

## The Face of Trauma in Therapeutic Work with a Refugee

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"Timor mortis conturbat me (Fear of death disturbs me)"

(William Dunbar, ca 1460 - ca 1525) [1].

### Abstract

In this paper I shall limit comment to some preliminary observations drawn from working with a refugee who was a survivor of torture and who experienced severe trauma. I hope that this will assist with the task of reconfiguring some of the problems we face in our psychological work with this group of patients. The paper explores the manifestation of trauma in a refugee who had been subjected to torture. It is presented as a case study that draws from clinical, therapeutic work with the refugee patient and explores issues associated with the torture, trauma and the activation of early psychic trauma that flooded the patient and made it difficult for him to function in everyday life. The paper also explores how the capacity to cope with the effects of re-living trauma during therapy largely depends on how far the ego's resources are mobilized to cope with the intensity of the affect. The degree of resilience the individual has at her/his disposal would determine whether internal and external phenomena could be integrated into cognitive and affective stories that maintain psychological stability. The case study highlights the importance of therapeutic assessment to determine the level of resilience in the traumatised patient so that the treatment plan and the clinical work itself could follow a sensitive approach to managing overwhelming affects in the patient and inform the clinician on the appropriate pace of the work. The clinical strategy of containing the patient's overwhelming affects in the case of Husein was not sufficient in itself to prevent a premature ending associated with separation anxiety. An alternative intervention is proposed.

**Keywords:** *Trauma; Therapeutic Work; Refugee*

### Introduction

Being a refugee involves displacement; (loss of home, relationships, familiarity with their home environment, culture and tribe). However, not all refugees will react to displacement in the same way.

Psychological reactions to adversity and the devastating consequences of having to go into exile can vary enormously from individual to individual; each person experiences external devastating events in a very individual way that depends on a number of different factors. This means that the mere existence of certain devastating events should not lead to a conclusion that every person exposed to them is likely to be psychologically traumatized ([2], p. 304).

Victims of trauma fall into different categories: Those who have been subjected to torture in a warzone and present for therapeutic work with trauma and those traumatized through an abusive early home environment. Both tend to feel guilty and confused, believing that something about themselves evoked the aggressor to violate them. Some individuals may avoid seeking help due to shame. It is therefore important that trauma is distinguished from other forms of distress that can be detected through anxiety states of mind, so that help can be tailored specifically to help the person deal with the traumatic experience. Even though persecutory anxiety, dread and despair may feature in the lives of those who have not been subjected to torture, what distinguishes terror from other psychic pain is the total inability to trust others.

Patients presenting with trauma associated with terror are often withdrawn into a frozen, frightful state marked by internal dialogues, hallucinations and flashbacks of the torture and abuse. These individuals are in psychological shock, are fearful of others and feel extremely vulnerable. The histories of terrorized patients often entail oppression, loss of freedom under authoritarian regimes and demand the employment of conscious strategies for coping [3].

Papadopoulos (2007) argued that ‘The refugees’ capacity for resilience and for accessing their own resourcefulness can be adversely affected if their ‘psychological immune system’ is damaged ([2], p.303). In relational psychotherapy, the perspective adopted for treating patients with damaged resilience is one where the therapeutic relationship and an established alliance form the bedrock of the work. Associated with the alliance is the development of safety that stabilizes the patient so that they can safely engage in the process of remembering, experiencing flashbacks and trusting the therapist to contain overwhelming affects that may emerge. Most importantly the approach rests on individualized formulations and treatment plans.

### The concept of terror

The concept of terror as a distinct area of psychological distress and one that is encountered in clinical work, particularly amongst people whose human freedom has been violated, appears to have received relatively little attention in psycho-analytic literature. Psycho-analytic understanding of terror is generally confined to fantasied and unconscious experiences that restrict understanding to a subjectivity of the primitive domain and the person’s early childhood life. These early influences may indeed have a decisive role in the response and management of terrorizing experiences by individuals, but do not sufficiently explain the relationship of the individual with the outside world.

Donald Meltzer’s [4] conceptualization of terror draws attention to persecutory anxiety, where the inner world is populated with dead objects threatening to destroy the individual. Meltzer exemplifies the notion thus: “Terror is a paranoid anxiety whose essential quality, paralysis, leaves no avenue of action. The object of terror (being in unconscious phantasy dead objects) cannot even be fled from with success” (p. 105). Meltzer understands the patient’s addictive dependence on a bad part of the self, the tyrannical part, and his total submission to it, as a way of preserving an illusory relationship. This destructive alliance results in doing away with good psychic objects and retreating into ‘autistic self-sufficiency or omnipotent paranoid-schizoid defensive fantasy’ as reported by Ogden ([5], p. 708) in his clinical presentation of forms of aliveness and deadness. Object relations perspectives treat terror, as a condition in which the individual’s psychological defectiveness is so pronounced that denial of reality becomes an important means by which the patient protects himself against primitive anxieties.

Papadopoulos [6], in his discussion on survivors of violence, firmly asserts that an intelligible and meaningful understanding of phenomena that include terror, must be examined within a wider, socio-political context. He argues that 'psychodynamic theories... tend to be based on a paradigm which is predominantly formulated within a pathology/deficit model' (p. 322). He argues that such formulations perpetuate the theoretical dichotomy between the individual and the environment. By employing a model that draws from Winnicott's idea of transitional space and transitional phenomena, Papadopoulos tries to resolve this dichotomy and places the individual in a space that is co-constructed between the individual and the environment. For example, shared understanding and shared narratives, have been found to be contributory influences to the creation of resilience (a coping mechanism) observed in some individuals subjected to violation and torture (p. 327). It goes without saying that the individual herself/himself would need to be endowed with the ability to participate in the construction of a shared understanding and narrative, as well as make use of its creation, in order to benefit and secure psychological survival. This model has obvious implications for the types of therapeutic strategies that can be employed in the treatment of terrorized individuals.

My own clinical observations show that patients in a state of terror display petrification - a total paralysis and withdrawal from object relations. This appears to have a direct connection with an overwhelming fear of being made psychologically dead by an externally attacking, hostile object. It is a survival tactic because the patient has a degree of awareness of his/her persecutory fantasy, which raises intense anxiety. In cases where the individual is subjected to sadistic acts of torture, inner good objects are immobilized, especially if weak, exposing the person to the mercy of a hostile world now confirmed. These dynamics act in the service of fear and anxiety providing them with a hegemonic position in relation to internal good objects. Thus psychic equilibrium is threatened and disintegration of the self becomes imminent. To preserve the self against disintegration, psychic reality is negated through projective identification, where the external world takes on a hegemonic role and by implication freeing the subject from the existential need to relate. In relating the person feels threatened and in withdrawing feels deprived of having her/his basic needs to form attachments met. Therefore the person arrives at an impasse and the strategy for psychological survival, fails.

The splitting between the internal and external world is designed to keep the danger outside and locate hostility in the terrorist who represents the hateful object. By the same token, such mechanism does away with the 'in-between space', that is the space of relationship, play and creativity. This means that the person is lost in an isolated narrative that is partial and incomplete because it is removed from the potential space of 'being with' another and in contact with the outside world.

There is a great deal that can be learned about terror from studies on trauma, particularly amongst refugees [7,8] which stress that trauma activates early object relationships giving rise to primitive fears that invoke overwhelming affects and threaten psychic survival. De Zulueta applies an attachment perspective to the understanding of trauma, arguing that children with secure attachments do not display unnecessary aggression, whereas avoidant children become abusers or victims. The author explains that, 'psychological trauma can be defined as the sudden uncontrollable disruption of affiliative bonds' (p. 203). In cases of imprisonment and torture, there is no possibility in sight for the re-establishment of affiliative bonds due to the loss of all basic freedoms removed by the oppressive regime.

The conceptualization of terror can be formulated as the psychological manifestation, of the biological response to the threat of death. It is this threat that the terrorized patient must guard against. Some of the most prominent defenses these patients use are splitting, fragmentation, delusions, displacement and dissociative states. The main feature is the total disengagement of the libido from the external world as has been found to be the case with the melancholias and the obsessional neuroses [9]. In such cases the patient resorts to isolation from relationships and is convinced that the world is hostile and persecutory. Psychological survival therefore becomes dependent on the substitution of reality with fantasy. Hence the therapist represents part of the perceived hostile world the patient is up against and therapeutic work becomes extremely challenging.

There is an important role that aggression plays in terror. The self-preservative aspect of aggression and hate is turned against the self with violent destructiveness, robbing the individual of the ability to relate and to trust. The clinical process suggests that the terrorized patient's ability to trust has been greatly damaged, making the development of an alliance difficult.

Winnicott's [10] paper on the 'Roots of Aggression' makes clear that aggression is a reaction to an experience of danger. Lack of holding of the anxieties associated with aggression in early childhood lead to a developmental failure. In his example of the timid child who experiences aggression in the external world but not in himself, Winnicott exemplifies that in the absence of real threat, this child relies on imagined attack. Due to defective maternal provision, such a child, upon waking from a nightmare, receives no soothing help from the mother. He never learned that kicking and screaming or even hating will not destroy the object of his love. Such a child defensively deludes himself that magically he can retain control over his environment (pp. 232 - 239).

Winnicott's timid child is analogous to the terrorized patient, who, in order to maintain psychological survival, guards against reality by flight into delusion and persecutory anxiety. The patient externalizes his aggression on to the crowd so that in a magical way he can control the threat. When the terrorized individual enters the therapeutic process, he or she is burdened by an indigestible experience and his or her ability to anticipate, as well as discriminate between real or imagined danger has been impaired by the trauma. Therefore, the individual is likely to treat the therapist as a threat and the therapeutic space as unsafe.

### The terror of inter-personal relating

The object of terror produced by oppressive regimes is in itself a reality better known by what it produces as well as induces in individuals subjected to it. The strength of power that oppressive regimes create rests upon the endangering of fear and soul murder and it requires real subjects for its existence. Without the reaction in the subject who is terrorized, terror remains an abstract, meaningless entity. The isolation of the individual from the collective is therefore a strategy used by authoritarian regimes to leave a person undefended and vulnerable psychologically.

In therapy this group of people tend to avoid relating to the therapist as a real person and often resort to defensive strategies such as idealization of the therapist and sexualization of therapy. Idealization acts in the service of dread from hopelessness, emptiness and futility, features found in the schizoid personality [11]. Thus, the patient establishes a safe exodus from the emotional reality of interpersonal relationships. In therapy, the terror, aggression and hostility tend to also be sexualized in the transference, which maintains a fantasied omnipotence that gratification will be actualized. In terrorized, borderline patients in particular, there is notable failure to experience the therapist as helpful and therapeutic work is hindered. 'In the borderline transference the insistence is on complete inter-subjective understanding with the annihilation of anything that might hint at the analyst having derived knowledge from or shared significant knowledge with anyone else' ([12], p.11). The notable idealization and sexualisation of the therapy are aimed at the annihilation of the therapist as a separate, thus unpredictable object, which maintains the illusory idea that the external threat is under one's control. The capacity for adult, interpersonal relating presupposes a secure attachment, in which the child could be alone in the presence of a containing, object. Whilst some individuals are able to work through a temporary merger with the therapist and relate to another as separate, those without a secure, 'facilitating environment' [10] remain fearful of the therapist's independent/separate existence. I will present a case in which I will try to illustrate how the patient used my body to locate his terror and show that the patient's incapacity to know when he could trustingly depend on others led to acting out and sudden termination. The material refers to my work with a male patient I will call Husein, who had been a victim of torture.

### Case Illustration

The patient, a male refugee in his early thirties, had been interrogated at twelve, arrested and imprisoned at fifteen and subjugated to brutal aggression, humiliation and torture. As an adolescent he had witnessed killings, arrests and disappearances of people in his country and had lived under a constant threat about his own life. Since his escape from a brutal regime and following several unsuccessful attempts to make a life for himself that both he and his parents would be proud of, he finally removed himself of the anxiety of relationships and became withdrawn and isolated. Speaking to people provoked intense anxiety and fear of being laughed at and he resorted to describing himself as a loser and a coward. This newly formed identity fed the need for exodus and flight into a passivity and withdrawal. The patient was besieged by paranoid anxieties to such an intolerable level that the external world became the repository of his hostile feelings. He spent most of his time alone in his room, a prison cell of safety that he created for himself. His main preoccupation consisted of internal dialogues and daydreaming, often involving victims and persecutors. There was a hallucinatory quality to these dialogues marked with flashbacks of the torture. In therapy he described how his head is inhabited by voices of people shouting at each other. The most dominant of these voices is that of a woman who tortures and humiliates an innocent man. Whilst the battle between the voices is taking place in his mind, the patient himself is curled up in a corner with his hands firmly held against his genitalia. This bodily sign could be understood, as a flashback of real attacks on him in the past and his reaction as a mechanistic reflex, developed to protect himself. Whatever the meaning, I was aware that I was witnessing a savage threat to his masculinity.

To manage his insomnia, the patient used alcohol and compulsive masturbation, strategies that emptied his head temporarily of the troubling noise. He daydreamed a great deal and this he described as 'the bad friend' who visited uninvited not allowing him a moment's peace. When we started the treatment he was concerned that he could remember very little about his past life and explained how he has been surrounded by a smoked glass that blocks him from seen anything.

With encouragement, he was able to speak about his relationships with his parents, albeit with coldness and devoid of any feeling. He remembered his mother as distant and preoccupied with her career as an academic. She was a well-dressed, attractive woman he said, "like you", he added, and went on to say how proud he felt to be seen in public with her. He bitterly added, that she was cold, unemotional and cruel. When she did pay attention to him was to mock him about his appearance. He remembered during his growing up that when people laughed he believed they were making fun of his looks, an early sign of paranoid ideation. His father, an army officer, was considered with high regard by the community for his army status. For Husein his father's army power enabled him to feel less vulnerable to persecution and terror by the authoritarian regime. He was away a great deal of the time, but his disciplinarian approach to the family lived on through his absence. Both parents aspired for their son to study medicine and despite his protests he had been sent to a reputable boarding school known for its strict disciplinarian regime.

Husein's early attachments were insecure and compounded by a social environment that was threatening and oppressive. At eleven, he suffered the first blow to his already fragile self. The disappearance of his father, who was believed executed, prompted a need to step into his father's shoes and protect his mother. This marked the beginning of a number of terrorizing events in his adolescent life. His memories of these years are that he was besieged by fear. The fear of himself being arrested and tortured by the militia led him to total isolation from relationships with people regarded as outsiders.

### The terror of inter-personal relating

The between space refers to the potential space where the individual is in contact with the environment. It is within this space that patient and therapist engage in the production of a co-constructed narrative based on creative understanding about the patient's biography. This space has the potential of being made creative or destructive by the patient. What follows is an account of the quality of deadness that developed in this between space during my work with Husein.

When he first arrived for therapy Husein looked ghostly, unshaven and unkempt. He swerved his body against the corridor walls ensuring I was not out of his sight as I walked behind, afraid I might attack him. He was lost for words but once he sat down he managed to utter a couple of sentences, in the form of questions about me, enquiring where I was from and the technique I would use to cure him. He was suspicious of me. When I remarked about how difficult it must be for him to come for help, he quickly corrected me by saying that it was his doctor who had suggested it. He seemed confused that I had made, in his mind, such a silly remark making the assumption that his own agency was active. My statement was linking a state of affect, i.e. his difficulty, with a state of action belonging to him, i.e. coming for help. This seemed meaningless to him because his own sense of self had been thwarted and annihilated by the external world. My remark about his silences would be met with, "I have nothing special to talk about", adding that it was my job to know what his problem was and to cure him. He seemed stagnated, empty and unable to make real contact with me. He hoped that by magic I could perform the task of getting inside his world and bring him back to life, when in fact all his efforts were designed to keep me outside. This inability to connect himself with the outside world was reflected in his muteness. If he was unable to tell his story, I thought, how could I help him reach meaningful understanding of his experiences? I felt stuck and frustrated having to rely on guesswork. During the silences my powerful bodily sensations with my heart pounding and electric currents running through my head captured what Husein must have been feeling. Somehow his inner dread had lodged itself inside my body consuming my vitality. This was the most poignant manifestation in the process of therapy. Husein was communicating his unsayable through the projected bodily sensations. He used me to transmit affects. My body was turned into a receptacle vehicle that could contain his toxic terror. I began to doubt whether I could sustain myself through the dread of these hours. It was clearly an unconscious strategy used by Husein to steer the badness outside himself that created futility and deadness in the countertransference. As Husein's audience I felt I had to constantly use my bodily sensations to understand the silences, the tapping sounds and the incoherent, fragmented words he occasionally uttered. It was like putting pieces together that were so abstract the mind's eye could not capture them.

The deadly atmosphere in therapy marked by hostile silences lasted for several months. The only sign of life from Husein was the tapping of his fingers against the wall and the ritualistic covering of his genitalia. The story unfolding was a mute story. At times when Husein left his shell and began to allow himself to see me he would quickly withdraw again. Being visible and separate produced catastrophic anxiety in him threatening his omnipotent fusion. The defensive pattern of maintaining his original "loser" perception was a reminder that he had given up the belief that he could help himself. Instead, he demanded I give him the cure he believed I was deliberately withholding. Eye contact seemed to confirm to him that I was outside himself, and he became paranoid that I was trying to hypnotize him. He felt so utterly threatened by any real contact between us, that he intensified the sadistic attacks on me and claimed that I was mean in depriving him of longer, two or three hour sessions, the only means in his mind that would bring about the desired cure. His demands corresponded with a fantasy he shared that therapists see their patients for ten hours every day.

His paranoid attacks on me continued and Husein's need to control me led to him instructing me on how I should conduct myself. What he had in mind was a question and answer session where we would both be interrogating each other. In one session he expressed suspicion that I secretly transcribed the sessions and sent copies to his GP. It later transpired that it was his own desire to transcribe our sessions that lay at the root of his suspicion. He explained that if I allowed him to transcribe our sessions he could listen to them later and try to understand, adding that whilst with me he felt so confused, he could not take in my responses. I wondered aloud whether he needed to re-play our sessions to fill the emptiness when alone. He replied that the only time he felt he could exist was in our sessions, saying how much he looked forward to them, adding that 'fifty minutes is not enough. Why don't you allow me to transcribe the sessions?' Gathering my strength, I told him that I had the impression he wanted to take the sound of my voice home with him to soothe his pain

from the flashbacks of torture. Interpretations along the lines of his need to possess me were dismissed as irrelevant. His disposition to concretize everything was unshakable and he reacted with hostility at what he saw as my refusal to meet his needs. The patient's hostility had a disturbing effect on me. I experienced the sessions like an explosive device ready to explode destroying both of us. The atmosphere was extremely tense. I feared that Husein would act out his violence in the sessions. I recognized that I was being invited through the transference, to play a sado-masochistic game and submit to the tyranny of Husein's insatiable need for merger. At these times I felt tired and weary. Despite my weariness I was hopeful that Husein's aggression was a sign of life, his attempt to relate to me.

It had taken us several months of surviving a painfully disturbing atmosphere in the sessions, before Husein could trust me. This made it possible for him to feel safer. I could now focus on helping him symbolize his trauma by co-creating a meaningful narrative of his experience which could bring together his fragmented, regressed self.

After twenty months of therapy Husein was able to return to work and to re-establish contact with friends prior to his breakdown. Although he continued to feel troubled by flashbacks, he was less colonized by them; having developed the capacity to think about them, his fear of being taken over, had decreased. His surge towards the world also opened him up to his aggression, which manifested in a number of road rage incidents he reported during therapy. It was clear that Husein could not tolerate his murderous rage damaging me, so he acted out through libidization and acting out his aggression.

### Merger transference

The trust led to a "merger transference" [13] and Husein's intense dependence on me led to erotic fantasies about us as a couple. The erotization of therapy was elaborated upon in the transference through his accounts, one of which of a friend who had the same racial background as himself and who married a racially different woman. Husein's curiosity about me increased. He constantly demanded that I tell him intimate details about myself. He reacted to my posture of anonymity with rage and associated my therapeutic stance as sadistic. My understanding was that he turned me into the withholding object, like his remote mother had been. We were now confronted with new territories in the patient's psychic structure. He became fearful of abandonment and I experienced the sense of merger between us as overwhelming.

The only time the "bad friend" in his daydream did not visit was during the sessions, he said, and demanded that I should see him for seven hours a day, seven days a week. This became an obsession and I the object of his scrutiny. By giving me access to his prison some emotional connection developed that reinforced my hope. However, Husein's experience of me as the only source of hope evoked anxiety and fear of losing me. His increased dependency on me exacerbated his vulnerability, causing an escalation of attacks on me as a withholding object. Oscar Wilde's words that 'Each man kills the thing he loves' ([10], p.237) highlights the conflict involved in the primitive impulse of merger love. The more Husein clung onto me the more threatened he felt that I would abandon and humiliate him. So he would violently protest at how little of my time he received. He behaved like a scorned, insignificant lover. Giving him only fifty minutes of my time once a week was experienced as teasing him. The gap from session to session fueled his fears of abandonment with the consequence of being left to the mercy of a hostile world.

The announcement of my forthcoming break led to intensification of the erotic transference. Husein's theme now focused on numerous people betraying him, including his bewilderment over the sudden desertion in the past, by a girlfriend he was attached to and hoped that their relationship would develop into a sexual one. This girlfriend whom he had met at University led him on, he said, describing that she had kissed him once and he had hoped they would eventually become more intimate. However, after his girlfriend's sudden disappearance, he felt betrayed and frightened of relationships. Husein explained that despite a frantic search to find her, he had to resign himself to the fact that she would never return.



I felt that Husein's account mapped the pain and confusion he felt when his father disappeared leaving him vulnerable to the whims of an oppressive regime. My going away, at a point when he experienced me as his protector meant that he would find himself, yet again alone and afraid. Husein began to tell me how fellow countrymen let him down, that people he considered to be his friends could not be trusted and he intended to cut himself off again from the re-established contacts he had made, convincing himself that he was better off without them. I said to him that by means of this story he was perhaps trying to convey how anxious and abandoned he feels with me going away and how much he perhaps wished he was able to stop me from leaving. He blushed, gave out a sigh of relief and then withdrew into a long silence. His reply came much later when in a trembling voice he said that my three weeks felt too long. He expressed his fear that he would have to start from scratch, that it would be difficult for him to remember where we left off, adding that it is hard for him to remember week by week what we talk about, let alone three weeks. He then asked whether other therapists take this amount of time away from their patients, suggesting that I was a bad therapist (mother). It seemed that Husein's coping with previous breaks was linked to him being cut off emotionally from others. This protected him from narcissistic hurt. Having established a connection with me intensified his fear of losing me. I attempted to understand his anxiety in the light of the transference relationship. I was aware that in his mind I was the teasing mother who was there for him one moment, only to abandon him later with her remoteness.

In spite of his efforts, Husein felt incapable of trusting and depending on others if he experienced them as separate. During the final phase of our work he began to allow himself to experience me as an affirming presence. His story line included for the first time references to being with others and needing others. However, his story line was interrupted by the realization that I was separate and this meant I could abandon him. Disappointingly Husein resorted back to his primitive defences of withdrawal from the world. He now once again turned me into an abandoning and threatening presence [14]. He could not trust that I could exist in his mind when I was not concretely present. Hence he acted out his anxiety and anger towards me by not attending his sessions on my return from the three week holiday and not replying to my letters. He never made contact with me again.

### Discussion and Conclusion

The capacity to cope with the effects of re-living trauma during therapy largely depends on how far the ego's resources are mobilized to cope with the intensity of the affect. The degree of resilience the individual has at her/his disposal would determine whether internal and external phenomena could be integrated into cognitive and affective stories that maintain psychological stability. Because work with terrorized patients activates early object relationships and exposes the patient to overwhelming affects manifesting through transference and countertransference, the primary function of the therapist is to contain not only the patient's affective experience, but her/his own reactions to the patient. Heimann, Racker and Winnicott are among earlier analysts who believed that in the blocking of her/his reactions to the patient, the therapist would lose an important technical instrument in understanding and helping the patient ([15], pp. 50 - 51). My own reactions to Husein, including the bodily sensations of dread during the phase of silent deadness, formed the nexus of the therapeutic encounter and aided my understanding of the patient's inner world, a world inaccessible through language. However, surviving, tolerating and containing the patient's overwhelming affects in Husein was not sufficient in itself to prevent the premature ending. On reflection, more work in preparing the patient prior to a holiday break, together with an arrangement for him to be seen by a colleague during my absence would have provided a more secure base, so that the patient could tolerate the separation anxiety and not feel abandoned.

Traumatized refugees who escaped persecution and find themselves in a foreign country not only carry traumatic memories, they are also forced to emotionally negotiate new ways, often in isolation, understand a new culture and values and face xenophobia from the host society. These conditions could potentially cause withdrawal and mistrust. Therapists are part of the host society, which can exacerbate and reinforce mistrust, factors that often militate against therapeutic engagement. The therapeutic alliance stands a better chance if therapists are mindful and openly acknowledge these factors.



I have tried to show, through my description of Husein, the unfolding of a clinical picture that describes how he emerged from deadness into life but found the life of interpersonal relating, particularly my separateness so unbearable that he enacted the anxiety of being abandoned by suddenly ending his therapy. Such premature and sudden endings are to be expected in cases where the overwhelming affects activated in patients are too much to bear, especially in patients with limited resilience and ego strength. During therapeutic work the overwhelming experience of terror floods the ego and threatens to dissolve the self. Even though I initially felt uneasy about this premature ending of our work, at the same time I wonder whether the best possible option for Husein was his choosing to block the catastrophic anxiety that threatened disintegration. On hindsight, he had unconsciously communicated to me his intention to leave. The premature ending constituted an integral part of therapy in that one of us had to be “killed” in order for the other to survive. This raises the question whether psychotherapeutic work with severely traumatized patients can be traumatizing in itself, with the implication of the patient surviving through ending therapy prematurely. As discussed earlier, the ending could have been avoided if more preparation work prior to my holiday had been done. I believe traumatized patients could be supported in managing overwhelming affects through arranging an interim supportive space with a colleague during therapist absence.

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