

# Self-harming behaviour and dissociation in complex PTSD:

*Case study of a male tortured refugee*

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## Introduction

Self-harming behaviour has been found to be related to experiences of torture and life-threatening events among some refugee populations.<sup>1</sup> The issue of intractable pain<sup>2</sup>, specifically associated with torture sequelae has had a central role in the identification of clusters denoting increased self-harming and risk-taking behaviour among traumatized refugees. The pathological environment of prolonged abuse such as incarceration and rape, fosters the development of a remarkable array of psychiatric symptoms.

The identification of Posttraumatic Stress Disorder (PTSD) in refugee populations,<sup>3,4</sup> and reactive dysthymia or major depression,<sup>5</sup> associated with combat experiences,<sup>6</sup> together with stressors related to captivity, incarceration and torture<sup>7</sup>, have suggested a focus on comorbidity issues with respect to PTSD in refugee populations. Kramer et al.<sup>6</sup> reported that Vietnam veterans with diagnosis of PTSD plus depression exhibited more suicidal and self-harming behaviour than those with PTSD alone or

depression alone. Ferrada-Noli et al.<sup>7</sup> found that among refugee samples, 56% corresponded to subjects diagnosed with both PTSD and a depressive disorder.

There have been some, albeit limited, studies on the high prevalence of passive self-destructive behaviour<sup>8</sup> and frequent suicidal ideations containing expressions of self-condemnation, guilt, anger or obsessive re-enactment of a torture theme. Some clear associations have been found between torture methods and the preferred suicidal methods. For example, Ferrada-Noli et al.<sup>2</sup> found interesting associations in a sample of 65 refugees who had survived torture. They found that out of 18 of the cases who had been subjected to blunt violence to the head and body, 14 reported jumping from a height or in front of a train as the content of suicidal ideation, of the 6 cases subjected to water torture (submarino) 5 reported drowning as the content of suicidal ideation, of the 5 cases subjected to sharp force torture, 4 had attempted stabbing themselves and of the 3 cases subjected to asphyctic torture, 2 had considered hanging as a method of suicide.

Repetition of harm following prolonged traumatization has been noted to be sequelae of severe trauma.<sup>9</sup> Many traumatized people expose themselves, seemingly compulsively, to situations reminiscent of

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the original trauma. Van der Kolk<sup>10</sup> has reviewed the topic in depth noting that the repetitive phenomena may take the form of intrusive memories, somato-sensory reliving experiences or behavioural re-enactments of the trauma. These behavioural re-enactments are rarely consciously understood to be related to earlier life experiences. This “repetition compulsion” has received surprisingly little systematic exploration during the 70 years since its discovery, though it is regularly described in the clinical literature.<sup>11,12</sup> Freud thought that the aim of repetition was to gain mastery, but clinical experience has shown that this rarely happens, instead, repetition causes further suffering for the victims or for people in their surroundings. Van der Kolk<sup>10</sup> reported a case of a Vietnam veteran who had accidentally shot a friend during the war, and every year, on the exact anniversary of the event, he would commit armed robbery, staging a hold-up, provoking gunfire from the police.

In an attempt to systematize these scattered observations, Horowitz<sup>13</sup> suggested that there may be an identifiable “posttraumatic character disorder” following certain forms of severe trauma whereas others such as Marmar<sup>14</sup> and Herman<sup>15</sup> have proposed the introduction of a category of “Complex PTSD”. Roth et al.<sup>16</sup> suggests that Complex PTSD is needed to describe some specific symptoms of long term trauma which are particular to captivity such as concentration camps, prisoner of war camps, prostitution brothels or child abuse. The first requirement for the diagnosis is that the individual experiences a prolonged period (months to years) of total control by another person/ persons. The other criteria are symptoms that tend to result from chronic victimization. According to Herman<sup>16</sup> these symptoms include:

*Alterations in:*

- a) Emotional regulation, which may include symptoms such as persistent sadness, suicidal preoccupations, explosive anger and difficulty modulating sexual involvement.
- b) Dissociation, having episodes in which one feels removed from one’s mental processes or body.
- c) Self-perception, which may include a sense of helplessness, shame, guilt, stigma and a sense of being completely different than other human beings.
- d) The perception of the perpetrator, such as attributing total power to the perpetrator or becoming preoccupied by the relationship to the perpetrator, including a preoccupation with re-enactment of trauma.
- e) Relations with others, including isolation, distrust and a repeated search for a rescuer.
- f) One’s system of meanings, which may include either sometimes sustaining faith or at other times sense of hopelessness and despair.

In addition, survivors of extreme trauma may use excessive alcohol, drugs or sex as a way of distraction and removing themselves from the trauma and alleviating psychological and emotional pain. They might also engage in self-mutilation and other forms of self-harm. For a substantial proportion of traumatized patients, the combination of Complex PTSD and depression causes people to seek psychological treatment.<sup>17</sup>

Although these findings are important, the associations found between specific forms of torture with the contents of self-harming behaviour deserve further study. To date, there have been no studies which focus on the specifications to the complicated path leading to re-enactment or reliving of the torture experiences. In the following case-

study, the case of a Mr. “X”, a male survivor of severe torture, specifically multiple rapes, some possible suggestions for the re-enactment, reliving and high risk-taking behaviour have been proposed. The purpose of the study has been explained in detail to the patient who consented to his story being written and disseminated to other professionals. The case is incredibly intense and complicated. The complete story is more extensive than the scope of this article. For the purpose of this article only some of the main issues namely anger, dissociation and extreme sexual acts as self-harming behaviour will be discussed. Other important issues such as his obsessional behaviour, coping mechanisms and the use of sex as coping, will be discussed in a future paper.

### Case study: brief background

A male in his early sixties was referred to The New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) by a Sydney based sexual health clinic consultant who became concerned about the person’s request for an elective bilateral orchidectomy. The patient could not explain the urgency behind the request, however he mentioned that he was a survivor of torture.

Initial assessment indicated that he was born and raised in a healthy, happy and functional family, where he always felt loved and cared for. Mr. “X” described his early life as uneventful and denied any sexual or physical abuse. He was married with young children, working in public service in a relatively junior position, when he was arrested at around the age of 40, with alleged political charges, although he denied any connection to political or religious activities. He was imprisoned for two and a half years, tortured and raped by 5 prison-guards all through the duration of incarceration. Some

of the torture methods that he experienced were:

- Multiple rapes and other sexual violence by the prison guards
- Inserting a hose in his rectum, forcing hot water inside to wash and discharge excreta (almost 3 times a week)
- In case of accidental defecation at the time of rape, he would be subjected to severe beating and electric shocks
- Beaten on soles of feet with batons (Falanga)
- Mock execution numerous times
- Noise torture
- Starvation
- Fed excreta
- Placed in cold, then hot water
- witnessing murders of friends.

He was finally released when he signed a false confession. For the next several years, while staying his own home country, he lived plagued by hate, sadness, and a sense of betrayal and intense anger towards his wife who had left the country with the children during his incarceration. He started compulsively following strange women in the streets, swearing, degrading and humiliating them. According to him, after every “swearing session”, he felt revitalized and invigorated. During this time, Mr. “X” experienced recurrent nightmares, flashbacks of the rapes by the prison guards, continuously reliving and feeling that he was in the cell being raped, and would “wake up” trying to punch the imaginary person off his body. He had two significant dissociative episodes where:

- 1) he broke the shower screen and the door with his own hands, unable to recall the event,
- 2) he broke a large glass wall in his house with his own hands, and did not know

how it happened (realised only by the injuries/bleeding on his own hands). He speculated that it might have been a way for him to “break free” of the pain that he was enduring.

At around the same time, he started having homosexual fantasies which he resisted for a while. Consequently, he started an extremely promiscuous behaviour, frequenting female prostitutes in order to “fix” his homosexual ideations. He came to Australia in 2002. By coming to Australia, he lost the limited social network and support that he had in his country. His feelings of anger and abandonment and the dissociative episodes increased, where he would find himself in the middle of the highway at midnight, only “waking up” from the cold breeze.

### Assessment

Over the course of six evaluative sessions, the mental state of Mr. “X” was assessed by administration of the Structured Clinical Interview for DSM-IV Axis I Disorder (SCID-IV)<sup>18</sup> as a screening for mood disorder and anxiety disorders. The SCID-IV is a structured clinical interview developed to determine the presence of psychiatric disorders as identified in the 4th edition of the Diagnostic and Statistical Manual current and past lifetime episodes of psychopathology. Moreover, the Structured Interview for Disorders of Extreme Stress (SIDES)<sup>19</sup> was used. This is a specific measure for complex PTSD and provides a comprehensive assessment of trauma history, past and current functioning and symptoms such as dissociation, disruption in self-perception, disorders in relationships, affect regulation and somatization. Moreover, the Hopkins Symptom Checklist-25 (HSCL-25)<sup>20</sup> was used at pre-intervention, intervention and post-intervention periods, in order to evalu-

ate intervention efficacy. The HSCL-25 is a well-known and widely used self-report instrument which measures levels of anxiety and depression.

The patient was also referred to a physician who assessed him for general medical conditions, and results indicated no evidence of physical impairments or dementia.

### Clinical presentation

Mr. “X” presented as a reasonably healthy man of medium build, wearing casual clothing. He was punctual, polite, pleasant and engaging. His speech had regular tone and rhythm but was often slow, as he appeared to be very deliberate in his choice of words. His affect was somewhat restricted, with a normal range; it varied in accordance with the content of the dialogue. His thought process was linear and clear. He acknowledged self-harming ideations but denied suicidal thoughts at the time of the examination. There was no evidence of psychotic symptoms. His capacity for self-reflection, insight and judgment were adequate and appropriate to the context of the consultation. In general, his thinking about a number of topics appeared to be flexible throughout the interview, yet he was concrete and fixed. His manner, punctuality and general behaviour has been consistent over the course of his treatment.

### Psychological review of symptoms

Following a complete assessment of the presenting symptoms, some of the psychological symptoms at the time of assessment at STARTTS were: Depressed mood most of the day, fatigue and loss of energy, diminished ability to concentrate, suicidal ideation, psychomotor agitation, lack of sleep and significant weight loss. He insisted that homosexual fantasies were causing his night-walking, and that he was going “crazy”.

He reported that he was unable to cry and grieve for his traumatic past, which was adding to his distress. He felt that crying would seem like he was losing control over his emotions, hence he would stop himself from crying.

As most of the rapes and other torture occurred during night time, he was experiencing fear of the night, where he would lock himself at home at night refusing to answer the door or the telephone. At night, he would run all the way home from the train and reach home out of breath, sweating and shaking. Also, he experienced an intense phobic reaction to groups of males in the streets. If he saw a few men walking in the street together, he would hide until they walked away. He reported shaking, sweating, heart pounding, acting and feeling as if they were about to attack him.

### **Risk taking behaviour**

Mr. "X" reported that before presenting to STARTTS, he had begun frequenting male "baths" where he had sexual relationships with numerous men. He tried to have as many sexual partners as possible, regardless of the use of protection, in order to record the number of encounters on his calendar. He revealed that the reason for this ritual was to collect (almost as a trophy) more sexual encounters than he had had in prison. If he were to miss a day of the "baths", he would compensate by staying for 48 hours without sufficient food or sleep on the next visit, in order to collect numbers of sexual encounters.

An interesting psychological symptom is that he had recurrent nightmares about the 5 prison-guards raping him, where he woke up shaking, screaming and had trouble breathing. On the other hand, when in the "baths", he experienced and enjoyed having sexual fantasies about the same men who

violated him. During assessment, he referred to himself as "Dr. Jekyll and Mr. Hyde".

Although having a very low threshold for pain (e.g. fainting at the slightest discomfort), when in the baths he reported volunteering to receive severe beatings and engaging in violent sexual acts for what he assumed could be up to 45 minutes, which he later did not remember. He only "woke up" after the act, when the sexual partner left, and he realised he had been bleeding. He expressed that he did not have any suicidal plans, however, if he were to accidentally die during a "violent session", that would be a desirable outcome for him.

### **Treatment**

Compulsive repetition of the trauma usually is an unconscious process that, although it may provide a temporary sense of mastery or even pleasure, ultimately perpetuates chronic feelings of helplessness and a subjective sense of being "bad" and out of control. The goal of the treatment is gaining control over one's current life, rather than repeating trauma in action, mood, or somatic states.

Mr. "X" has been visiting STARTTS for weekly sessions for a year and a half for support and treatment. Parts of the "Phase Oriented" treatment programme specific to complex PTSD by Luxenberg et al.<sup>17</sup> were adopted for this patient.

As initially his numerous phobias were affecting his everyday life a Stabilization Phase was necessary to assist the patient in making sense of his experiences. In this phase, the treatment was supportive and reparative rather than explorative. Basic psychoeducation about the effects of trauma on individuals and his symptomatology was provided. It included a rationale and explanation for the specific symptoms: the flashbacks, nightmares, panic attacks and

intense fear. He was encouraged to keep a Mood Diary in order to record his feelings, different moods, thinking pattern and daily experiences. Such identification allowed him to begin evaluating realistically the amount of danger actually present in his current environment, rather than continually experiencing panic attacks in situations. Issues of safety were discussed in detail. In a few months following the commencement of sessions, he was able to identify flashbacks, nightmares and anxiety provoking situations, and explain to himself that these were merely reactions of his past experiences. He started expressing that the behaviour was pathological but no longer inexplicable.

In this *first phase*, recovery and safety were also focal issues. An additional strategy was to teach the patient relaxation and distraction techniques so that he would be able to perform the exercises without help from the therapist. Progressive muscle relaxation, deep breathing and guided imagery were introduced to the patient. During the end of phase one, the symptoms of panic regarding crowds, men in the street and neighbours were eliminated and his Hopkins Anxiety rating decreased from 3.4 (highly symptomatic) to 1.2 (non-symptomatic). Also the anger reaction towards women had subsided.

*Phase Two:* This stage involved the processing and grieving of traumatic memories and exploring the traumatic events in depth. The aim was to integrate the traumatic memories into a coherent narration of the patient's life, along with desensitization of the intense negative affect associated with these memories. This stage is the longest as it incorporates allowing the patient to express his feelings, re-live the traumatic events and re-tell his story. This helped him in desensitisation of the trauma facilitating the gradual decrease of painful memories.<sup>5</sup>

This stage helped address the alter-

ations in the individual's meaning systems by instilling a sense of hope for the future that it is no longer merged with a traumatic past. Because of the severe and complicated nature of the present case, exposure-based treatment, as advised by Luxenburg<sup>17</sup> was not used. Instead, close attention was paid for signs or accounts of dissociation, helping the patient in "grounding" himself. As the dissociation usually happened at night at his home, the patient was taught techniques to deal with the episodes using identified objects (blanket and a family picture) to ground and reassociate himself. A contract was prepared by the patient and the therapist as an agreement regarding suicidal ideation and the steps which he could take if and when thoughts of ending his life would come to his mind. An important positive outcome of this stage, perceived by him, was that he became able to cry and express his pain while telling his story.

*Phase Three:* This stage involved reconnection and integration of his experiences at the level of faith, vision of life, perception of self and others as well as personal and social values which he found important. Unencumbered by many of the initial after-effects of chronic trauma, attention was now shifted out into the world of relationships. New friendships, membership with various associations, hobbies and activities were explored and encouraged. Consequently, the patient became connected with his religious group, cultural association and a support group for refugees. This does not mean that traumatic material was no longer present, but it was not the preliminary focus of this phase of treatment. Moreover, it no longer consumed the patient's life or sense of self.

By this stage, he had stopped writing the number of sexual encounters on the calendar, agreeing that this was increasing his risk-taking behaviour. Moreover, during the

last few months, he has refused unprotected sexual encounters.

Another major positive outcome of this stage was regarding his dissociative episodes. He has encountered two situations over the last three months where he “woke up” during a violent sexual act and realised what was happening. He stopped the person before further bleeding occurred and went to the hospital for treatment. Feeling the pain during the violent act was new and frightening to him, however he expressed that it made him feel “human”.

### Discussion

Survivors of rape who seek professional help present with a variety of symptoms. Detailed inventories of their symptoms reveal significant pathology in multiple domains: somatic, cognitive, affective, behavioural and relational.

In a torture setting, the victim’s perception is not that torture is transient or non-lethal. To the contrary, what is perceived by the victim is the threat of his/her physical annihilation through the systematic repetition of torture, a threat which is often verbalized by the torturer. In addition to inducing terror, the perpetrator seeks to destroy the victim’s sense of autonomy.<sup>15</sup> In the present case, the insertion of water, forceful emptying of the intestines and beating in case of defecation is an ultimate act of controlling the victim’s body and bodily functions. Narrowing in the range of initiative becomes habitual with prolonged captivity and must be unlearned after the prisoner is liberated.<sup>15</sup>

The patient continually referred to himself as a non-human, which is supported by other authors such as Niederland<sup>21</sup> who in his clinical observations of concentration camp survivors, noted that alterations of personal identity were a constant feature of the survivor syndrome. While the majority of

his patients complained “I am now a different person”, the most severely harmed stated simply, “I am not a person”. The essential element in the facilitation of the emotional process during treatment is the rehearsal of the emotional reaction. The patient should be encouraged and allowed to express feelings of shame and disgust in revealing the sexual traumatisation.<sup>22</sup> Helping the victim “digest” the traumatic events, accepting what happened, and listening empathically could help the patient find himself again.<sup>22</sup>

By inviting physical and sexual pain, our patient essentially re-enacts the rape scenes. He may wish to re-enact the “inconclusive” pathway of the injury caused by the perpetrator, and complete the task by ending his own suffering. The association between mode of torture and content of suicidal ideation may be understood in terms of the psychodynamic concept of compulsive repetition of a past trauma<sup>23</sup>. The endeavour is to reach control over one’s life. To reach a solution of the unsolved horrifying event or to obtain satisfaction not experienced, or belatedly to master anxiety or guilt. They are likely to repeat the experience in order to gain a sense of mastery over their initial experience of victimization, as well as to be able to attach meaning to it, such as gaining back control and mastering their own fears and emotions.

Horowitz<sup>24</sup> found that trauma victims alternated between compulsively repeating the event through flashbacks or nightmares and denying it. Thus, it appears as if the mind attempts to organise and process overwhelming stimuli to reach control. Studying this intriguing association using larger samples, may help find new answers to the complicated issue of self-harm dynamics.

The rage of the imprisoned person also increases the symptoms.<sup>25</sup> During captivity the patient could not express anger at the

perpetrator, to do so would jeopardise survival. Even after release he may have continued to fear retribution for any expression of anger against the captor. Moreover, he carried a burden of anger against his wife and children who remained indifferent and failed to help. Herman,<sup>15</sup> stated that internalization of rage may result in a malignant self-hatred, risk-taking and self-harming behaviour. Hence, one of the main therapeutic goals should be to express and re-tell the story as a way of dealing with the anger which is deep-seated in his psyche.

People in captivity become adept practitioners of the art of altered consciousness.<sup>9</sup> Through the practice of dissociation, voluntary thought suppression, minimization and denial, they learn to alter an unbearable reality. Prisoners frequently instruct one another in the induction of trance states. These methods are consciously applied to withstand hunger, cold and pain.<sup>26,27</sup> During prolonged confinement and isolation, some prisoners are able to develop trance capabilities ordinarily seen only in extremely hypnotizable people, including the ability to form positive and negative hallucinations and to dissociate parts of the personality.<sup>15</sup> Disturbances in time, sense, memory and concentration are almost universally reported.<sup>28-30,31</sup> The rupture in continuity between present and past frequently persists even after the prisoner is released. The prisoner may give the appearance of returning to ordinary time, while psychologically remaining bound in the timelessness of the prison.<sup>32</sup>

In situations of captivity, the perpetrator becomes the most powerful person in the life of the victim, and the psychology of victim is shaped over time by the actions and beliefs of the perpetrator. The methods which enable one human being to control another are remarkably consistent. The methods of establishing control over another person are

based upon the systematic and repetitive infliction of physical and, most importantly, psychological trauma. These methods are assigned to instil terror and helplessness, to destroy the victim's sense of self in relation to others, and to foster a pathologic attachment to the perpetrator. Fear is also increased by unpredictable outbursts of violence towards the victim and by inconsistent enforcement of numerous trivial demands, submissions and petty rules.

Repetitive phenomena in the present case study is an interesting yet disturbing fact which has also been observed and noted by other authors. After prolonged and repeated trauma our patient had victimized himself by placing himself in risk of repeated harm. This is consistent with other findings where about 10% of psychiatric patients are thought to injure themselves deliberately<sup>33</sup>, or by self-mutilation which appears to be quite distinct from attempted suicide.<sup>12,31</sup>

### Conclusion

To date, the situation of the patient has definitely improved, although his request for orchidectomy stands. He still has sexual relationships with men, although with protection and without violence. Despite enjoying the sexual relationship, he expresses that he despises every one of these men and would never want to have a social/friendly relationship with them, somewhat distancing himself from them. His anxiety and depression symptoms have also subsided. In the last two months, he has been feeling intense internal pain during sex. Following our referrals to three medical specialists in three different hospitals, no physical reason has been found for his pain.

Is it possible that the pain was always present but concealed by dissociation? His road to recovery is long and arduous. The pain and suffering which he carried with

him for years, are deeply embedded in his psyche, which in turn protected him by masking the memories.

This case has undeniably been incredibly difficult, challenging and emotionally draining for the therapists. We, the therapists, have constantly been confronted by issues of transference, mixed feelings of helplessness, compassion, sympathy, commiseration, empathy, fear and guilt for not “helping” him fast enough. We have tried to cope with these feelings by maintaining regular supervision sessions, debriefing after sessions and discussing, observing and exploring our own feelings as they emerge. The case is ongoing and he will undeniably need further long-term therapy and support. By sharing this case, we hope to relay the clinical issues of the patient, and also briefly elicit the emotional experiences that therapists have to deal with in such complicated cases, which we will detail in a later article. We hope that this article will assist in informing and increasing awareness of the serious issue of male rape, torture and its sequelae, in prison settings. Perhaps one day our patient and other survivors might feel some peace and serenity.

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