Torture in the Therapy Environment: Counter-transference in Working with Victims of Organised Violence

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Abstract

Emotional reactions of helpers who work with victims of psychological trauma, as well as psychic disorders or physical disorders that ensue from this reaction have been described in a variety of ways. They are closely linked to the empathic relation towards patients and the re-experiencing of traumatic events by the helper. This paper aims to point out the practical potential of understanding the psychoanalytical counter-transference and some specific features of the counter-transference reactions in working with torture victims, which relate primarily to the dynamic of posttraumatic states and repetitive reiteration of trauma in the transference situation. Practical examples are illustrated by interpreting a selection of materials from the protocols on the work with clients - victims of torture.

INTRODUCTION

When a person who has been detained and tortured comes to seek assistance, the traumatic story is the backbone of the entire process. The person providing assistance (physician, lawyer, humanitarian worker) almost always hears at least a part of the traumatic experience; if this involves a psychotherapist, then the work on trauma paves the way to healing. Nevertheless, the traumatic story leaves traces on the helper; emotional reactions that it triggers do not only cause anxiety, but sometimes more lasting consequences, such as depression or psychosomatic diseases. These emotional reactions could be divided into two extreme types: excessive involvement in helping the victims and showing empathy with them or, on the other hand - avoidance of and distancing from the problem (Wilson et al. 1994), which have been defined in the psychoanalytical theory as the *traumatofilic* and the *traumatophobic* therapist. Sometimes it is clear that these disorders cannot be explained only by the extensive scope of work, as well as that they are closely linked with the empathic relationship with clients and the experiencing of traumatic events by the helper. Given the lack of consensus regarding the phenomenon or causes of pathological manifestations in helpers, the expert public most frequently uses expressions such as *burnout syndrome* (Maslach et al. 2001; McManus et al. 2002; Gundersen, 2001; Maslach et al. 2001; Peiró et al. 2001), *vicarious traumatisation*, as well as *secondary victimisation* (McCann and Pearlman, 1990; McCann and Colletti, 1994) and sometimes *the wounded healer* (Jackson, 2001). We believe that for understanding the dynamic interaction between the clients - torture victims - and the psychotherapist, which contributes to the problem of exhaustion or burnout, it is necessary to understand the concept of *counter-transference*. In this paper we would like to convey the following ideas:

Unconscious counter-transference reactions of the therapist in the therapeutic process can have destructive consequences, both for the therapeutic process and its participants, but if recognised and elaborated, this danger may become a powerful therapeutic tool; *"counter-transference is the best of servants but the worst of masters"* (Segal, 1986b).

1. Although based on general assumptions, the counter-transference mechanisms have specific features in the work with torture victims; these specific features relate primarily to the dynamics of posttraumatic states and the repetitive reiteration of trauma in the transfer situation.
2. Clients' defence mechanisms are centred around two basic emotions - the feeling of helplessness or guilt - and these unbearable emotions happen in the transference contents as well as in the counter-transference reactions.

COUNTER-TRANSFERENCE – THEORETICAL FRAMEWORK

The extensive topic of counter-transference cannot be fully addressed in this paper. Nevertheless, some important points in the development of this theory need to be mentioned. R.D. Hinshelwood believes that *"the concept of counter-transference retains the early meaning that Freud gave it: the neurotic transference of the analyst to the patient"* (Hinshelwood, 1999). In the first half of the twentieth century the dominant viewpoint has been that such thing was undesirable, harmful and that emotional reactions towards the patients should be eliminated, the ideal posture of the therapist being the one of impassiveness, like a receiver. Plenty of time needed to pass since the Freud's first observation from 1910 that *"no psychoanalyst goes farther than his own complexes and resistances permit"* (Freud, 1910), in order for the first papers to appear around 1950 describing the counter-transference as a useful tool in the therapeutic process. *"Re-discovering"* is marked by two simultaneous works by Paula Heimann (Heimann, 1950) and Heinrich Racker (Racker, 1953). Contributions to the counter-transference theory before these two authors are scarce and the topic itself was introduced suddenly and caused a certain revolution, after which the work of the analyst has been subjected to more scrutiny and harsher criticism (Etchegoyen, 1991).

If in the earlier period the appropriate intellectual climate did not exist, the last years of the twentieth century in the field of psychoanalysis could be called the years of counter-transference, *"for in this time few concepts ... have gained as much attention, have been as widely explored and written about, and have been the subject of as much controversy as has the question of countertransference and its role in the analytic process"* (Jacobs, 1999).

John Steiner has summarized the modern understanding of counter-transference:

> *"We have learned that internal conflicts in the patient become externalised in the transference and elements from the patient's internal world are projected into the analyst. Feelings are created in the analyst through projective identification that lead him to be drawn to actions through which he often finds himself playing a role ascribed to him by the patient. An important possibility for communication emerges if the analyst can contain his propensity to action since he can then look at the pressures put on him and the feelings aroused in him as a part of the situation that needs to be understood. The period after giving an interpretation is also very important and it is often only after the analyst has been drawn into an enactment that he can become aware of what has happened." (Steiner, 2000).*

In another passage Hinshelwood talks about the steps in the Kleinian understanding of counter-transference (Hinshelwood, 1989), which the authors have chosen as their theoretical position, albeit aware of the contributions by other schools of thought; we shall cite them here, since they are important for understanding this paper. These steps are the following: 1. counter-transference feelings are the specific response to the patient and not a non-specific neurosis of the therapist; this specificity allows the introduction of the indicator function for understanding the patients condition; 2. understanding normal and pathological projective identifications has led to a clearer picture of the interpersonal situation in the therapeutic process, in which the analyst serves as a container for the experiences that the patient is unable to withstand; containing these unbearable experiences leads to the therapeutic mechanism of translating experiences into words; 3. Bion's theory of maternal container has allowed the insight into the creation of meaning and introjection of the function that can understand experience; 4. differentiating between normal and pathological counter-transference - by defining the latter as the failure of the analyst to comprehend when the patient begins to resemble an aspect of the analyst that the analyst still has not learned to understand - brings the modern concept closer to the classical one through the explanation that in the pathological case the therapist is unable to understand the patient because of his/her own neurosis; 5. the last description relates to the contributions of the *neo-Kleinian school* and talks about the experience of the therapist's mental space as the patient's object.

COUNTER-TRANSFERENCE IN WORKING WITH TORTURE VICTIMS

Based on what we have stated above, it could be said that working with torture victims entails the same transference / counter-transference mechanisms and that on a certain level of generalisation there are no significant differences. Nevertheless, there are certain differences strong enough to influence the technique, and we shall elaborate some of them in the following passages. They rest primarily on the specificities of the dynamics of psychic disorders occurring after severe traumatic experiences such as torture. Irrespective of the direct connection with types of contents that the client can reproduce during the sessions or insert into the therapist, it is necessary that the other side - the therapist - with all his/her complexities and conflicts should participate from the other end of the dyad relationship in establishing the transference / counter-transference enactment.

In literature we can often find a different viewpoint; emotional reactions towards statements of clients who have survived ill treatment are seen as "universal" reactions that occur in all persons who listen to the horrifying traumatic revelations (McCann and Colletti, 1994). Therefore *vicarious traumatisation* is defined as *"transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae"*. (Figley's concept of "secondary victimisation" was defined in a very similar way (McCann and Pearlman, 1990; McCann and Colletti, 1994).) This concept neither reflects the pathology within the therapist nor implies intention on the side of the patient. Nevertheless, an important point is missing here

that would acknowledge the importance of the unconscious counter-transference reaction. This comparison is maybe better explained by an example: one things is to feel compassion with a client, woman who had lost her husband and two children in war and has been severely abused at the time, which would be a supposedly universal reaction, whereas it is a completely different thing to doubt that any possible intervention could help this person and bring her any good - which would be an unconscious identification with feelings of hopelessness and helplessness that, although originating from the traumatic experience of the patient, could develop more easily if there is an unconscious conflict within the therapist related to the feeling of own competence.

Non-integrated, dissociated or split parts of the traumatic experience

One of the key distinctive characteristics of stress related disorders is the quality of re-experiencing the traumatic experience: memory is distorted, wiped out by amnesia, appears in *flash-back* episodes, fragments, overpowering narratives or other forms, depending on the level of integration, but especially in transference reactions, i.e. in the therapy relationship (Laub and Auherhahn, 1993). Or, if put in Freud's words:

> *"The traumatic neuroses give a clear indication that a fixation to the traumatic accident lies at their root. These patients regularly repeat the traumatic situation in their dreams; where hysteriform attacks occur that admit of an analysis, we find that the attack corresponds to a complete transplanting of the patient into the traumatic situation. It is as though these patients had not finished with the traumatic situation, as though they were still faced by it as an immediate task which has not been dealt with..." (Freud, 1916).*

The idea of the patient re-enacting traumatic events from the past is not new in transference - it lies in the basis of psychoanalytical theory. Freud describes this mechanism very early in his work:

> *"The core of a hysterical attack, in whatever form it may appear, is a memory, the hallucinatory reliving of a scene which is significant for the onset of the illness. […] The content of the memory is as a rule either a psychical trauma […] or is an event, which owing to its occurrence at a particular moment, has become a trauma. […] In cases of what is known as 'traumatic' hysteria this mechanism is obvious to the most cursory observation; but it can be demonstrated also in hysteria where there is no single major trauma. […] A hysterical attack is perhaps to be regarded as an attempt to complete the reaction to the trauma."* (Freud, 1886)

This passage dates from the period before *"the abandoning of the seduction theory"*, as the literature usually defines Freud's relinquishing the theory of external events as the specific causality of *all* psychic disorders. This theoretical shift, which has enriched our knowledge about mechanisms of integrating external events into psychological space, is considered by some authors to have left an unjustifiably large void in the understanding of psychological trauma (Bohleber, 2002). In the following text we shall be returning to Freud's later, more complex and better-elaborated theories of how trauma affects the personality, which largely refute such opinion.

Re-enacting traumatic events in the therapy situation involves attributing certain "roles" from the traumatic situation to the therapist, often the roles of violent persons or the "torturer". The violence is also evident in the therapeutic interaction in which something that should remain hidden is invited to come out, or when something that wishes to remain unheard becomes loud and clear - as when the client experiences the therapy situation as interrogation, or when the therapist feels as if being forced to be present at a certain event. Examples of re-enacting the traumatic situation in the therapeutic process and interpersonal relations are cited elsewhere (Jovic, 2002). A very illustrative example is that of a young woman who had been sexually abused in war and who comes to the first interview dressed in the very same clothes as on the day she was arrested, becoming aware of this only at the point of leaving the session.

Impaired process of thought and symbolisation

What is seen in phenomenology as the re-experiencing of the traumatic event is in fact a consequence of the pathological *process* described as the impairment of thinking, as well as the possibility for symbolisation, assimilation and attribution of meaning. Bion's theory of thought enables us to understand how the sensory experience is transformed by a certain function of thinking (alpha function) into mental contents, which becomes the "furniture of dreams" and suitable for further mental 'digestion' (Bion, 1962). One of the characteristics of the posttraumatic conditions is that the person is unable to think about the event - thinking about the event becomes the event itself. These people usually do not dream; if they do, their dreams are a reproduction of real events, unchanged by the work of the dream. Narratives about the trauma are either missing, in amnesia or the impossibility to describe the experience, or they are evacuatively expressed in a compulsive manner, although this rarely happens. The traumatic event has not been assimilated into the everyday experience and it cannot be disposed with in the everyday usual speech, in free associations or metaphors; thinking is more concrete, devoid of symbols. In order to be able to symbolise something, one must first finish grieving it (Segal, 1986a); the grieving process marks the complex process of integrating experience into a higher level and the passage from the paranoid-schizoid position into the depressive one.

Non-integrated traumatic experience imposes itself through re-experiencing and is again suppressed or split - depending on the complexity of the defence mechanisms, i.e. the maturity of personality; it has three possibilities: to move into the body, into the sensory sphere or into enactment, i.e. *"into psychosomatic dysfunction, perceptual hallucination or*

symptomatic action" (Britton, 1998). The distinction in relation to psychotic disintegrative processes could probably be found in the quality or strength of defence mechanisms: according to Bion, dissociation compared to splitting respects *"natural lines of demarcation between whole objects"* (Bion, 1958). Although the person suffering from a psychotic process and the psychologically traumatised person both use projective identification to free themselves from beta-elements and are not capable of symbolisation and suppression, *"by means of projective identification and pathological splitting, the psychotic patient tries to free himself not only of the object but also, and deliberately, of all ego functions which correspond to the onset of the reality principle (primary thoughts, consciousness, attention, judgment); and particularly of those elements with linking functions"* (Grinberg et al. 1974). Thereby *"bizarre objects"* are formed, consisting of *"beta-elements plus traces of ego, superego, and external objects"* (Grinberg et al. 1974). While the psychotic person lives in a world surrounded by bizarre objects, the traumatised person is surrounded by damaged objects, which are beyond repair and cannot be integrated into the personality; their life is like a theatre in which the traumatic scene is constantly playing.

In fact, the process of integrating traumatic experience could be understood through the impairment of ordinary processes for translating external experiences into the internal contents – introjection, identification and assimilation.

The term *assimilation* is used here as described by Paula Heimann (Heimann, 1942). Internal objects are formed by introjection and are available to the ego for identification; by assimilation they become a part of the ego, reinforce it and ensure skills, attitudes, qualities and defences that are now at ego's disposal though identification with internal objects. Contrary to this, objects that remain non-assimilated become alien bodies within the personality. Indeed, while working with patients with usual non-traumatic pathology, we can often see non-assimilated parts of the personality such as persecuting guilt, envy or jealousy, as well as positive parts such as capability to love, need for others or care of one's health. In working with persons who have survived a traumatic experience of high intensity, the split non-assimilated parts contain large fragments of experience (traumatic "scenes"), fragments of object relationships or "big themes" directly related to trauma, such as basic trust, sense of belonging, re-examining the meaning and value of social institutions, etc. Externalisation through re-enactment of traumatic events can have the function of gaining control over the traumatic experience (Fenichel, 1961).

In the flow of therapy, this impaired thinking process is manifested through long periods of silence, lack of understanding, confusion, impossibility to establish a therapeutic alliance, understand the aims of therapy, observe the inner space or even think or talk about feelings. In this respect these patients greatly resemble people with psychosomatic disorders and alexithymia. Krystal referred to this phenomenon in traumatised people as to the *"re-somatisation affect"* (Krystal, 1978). Transference contents are enacted on the non-verbal level and are therefore harder to follow. At the same time, counter-transference feelings are here proved to be an immensely valuable tool.

Internal objects and positions

The clinical *phenomenology* indicating the dynamics of the pathological process, in the language of internal objects, could partly be explained in the following way: on the level of unconscious fantasy the function of thinking, the material container, is perceived as an omnipotent good internal object that understands, appeases, brings comfort, warmth and peace. The traumatic process seems to damage this internal object and leave the impression of the impossibility of understanding (like in the *"trauma membrane"* phenomenon, when the victim is unable to feel empathy by another person who has not had the same experience) as well as the impression of being separated or alienated from others, which is also described as the *"collapse of the empathic process"* (Laub and Auherhahn, 1993). It is important to understand that on the level of unconscious fantasy, in the primary process space, this impairment is experienced either as own attack on the good object or the impossibility to protect it from the attack by the bad object - which forms the basis of the profound unconscious guilt feeling. The good internal object is destroyed and with it also perish the functions it ensures: trusting others, self-confidence, relationship towards one's own body, adequate perception of time and regulation of basic needs (we believe that eating disorders, substance abuse or self-injuring behaviour originate from here) as in addition to the already mentioned capability to think and symbolise.

This destruction initiates the reparation mechanisms, which often have the form of manic reparation in traumatic impairments of mental functions: the denial of loss leads to maniform reactions, such as those of the disabled after injury, described by Abraham in 1918 (Abraham, 1955), attempts to re-create the object by importing good contents from the outside (food, alcohol, drugs) or by throwing out the objects, when the neglect, abandonment or indifference are attributed to others (often through transference enactment in the form of accusations addressed to the therapist).

This is not the only change in the structure of internal objects that occurs in trauma. In case when the projective identification has been used in a more "massive" way, there is also a specific fusion between the victim and the perpetrator, such as the one in the frequently mentioned *"Stockholm syndrome"*. The unbearable nature of the external reality and internal anxiety is relieved by projection of good objects into the perpetrators and by certain idealisation and attachment (the case when projective identification serves to insert good objects into the external object for the purpose of annulling the separation). Likewise, the re-introjection of projected parts leads to the "borrowed guilt", i.e. introjection of bad persecutory or criminal act identified with the perpetrator and reversing the accusations towards this introjected part, resulting in self-accusation and guilt feelings for the torture endured (feeling of guilt for what was done or failure to do something, almost ubiquitous in posttraumatic conditions). In this part, the described mechanism resembles the one in the *"Grieving and Melancholy"*. In a different way, Ferenczi has drawn attention to this mechanism in his exciting article from 1932 (Ferenczi, 1988); although in this paper he spoke about patients who were victims of abuse in their childhood, we believe that these words also apply to the mechanism of posttraumatic dynamics development in general:

"The same anxiety, however, if it reaches a certain maximum, compels them to subordinate themselves like automata to the will of the aggressor, to divine each one of his desires and to gratify these; completely oblivious of themselves they identify themselves with the aggressor. Through the identification, or let us say, introjection of the aggressor, he disappears as part of the external reality, and becomes intra- instead of extra-psychic; the intra-psychic is then subjected, in a dream-like state as is the traumatic trance, to the primary process, i.e. according to the pleasure principle it can be modified or changed by the use of positive or negative hallucinations. In any case the attack as a rigid external reality ceases to exist and in the traumatic trance the child succeeds in maintaining the previous situation of tenderness.

The most important change, produced in the mind of the child by the anxiety-fear-ridden identification with the adult partner, is the introjection of the guilt feelings of the adult…

In order to understand this mechanism we can use the language of positions by M. Klein and say that in this process the paranoid-schizoid defence mechanisms are the dominant ones (*splitting, projective identification, denial* etc.). We should know that these mechanisms serve to defend the one from unbearable emotions from the position of depression, such as the feeling of ultimate helplessness, which represents the return to the prime narcissistic injury, the feeling of separate existence of objects. In a traumatic situation the massive projective identification also serves to cloud the boundaries and thereby polarise the roles of perpetrator / victim, which are attempts to restore control over the perpetrator. For any one of us, the knowledge of own vulnerability, separation from others or ultimately - mortality, are cognitions against which strong defences are raised, while the traumatic experience brings the destruction of these defences. As said by Ferenczi: *"One had to have overestimated one's powers and to have lived under the delusion that such thing could not happen, not to me"* (Ferenczi, 1949). Stolorow calls this the *absolutisms of thought* in everyday life (Stolorow, 1999), expressed in such simple and ordinary sentences as "goodbye", implying that we shall meet again, thereby negating the unbearable truth that someone close and dear to us could easily disappear. Money-Kyrle wrote earlier about basic facts that is mastered in the cognitive development of each individual: the feeding breast, parents in creative coitus and death (Money-Kyrle, 1968).

In fact, these theories describe the phenomenon of being faced with limitations and complete helplessness from the first day of life, we live in a state of delusional blending - with the object, time and space; *growing up is a process of renouncing the omnipotence through the process of grieving*. Trauma is a rupture in this gradual and relatively slow process; according to Winnicott, breakdown in the area of reliability in the “average expectable environment” at the stage of near absolute dependence (Winnicott, 1989). A traumatic event has a similar effect on the already mature personality structure - feelings of complete helplessness and pain that are reactivated in this way trigger the reactivation of

massive projections and the return to the paranoid-schizoid position by way of mechanisms described in previous passages. In this sense, the pathological posttraumatic dynamics is maintained in persistent oscillations on the edge of depressive position, between: 1) the feeling of helplessness, and 2) persecutory guilt feeling, accompanied by splitting of internal structures in order to keep the traumatic situation outside the mental space (as we said, in the body, in the sensory field or in re-enactment).

Idealisation and the accompanying persecutory feelings represent an important challenge for the helper in therapy. This can have a particularly destructive power if the therapist is unable to realistically assess his/her own role and the aims of therapy. Idealisation of the victims, the helper or the process of assistance provision can be found in humanitarian emergency programmes; in this context, we have observed the most severe psychic or physical reactions of insufficiently trained professionals to their work with victims. Especially difficult is the idealisation on group level, e.g. when the team from the Centre would visit a new refugee collective centre where they would be received as saviours, trapped into unrealistic expectations and simultaneously - as time goes by - became containers for all feelings of discontent.

Nevertheless, death is what ultimately tests the ability of thinking and withstanding helplessness by the therapist, as mentioned earlier in the case of the woman who had lost her entire family. The analogy with potential personal experience of loss of the therapist is not the only thing that carries a potential of provoking pathological counter-transference reactions; in any case the effects would be the result of an interaction with the experience of death such as it is represented in his/her internal space.

Regression and fixation on trauma

Since we have spoken about *phenomenology*, pathological processes and the structure of internal objects, we should supplement this picture with genetic understanding of destructive effects created by psychological trauma. Here we come to the concept of death instinct. Let us illustrate this with a quote:

> *"By all logic, we cannot conceive of the existence of any traumatic situation without the participation of this instinct. If, like Freud, we admit that the function of the libido is to bind (bändigen) the death instinct, we must admit that the traumatic situation, by altering the dynamic equilibrium of the drives, contributes to unbind what the libido has bound, and that this frees a certain quantity of death instinct. Freud maintains that we almost never find pure instinctual impulses, but instead fusions of both instincts in different proportions. The trauma influences these fusions, provoking an Entmischung or diffusion, which in turn activates the compulsion to repeat on the one hand, and on the other, demands new libidinal cathexes and new defensive measures of the ego (inhibitions, avoidances, phobias, etc.)." (Baranger et al. 1988)*

We should bear in mind that the compulsion to repeat is not a derivative of the death instinct, but quite the contrary, it is an elementary defence from it, an attempt to gain control over it and re-bind it; in this sense, the opposite tendency - to forget the event - is a more direct representative of the death instinct. Diffusion of instincts is responsible not only for the compulsion to repeat, but also for the regression after trauma. Regression is used to describe the return of libido to the earlier (less complex and differentiated) stage of psychological development, modes of satisfaction and structure of object-relationships, or to the *"points of fixation"*. Fixation and regression are complementary phenomena; it could be said that fixation prepares the ground for regression. Trauma plays a decisive role in both cases: *"When stirred too intensely (by whatever situation), anxiety contributes to a fixation of the libido at that point, and may check further development. A fixation is thus partly to be understood as a defence against anxiety"* (Heimann and Isaacs, 1991). Nevertheless, these authors equate anxiety with aggressiveness and maintain that fixation occurs as a consequence of *"aggressive components in the pre-genital stages of development"*. The sequence would therefore run like this: trauma in mature age would lead to diffusion of instincts and the overpowering death instinct (on object level the destruction of the good object), which would lead to the regression to a point of fixation, i.e. to the libidinal stage that served as satisfactory defence when the basic infantile trauma had led to a similar overpowering by death instinct. Let us try to explain what is understood by the concept of *"basic infantile trauma"*.

In 1926, in the article entitled *"Inhibitions, symptoms and anxiety"* (Freud, 1926), Freud made another step towards understanding trauma, by shifting focus from the isolated incident to the *"traumatic situation"*. According to this theory there are a number of paradigmatic traumatic situations that are inherent to the development of each person (rejection from the breast, castration, birth of another child and, later added by other authors, fear of annihilation or devouring). These situations cause overpowering helplessness, which is the basic traumatic situation and all other traumatic situations relate to it. In this case the situation of danger would be the *"recognised, remembered, expected situation of helplessness"* (Freud, 1926). This theory *"includes both the interaction of internal and external situations and also the inter-structural nature of all traumatic situations"* (Baranger et al. 1988). For instance, during the NATO air strikes in 1999, to the questions asked about the fantasised form of death, one could always here very similar answers: fear of mutilation, fear of annihilation ("thermal bombs", direct hit, etc.) and fear of losing close people, with a few other exceptions.

With patients who have survived extreme forms of torture and had been well adapted premorbidly, it is very difficult to talk about regression to the earlier stage of fixation. This ensues from the dominant significance of the recent experience in the aetiology, as well as from the kind of relation towards trauma: it is difficult to talk about problems of childhood separation with persons whose all family members have been killed, because this somehow de-sacralises the act of victim. Generally, linking adult trauma with infantile experiences is still one of the taboos in the professional community. Nevertheless, if political correctness gives way to scientific objectivity for a moment, we could say that

irrespective of the type of psychological trauma in adult age we have always found some form of equivalent in the infantile experience. This observation does not tell us very much about etiological connection; we should by no means use to conclude that posttraumatic pathology of adults is determined only by infantile experience. However, it does speak about the complexity of our perception of external events and interaction between new experiences and those acquired earlier in time, often way back in the past. When we discuss the possibility of new experiences modifying the meaning of past experiences, we speak about the mechanism of *"deferred action"* (*Nachträglichkeit* in German or *après-coup* in French), the complexity and practical implications of which are far beyond the scope of this paper. Let us only quote the following words: *"this causality and this temporality are the ones that sustain the possibility of a specific therapeutic action in psychoanalysis: if this retroactivity in the constitution of the trauma did not exist, there would be no possibility of modifying our history, that is, our treatments would have no future"* (Baranger et al. 1988).

In order to illustrate these mechanisms we shall briefly describe a part of therapy of an elderly refugee woman, who had never been detained, but has been subjected to persecution by her neighbours and former friends, as well as by colleagues at work. Persistent insomnia was soon replaced by continuous dreams, which represented the said situations though symbolic elaborations. Soon the situation from childhood appeared in conversation: since she had lost her parents very early and as a young girl she was placed in a foster family, "where there was no chair for her ". These two memories partly overlapped: as if the real feeling of peril from her childhood could only be reached though the feelings from the beginning of war in 1991. Therapy stopped here, the woman began to sleep regularly and the therapist started thinking about closure; then an event, basically a counter-transference *acting-out* led to subsequent understanding of elements that have been contributing to the halt in therapy. On the day when the state of emergency was introduced the therapist cancelled sessions with all patients (which was a reaction corresponding to the realistic circumstances) except this particular patient. The woman spent all afternoon riding through the town in a bus that was trying to pass all police blockades and finally arrived to the closed office. Elaboration of counter-transference emotions within this event, accompanied by the strong guilt feeling, related mainly to doubting the value of therapy efforts in working with a person in an age where she would increasingly be facing her own transience and death. This was linked with depressive feelings of impossibility to repair objects acutely tied with the therapist's life situation of loss.

CASE STUDIES

The dynamic of psychological trauma described so far, although given only by overview and very selectively, should serve as an illustration of specificities of counter-transference reactions in working with torture victims. In order to make this more accessible, we shall offer here two case studies with comments that should clarify the dynamics of counter-transference. The case studies are abridged and partly modified from the protocols maintained during first interviews led by one of the authors (N.C.-J.); for the sake of clarity

and conciseness, most parts are briefly narrated, while the text under quotation marks is the original text from the protocols. Due to the nature of material (first interview) it was impossible to analyse the deeper transference / counter-transference mechanisms belonging to later stages of therapy. What we do get by this selection of material is the illustration of the acute nature and speed in which the traumatic events and counter-transference reactions in therapeutic situation develop, as well as the speed and potential destructiveness of mutual interactions between the victim and the helper in general.

CASE STUDY 1

This case involves A., a middle aged man who has spent over 3 years in a prison camp. He came to the first interview with his cousin and insisted that she accompanies him into the counselling room. Initially, the therapist agreed to this. When enumerating the types of torture he had sustained (*"beatings daily, regularly, burning, strangulation, asphyxiation, humiliation, deprivation"*) he nervously begins to refute the allegations of sexual abuse. At the same time, his cousin *"keeps giggling almost aloud"*. The therapist requests the cousin to leave the counselling room, for which the patient is thankful, *"because if he had requested it she might have got angry and would not take him around Belgrade any more"*. Then A. *"asked for some time to collect himself. Again he took out his medical records and began saying how he is fortunate not to have pains. His ribs had been completely broken, one kidney was dislocated, lungs torn, he had multiple fractures of arms and legs. Contact with his body existed only through the medical findings; he is buttoned up to the neck."* Again he describes the types of torture he had survived, but talks as if it was another person. In these moments, the therapist *"feels strong empathy for this man"*. *"When we come to the issue of sexual abuse he becomes very agitated and this agitation is accompanied by almost involuntary facial cramps and sweating. He says he was not sexually abused – because he had fainted. He briefly explains what happened and at which moment he had fainted. He begins to feel nauseous, but is unable to get up – as if in that very moment the connection between his head and his body was broken. It took him quite some time to calm down."* Therapy with this man was taken over by another psychotherapist (this was standard procedure). Occasional meetings in the Centre were unpleasant: the therapist sees that on such occasions the client *"begins to sweat, his breathing becomes more difficult, he looks the other way and seems as if he would like to run away"*. All this was rather upsetting. In a conversation about reimbursements for travel costs, the secretary complained about this client saying that he was abusing assistance provided to him and that he is not really interested in therapy. By chance, the therapist who made the first interview and the therapist who continued working with the client were both present there. The first one was in favour of *"setting some limitations without being rude"*, but the therapist took his client in defence by saying: *"Leave the man alone, he had suffered horribly!"* This comment was taken as an accusation for *"a cold attitude towards clients and hiding behind the mask of professionalism"*. The entire episode left an unpleasant impression and the need to avoid further contact with this client or any information about the course of his therapy.

Handling traumatic contents is one of key therapeutic elements filled with traps of counter-transference acting-out. The intrusive nature of traumatic memories and the attempts of avoidance by various mechanisms within the patients are accompanied by attempts to prevent an "entry" from the outside. In this case the therapist faces the challenge of acting the "violence" or avoidance. However, avoidance reinforces the patient's feeling that the therapist is unable to handle the traumatic situation or even think about it, which confirms the perception of the object that does not and cannot understand. The therapy can then last for some time, with mutual tacit consent to avoid real work, and usually ends when the patient "no longer sees the point in coming", intuitively sensing that he cannot get the true help he needs.

Dissociated traumatic experience, in this case the sexual abuse, is accompanied with harsh judgment that the patient has imported into the therapist. The person who now possesses the knowledge about the traumatic event has been equalised with the event itself on the concrete level and represents the external persecutor, hence the object of avoidance. By coincidence or not, something similar happened in the episode with travel cost reimbursement. Although the real gain for the patient was really small, he initiated the scene of "compensation", which is rather common in working with torture victims. We avail ourselves of the right to say that however often these people may be living in poverty, the requests for compensation are actually based in their unconscious feelings of having sustained damages. Abraham wrote about this: *"The pension compensates merely for the reduction in earning capacity which can be objectively assessed, and not for that which is far more important in the eyes of the patient, his impoverishment in object love, for which he cannot be adequately compensated"* (Abraham, 1955). Therapists often find it difficult to deal with the requests for compensation, since these requests seem to devaluate the therapy itself; we have frequently heard that *"they are here only to see if they could get something concrete"* (material assistance).

It seems that this incident with reimbursement misuse in fact had the meaning of *acting-out* the survivor's guilt feeling; moral judgment against the passive role in the sexual abuse, related to the struggle for survival, was now transferred to the therapeutic level through judgment related to the reimbursement. In both cases the patient took something that he deeply feels he is not entitled to. We are unaware of the contents in the flow his real therapy that were ongoing at the time of this event, but we can assume that this was simultaneously a symbolic introjection of contents that were projected into the therapist. The group dynamic is particularly interesting – the whole event finally involved several people (at least three) who successively took the position of attacking and defending the client. This leads us to the counter-transference phenomena on the group level, which have a significant impact on the everyday life of the Centre. We are unable to elaborate on this in the present paper; we shall only mention that, as said by Elliot Jaques (Jaques, 1955), management organisation and the distribution of tasks could be analysed as a defensive structure that protects from primitive anxieties of psychotic nature. In this case *"one of the primary cohesive elements binding individuals into institutionalised human association is that of defence against psychotic anxiety"*, which does not imply that these persons or institutions are "psychotic", but *"it does imply that we would expect to find in group*

relationships manifestation of unreality, splitting, hostility, suspicion, and other forms of maladaptive behaviour". In our work we were able to notice many phenomena on organisational level that contained feelings of helplessness, deep guilt or manic reparation, for which we could assume originated from interactions with clients.

CASE STUDY 2

This case involves B., a man in his fifties, single, no children, who had spent several months in a prison camp, where he was subjected to various types of torture. In the first interview he said he was very pleased that the state has done everything possible in his case. Before the war he used to work as a contractor. *"He says he was a man for young people, for love, not war. He looks very colourful, dressed as if going to the beach, wearing clothes more becoming an adolescent (Bermuda-shorts, white modern sports shoes, visor ca, and an especially striking unbuttoned Hawaii-shirt). At the beginning of the conversation, he often looks at his chest and pulls tight his muscles, persistently maintaining the same position of the body although it looks uncomfortable. It seems he's trying to flirt with me, h tries to engage in a casual conversation about the weather or Belgrade."* When our discussions went towards the war related events, his captivity and torture, his behaviour changed, *"he altered his position, slightly adjusted his shirt and I generally lost the feeling he was trying to flirt". "At the beginning his story resembles a typical one, accompanied by a rather flat affect, with plenty of detail, technical stuff for which he checks my understanding. He is difficult to interrupt – I get a repeated impression that there is a text that can be neither summarised nor prolonged; there is no difference between more or less important. In short, it is just like retelling a movie currently playing in his head*." Then B. suddenly made a shift and refused to talk about the last months of captivity prior to his release. To the question about why he was leaving come things out he briefly replied that *"afterwards it was more or less the same"*, he wanted to finish the interview, remembered that it was already time and that he would miss his bus home, then compulsively began to talk about what he was doing at that time, how he was politically active, *"how he is physically fit and generally how healthy, strong, clever and enterprising he is. This part was very strange, almost psychotic, megalomaniac"*. After some time and without an intervention by the therapist, B. became cooperative and then again broke the flow by stating he would like to say something. Some time before this he recognised a woman who had been in the prison camp with him and who was raped – who he had raped when threatened by death. *"He wanted to forget this – since he was released he has never told anyone about this. He says he was forced to do it, that he couldn't have refused, that any refusal would mean instant death for him or, even worse, more torture. He would like to assure me that he did not experience any sexual pleasure whatsoever. He thought it would be difficult for him to tell this story – his secret – he saw how people were fascinated by tales of torture and how they keep saying or thinking why he did not do this or that, as if they would have acted better in such case." «You will not judge me, you are a professional, you asked me as if you already knew everything.» While he was saying this, he opened his shirt again and assumed a "macho–youth position". "He says he likes my not giving him*

advice what to do in this matter. He can't even say hello to this woman because she could not understand him." At the end of the interview the therapist feels content with the work and the act of refraining from comment, which probably led to the man liberating himself from this trauma. What followed is that while writing entries into the protocol the reconstruction of the material *'took a form of several separate stories that were not mutually connected. For one moment it seemed to me that he was the victim – and that all what had happened was worse for him than for the woman he had raped. In the other moment it seemed as if there was some perverse enjoyment in this rape, and finally that all this was a fantasised construct."*

The complexity of this material, taken only from the first interview, illustrates the difficulties in working with torture survivors. We shall limit ourselves only to a few comments.

The counter-transference reaction was similar to the client's mental state: split parts of the experience and probable severe split in his personality related to his experience were briefly covered with the maniform idea of success, competence, which resembles the triumph over the fear of castration. It was only after a while that the insight into own feelings of the therapist has shown the fragmentary nature of the entire experience - the idea that all of this was imaginary, unreal or crazy probably shows the destructive potential of narratives and the incapability to think about this. In this respect we could contemplate the idea that this feeling also had a communication value: what was inserted into the therapist were not only the parts of experience that should be judged for their perverse sexuality or forgiven because of one's own horrible fate, but also a certain type of epistemological crisis occurring due to the conflict that cannot be resolved - who is the victim and who is the perpetrator, who is bad and who is good, was it possible to justify this action or was it the result of evil motives and perverse sexuality? Our tendency to split the reality into "good" and "bad" when faced with trauma (which is one of the consequences of the "diffusion" of instincts) is challenged once we come before individual, single destinies and try to understand the motives of the real person sitting in front of us.

By his attitude and behaviour the client gave an impression of being alive and holding things under control. This is indeed a defence from the feeling of helplessness, in this case, the manic reparation of own sexuality, damaged by destruction in the act of abuse. At the same time, this is the reparation of physical health or creativity in general and the strong defence from guilt feeling. Flirting in this case does not have the form of erotisation in therapy, it has more elements of a compulsive game, which transforms the anxiety and guilt into something bearable and pleasant, like when children play games that serve as defence from own aggressive impulses (Heimann and Isaacs, 1991). The "seduction game", if we can so call it, repetitively played in therapy situation, aims to annul the aggressive sadistic elements in own sexuality and thereby protect objects from the outside.

In both case studies some form of sexual trauma is present, which is not the situation in most of our cases, especially men. Therefore this choice of case studies is not accidental, because sexual abuse within torture arouses especially troubling feelings in the

helper. Nevertheless, it could be said that in every form of torture there is something sexual – irrespective of whether it involves explicit sexual abuse as original trauma or the experience of violated (injured) intimacy or, even more powerful, the feeling that being under the control of the torturer has a sexually sadistic connotation of absolute control over one's body. In this respect working with torture victims also corresponds to the structure of object relations in the therapist and the maturity of his/her own sexuality. Sometimes the therapist is drawn though counter-transference into the 'peeping Tom' impulses or real fascination with torture as a space where it is possible to witness the destruction and sadistic sexuality and partly identify with the actors and yet remain partly aware of the separation and on safe distance.

Especially disturbing are the moments where such distance is lost and the traumatic event is re-enacted in the therapeutic situation. Then the therapist is drawn into the traumatic situation, loses the possibility to think and becomes identified with the participants on a concrete level. We shall illustrate this with the following example: a client, man who had witnessed the killing of his fellow-soldiers in the prison camp, when describing this scene, made a gesture during the therapeutic situation, probably in a dissociative *flashback* episode where he was identified with the aggressor: he touched the neck of the counsellor in the place where the killer had slashed his victim with a knife. The scene that was thereby re-enacted had a dramatic effect. The counsellor, a young and talented woman, was very upset. She stopped working with clients immediately after this; some time later she left the Centre altogether.

CONCLUSION

Understanding one's own emotional reactions and unconscious processes can greatly contribute to the more successful overcoming of challenges faced by therapists working with torture victims. The dynamic of the traumatic processes is highly important; feelings of helplessness and guilt, as well as defences from them lie in the foundation of transference / counter-transference enactments. Non-recognising this dynamic could lead to unpleasant consequences both for the client and the helper, as well as halt or damage the therapeutic process. Assistance, support and additional training provided for helpers in this process have dual value - on one hand they serve to assist people at the forefront, and on the other, indirectly, to assist the clients through the supposed improvement of the helper's quality of work.

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