

TRAUMA, SHAME AND PSYCHOTIC DEPRESSION EXPERIENCED BY ex-POWs AFTER RELEASE

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SUMMARY

Modern societies are growing ever more sensitive to the various sources and many kinds of psychic traumas, resulting even in psychotic reactions or states of functioning. Especially the war captivity situation represents the prolonged basis for chronic severe psychic stress and traumatising, that may become deleterious even for the core self of the person.

Severely psychotraumatized war veterans, or ex-POWs in the aftermath of the war captivity situation, survivors of extreme forms of violence and humiliation, are very reluctant to recall traumas. This avoidant behaviour is many times one of the most prominent symptoms that should be recognised and confronted in order to start the retraumatising process of healing the previously unthinkable traumas. The authors believe that shameful feelings are at the very basis of the psychotraumatized persons' withdrawal, depression, suicidal attempts, and even psychotic answers. The main feature of the first phase of any therapeutic work with these patients is the mourning process that should be gradually unfolded. The clinical examples will illustrate therapeutic work with these patients.

The authors will expose some basic psychodynamic approaches and concepts regarding shame. This difficult feeling will be put in relationship with the psychotic answers. In that frame of reference the concept of 'near psychosis' will be described.

Key words: war - concentration camp – depression – shame - psychotic functioning

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Community under stress: Traumas and losses

After the introduction of posttraumatic stress disorder (PTSD) in DSM-III classification of mental disorders a great deal of knowledge has been accumulated from various sources of man and nature made disasters. Nowadays it is known that nature-caused disaster has not the same deep and durable impact as man – induced ones. The traumas and losses due to the collapse of the community life styles and structures cause severe stress not only to individuals, but family lives, and the social and cultural tissue at large. The consequences of war deeds have not only an immediate impact, but leave long shadows that are difficult to deal with. The Renaissance writer from Dubrovnik, Marin Držić (1979:10) wrote that war is the woe of human nature. The Croatian society, as part of the Yugoslav state that was undergoing the process of falling apart, at the end of the 20th century had to pass through another woe of that

kind, after having suffered two world wars and experienced three entirely different political and social systems.

The war in Croatia (1991-1995) and in Bosnia and Herzegovina (1992-1995) caused many great resettlings of population according to their ethnic and religious identity. Besides becoming refugees or displaced persons many perished in armed clashes and campaigns, and some had to pass through tortures in prisons and concentration camps. Many lost not only their properties, and with that their roots were cut, but even their family members, friends and neighbours. At the psychosocial level the acknowledgement of all these traumas and losses had to be recognised, in order to enable the process of grieving to develop. As almost one third of Croatia was occupied by what remained of the former Yugoslav army that was taking the side of the Serbian nationalist leadership. From their point of view the Croatian resistance was seen as enemy activity and not only

soldiers but even civilians were captured. Many were shot without trial, many put in concentration camps.

People that joined the resistance, that was with time transformed into the Croatian army for the greatest part were not professional soldiers, and the situation of an active front line was completely new for them. They had to accept killing, as well as other forms of liquidation of enemy soldiers and armed civilians of the other ethnic groups from the region swept by war. The bloody dying process of one society and ideology and the emerging of the new ones had very strong and stable roots in actual political transitions and inter-and-transgenerational transmissions of emotions, 'chosen traumas' and 'chosen glories' (Volkan, 1979).

The sociopolitical earthquake: Reframing life framework through war events

Describing PTSD in its various ethiological factors, severity and duration it is important to understand that Croatian psychiatrists, psychologists and other helpers from psychosocial fields were sharing the same situation of threat and dangers as the soldiers and refugees. These circumstances were creating the very specific situation which could be compared, up to some degree, with the situation in Israeli and Palestinian lands, where helpers and people to be helped are sharing the same threats and dangerous security issues.

The warning about countertransference, in these cases, is very appropriate, due to the possible countertransference difficulties regarding being overwhelmed with extraordinary life events, or trying to avoid emotional enmeshment (Urlić 2005). Nevertheless the helping professionals were well aware of these countertransference traps and so constant supervisory processes should have been kept in action continuously to ward off at least some major deviations from the therapeutic lines on various levels, or burning out. The multiple social synapses were completely stirred up. Among many defense mechanisms that were set in motion, like massive projections and projective identifications, dissociations and splittings, negations and primitive idealizations, the world in these days had lost its colourfulness and has become black and white, i.e. good or bad, reliable or diffident, holding or exposing, friendly or on the enemy side (Urlić 2009, Cozolino 2006).

The prevailing psychological features was the one of heavily disturbed attachments, and blaming for guilt was projected on the side of perpe-

trators, while victims were perceived only as heroes or sufferers. From this developed a kind of psychology of the severely and and endangered social synapses, structures and boundaries. Through the following two clinical examples the authors will expose the cases of one ex-POW and ex-soldier – veteran of war that presented themselves as overloaded by feelings of guilt. They were complaining that these guilt feelings proved to be 'untreatable'.

Life stories and therapeutic interventions

Clinical example 1

It was in 1994, the third year of war in Croatia. Yugoslavia was split off into several new states that were struggling for their independence. Croatia and Bosnia – Herzegovina were in a total war situation. Cities were shelled, territory divided among uniethnic armies that were controlling different provinces. The land was devastated due to war activities. Houses burned, inhabitants fleeing the war zones have become refugees, searching for some secure place where to survive. By that time it was still impossible to see the end of that war. Many refugees have found shelter in Croatia, mostly in touristic facilities.

We, Croatian psychiatrists, psychologists, social workers and members of the other complementary professions, have organized ourselves to offer help, either as local facilitating groups or in the frame of reference of great international helping organizations. The confrontation of professional helpers with pains and needs of refugees occurred almost daily, and supervision was offered to prevent the development of burn-out syndrome.

Amidst that war situation the Ministry wanted to control the number of refugees and their territorial distribution. That was the formal cause of encounter with the lady from Vukovar (I.U.).

Vukovar is a Croatian city on Danube and at the border of Serbia. It organised fierce resistance to the occupation by the Yugoslav Army and Serbian paramilitary units. After almost three months of siege the city was captured and the population was sent to concentration camps, prisons in Serbia, or were shot dead and their corpses were thrown into mass graves. It was there that the story of the lady from Vukovar started, when I met her in the outpatient department of the Clinic for psychiatry in Split.

She appeared as a very thin, pale female creature, uncovering with her outward careless

attitude. She was not showing any expression or emotion. Declining to take a chair she let two forms slip across the table towards me, saying that she needs these forms filled up for her husband and for herself. At first she was very reluctant to enter into any dialogue with me, repeating: „Please, fill up these forms because I'll miss my ferry. After a while she confessed that recollecting the days of the fall of Vukovar and what has happened after was always very traumatic to her. That day she was taken away from Vukovar, and after passing several prisons she was put in a concentration camp for women. Previously it used to be a cow farm. She shared one box with two other Croatian women. Almost every night the guardians were getting drunk and were mistreating them. The two other women were often raped. She was pregnant in a visible way and the guardians were playing sexual games even with her, but she was at least spared of being raped. That 'unequal treatment' provoked in her feelings of guilt in front of her cell-colleagues. After three months she was exchanged through Red Cross negotiations and found herself in a Croatian centre for refugees. There she found that her husband was alive and she could reach him in a few days time. Soon after that she gave birth to a boy. They were supposed to become a happy family again, at least because all of them had survived.

But she could not feel calm and satisfied. She was losing her appetite and body weight, becoming more and more like an anorexic girl. Resuming intimate relationships with her husband and taking care of their child and the room in the hotel for refugees she was practically dying filled with enormous anxiety and feelings of unworthiness.

As a traditionally brought up, religious person, trying to avoid ideas of suicide, she decided to make a confession to the priest. The priest said that it was not her fault that she was the object of sexual maltreatment, that the guilt lay with the concentration camps guardians and that she should pray for the souls of the abusers. She followed the advice but it did not bring any calm to her. She could not sleep and was feeling even more exhausted. Then she decided again to commit suicide and started to collect medicines. Having dilemmas and remorse she went to another priest, but he took the same attitude as the first one. Then she decided to finally end her life of hell. In the meantime the forms arrived and her husband asked her to go to see the psychiatrist according to the request of the Ministry. „That's why I am now here“ she concluded in a very unaffectionate way.

„Could you name the pervasive feeling that is so deeply disturbing to you?“, I asked.

What followed was long silence. It was impossible to find out her emotions from her pale, expressionless face.

„May I help you in searching for the name of your terrible feelings?“

She slightly nodded.

„Might it be the feeling of shame that is overflowing day and night?“

Her face remained stony, motionless. I started to fill up the forms. After some time the stream of tears was pouring down from her eyes. She was crying silently, without any sound, or gesture. Then she has become able to utter that she was feeling „dirty“ in front of her husband because she was sexually maltreated. Nevertheless she was forced to endure the situation that she was feeling shameful in front of him and herself. Then she added that if her parents were alive they would prefer to see her dead than to see her as a survivor with that shame on her and on the whole of the family. She did not feel guilty, but shameful due to the unimaginable sexual maltreatment she had to endure. That experience has made her feel like a whore, cheating her husband and bringing shame on the whole family, ancestors included.

I asked her whether she could talk with her husband more openly about her experiences. He has been in the concentration camp for men. Did they talk about his experiences? She decisively refused to open that topic with her husband. „I am sure that he could understand the situation I was in. But, he might start feeling disgust towards my body, or me as a person... besides, there were rapes in camps for men, too... No, I don't want to touch that topic with him“.

Handing over the forms to her I asked her whether there is anything else she would like to share with me. There were no answer. She took the forms and went to the door. Then she turned towards me and looking at me with her tearful eyes she said: „Thank you for enabling me to get in contact with my tears. I couldn't cry for almost three years“.

We could arrange the psychotherapeutic encounters. When she has become able to confront the feelings of shame suffered in the concentration camp, and the perception of her putting shame on the whole family, ancestors included, she started to work through these feelings which were so devastating for her. Then she had to finish psychotherapy because of circumstances that were unfavorable regarding her travelling to Split.

Clinical example 2

At the beginning of the war in Croatia, in autumn 1991, I (I.U.) met a Croatian soldier who was searching for psychiatric help after being released from a Serbian concentration camp. This ex-POW was about 20 years old, single, living with his parents as a refugee. His small town was occupied by the Serbian paramilitary units and his family were ousted as Croats. He then joined the Croatian army that was in its beginnings. The front line was not firmly established in many spots. During one military action he found himself and a few soldiers of his unit encircled in a village. In a panicky situation he entered a pigsty and for three days he drank dirty water left by the pigs. Living in that stench the situation had become unbearable. He could hear voices of enemy soldiers, some threatening if they would catch any Croat. In spite of great fears he decided to surrender.

He passed three weeks in a concentration camp for Croats. Even mentioning that experience he started to shiver and said that he was overwhelmed by feelings of fear and anxiety. By the same token he was blushing, sweating and withdrawing. Regarding his concentration camp experiences he confessed that he was maltreated physically and psychically, being humiliated and exploited in dishonest, shameful ways.

During psychotherapeutic treatment he could only repeat his complaints, especially experiences from the concentration camp, but was unable to elaborate these recollections. In that way his anxieties, and fearful attitudes have become repetitive, without any possibility of gaining some insight and working through of the accompanying horrible emotions. He withdrew from his friends and couldn't even think on establishing a closer relationship with a girl.

After two years his psychic functioning was still deplorable, and he was unable to share his worst experiences in a more detailed way.

He decided to go to the USA in order to change the ambience, and asked me whether I could get him in contact with a good psychotherapist, which I did.

Three years later he reappeared in Croatia. His outlook had not changed much during these years. He brought the letter from the American psychotherapist saying that the patient could not develop a trustful enough relationship to enter into an more ambitious psychotherapy. The impaired capacity for closeness and trust was obviously the expression of impaired core-self from suffering

tortures that had even included elements of sexual maltreatment. Experiences of this kind provoked deep feelings of being put into a shamed position and the topic was unspeakable for the patient. The proposal for further elaboration of feelings of shame could not be accepted by this patient, thus encapsulating even more the worst aspect of highly traumatic experiences.

Fears and silences: The multiple deaths

Encountering many ex-POWs the almost general attitude that could be observed was the tendency to encapsulate the horrible memories. Due to that fact the psychotherapist knows that helping these patients to recollect their most painful memories means for him/her a retraumatizing experience. This is the only way to bring these deep inner wounds to the possibility of emotional and cognitive elaboration. One of the authors (Urlić 2004) wrote, talking about deep emotional wounds, that the 'inner innocence' of severely traumatized persons was killed by the facts of war, that changed them profoundly. The approved expression of psychic stress in various culture patterns varies. In our clinical examples, as well as in many other therapeutic experiences we could reconfirm this notion. In the case of the lady from Vukovar, the institutionalized confession as a means of relieving psychic stress did not bring about a desirable solution (Hallowell 1936). Because of this, one of the very fundamental strategies in coping with trauma is naming of the feeling that oppressed a war veteran, exPOW, or otherwise deeply hurt person. By finding the true name of the condition and by being no longer imprisoned in the wordless condition of the trauma, a deeply hurt person can start the process of mastering the problem. Through the clinical examples it is possible to follow the vicissitudes of fear of shame that were secluding patients in silence. Their silence about the most profound psychic wounds connected primarily with feelings of shame turned out to be, as a matter of fact, 'outer' phenomena, while their inner worlds were continuously echoing the horrendous, 'unspeakable', experiences that they were not able even to mention.

The precondition to work through deep traumas and their longlasting shadows is to create the possibility to mourn the losses. Bouza and Barrio (1999), writing about the mourning process consider that the normal working out of the loss requires going through all the stages, which takes

about one year on average. In order for the process to take place without major problems the stage of anger and its venting is absolutely necessary, as well as relinking with reality. In treatment of pathological mourning they distinguish four main goals:

- preventing repression: to enable the patient to remind and relive the events;
- emotional support: to compensate for helplessness;
- social assistance: an apprenticeship in coping with life events and problem-solving skills;
- reconstructions: establishment of new bonds.

In her book on 'Understanding Trauma' Garland (1999) wrote that mourning is always immensely hard work, even when the relationship was relatively straightforward. The individual may feel he/she simply does not have the internal resource to do this work in the context of feeling that his/her own personal world is in pieces. Some of that mourning must be for him/herself, for his/her own lost world, his/her own pre-trauma life and identity.

Parkes (1998) distinguishes three main components that affect the process of grieving: The urge to look back, cry, and search for what is lost, and the conflicting urge to look forward, explore the world that now emerges, and discover what can be carried forward from the past. Overlying these are the social and cultural pressures that influence how the urges are expressed or inhibited. The strength of these urges varies greatly and changes over time, giving rise to constantly changing reactions.

Through our clinical examples we wanted to explore the vicissitudes of two patients, i.e. two kinds of patients that the deep, untouchable feeling of shame was blocking in developing the mourning process regarding lost parts of their ideal – egos. It was obvious that their dignity has been affected and that they have been reduced, by the 'Other', to the level of a shameful object (Bernard 2006). They were confirming what Bettelheim (1986) said that what cannot be put into words cannot be put to rest. The poisonous pressure of deep hurts and connected shame feelings, causing fears and anxieties, but covered by silences, cause the 'multiple deaths phenomenon' in our patients. Due to the deep trauma they remained emotionally and socially 'dead'. This feeling of dying out was very present in both of our patients, as well as in many others. We are suggesting that in all cases of severe psychic traumas the issue of shame should

be explored, because it represents an intimate part of the core essence of psychotraumatized people.

Trauma and psychosis: Elaboration of deep wounds

Nevertheless various traumas can provoke shameful feelings, the feelings of shame are a traumatizing experience in themselves. Rustomjee (2009) considers shame to be the most personal and private of all feelings. It is not easily visible as an emotion, and one can feel extremely vulnerable and overwhelmed at the thought of sharing an unresolved experience of shame, even with one near and dear. When the shame experienced is high in intensity it is experienced with feelings of intense humiliation following discovery. „One's credibility, honour and very essence of self worth as a moral and ethical person can be so easily threatened when a potentially shame producing event in one's life is brought out into the open and referred to with contempt“. Because of these reasons people try their utmost to avoid a confrontation with shame, and numerous resistances try to prevent the shame laden topics from emerging into consciousness. The person feeling deeply shamed is at high suicidal and/or homicidal risk, i.e. his/her shame can bring about lethal consequences. According to some research results, after torture the most common reaction was major depression or dysthymia in 60% of released torture victims, while some 10% were fulfilling criteria for functional psychosis (Wenzel et al. 2000).

The phenomenon of 'multiple deaths' is disclosing the essential lesion of the core self, even bringing about defenses of psychotic character. We would like to suggest that the concept of 'near-psychosis' (Marcus 1992) may well serve as a concept that helps discern the shame as a trigger of some previous disorganised psychic functioning from the reactive psychotic state. There is evidence that in reactions due to extreme environmental stress a condition related to psychoses or a borderline state exists (our clinical examples 1 and 2). The chronicity of the condition, the clinical symptoms and poor response to treatment (very often) support the hypothesis that severe trauma results in unmodifiable ego changes (Grauer 1969, Lavallée 2003). This leads to ego exhaustion and changes in the ego - superego boundary as a result of guilt and shame feelings. Following this point of view the reaction to some deep traumas causing bleeding psychic narcissistic wounds can provoke the psychotic answer. It can indicate, as stated

above, the development of reactive psychosis or exacerbation of a psychotic state in the frame of reference of the psychotic personality structure, or 'near – psychosis'.

The concept of 'near-psychosis' was developed by Marcus (1992). According to that concept, near-psychosis, like psychoses, represents a mental state when a realistic experience is used to express an emotional experience. That phenomenon the author calls near – psychosis, because the resulting condensation shows that it almost took the place of the conscious realistic experience.

The near-psychotic answer of persons that previously did not function on the psychotic level is different from the 'real' psychotic answers in to following characteristics:

- The structure of condensation is located in the preconscious;
- The reality testing processes are not part of the near–psychotic condensation.

What results from our theoretical considerations and clinical experiences, is illustrated by the two clinical examples. These illustrate severe stress – and here we are taking into focus the vicissitudes of exPOWs – and it is not easy to enable the patient to disclose very deep narcissistic wounds and connect with their consequences. In the aftermath of severe trauma experience the decompensation of psychic life can be shown in the clinical picture of complex PTSD that with some characteristics is well described by the concept of 'near- psychosis' (Urlić & Tocilj-Šimunković 2009).

Essential in the therapeutic approach is that all losses have to be mourned. This concerns loss of self respect, safety, physical ability, rights ... etc. All this should be recognized and acknowledged. Only in that way it is possible to assess losses on a more realistic level and to integrate representations of their most desirable aspects into the core self. Being overwhelmed by feelings of shame represents an additional difficulty for the therapeutic approaches. Therefore, we are advising that special attention should be paid to deep hidden feelings of shame connected with important losses.

Epilogue

Some five years ago there appeared at the door of my consulting room (I.U.) a well-looking lady, entering with another woman who was obviously distressed, and trying to push forward an embarrassed boy of 12-13 years. She said: „You won't recognise me. I am the lady from Vukovar

and this is the boy I was mentioning to you when he was just a little child and I was in deep psychological crisis. Here is one of my best friends and I hope you'll help her as you helped me. I'll come another day to tell you how my life proceeded after our sessions“. So far she has not visited me and I believe that after overcoming the main feature of her distress caused by war deeds she flew away like adolescents do, feeling their wings strong enough to let them fly freely and self – confidently.

The male patient, exPOW, after visiting when returning from the USA, did not show any more.

Through many experiences from therapeutic approaches to people traumatized by many aspects of war, where the victimhood and sense of guilt look like prevailing in the emotional and cognitive spheres, we are suggesting that the issue of shame should not be neglected as one of the major causes of severe traumas and their consequences.

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