

Witnesses to Reality: Working Psychodynamically With Survivors of Terror¹

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As generations of young men and women return from combat scarred not only physically but also psychologically by their experiences, as civil wars and genocide proliferate and refugees seek sanctuary in America from persecution in their native countries, even while others are held in violation of their international human rights by the United States government, this paper asks what role psychoanalysts can play in working with those who have survived violence and terror as adults. Offering a relational formulation of adult onset trauma, the author reviews some of the difficulties inherent in being called upon to bear witness to destructive social forces. The paper concludes with the case of a man who has been detained in Guantanamo Bay for the last 6 years.

ONE OF THE MOST REWARDING PROFESSIONAL TASKS I UNDERTAKE is the psychological evaluation of refugees who are seeking political asylum in America. Sometimes, when there are no physical signs of torture, asylum depends on the opinion of a mental health professional. Not everyone seeking political asylum has been tortured, but most of them have; not all torture has left physical scars, but the psychological scars are legion.

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The attorneys representing these asylum seekers supply the evaluators with an account of the reasons their client had to flee her native country and what she fears would happen if she were forcibly returned. It is the psychologists' job to decide whether the story is plausible; to summarize the findings; and, if necessary, to testify before the Immigration and Naturalization Services judge.

As the evaluator, I have to know exactly what has happened to the person sitting in my office or sitting forlornly in the INS jail in Queens or Newark, and I have to find out in one 2-hour visit, or at the most two visits. It is not all that easy. Sometimes the asylum seeker cannot believe I really want to know what happened. No one else has listened; the story is too awful to tell. Celeste was among these. As she reviewed the broad outline of her life in Rwanda, she was calm and presented the facts in an organized and clear fashion. Even as she described the deaths of her parents and younger siblings and the disappearance of an older brother with whom she had been living, she seemed quite composed; her remarks sounded rehearsed. She repeated almost word for word the account she had given her attorney some months earlier. In order to write an effective brief, I had to know something more. "Yes," I said, "your attorney gave me your earlier report. I wonder if you could tell me more about what happened to you." She looked at me as if to gauge whether I had any idea what I was asking. "Do you mean step by step?" She continued to look at my face very closely as she took me through those awful events.

As we spoke, she became increasingly tearful, fearful, and despairing. At times during this part of the interview there was a great deal of noise over the intercom and outside the door of the room in which we were speaking, but Celeste seemed quite oblivious. It was as if the details she was recounting had much more reality than the present moment.

There were times when she would grasp my hand for reassurance, or ask me, "Is it really okay if I tell you this? Do I dare say this?" And I had to say, "Yes, I am with you in this. We shall get through it, and god willing you will not be sent back there." And many months later she got asylum.

Celeste's story haunted me for several weeks after that interview, sometimes I would find myself spacing out, remembering how she was hunted by men who were wild with hatred and bloodlust, determined to rape her, *not* because they desired her, they told her—because she was disgusting—but because they knew this was a way to dishonor her brother.

Yet in some ways working with Celeste was easy because she remembered what she had been through and she had been waiting for someone to witness the unspeakable losses she had endured. She found words for those

losses. Many people cannot. Sometimes the shame of what has been endured, the memory of the terror and humiliation, is so great that it overwhelms the capacity to speak of it. Others fear that in speaking of their experiences, they will relive the horror and that is not worth it, not even to get asylum.

Sometimes the memory cannot be accessed. It is lodged in fleeting impressions rather than words, in fugue states, in bodily pains. Evaluators must deduce from gaps in experience, from broken narratives, from chronic physical complaints that have no basis in reality, what might have happened to this man or woman who is seeking sanctuary in America.

Psychoanalytic Theory Making and Adult Onset Trauma

For most of the 20th century, psychoanalytic theory paid scant attention to those who had been wounded by reality (Boulanger, 2007b). There were notable exceptions such as Kardiner's (1947/1969) groundbreaking study *The Traumatic Neuroses of War*, with its emphasis on the phenomenological and clinical aspects of battle fatigue, and Henry Krystal's (1968) equally significant edited volume *Massive Psychic Trauma*, but by and large there have been few attempts by psychoanalysts to account for the ravages of violence on the adult psyche.

With the relational turn, psychoanalysts have become increasingly political and increasingly aware of a century's failure to provide for many survivors of these terrifying realities. As generations of young men and women return from combat scarred not only physically but psychologically by their experiences, as civil wars and genocide proliferate and refugees, like Celeste, seek sanctuary in America from persecution in their native countries, psychoanalysts search for ways to address this suffering.

It is sobering to acknowledge that in this post-9/11 era, the United States is adding to the numbers of the oppressed, operating detention centers in which foreign nationals are held in abject and sadistic conditions in violation of international human rights law. Debates about torture have become as much a part of daily media discourse in America as fluctuations in the stock market and the rising cost of gas. Mental health professionals, and particularly psychologists, advise the military and the CIA on the effective use of "stealthy tortures," as Rejali (2005) referred to them, psychological tortures that leave no physical marks, and psychologists, in part, are responsible for implementing these strategies. The American Psychological Asso-

ciation defends these practices arguing that the presence of psychologists ensures that interrogations can be made safe and ethical (see Soldz's paper in this issue).

Rejali pointed out that psychological torture is more characteristic of democracies, for when there is a possibility of media attention, covert violence increases. He added that many decent professionals leave their posts when the state begins to torture, while those professionals who continue to work for the state create a culture of impunity. It is incumbent on those of us who wish to separate ourselves from the American Psychological Association's current practices to point out the hypocrisy behind this culture of impunity and to inform ourselves of the far-reaching psychological consequences of torture.

In her great pacifist essay *The Iliad or the Poem of Force*, Simone Weil (1940/2005) wrote that violence turns anyone subjected to it into a "thing." Being the object of another's malevolence, of another's determination to "break you down completely" (Lagouranis, 2007) to use the interrogators' jargon, leaves an indelible mark on the psyche, even if that malevolence does not involve lasting physical damage. Not only do those who are directly subjected to violence become "things," but also many of those who commit violence, and many of us who stand by and watch.

My focus in the first half of this paper is on the experience of being violently reduced to a "thing," on the long-term consequences of becoming an object that is denied subjectivity, denied history, and denied a meaningful context in which to live and to relate to others.

Physical and psychological violence can lead, quite literally, to a vicious cycle—a reversal of subject and object—where, over time, the object of violence makes someone else the object of his own hatred and aggression (Davies & Frawley, 1994; Grand, 2000; Stein, 2006, among others). However, persecution and terror do not always engender violence; they can, and frequently do, lead to the collapse of the self, a psychic disenfranchisement that makes the survivor question whether he or she did, in fact, survive. The death of the spirit has preceded the death of the body.

Constant devaluation of others and chronic emotional detachment enable the psychopath to commit psychological and physical violence with impunity. But not everyone who commits an atrocity is a psychopath. Meting out violence can be as psychologically destructive as being the victim of violence. In collecting data for the epidemiological study with which I began my career (Kadushin, Boulanger, & Martin, 1981), I debriefed many Vietnam combat veterans. Summing up the way he felt he had

changed since being in Vietnam, one veteran said, "I show no sad emotions ... I have no feelings. It's like there's nothing there. It's like half of your personality is gone because when you do a lot of killing and stuff like that ... when you see a lot of death, you lose your feelings and your personality."

Each night this man relived one of the violent encounters he had had in Vietnam. Posttraumatic dreams are like a psychic hiccup, reflecting the psyche's struggle to grasp the traumatic signifier and repeatedly failing to do so. Reality has overwhelmed psychic functioning. The unconscious has ground to a halt before this overwhelming blow and the creative dreamwork of condensation and displacement is unavailable (for contemporary accounts of Iraqi interrogators' struggles to come to terms with their own violence, see Fair, 2007, and Lagouranis, 2007).

A Relational Perspective on Adult Onset Trauma

For many years the metapsychological choices available to psychoanalysts dealing with the extremes of human experience as they are survived by adults have, in essence, blamed the victim for not bouncing back. Typically our theories have singled out psychodynamic causes such as psychic conflict, developmental arrest, early failures of recognition, and most obviously a childhood trauma and have situated the source of the problem not in the recent terrifying event but in childhood. It is a comforting belief that the effects of massive psychic trauma can be reduced to internal conflict or the disappointments and even the horrors of childhood. Being confronted with the unimaginable terror of annihilation as an adult (not a symbolic death but actual and sudden extinction) is a different order of psychic experience and it demands a different level of psychodynamic understanding. Subjectively and metapsychologically, adult onset trauma requires careful consideration in its own right. If this position is not clearly understood, adults who have survived catastrophes are in danger of being situated beyond the reach of effective psychoanalytic practice.

The rediscovery of dissociation and the use of this concept to understand childhood trauma has revolutionized the psychoanalytic treatment and understanding of adults who were abused as children. Relational analysts contend that when anxiety prevents a child from integrating a particular experience, she defensively dissociates in the face of her confusion and the unmanageable stimulation she is experiencing, forming split-off self states to encapsulate the traumatic self and object representations; leaving other self states free to engage a less threatening world.

However, this particular view of dissociation can be confusing when it is applied to patients who have survived catastrophes as adults. There is a distinction between dissociation as it occurs in childhood and catastrophic dissociation. Howell (2005) pointed out that the capacity to dissociate decreases with age. In adulthood, catastrophic dissociation does not create further splits in a developed personality, it does provisionally offer protection from terror, but ultimately it leaves the survivor in a state of confusion and anomie.

Adult survivors of massive psychic trauma find every aspect of their waking and dreaming lives, every self state, permeated by the sense of a collapsed self. Other psychoanalytic writers have described this phenomenon, Shatan (1973), Kohut (1984), Laub and Auerhahn (1989), Herman (1992), and Lifton (2005), among them. However, little attempt has been made to deconstruct the actual process by which the adult self collapses during this disastrous confrontation. Next I offer a relational understanding of the dynamics of adult onset trauma.¹

Damasio (1994, 1999) described an ever-changing biologically based core self; “not so much that it changes, but rather that it is transient, ephemeral, remade and reborn continuously” (Damasio, 1999, p. 216). In understanding the effects of adult onset trauma, this core biological self is a foundational must. The core self is employed constantly in monitoring signals from the environment, monitoring its own responses to these signals, and integrating the results as a way of maintaining a steady state.

I add to this Bucci’s (2001) description of the subsymbolic sources of the self, as they shape and are shaped by the core biological self. Bucci, whose work integrates the concepts of psychoanalysis, cognitive behaviorism, and the neurosciences, pointed out that these subsymbolic systems are more far reaching than has previously been taken into account by psychoanalysts. Existing at the edge of awareness, they are comprised of the tactile, motoric, visual, sensory, and affective senses and are central to knowledge of one’s body and emotional experience. Understanding how these systems function offers clinicians working with the fundamentals of emotional experience a way of envisioning the nexus where body and mind, affect and neurophysiology meet. Although subsymbolic systems underlie symbolic experience, they are not archaic as Freud would characterize them, and

¹In arguing for a core self admittedly I am taking an unpopular position for a relational analyst. In my defense I quote Fairfield (2001): “To say that a cohesive self is a fiction or illusion is to assume that a multiplex subjectivity is not” (p. 226). In fact, I argue for both core selves and multiple self states.

their importance does not wane with the advent of verbalization; they exist alongside and inform the symbolic system.

By incorporating these neurological and sensory data into an understanding of human subjectivity, it is possible to conceive of an underlying core self that establishes broad physiological and psychological parameters, while shifting self states embedded within the core are informed by the relative durability of the core self or—in the case of adult onset trauma—by the traumatically undermined core self.

Despite the exigencies of daily life, the moments of shame, humiliation, anxiety, and sometimes panic that occur in every life, there is little reason to question that the core self lies in established patterns of physiological, affective, and behavioral regulation. These established patterns grant continuity to experience as they adapt to developmental changes and accommodate contextual ones. Under normal circumstances, this self is constantly evolving through experience. But when the brain detects danger, there is, to quote Damasio, a profound departure from business as usual. Neuropsychologists describe the “cascade of biobehavioral changes” (van der Kolk, McFarlane, & Weisgeth, 1996, p. 218) that occurs in individuals exposed to trauma. Multiple levels of biological functioning, from the regulation of internal homeostasis, to perceptual, higher cognitive, and analytical functions are chronically affected. The shattering and far-reaching disruptive effect on the homeostatic brain system brought about by terror has long-lasting neurological consequences.

I am, then, advocating a different way of envisioning the effects of early development and the subsequent blow of adult onset trauma. Developmental experiences and the neural pathways that embody them are not an indelible imprint as classical theory has posited, but a baseline for ongoing self-experience. In the early years, traumatic experiences can be incorporated into dissociated self states. In adult life, however, physiologically and psychologically massive psychic trauma catastrophically disrupts the baseline sense of self that under normal circumstances would never be in doubt.

Psychoanalysts who have incorporated nonlinear dynamic systems theory into their work also emphasize the transitory quality of psychic structure: “There is a point in nonlinear systems at which change in a particular input will change the basic dynamic of the system” (Seligman, 2005, p. 281). And further, “Once new adaptive processes are set in motion, they can reinforce themselves as different parts of the system respond to each other and/or to the changing environment” (p. 281). Within this system, it can be argued the long-lasting biological, neurological, behavioral, and consequently psychic effects of adult onset trauma, set in motion by a cata-

strophic external event, become self-reinforcing as the traumatized individual withdraws further and further from the danger that the world has come to represent.

Neuropsychologists and biologists have accumulated an impressive body of evidence of the chronic disruption of neurological functioning that occurs after massive trauma. Although there is an exciting consilience between what survivors of massive psychic trauma report about their sense of collapse and recent neurobiological findings, there have not been sufficient attempts to understand the phenomenology of the collapsed self.

In describing that phenomenology, I am reminded of the ways in which Daniel Stern (1985) has parsed out the senses of agency, physical cohesion, continuity, and affectivity as the preverbal components of the core self. These “invariants” or “islands of consistency,” as Stern has called them, make possible and in turn are elaborated by intersubjective experience. Stern emphasized that his core self is not simply a cognitive construct, not a hypothetical psychic structure, but an actual experiential integration.

As the psyche matures and self regulation consolidates, the core self becomes the unarticulated ground against which the figure of experience is projected. Normally completely taken for granted and operating out of awareness, it is the psychic equivalent of a heartbeat or regular breath. When sustained terror intervenes, this core self is catastrophically and chronically dysregulated not just neurologically, but psychically as well. At this autonomic level, physiological and psychological experiences inform one another. Terror leaves a lasting biological impression with profound psychological reverberations.

In the language of nonlinear dynamic systems theory, catastrophic dissociation is an emergent, complex, and evolving process that arises in response to an environmental event and involves the interaction of the neurological, cognitive, psychological, and affective systems. Consistent with this argument, there is no single cause, but rather complex neurological, cognitive, and affective responses to the environmental event. It is important to acknowledge that the process of catastrophic dissociation follows a different course with each survivor depending on individual history, but, at a certain critical tipping point, the subjective experience of having lost touch with a familiar self is similar for many survivors, amounting to a radical and long-lasting discontinuity with his previous sense of self.

Next I briefly deconstruct the process of catastrophic dissociation with two goals in mind: First to convey a sense of what happens to the core self as terror leads to catastrophic dissociation so as to illustrate how, under these pressures, the self collapses, and second, to show how the effects of cata-

strophic dissociation continue to reverberate through the traumatized core self long after the actual danger has ceased. For, in the very act of surviving, in the state of catastrophic dissociation, the self experiences its psychic foundations in ways that do not happen in the average expectable life. The survivor loses the comforting familiarity of a self on whom he had come to depend. He finds himself stripped to his bare and unfamiliar psychic bones. And, in the aftermath of that loss, it is frequently difficult to regain his psychic footing.

I turn first to the sense of agency. Paradoxically, it seems, we do not question that we are the author of our actions until we have lost that conviction. We take it for granted we can and do control our lives. This earliest and most fundamental invariant of core self experience and the sense of being the author of one's actions is initially acquired through motor behavior. Control over motor behavior is often lost during the moment of trauma. People say things like, "I was frozen in place" or "It was like a nightmare where you want to move but can't." Some survivors will tell you, when they have gotten to know you well enough and feel trusting enough, that, in a state of terror, they lost control of their bodily functions.

Losing control to external agents, being at the mercy of another, shifts the lens through which the psyche focuses to the paranoid schizoid position. In this world, the self exists only as an object; the subject who makes choices and follows through on them is lost. This is how Bettelheim described his reactions to being in a concentration camp: "I became convinced that those dreadful and degrading experiences were somehow not happening to me as a subject but only to me as an object" (Des Pres, 1976, p. 81).

Survivors of such experiences seek to reverse the involuntary loss of motor control as soon as possible. Tortured by the right-wing regime in Argentina in the 1970s, Timerman (2002) described making almost imperceptible movements with his arm after each torture session as if to restore some sense of agency.

Once the immediate need for psychological escape through dissociation no longer exists, the survivor finds that she cannot escape the intrusive memories and thoughts common to posttraumatic states. Once again she feels she has no agency. The paranoid schizoid self as object is chronically plagued by persecutory convictions. In this state, thoughts, feelings, and perceptions are conceived of as constituting things in themselves. There is no subject, no self, no "I" to create and give meaning to experience; instead experience is driven by sensation. State dependent traumatic memories, prompted by a sound, a smell, an affect, a visual cue, a sudden turn in the

weather, even a particular word, feel as if they are intruding, persecuting, unbidden, and uncontrollable. The survivor experiencing these intrusive memories, thoughts, or feelings imagines she is at the mercy of harrowing terrors over which she has no control.

The body, as the literal site of the self, “without which agency would have no place of residence” (D. N. Stern, 1985, p. 82), is paramount in arriving at a sense of core self. It would be tautological to suggest that nowhere is the dialogue between psyche and soma harder to hear as two separate voices than in the sense of physical cohesion. In this most fundamental realm, psyche and soma are one until they begin to articulate their separate positions.

Psychologically this is the world of Ogden’s (1989) autistic contiguous position, “the barely perceptible background of sensory groundedness of all subsequent subjective states” (p. 80). Here, experience is generated by touch, and by signals from the body. And it is here that the first effect of trauma is registered, generating changes in the musculoskeletal system caused by neural and chemical signals, and particularly and more fundamentally in the viscera, registering danger well before reason sets in (Damasio, 1994). The body’s familiar rhythms are interrupted by sustained terror. Autistic contiguous anxiety implies the impending disintegration of the sensory surface, the rhythm of safety.

Ultimately, the material body is less vulnerable than the psychic body, the body-in-mind, host to agency, and container of affects. This body-in-mind is subject to fragmentation and depersonalization when the psychic skin loses its reassuring and consolidating embrace. And skin is the literal divide between self and other, between inner and outer. The skin does double duty as both psyche and soma. Anzieu (1985) described the skin’s pivotal role in structuring all of the other senses by providing the earliest and most fundamental bonds with the outside world. The psychic skin is a container, capable of establishing an interior object world inhabited by a benign object and capable of recognizing the separateness of others.

A traumatic assault on the body in mind leads to the loss of physical cohesion, the skin’s psychic properties erode; the body no longer contains agency, affect, or objects; inner and outer lose their distinctiveness; and the fundamental bonds to a benign other are lost.

Just as physical cohesion represents the psychic envelope that contains the other senses of the core self and houses the benign internal object, continuity, the sense of time, what Winnicott (1965) called “going on being” provides an inner sense of coherence. The sense of continuity is doubly affected by trauma. During the immediate unthinkable terror, temporal dis-

sociation is frequent, a fugue state possible. People say things like, "Time stood still" and "I felt as if things were happening in slow motion." Later, with the traumatic short-circuiting of normal integrating memory functions, time continues to stand still long after the event. There is no longer past, present, and future, the traumatic event itself does not become history, it is an everlasting and recursive present. Again, this experience parallels the paranoid schizoid position where there is no sense of history because as Ogden (1989) put it, "the present is projected backwards and forwards, creating a static, eternal, nonreflective present" (p. 62).

In this timeless state, the survivor is constantly subjected to a barrage of unintegrated visual and somatic memory fragments, intrusive thoughts, and occasionally auditory events. Reacting to these intrusive memories inevitably interrupts going on being, which, as Reis (1995) pointed out, annihilates the continuous experience of consolidated subjectivity and forecloses the survivor's ability to remain conscious of his consciousness.

Catastrophic dissociation is most frequently associated with numbness. Time and again survivors will say that after a moment they ceased to feel terror, they simply went into automatic pilot. But the numbness can endure long after the terror has passed; it alienates the survivor from all that is familiar. Without familiar feelings to guide her, with traumatically disrupted internal patterns of arousal, and her failure to register subjective self states affectively, the survivor has lost her sense of continuity, becoming unfamiliar to herself.

The "I" who experienced a range of feelings is gone, and with it the sense of ownership of experience. No longer punctuated by affect, life has become rote. Not only current experience, but memories too are devoid of emotional impact. Losing the ability to experience feelings in a consistent fashion leads not only to a loss of familiarity with the self, but this catastrophic loss has widespread interpersonal consequences. With the failure to register one's own feelings comes both the failure to share one's affective state with an other, and the failure to appreciate the other's affectivity, which is the basis of intersubjective experience, the heart of the capacity to feel related to others.

Many relational analysts believe that the failure of relational ties causes the posttraumatic reaction (Bromberg, 1998; Coates, Rosenthal, & Schechter, 2003; Ferenczi, 1933/1980, among others). "Traumatic aloneness is what really renders the attack traumatic, that is causing the psyche to crack," Ferenczi (1933/1980, p. 193) concluded. Grand (2000) wrote, "In her core, the survivor remains solitary in the moment of his own extinction" (p. 4). This profound isolation has three interdependent sources: The

loss of structuring ties that represent the internal object world. The loss of external social ties as others recoil from or grow tired of the survivor's changed personality. Finally, when survivors question whether they have, in fact, survived, they feel as if they have lost their membership in the human community (see also, Rosenbaum & Varvin, 2007).

Coevolving and codetermined as they are, a threat to one aspect of the core self sets up profound reverberations for the whole. Van der Kolk et al. (1996) referred to the cascade of biobehavioral changes that occur as a result of trauma, but psychically as well as biologically there is a domino effect when aspects of the self are traumatized. Realizing that she cannot alter the course of events, that contingency not agency is the rule, the survivor no longer feels herself to be a subject but an object, subject only to the whims of an unreliable and dangerous world. With threats from without and within, when the distinction between inner and outer no longer holds, the body-in-mind that houses this disenfranchised subject is not up to the task of containing agency, affects, or objects. The loss of interiority brings with it the loss of an internal object world and difficulties keeping thoughts in mind. The traumatic disruption of memory and internal patterns of arousal leads to unfamiliar feeling states that threaten the sense of continuity. The ruptured sense of time interrupts going on being, further compromising subjectivity and thus the possibility of intersubjectivity. With the loss of self as subject comes the loss of the self as interpreter and conveyor of meaning.

This brief account of the core self's collapse in the face of massive psychic trauma attempts to capture the vortex in which the traumatized self is caught and provides clinicians who are treating massively traumatized adults with a way of listening to their patients' experience (for a more detailed description, see Boulanger, 2007b).

The Clinician's Role

Survivors who have traumatically lost the structuring ties to another, for whom the distinction between inside and out is no longer clear, who no longer believe in the possibility of benign ties, who have no sense of their own subjectivity, meet mental health professionals, whether for assessment purposes or for treatment, with little hope that this encounter will have any impact on their condition. As mental health professionals, it is our task first and foremost to pay close attention to what the survivor is telling us—and sometimes they can only tell us implicitly—about their experience because it is our job to testify, whether formally in court, or clinically in the treat-

ments we undertake, to the reality of the psychological damage they have sustained.

When there are no physical scars to point to, the public and the press have many ways of defending against our collective uneasiness at reminders of the frailty of the human spirit in the face of horror. Adult survivors often find, or expect to find, that they have worn out the other's sympathy if they have not made a speedy recovery from a terrifying experience. Our particular psychological discipline has taught us the danger of evading what lies beneath the surface, knowing that finding a cognitive rationale for the reaction to horror does nothing to heal that reaction, but it does increase dissociation both on an individual and on a societal level. At the same time, our particular psychological discipline has provided a very narrow range of understanding when it comes to adult onset trauma. There is truly a confusion of tongues between analyst and patient when the patient has survived massive psychic trauma and the analyst is not prepared to witness this experience.

Thomas (2008) pointed out that witnessing in a therapeutic sense involves an active engagement on the part of the analyst. That active engagement begins with the survivor's need to have her experience validated. Catastrophic dissociation is often registered as a sense of depersonalization. The depersonalized self does not recall accurately; what may have seemed clear at the moment of terror starts to disintegrate under more benign conditions. One of the worst fates for survivors of torture and other violence lies in the difficulties encountered in crediting their own experience. Primo Levi (1958) spent many years struggling with his need to tell the world about his experience in Auschwitz. But this need was constantly juxtaposed with the words of an S.S. officer who had jeered at him that if he survived the concentration camp no one would believe the story he had to tell. For Levi, worst of all, was his own doubt: "At this moment, as I sit writing at the table, I myself am not convinced that these things really happened" (p. 161).

I observed this phenomenon in a native of Guinea, whom I evaluated in connection with his bid for political asylum. Mr. Abdoul kept pausing in his narrative, continually qualifying his descriptions. When the interpreter became confused by these repetitions, I asked Mr. Abdoul if some words felt more accurate than others. No, he said, but he was afraid that he was exaggerating what had happened to him in prison, that he was making it up in some way. In fact, physical symptoms corroborated his story. It was as if his body had to witness his past because psychologically he could not bring himself to do so.

When experience has overwhelmed the capacity to remember or, more accurately, to believe the experience, the need for a witness is paramount. When the self has collapsed, when there is no subject to register what hap-

pened, the traumatic past is a collection of impressions too frightening to credit. The survivor's failure to contain the story herself compels the empathic listener to act as the container for the horrifying event, giving shape and credibility to the different impressions as the narrative starts to emerge. This presents a particular conundrum for relational analysts who believe that experience is formulated and memory is constructed dialogically. "Trauma represents the most severe test for constructivist psychoanalysis" (Moore, 1999, p. 166). Indeed, if the analyst adopts a stance of extreme relativism, social construction can prove as destructive as a search for truths about underlying psychic conflicts. "In such moments," wrote Grand (2000), "psychoanalysis appears to border on a relativism that is bankrupt with regard to real evil" (p. 43).

A traumatic event in adult life is usually indisputable; whether it is a life threatening accident, torture, a terror attack, or a more private assault, the harsh "facts," a word I use advisedly in this context, lie beyond the reach of social construction. Yet, like Primo Levi or Mr. Abdoul, the survivor's dissociated experience can lead her to question her response to the event and even the severity of the event itself, fearing that she overreacted, or that she imagined it, or in some other way fabricated it. It is dangerous and demeaning and further undermining if the clinician does not recognize that this uncertainty is a defense against reliving the annihilatory terror.

I began this paper describing my role as a witness to Celeste's trauma, preparing quite literally to testify in the INS court to the psychological damage she had suffered. Exploring the therapeutic function of witnessing as a social process, Ullman (2006) maintained that witnessing must involve the actual existence of evil or injury. While I agree with the spirit of Ullman's argument, I suggest substituting the word *horror* for *evil*. *Evil* is an uncertain signifier, and, as the growing roster of natural disasters in the United States, in Indonesia, in China, and in Burma suggests, catastrophe can strike without evil intent.

It has become something of a cliché for psychoanalysts to describe themselves as witnesses to their patients' experiences (see also Thomas, 2008). Before this powerful concept has devolved into meaninglessness, I suggest a narrower definition by juxtaposing the concepts of recognition and witnessing. In a clinical context it may seem artificial to draw a sharp distinction between survivors of adult onset trauma and other patients who describe the small and not-so-small terrors of childhood and their ongoing difficulties in crediting these and later experiences, nonetheless I would argue that it is important to maintain a distinction between witnessing and recognition when that is possible.

Witnessing and recognition are both valuable concepts but they are too easily conflated. Pizer (1998) emphasized patients' urgent need for recognition. He described the fundamental quality of therapeutic recognition—"whether in verbal, gestural, or tonal form—is that the therapist is making an internal adjustment to the patient; the therapist is registering the imprint of the patient's state even while striving to preserve personal integrity and equilibrium" (p. 130). Often clinicians resonate to situations in their patients' lives with which they can identify only too well; locating parallel experiences and feeling states in themselves. These states are not identical to the patients', but they are familiar to the clinician. This often unacknowledged resonance between the patient's and analyst's experience signals a level of acceptance and understanding that, can be transformative and, at the very least, promotes deeper analytic reflection (Boulanger, 2008; Pizer, 1998).

However, in working with survivors of terror and violence, most clinicians cannot rely on this resonance, for they cannot claim to have had experiences of adult onset trauma. Ullman (2006) acknowledged the clinician's necessary separateness in such instances: "Witnessing is a distinct and curative function in which *the analyst's involved otherness* [italics added] enables recognition of a denied or dissociated reality." When resonating to a familiar affect state is not possible, clinicians must be prepared to serve as containers to terrifying and alienating experiences without losing their connection to the survivor. Inevitably that connection is sometimes lost as the clinician struggles against her own tendency to dissociate in the face of horror.

I was particularly aware of this dynamic during my brief encounter with Celeste. As she described her imprisonment and rape, the tension between joining and observing—the tightrope that clinicians walk in every session—dissolved, I became one with Celeste. My own boundaries were temporarily suspended as I absorbed horror, disgust, humiliation, pain, and grief that were to haunt me for several weeks. In my subsequent conversations with Celeste, I learned that knowing that I was a separate person who had voluntarily stepped into her experience, that I was prepared to bear witness to this experience, and bear up under the experience began the process of reanimating her object world, and reduced her sense of having been rendered untouchable by her rapists.²

²It is beyond the scope of this paper to discuss the particular difficulties that arise when therapists who have themselves sustained massive psychic trauma are called upon to work with patient survivors.

Sickness Unto Death: Catastrophic Dissociation in Guantanamo Bay

Celeste told me the idea to come to America occurred to her when she remembered the words of a song she had been taught in nursery school about America, the land of the free. Since I interviewed Celeste, America has ceased to be the land of the free. In the summer of 2007, I was invited to present a paper at the American Psychological Association's mini convention on Ethics and Interrogations (Boulanger, 2007a). This mini-convention was an attempt by the American Psychological Association to counter growing protests against their continued support of the presence of psychologists in Guantanamo Bay and other sites in which foreign nationals are held in violation of their fundamental human rights. I became familiar with the case I describe next as I was researching that paper.

An Arabic scholar and schoolteacher, Muhamad left his native Algeria to care for Muslim children orphaned during the Bosnian conflict. After the war ended, he married and settled in Bosnia. A month after 9/11, officials at the U.S. embassy in Sarajevo insisted that the Bosnian government arrest Mohamad and several other Algerian emigrants on suspicion of plotting to blow up the embassy. Ninety days later, when the Bosnian government concluded that there were no grounds for these charges, they were taken prisoner by American operatives; led onto a plane hooded, with earmuffs to prevent them communicating with one another; shackled to the floor, their hands manacled; and flown—with several stops in which more detainees were picked up—until 30 hours later, without food or bathroom facilities, 500 prisoners disembarked in Cuba in January 2002.

When his attorney met him for the first time in December 2004, no one had spoken to Muhamad except interrogators since his arrival. Notes from early meetings with his attorneys reveal Mohamad to be a scholar and a thoughtful strategist, contributing actively to questions about the disposition of his case, demonstrating his knowledge of international law and current events. He had a sly sense of humor and an ability to capture in words the impact of his detention and of being kept in solitary confinement. During the earlier period of his detention, these qualities led to his being singled out as a leader by prison authorities and detainees. In fact, when the commander of Guantanamo was preparing to leave his post in June 2006, he asked Mohamad if he could do anything for him. Mohamad asked to be sent to Echo *Block* rather than the block where he was being detained. But instead he was sent to *Camp* Echo and put into solitary confinement.

At that time, in addition to having been kicked in the head and suffering the violation of his religious practices, near suffocation, and the threat of attack dogs, Mohamad had spent more than half his 5 plus years in varying degrees of forced isolation. Isolation is one of the methods that Rejali (2005) called stealthy torture. It leaves no physical marks, yet the insidious effects of sensory deprivation and isolation have been well documented. Even those who do not have predisposing psychological disorders may develop paranoid delusions and schizophrenic symptoms in solitary confinement. Basoglu, Livanou, and Crnobaric (2007) concluded that isolation causes "at least as much if not more distress than some physical stressors" (p. 279). The Army Field Manual's (Department of the Army, 2006) guidelines for how much sensory deprivation and isolation a prisoner may be subjected to are clear: "Physical separation of an individual may only last for an initial period of 30 days. Any extension of that initial period must be reviewed by the Staff Judge Advocate and approved by the General Officer who initially approved the use of separation" (para. M-29). However, extensions are routine in Guantanamo.

On August 17, 2006, 6 weeks after being returned to isolation, Mohamad swore in an affidavit, "I have suffered being totally alone, not seeing the sun and not having anyone to speak with in a language I understand. I feel hopeless being here in isolation, with no reason."

Mohamad was in an 8 × 6' cell. A fluorescent light was kept on 24 hours a day, and the only window had been painted over, limiting the natural light; there was no distinction between day and night. He received no family mail, was not allowed to keep the legal mail he did receive, and was denied a pen to write his counsel. Five months after his affidavit was recorded, in November 2006, when his attorneys next visited him, Mohamad had lost approximately 38 pounds. At that time, his attorneys observed him talking to himself and bursting into spontaneous laughter and shouts apparently in response to hallucinations. In the moments when he could communicate clearly, Mohamad told his attorneys that he thought of killing himself every day.

At his attorneys' next visit, in March 2007, Mohamad would not respond to the invitation to visit with them and their requests to interview him in his cell were denied. "When he was informed we were there, we were told that he was lying listlessly on his bunk staring at the wall. He has been unresponsive for some time," his attorney told me.

Mohamad's symptoms take the concept of catastrophic dissociation to a new level. Agency, affectivity, the sense of time, the sense of a self that inhabits a body, the relationship to others are no longer in evidence. Krystal

(1978) described this as a lethal surrender pattern. “The physical immobilization observable in this state is accompanied by a massive blocking of virtually all mental activity, not just affects, but all initiative” (p. 94). The sudden outbursts of activity, such as suicide attempts or self-mutilation, or the shouts reported in November, represent a life saving attempt at mastery, a bid to interrupt the state of helplessness and avoid the process of surrender. These behaviors grow out of the need to create some kind of stimulation to distinguish inside from outside. But these last-minute protests appear to have ended by the time Mohamad’s lawyers returned in March 2007. The psychological surrender had become lethal. A year later, Mohamad is no longer in solitary, but he still refuses to interact with his attorneys, who had earlier been a source of comfort and hope to him. He does not leave his cell. It is not clear that he can be engaged by anyone.

We have to be careful about making comparisons between the Holocaust and the current situation in camps where the U.S. government is holding detainees without due process. But psychogenic death is psychogenic death whether it occurs in Auschwitz, where Henry Krystal observed it, or in Guantanamo Bay, where it is observed by attorneys seeking to bring justice to their clients who have been detained illegally, sometimes for over 6 years.

The necessity to bear witness to destructive social forces often takes us out of our consulting rooms and into the political arena where we are called upon to offer testimony, as I did in the case of Celeste, or to speak out against injustice, as I believe is important in the case of Mohamad. These are extreme examples. Increasingly survivors of violence and terror find their way into clinics and our private offices, where we do well to remember the ways in which our clinical stance and theoretical understanding must be modified to accommodate the singular needs of those who have been wounded by reality.

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