the possible types of assistance and other important issues such as the gender of therapist, free and adequate terms of sessions, etc., which enables clients to receive all necessary information and impressions that could be of importance for their autonomous decision about the treatment.

MOTIVATION

The issue of motivation of traumatised people in general is a very important specific feature for initiation of psychoanalytic psychotherapy, especially when it comes to motivation of severely traumatised clients. This is well known from the literature where psychotherapists talk about their experiences in working with traumatised persons. For many years the problem of Holocaust has remained unrecognised partly because only a small number of survivors actively sought psychological assistance (Solkoff, 1992). The situation with our traumatised and tortured clients is very much the same.

The issue of motivation was recognised and defined very early as one of the cornerstones of successful therapy. Sufficiently expressed motivation for change enables both the therapist and the patient to begin and develop the psychotherapeutic process, to successfully overcome expected obstacles and setbacks in its course and to end it with success. Motivation for psychotherapy is most often based on the intensity of psychic suffering and certain degree of recognition that psychological means can affect this suffering. It is also founded on the basic assumption and confidence that another person

could help in this process. Other characteristics such as sociocultural, intelligence, education level and support of the environment sometimes have even the decisive influence on the success of psychotherapy.

In the culture of our country and the overall former Yugoslavia, where our clients come from, psychiatrist and psychotherapist evoke associations of numerous fantasies and negative stereotype constructs, usually carrying negative connotations both for them and the person who needs their consultations or assistance. In this cultural discourse, requesting psychological assistance means being completely helpless, dangerous for the environment, suspicious in some way or insane.

The suffering of body is significantly more legitimate. Therefore it is not surprising that alongside the nature of torture syndrome with a tendency to relocate the pain into the body and the psychosomatic, our patients prefer medical assistance, somatic and laboratory examinations. Besides shifting the pain into the body, there is another phenomenon visibly present in our traumatised and tortured clients. It is expressed through various forms of the need for redress: legal, judicial, material and other forms of compensation and reparation. Therapists and other people employed in the Centre see this as an understandable need of our clients, since on the conscious level this seems as a highly legitimate expression of the reaction to inflicted suffering and injury. An important aspect of work in the Centre is support and advocacy for such needs of our clients. However, a problem may occur in the psychotherapeutic process if this otherwise unconscious elaboration of the feeling of injury and need for compensation should be experienced as rend tendency, secondary or tertiary gain. Young and Gibb (1988) talk about this dynamics, which is not culturally conditioned, as a very frequently present phenomenon in the posttraumatic picture. The experience of extreme violence, cruelty, injustice and humiliation breeds strong aggressive and vindictive impulses in the victim. However, these impulses can be estimated as unacceptable by the previously established standards in the personality and consequently be effaced, dissociated or projected into the outside world. While working with our clients we have often encountered this phenomenon. The experienced torture frequently leaves behind such dynamics that has a tendency to persist. This possibility is even higher if the painful experience of torture is linked with potential constitutive or childhood experiences of injury, persecution and injustice, as well as the need for revenge. Thereby, once experienced in early stages of personality development and subsequently reactivated by the incident of torture this dynamic could lead into a vicious circle, which according to our experience most often prevents its exploration in the psychotherapeutic situation. We could even say that a significant number of unsuccessful therapies with torture victims were such only because of this reason.

SUPPORTIVE ELEMENTS IN THERAPY, NEUTRALITY OF THERAPIST AND THE SETTING

Baring in mind all above-mentioned specificities, it is understandable that a certain modification is necessary in the classical psychotherapeutic relationship of the therapist

towards the client who is a torture victim. In such relationship it is difficult to establish the classic neutrality. We could even say that it would be fake, since the therapist cannot remain indifferent (in this case we could think about the burn-out syndrome) to the suffering experience by his/her tortured patients. The classic neutral relationship could therefore become insufficient for several reasons. Firstly because it can seem overly artificial and perceived by the client as manipulating. On certain level at least the therapist has the need to redress and support someone who had been subjected to such evil. If neutrality and distance are largely present in this relationship then they are rather an expression of the therapist's defence from being overwhelmed by feelings of horror, helplessness or powerlessness. Therefore a completely neutral approach to the tortured client could even prove to be harmful since it is inadequate for the degree and nature of the clients' injuries. Without intention to go too far, we could say that a completely neutral therapist might on a certain level be perceived by the client as a new torturer.

During therapy our clients often demonstrate the need for a more open support, expression of attitude or higher engagement of the therapist. The need for more or less educational work is almost always present, especially at the beginning of therapy, in order to explain the nature of the problem as well as the characteristics and aims of the therapy.

From the above-mentioned reasons we could say that in practice the psychoanalytic psychotherapy with torture victims often represents a combination of a certain degree of supportive and explorative dimension in technical approach. These techniques are frequently said to contaminate the true psychoanalytic psychotherapy and are seen as techniques of lesser value or secondary importance in relation to interpretative approaches. However, it was already Wallerstein (1986), citing Menninger's study, who pointed out that many psychoanalytic therapies contain more supportive elements than it had been assumed and that these elements often were the agents of change in the psychoanalytic process or in the client himself.

Suggestion, abreaction and manipulation, as the most frequent supportive techniques, are aimed at changing the dynamic forces and achieving new equilibrium, more through living a new experience than through attaining and insight (Rockland, 1992). According to Bibring (1954) they have a positive potential and effect when their activity is founded on primitive parts of positive transfer. If carefully used, they can also open the way towards an insight and more stable changes.

However, what makes the work with these techniques very sensitive is the high potential for manipulation to the client's detriment. Here we primarily mean the potential excessive encouragement of the patient, breach of his/her autonomy or charismatic seduction by way of knowledge and power of the therapist. Therefore, contrary to the usual opinion that since these techniques and this approach are less specific and expert and could therefore be used by less experienced, less skilful or less trained therapists, we believe that it is necessary to have the most experienced therapists working with torture victims. Only an experienced therapist will be able to recognise how much a certain client would be responsive to explorative and how much to the supportive approach, and then to carefully

apply these techniques only in situation when he/she is sure that they could not have some of the above adverse effects.

We have a similar viewpoint regarding the role of setting in working with torture victims. A safe, reliable and foreseeable framework in which the relationship with the therapist occurs has an additional significance bearing in mind the difficulties and intensity of basic trust breach and disorder in the inner world of the victim. Therefore it is necessary that the setting be carefully prepared, maintained and analysed throughout the course of therapy. Already during the first interviews with the torture victim it is necessary to determine the timing of sessions, give a clear orientation about this and how important each session is. Only a good setting will become a medium for the re-establishment of the basic trust and re-creating the former destroyed relationship with others or creating an entirely new one.

THE COURSE OF THERAPY

If it aims at reconstructing the damaged ego structures, the therapeutic process is very long. Although, as other therapists, we have experienced dramatic improvements and recoveries, most often in the form of abreaction, in working with such severely injured clients these are primarily exceptions confirming the rule. Besides high specificity of the course of each therapy, especially in working with such difficult disorders, we could say that the therapeutic process passes through certain phases, each with its own specific characteristics and requiring special, different engagement of both the therapist and the patient.

Herman (1992) talks about three stages of the therapeutic process:

1. establishing safety
2. remembering and grieving
3. re-connecting

She describes a successful therapeutic process that enters from the initial unpredictable anxiety and insecurity into a phase of reliable safety, from the dissociated traumatic experience towards establishing memoric ways and finally leads from stigmatised isolation to social reintegration. Other psychotherapists also distinguish similar phased processes – Kuhlberg and Horowitz (1986) stress that these specific phases are not only a formal thing, because a useful intervention in one phase that induces change could be damaging in the next one.

The guiding aim in the first phase is the establishing of elementary safety with simultaneous revival of damaged basic trust and therefore the intervention should be directed towards developing these affects. There is a probability that insisting on elaboration of the traumatic experience in this phase could have an adverse effect. A number of therapies probably end prematurely due to the impossibility of the client to face the source of pain and unbearable anxiety in the still insufficiently safe atmosphere and the

undeveloped relationship toward the therapist. In this phase more work should probably be done on defining the contract, strengthening the working relationship, reinforcing the patient's sense of control and the positive elements of transfer.

In the second, probably the longest and often the most difficult phase, the therapist faces challenges of having a strong sense of tactfulness, timeliness and empathy. It is in this phase that the unravelling of torture experience most often begins anew and usually in absence of adequate emotional flow at the outset. Danieli (1988) talks about the necessity to link earlier pre-traumatic relationships and experience, values and norms, ideals, conflicts and problems. Encouraging the emergence of such contents could create a context in which the traumatic experience may acquire meaning and thereby enable the re-creation of the emotional response to it as well as re-establishing the inner feeling of continuity and wholeness that had been experienced as temporarily threatened and damaged, yet basically not destroyed for good.

The last phase is dedicated to reconstruction, reintegration and separation from the therapist together with inclusion of the patient into social life. This phase is also characterised by elaborations and verification of the degree of trust and confidence in others, re-examining social relations and planning new life.

However strong and stable the recovery and however high the quality of integrating new insights into own experience, torture leaves severe consequences. The torture victim will always remain conscious of how powerful the feeling of helplessness and fear he/she has experienced, as well as to what limits of inhumanity some people, groups or systems are capable of going.

THERAPEUTIC RELATIONSHIP

Therapeutic relationship is very demanding and often difficult for both parties. It is expressed in the already described boundaries and rules o the analytic relationship. Nevertheless, the impression remains that there are certain particularities at least in its intensity. From the client's side there is the strong initial mistrust, tendency to idealise ad then disparage, excessive or non-existent expectations from the therapist, inclination towards regression to pre-verbal levels of functioning, re-living the unbearable pain of which the therapist is the witness, but from the victim's side, in the unconscious and especially in the parts of negative transfer, also the one who provokes. Some authors have particularly pointed to the depth of regression in such clients (Werbert and Lindbom-Jakobson, 1993). Elaboration of extreme helplessness during torture, fear of complete annihilation and death, extreme haunting feelings as well as reactive desires for flight and revenge are probably the unavoidable contents in the processing of traumatic experience. Such set of experiences and affects could represent or be perceived in the unconscious as tantamount to those feelings and experiences that the person could have had as a child in the earliest stages of development when some real of fantasmic experience created the internal persecuting object while the mother or another one of child's important objects

were unable to help in processing and integrating such experience. This could serve as explanation for the relatively frequent and for the patient consciously hardly bearable negative transfer feelings.

Dori Laub (1991, 1995) has developed a *theory of empathic collapse* while working with Holocaust survivors. In the course of development and as a consequence of positive experiences an empathic protective barrier develops, based on communication between the good internal object and the self. According to this theory, as a consequence of extreme and prolonged trauma the communication, together with the support between good internal object and self, breaks down and the empathic barrier is destroyed, followed by the accompanying feelings of complete loneliness, abandonment and helplessness. Thereby basic trust is lost in the possibility of continuance of the good object or in its imminent recovery or return and consequently trust is lost in the possibility to expect that a human being could empathise with us, the possibility that others would recognise our basic needs and respond to them.

The loss of the inner good empathic dyad relationship entails the loss of possibility of understanding and articulating experience and need. The cause of this loss of empathy is the need to exclude any possible relationship with the torturer and his potential internalisation. The experience of torture victims is that the perpetrator constantly occupies their mind and their inner world. The relation to the world and the self is often formed only through this relationship. In order to prevent this unbearable situation and the dangerous intrusion as well as potential identification a breakdown occurs. Torture victim attempts to establish the pre-traumatic object relations.

Some therapists use the concept of projective identification as a way to understand the frequent feelings of powerlessness, insufficiency and emptiness as well as aggressiveness experienced by the therapist. While working with these clients, the therapist is constantly in a situation of experiencing a whole spectrum of difficult feelings. Therefore he/she often unconsciously defends in inadequate ways, which could contribute to a halt or discontinuation of the therapeutic process. However great the capability for empathy and identification with the client, the therapist does not have the personal experience of torture. Consequently, his/her capabilities for understanding and processing the horrors of this "man made disaster" are inevitably limited. It provokes in the therapist various unconscious examination about meaning, about life and death, relationships with other people, relations to one's own work, power and powerlessness, sense and senselessness of aggressiveness, vengefulness and destruction. Dissociation and passiveness, requirements and aggressiveness on the unconscious level could provoke a need for manic reparation or rejection of the client. Reactive omnipotent fantasies or hidden depressive potential in the therapist could lead to exposing the client to untimely or maladaptive interventions, which on the unconscious level could be tantamount to taking on the role of the torturer. The therapist should therefore be objectively aware of all these limitations and dangers. Self-analysis, relaxation and especially consultations and supervision assistance of colleagues could be of great help in such situations.

Basic form of communication but simultaneously the means of therapeutic action and change is the word. Torture victim is either preoccupied or overwhelmed with the story of traumatic experience to the level of rumination, which is rare, or more frequently he/she speaks with difficulty or not at all about large parts of this painful experience. Certain parts of this experience are affected by amnesia. In both cases it is clear that the victim is unable to name his/her feelings experienced both at the time of the event and at the present time when he/she tried to think about it. Therefore the experience remains separated, not integrated, fragmented and non-metabolised thereby representing a constant source of overwhelming anxiety. Integration of this experience could be understood as an important therapeutic challenge. Some therapists could be preoccupied with this aim, as a traditionally important element of healing. Empowering the damaged ego functions, taking over a certain amount of control and proaction in one's own life, developing certain concealed creative and imaginative capacities, inclusion into the family and wider social community, reduction of aggressiveness, self-aggressiveness and feelings of guild and shame as well as isolation and worthlessness, each in itself represent sufficiently important aims. However, it is often more important to establish basic elements of human relationship that involves trust, reliability and permanence.

CASE STUDY 1

The young woman that I will here call Vesna I met in early 2002 when she came to me after having heard about the Centre from one of our clients. She was told that she could "exercise her rights" through the Centre, as well as talk to one of the psychiatrists should she have any problems. She then realised that she wishes to talk to "some expert", since she could no longer withstand the discomforts she was feeling and because her life, as she said in the first interview, was beginning to move into a direction she did not like.

Vesna is in her early thirties, economic technical assistant, and unemployed. She is married, but during last two years she hasn't been living with her husband; she lives with her parents and her daughter in a small town in Serbia. She is originally from Croatia, where she had lived until the beginning of war, after which she fled to Serbia. She has a refugee status. She wants to immigrate to Canada and join her brother who lives there with his family.

She is the second of four children in her family. She was born in the country in a complete family; besides her parents, her paternal grandmother and grandfather also lived in the household. When she was little, her mother and paternal grandmother took care of her. She remembers her childhood as pleasant. She did not lack anything, she stresses that she had everything that other children had, even more, and that she felt safe and protected within her family. She was her father’s favourite, but was always closer and more attached to her mother. She describes her mother as warm, caring and sensitive, always there for her children and cheerful, and her father as gentle and self-sacrificing. The parents always got along well. She got along well with her siblings, especially with her brother and elder sister who were closer to her age, while the other sister was much younger, resulting in Vesna

feeling as her "second mom". She started school in time, fit in nicely and was an outstanding pupil. After primary school she chose to go to the secondary economy school, which she finished in time, also with honours. She wanted to study at the university, but the war began and thwarted her plans. At the very beginning of the war, the father sent her and her brother to Serbia, "for a couple of days". The outset of her life in exile was very difficult for her. She missed the house, her parents, sister, friends, she felt "uprooted". A year later her parents came to Serbia together with the younger sister, so then she felt a little better, but at that time she slowly became aware that she would probably never return to her native place. Her elder sister, already married at that time, remained in Croatia and Vesna occasionally went to visit her, despite the armed conflict. During one of such visits, the town where she was came under siege by enemy troops and Vesna found herself in hostile surroundings. Her sister managed to evacuate with the baby and cross over to the free territory, while Vesna remained alone in the house. The next 50 days she spent in house arrest. She did not have contact with anyone. She was unable to use the telephone because the phone lines were down. Several days later she could no longer stand the hunger so she went out into the garden one night to pick some vegetables. While she was in the garden the enemy soldiers spotted her. With curses, insults and slapping they forced her into the basement and then raped her. They constantly beat her and abused her verbally, while one of them urinated all over her. They were laughing and saying how great it was to hear her enjoying it. They left her threatening they would return with others. She does not know what happened to her afterwards. She only has fragmented memory of the days that followed. She lost track of time. She became numb, having lost all hope that she would survive. However, after a while (later it became evident that it was over a month) one of the local inhabitants came into the house and found her. He carried her over to his house where she stayed for some time, and then together with some other people took her to the UN protected bus line that transported her back to Serbia. She was resolved to go on with her life "as if nothing had happened". However, she soon started feeling discomforts. She changed, once a cheerful girl became withdrawn and silent. She constantly felt anxiety and fear. The images of torture that she had been subjected to were often recurring against her will. She had nightmares from which she woke up soaked in sweat and frightened. She began to distance herself from others, she felt worthless and futile. She became preoccupied with cleanliness and neatness. She had bathing rituals and she took baths several times a day. Her loved ones noticed that something was wrong with her, but she kept convincing them it was nothing. After a while she decided to change something. She took a job and soon got married to a man who she had been dating even before the rape. She soon had a child. However, she avoided sexual intercourse and when these occurred she pretended "it's happening to someone else". Such situation became the cause of her husband's jealousy and soon led to their separation after which she moved back with her parents. Nevertheless, none of them filed for a divorce.

Already during the first interview Vesna told me about these traumatic events. She spoke long about everything, describing the rape to the smallest detail. It was striking that she spoke about it without adequate emotional accompaniment. She only kept looking at me persistently and in a controlling way all throughout the conversation, or better said, her monologue. I had the impression that I was riveted to the chair in which I was sitting and it

seemed to me that I should not move nor take my eyes off her for even a second. She pointed out that she had never told this to anyone before.

We made an agreement about commencing psychotherapy.

Vesna continued coming to me once a week. During initial sessions she mostly kept silent and looked at me piercingly. If she would say something it would most often relate to her mother-in-law who she considered the culprit for her unsuccessful marriage. She described her mother-in-law as woman of low moral standards, egoistic and selfish, lying and deceitful, ready for any kind of intrigue. She did not accept my interpretations that maybe similar feelings exist towards me at this situation now, that I might be someone towards whom it is difficult to feel trust. She said that the fact she kept coming was a reliable sign of her confidence in me.

I would like to point out parts from two sessions that are particularly interesting, maybe because they mostly portray the dynamics of our relationship and the course of psychotherapy.

Session 1 (approximately after six months of therapy)

She kept looking and me persistently and for a long while. She looked around the room, precisely noticing the smallest changes. Such as that my bag was now on the couch and the coffee mug on the desk. (From the very outset of her therapy, i.e. from the initial sessions, she paid a lot of attention to the space in which we were, commenting if something would seem to her different than before.) I tell her that she noticed the change again and ask her how she feels about it. She says that has no particular meaning, these are trifle things, although she would like it to be as she had left it. She continues about her plans for leaving and how she spoke with her brother. He thinks that everything would be fine and that she would be able to come soon. I ask her how she feels about it. She can't wait; she only wonders how her child would take it. She has nothing to look for here any more, she wants to start a new life over there and forget all ugly things that happened to her here. I tell her that on one side there's her need to leave and on the other her worry about how her child would take the change and that this seems to me as being connected to the worried of her own "childish" needs, i.e. that she would not be able to take care of herself in such situation. She thinks that what I said makes no sense. She continues about her mother-in-law and how their relationship ended when she spat on her child because it looked like her. She ruminates this relationship again and how this woman is completely different from her mother, how she is selfish, primitive and evil. I tell her that here, in the relationship with me, it also seems that there is a suspicion if I am like her mother, i.e. someone who could protect her and care for her, or if I am like her mother-in-law who is selfish and evil. This also has no specific

meaning for her. She would not spend a minute in here if she did not trust me. I tell her I think it's true, that there is this part of her that trusts me and brings her here, but that there's also the other, suspicious and distrustful. For her this is not so, she either trusts people or she does not. I am a psychiatrist and she can trust me. After long silence she says that nightmares became more frequent again. She keeps dreaming of people who persecute her, enemy troops that are closely behind her heels and catching up with her. She tells me the latest dream she had - She is in a house. The house is made of concrete, resembles a bunker. It is round in shape and instead of windows it has narrow openings on the top, which are loopholes. She is inside, running in circles, frightened for not being able to find an exit. Again intensive fear awakens her. I ask her whether anything comes to her mind related to this dream. She says it is all clear. The dream tells her how afraid she is of not being able to succeed in her plans for going to Canada. I tell her that she is alone in the dream, locked in a house resembling a bunker and that it seems to me that this house is a place inside her, which is closed in the same way and from which there is no way out. She asks me what I mean. I tell her I mean the situation of abuse that she had been subjected to. And the consequences that she suffers because of that. She says she does not want to talk about it. I tell her that this is exactly like in the dream. As if she needs to be alone and look alone for the way out of something that makes her feel so bad. She looks at me for a long while. Finally she asks me if I really believe that such things could be overcome. I tell her that I don't believe they could be forgotten, but I do believe they could be overcome. She dismisses this lightly and until the end of session keeps talking about a bookstore se was planning to open with her husband but all these plans have now fallen through.

Session 2 (after one year of therapy)

She says that she has been moody lately, that she has problems with her daughter who opposes the going to Canada. She is doing less well in school and became quarrelsome. This brings her back to her own childhood, she says she was different, mostly a good child and never gave trouble to her parents. Her daughter is in contact with the father, he comes to see her and then they talk. They even went out on a few occasions and she felt good with him. She wondered whether it was indeed all over, she thinks that there is hope their marriage would not fall apart altogether. She told him about her plans regarding emigration and asked him whether he would some to live with them there. He told her that he needed to think about it but that the idea does not seem bad. She concludes that in Canada all three of them could start over. She continues telling about a dream - she is in a room resembling a hospital, but everything is run down and filthy. There are dried bloodstains

on the floor; the paint is peeling off the walls. She notices a bed with someone on it, dead and covered with a white sheet. She approaches and as she is about to lift the cover to see who that is she realises that the person is not dead because the white sheet suddenly becomes soaked with blood leaking out of a chest wound. She lifts the sheet and sees that this "corpse" is in fact she. She thinks this is another one of her nightmares; they are less frequent now, but the fear she feels is more intense. After a period of silence she says that this is exactly how she felt for a long time - dead. I tell her that, like in the dream, she thought that a part of her was dead, but in fact it was alive, yet wounded. And that maybe what frightened her so much was in fact the fear to come in contact with feelings that are very painful for her. This was the first time she cried. She was crying for a long while, bended over. When she calmed down she said that something silly has just occurred to her. I ask her what that is. She says that she remembered her first sexual experience and how this boy was inexperienced and made funny moves. She starts to laugh, say how silly it is that she remembered this now. I tell her that this memory was now partly the need to evade difficult feelings, but on the other hand an attempt to establish contact with a part of her self with which she found it difficult to be in touch for a long time.

Sessions that followed were marked by Vesna's need to elaborate the traumatic experience. During one session she said she had a dream of three evil dwarfs dressed in soldier uniforms. She interpreted her own dream by saying that her violators are now only evil dwarfs. Together with this she regained the memory of the pre-war times. Vesna was again able to find the cheerful, optimistic person she used to be. Plenty of time at the session she dedicated to thinking about the future and making plans. She showed surprise and satisfaction with the achieved change and expressed gratitude and confidence towards me. Vesna has not yet left for Canada. She still hopes to get a visa and be able to emigrate with her daughter to "start a new life" there. She still comes in for therapy. I decided to leave the ending of therapy to her. She has not raised it so far, although judging by the dreams she brings and her associations I feel this moment is near. She still lives separated from her husband, but their relations are getting much better. She began having sex with him again. She contemplates whether to tell him what had happened to her. There are no more nightmares.

CASE STUDY 2

Milan, man in his fifties, is a former Yugoslav Army officer in retirement. He is married, with two daughters. He has been living with his family in a small town in Serbia since 1991. Until then he had lived and worked in Croatia. In autumn of 1991, together with several other army officers, he was captured and took to a prison. In the prison where he spent three months he was subjected to psychic torture. He was insulted, humiliated,

exposed to death threats. Most of the time of his imprisonment he spent in solitary confinement. He did not know what was happening with his family, his colleagues and friends. He listened to the cries and screams coming from other cells. After three months of captivity he was exchanged and sent to Serbia. Soon after arrival he felt the first psychic discomforts. It started with insomnia. He could not fall asleep for a long time and frequently kept waking up during the night. Then came the nightmares related to the traumatic event. He would wake up in panic fear and sweat. He began to distance himself from others, became tense and moody. He felt betrayed and disillusioned. He noticed he was becoming irritable with no apparent cause. He found it increasingly difficult to function at work, he couldn't keep his concentration. He requested retirement. The symptoms fluctuated over time. There were periods when he felt better. Consequently, he did not go to a psychiatrist. However, since March 1999 and the air strikes against Yugoslavia his symptoms intensified and he decided to seek psychiatric assistance. Before the war and the experience of torture he had functioned well in all aspects of life.

I met him when he came to CRTV in March 2002. He read about the Centre's activities in the newspaper. Given the introspectiveness and motivation he demonstrated during initial interviews we made a psychotherapeutic contract. He was happy about it, a long time ago he wanted to study psychology, but the "life has led him into another direction".

However, despite the initial motivation, he soon showed signs of resistance. Milan nevertheless respected the therapeutic contract, he came to sessions regularly and at agreed times, but he attempted to render intimate our relationship or would agree with everything I said because I was "the expert and I know" or would simply be silent and look at me suspiciously, so that my interventions at the beginning of therapy related mainly to attempts to clarify his resistance with gratification of his effort. The trend to maintain such state continued. I soon began to catch myself hoping that he might not come for the session, finding it difficult to listen to him at sessions, being distant and sleepy. I felt useless and isolated. Once when it was his time to come, I thought "another 5 minutes of torture". At that moment it became clear to me tat I was drawn into a countertransferance acting out. For the first time after a long while, I was able to think about Milan at the session. Again I felt competent and able to do something and to help him. I asked him why in fact he was coming. He was surprised by my question. And just as he began to praise my expertise, the assistance he was getting and the therapy, as many times before, I interrupted him and told him that I more or less know what he was going to say and that I do not have the impression that the therapy is in fact helping him and that I would like to know how he really felt, here at the sessions, as well as outside the sessions. It turned out that he was thinking about not coming any more but he was embarrassed to tell me because I had been putting so much effort into this and he wasn't getting any better, even his nightmares became more intensive. I explained to him that the intensifying nightmares could be related to therapy, i.e. with the fact that time here was not used for analysing his feelings because he finds it difficult and painful to face this and that it seemed to me that he had the need to protect me as well from his feelings that he himself judges and rejects and unacceptable. Following sessions we spent mainly in strengthening the therapeutic alliance. Milan

gradually understood to what extent it was difficult for him to face the sources of his pain and suffering and soon he started using the session time in a different and more constructive way. Slowly he gained the knowledge that the therapeutic situation was a safe place despite the difficulties that we have carefully analysed.

Session 1 (several months after the initiation of therapy)

He talks about his daughters. He stresses he is very proud of them, that they are all he has in life. (Milan has devoted plenty of time at sessions to his daughters. he avoided talking about his wife and their relations.) The elder daughter is more successful. She reminds him of himself when he was young, but she is much younger and sweeter. He worries about their future; they are both jobless, he wonders in what way he could help them. Earlier he could have done it, he had some "connections", but now it's different, "nobody needs him". I ask him whether he socialises. He says he's withdrawn, spends most of the time on his farm, because he feels best in the company of animals. As for people, he regularly sees the parents of his killed soldier. I ask him to clarify this. He says it's about the boy who was killed during the NATO air strikes. He was not his immediate superior officer but he felt the need to let his parent know that their son was killed. Somehow he felt that he could be the one to achieve an understanding with them in a best way. Since then they have been visiting one another quite often. He also became close with some other families in the same way. It turns out that during the NATO air strikes Milan had the need to convey the tragic new to the families of killed soldiers. I ask him how he understood this need of his. He says that it is not entirely clear to him, but he felt that he completely understood these people. I tell him that it seems to me that it was maybe a way for him to face some of his own painful feelings. His worst fear during captivity, he says, was that something could happen to his children. Especially because he did not know what was happening to them and there were threats that his "chetnik women" would be killed. And that later, during the bombing, as an officer, he felt guilty for horrible tragedies that have happened. Deaths that hit on "young and innocent soldiers". It became clear to me that the inner interpretation of torture for Milan was that he was guilty. He keeps on telling about the anger and rage he felt against his superiors and about how he requested to be retired once he realised that "things can get out of control". I ask him what he means by that. He says that all sorts of things have occurred to him, he was ready to kill someone since he was tired of watching innocent people die because of stupidities. I tell him how it seems that then he decided to "retire" many of his feelings that we unacceptable for him, and that he had towards people in uniform, but that it seems to me that these feelings went on living inside him even after he was retired, and that they event became more alive.

During this as well as following sessions, Milan gradually began to talk about the feelings of helplessness, powerlessness and guilt that he had in captivity, as well as about the feeling of anger and killing rage against his torturers. I supported him and encouraged him in this. Recognised as expected and for the given situation adequate, these feelings could finally be processed.

Session 2 (several months later)

He says that lately he's often been thinking about his "former best friend". I ask him to tell me more about this man. They had met at the military academy. They understood each other perfectly, he could talk to him without restraint, and he felt accepted. Later, when they both got married, they continued to socialise and their families often went to summer and winter vacations together. Several years before the war, his friend (who is of a different ethnicity) told him that he was planning to leave the army and move abroad with his family. Milan disagreed; he thought that there would be no war and that something like that was impossible. His friend went abroad, but they remained in contact. However, after Milan's released from prison and came to Serbia, they lost touch. The friend nevertheless called several times, but Milan was not ready to talk to him, so the other stopped calling altogether. I ask him how he understands the distancing from his friend. He says he has struggled with different feelings towards him. Since the early days he had admired his friend and considered him much more successful than himself. When the other decided to resign from the army, deep inside Milan felt this as a gesture of cowardice by his friend and for the first time felt he was better that him. However, the events that followed have soon disillusioned him. He felt ashamed. After he was imprisoned and subjected to torture by his former colleagues who were of the same nationality as his friend, he felt hatred towards him. I tell him that it was easier to hate someone close than his torturers who were unknown to him. He says that he felt very clear hatred towards his torturers, but now as we speak he keeps thinking how he somehow identified them with his friend and that after he came from the prison to Serbia it was impossible for him to talk to his friend. As if he would thereby give legitimacy to the torture he had survived. I ask him how he understands the fact that lately he has been thinking about his friend, as he said at the beginning of the session. After a period of silence he says that he feels embarrassed, but that this seems to relate to the fact he has decided to forgive him. I ask him what. He replies - the fact that he is of the other nationality, although Milan realises how absurd this sounds while he's saying it. I tell him I think that forgiving makes very much sense. He asks me whether I think he should forgive his torturers. I tell him I meant he should

forgive himself, to understand that he is not the one to blame for what had happened to him.

Therapy with Milan lasted slightly over one year. During this time there was a significant improvement in his psychic state. Through therapy, the interaction with another person, he has re-established confidence in the goodness and understanding, so he was able to feel more goodness and understanding from the inside. The positive therapeutic outcome had an impact on positive changes in his life: Milan included many more things in his life. He was no longer trying to be isolated, he began going to meetings of his veterans' association, became a member of the orchestra and started going with his wife to their farm. Their relationship acquired a new quality. The difficult experience of captivity was no longer a taboo subject. They openly spoke about it and Milan managed to tell her what he had been through and how desperate and lost he has been. He re-established contact with his "former best friend". He was now able to sleep peacefully again after twelve years.

PSYCHOANALYTIC PSYCHOTHERAPY AND PSYCHOPHARMACOTHERAPY

Finally we would like to comment on the issue of combining psychotherapy and pharmacotherapy. Although in the given case studies this was not the case, since neither "Vesna" nor "Milan" were treated with psychopharmacology drugs, during our psychotherapeutic work with torture victims we are often in a situation to introduce a third party - the drug - into this already delicate relationship. Reasons for this are numerous, both rational and irrational, recognised or non-recognised. Firstly, most torture victims suffer from such serious psychic problems that the introduction of psychopharmacology drugs would seem and inevitable form of assistance. By administering a drug that provides quick relief and improvement (although this is not always the case) we are often in a situation to influence the more rapid gaining of the patient's trust and thereby reduce the interruptions of therapy. On the other hand, we are at risk to render the patient passive by giving the drug and thereby in fact increase his/her basic problem, block free associations or create confusion about what has the curative effect - psychotherapy, drug, both or none? From the therapist's side, administering a drug can sometimes serve as support in handling the feeling of helplessness when establishing contact with the torture victim, or be an expression of distancing from the immediate relationship with the patient, as well as prevention or a sign of the burn-out syndrome, etc.

Similar, or even more complicated issue is the recommending other forms of assistance or activities such as giving additional information to the client, issuing findings and reports that could influence the legal status of the client, referring the client to medical examinations, etc.

Although they were considered earlier as factors that largely compromise the therapeutic relationship, these issues seem to meet a far less stringent viewpoint today with the majority of contemporary psychoanalysts. Some of them even advocate, especially in

very severe cases, that administering the drugs is done parallel with the treatment. Others have done this through a compromise with the idea that a third person would administer the drug while the therapist would deal only with psychic aspects of his/her patient.

We could say that during our work with torture victims we have been using drugs only after careful analysis of all above-mentioned factors that could influence the success of the therapeutic process. In most cases the combination of psychotherapy and pharmacotherapy has proven useful and justified.

CONCLUSION

Although psychoanalytic psychotherapy is by definition ambitious, its aims in working with torture victims should be set as realistic and above all adapted to the capacities and needs of the clients. Despite the many examples in our experience and literature of dramatic improvements following a far less intensive treatment, it is more realistic to say that torture victims re very resistant to therapy. This is especially the case from the point of view of the medical disease model where the primary aim is the removal of symptoms that did not exist in the premorbid stage. Our experience confirms that easier to achieve is the withdrawing of so-called "positive symptoms" in terms of intrusion, nightmares and anxiety, whereas the so-called "negative symptoms" such as isolation, withdrawal and exclusion from social life are much more resistant. Torture victims, besides the necessity to wipe away the symptoms that torment them also have the need, often difficult to verbalise, to find a new meaning of life and new confidence in themselves and others.

The chronic nature of discomforts and the belated initiation of therapy, which were the usual circumstances in our Centre, are unfavourable for therapeutic aims. The chronic PTSD is a disorder that has a permanent effect on the level of functioning and overall realisation of personality. Reparation often consists in reorganising one's self, finding a new balance, which is a difficult task for both the client and the therapist. Realistic and achievable aims should be recognised by the therapists from the outset of therapy and he/she should discuss these issues openly with the client. Otherwise there is a serious possibility of complicating therapeutic relations, disappointment, discontinuation of therapy, exhaustion of both the client and therapist, burnout and more or less recognised transferance-countertransferance acting out.

This leads to the conclusion that work on establishing, maintaining and understanding the relationship between the client and therapist is of utmost importance, sometimes even more important than shedding the light, clarifying and interpreting, as well as establishing links between split parts of the person's experience.

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