

Final Version

NOT TO BE USED UNTIL PUBLICATION IN J. OF TRAUMA AND DISSOCIATION SPECIAL  
ISSUE (EARLY 2013)

**TRANSFERENCE FOCUSED PSYCHOTHERAPY WITH FORMER CHILD SOLDIERS:  
MEETING THE MURDEROUS SELF**

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Words article: 5700

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Abstract: 139

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Acknowledgement: The authors thank dr. Frank Yeomans, PhD, for his very helpful remarks.

Key words: aggression, anger, treatment, transference focused psychotherapy, trauma, refugees, child soldiers

**Abstract**

This article describes the application of Transference Focused Psychotherapy (TFP) to the treatment of former child soldiers suffering from DID. It focuses on the problems with aggression faced in psychotherapy. TFP provides a psychodynamic, object-relational model to understand the aggression arising in psychotherapy, focusing on the transference and countertransference in the 'here and now' of the therapeutic relationship. Aggression is considered as an essential and vital inner dynamic aimed at autonomy, distancing and prevention of injury and dependency. In extremely traumatized patients there may be aggressive and oppressive inner parts that want total control - identifying with childhood aggressors - thus avoiding vulnerability. According to TFP it is vital that this aggression is addressed, as belonging to the patients themselves, in order to reach some form of integration, balance and health. This will be illustrated in a case description.

Aggression and anger are highly prevalent in combat related PTSD and negatively influence treatment outcome (Yehuda, 1999). Yet theories and treatment of PTSD focus predominately on fear as the central emotion (Orth & Bieland, 2005). Anger and aggression are largely neglected in the treatment literature of traumatized individuals, including refugees (Ehnholt & Yule, 2006; Nicholl & Thompson, 2004). Similarly, severe aggression in dissociative identity disorder (DID) patients is often not a central focus (though see Chu, 1998). Managing split-off aggression in DID, is even more problematic than in PTSD, given its dissociated, egodystonic ('not me!') character.

It is our clinical experience in treating traumatized refugees, that the use of state of the art treatments for PTSD, such as Narrative Exposure Therapy (NET), Eye Movement Desentization and Reprocessing (EMDR) or Testimony Therapy, is ineffective and can even be re-traumatizing as long as the therapeutic relationship is dominated by feelings of distrust, guilt and shame which result in aggression and/or dissociation. Lack of emotion regulation and dissociation in the interpersonal context should have priority in psychotherapy, because they cause more functional impairment than PTSD symptoms. Past studies on emotion regulation in complex PTSD, such as anger and anxiety management, have focused on treatments containing components of psycho-educational, cognitive and behavioral aspects, and medication or a combination of these components (Chemtob, Novaco, Hamada, Gross & Smith, 1997; Cloitre, 2009; Glancy & Saini, 2005; Saini, 2009; Yehuda, 1999). Approaches such as cognitive behavioral therapy to control anger and anxiety may be successful in treating the situational aspects of anger and fear expression, but typically not their underlying dispositions.

In working with adult refugees who are former child soldiers, using a staged approach treatment with supportive, psychoeducational and emotion regulation techniques, had little success. Due to the extreme interpersonal fears in contact with the therapist, these patients have great difficulties absorbing and processing new information and thus are unable to fully acquire emotional regulation strategies.

We therefore address the following issues: How to handle severe and split-off aggression in such patients? How to handle oppression of the therapist by the patient and the extreme fears this induces in the therapist? How to meet the ‘murderous self’ and how to integrate this self into the broader spectrum of aggressive affects with appropriate mastery?

### **Former child soldiers**

UNICEF (2007, p. 7) defines a child soldier as *“any person below 18 years of age who is or who has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, messengers, spies or for sexual purposes.”* Child soldiers are used by both rebel armies and government troops. Africa has the largest number of child soldiers. Most of these children are forcibly recruited and abducted by armed groups. Others join these groups for purposes of survival or to avenge slain family members (Betancourt et al., 2010, Schauer & Elbert, 2009).

The consequences of being a child soldier are considerable. These youths grow up in extreme and savage conditions in the jungle in which only the strongest survive. They form the bottom of the pecking order, making them the target of constant abuse, molestation and harassment. These children are deprived of the necessary care and protection from family and community, and miss key services

such as healthcare and education. The majority of child soldiers have been victims, witnesses and/or perpetrators of severe violence and cruelties, such as combat situations, bombings, decapitations and amputations, burning people alive and rape (Betancourt et al., 2010). After war, they are further vulnerable to reintegration failure due not only to being exposed to traumatic events but also being blamed and stigmatized because of their affiliation in the conflict (Schauer & Elbert, 2009). After arriving in the Netherlands, they are subjected to a lengthy and often exhausting asylum procedure. Once again, they are confronted with an inability to fully participate in society due to the minimal rights they are granted during the asylum procedure. They suffer from the loss of their social role, future possibilities and their own cultural surroundings, such as language of origin, customary food and social networks.

Prolonged exposure to toxic forms of violence, especially in childhood, has devastating long-term consequences. In response to threat, aggressive states are quickly and dramatically alternated by fearful flight or avoidance states. Because children are often physically incapable of fighting off their captors or fleeing the situation, the most common reaction to traumatic events is to detach themselves from the external and internal worlds through dissociation; experiencing numbing, depersonalization and derealization (Schauer & Elbert, 2009). Youths who are exposed to such a degree of violence and threat are often unable to complete developmental tasks such as safe attachment relationships, a stable and integrated concept of self and others, and the competence to self-regulate emotion and behavior (Van der Kolk, 2005).

The reaction of many former child soldiers to repeated and prolonged interpersonal trauma may be best described by concepts such as “complex trauma”

or “developmental trauma disorder” (Cloitre, 2009; Klasen et al. 2010; Van der Kolk, 2005). The symptom profile refers to the presence of PTSD with additional disturbances in the domains of affect regulation, interpersonal relatedness and self-identity. In addition to complex PTSD, these patients often suffer from depression and DID, in which both the memories of atrocities as well as participating perpetrator parts are totally split off from awareness. In the literature on dissociation these self-states (or ‘alters’) are described as ‘protector parts’: Emotional Parts of the personality, that are “fixated in the protective “fight” subsystem, and attempt to manage the difficult emotions of rage and anger and to avoid feelings of hurt, fear or shame” (Van der Hart et al., 2006, p. 82).

In treating former child soldiers, clinicians are confronted with oppression and dissociation in and outside psychotherapy. Relative minor stressors can trigger classic fight, flight or freeze reactions, manifested by severe aggression and/or regressed dissociative states. These patients have difficulties in controlling aggressive impulses, they perceive violence as a legitimate means of achieving one's aims, and have insufficient skills to handle daily life without aggression. Clinicians are pulled into the re-enactments of old trauma scenarios and become part of a wild therapeutic ‘dance’ of approach and avoidance, which can feel like war. They are faced with severe transference and countertransference problems.

### **Transference Focused Psychotherapy and its application**

Transference Focused Psychotherapy (TFP) is an evidence based, manualized, psychodynamic treatment based on object relational theory (Clarkin, Yeomans & Kernberg, 2006, 2007; Yeomans, Clarkin & Kernberg, 2002). It is developed to treat patients suffering from severe personality disorders, that is, with a borderline

personality organization (BPO; Kernberg, 1974). BPO refers to a psychological structure characterized by identity diffusion (a fragmented and fluctuating sense of self: oscillation of self-and-other representations and emotions linked between them) and 'primitive' defenses (splitting, denial and projective identification) with reality testing generally intact but prone to distortions under stress. The patient communicates not only verbally and non-verbally, but also via projective identification (so called 'belly talk'), in which intolerated emotional states are externalized and induced in and sensed by the therapist.

The aim of TFP is to integrate these conflicting inner self-and-other states into a more coherent personality structure. The basic assumption of TFP is that human beings are social animals (who want to bond and be autonomous as well), whose inner world consists fundamentally of relational elements, 'dyads', consisting of images of self and other (the 'object') and the linking emotion. In BPO this inner world is divided into 'all-good' and 'all-bad' dyadic elements which are perceived as in conflict with each other and kept apart through the process of splitting. In severely traumatized patients this basic division is further accentuated by dissociation. The theoretical questions about how splitting and dissociation interrelate and whether splitting itself is a dissociative, trauma-related phenomenon, is beyond the scope of this paper. In fact, in the severely traumatized patients splitting and dissociation are totally intertwined. The major importance to focus nevertheless on what splitting stands for is that it is conflict-driven: the conflict between the tendency to approach, to seek intimacy and to bond, versus the tendency to avoid contact and dependency and to defend against being hurt or controlled (i.e., the dynamics of 'love' versus 'aggression').

The 'all-good' dyads consist of longing and perfect loving relationships with an 'ideal object', such as 'perfect' mothers or fathers. These 'all-good' dyads, since they are not integrated with realistic shortcomings and disappointments, are unrealistic and can lead to pathological frustration and a flip into the reverse "all-bad" dyads. All-bad dyads consist of images of persecutory/dominating relationships, based on a mix of past subjective reality, one's own aggressive affects, identification with aggressors and strong fears. In relationships, and in psychotherapy, the inner dyads oscillate: the anxious 'victim' inside fearing retaliation by an overpowering other, can suddenly switch into a dominating force attacking the now weak other. If the therapist is experienced as a 'bad object', the patient may attack to protect himself from being overpowered – thus enacting aggression without full awareness of being aggressive. This model of object relational thinking has the therapist exploring these projections empathically with the patient, looking as if through the patient's eyes. This perspective is very helpful in understanding and handling the constant push and pull in moment-to-moment interactions in the treatment of patients with personality disorders as well as severe dissociative disorders (Draijer, 2009, 2010).

TFP interventions consist of *exploring* the inner world of the patient and his view from that world on the therapist. To be able to do this it is particularly important to fully experience the transference *in the here and now* (what is the patient 'making' of me?), empathically following the patient in his 'creation' of the therapist, containing the dyad expressed in it, and presenting this to the patient. Thus, an intervention might be constructed as follows: 'When I properly listen to you, it is as if you see me as a cruel and dominating person. That must be a very scary situation for you.' When patients experience being understood properly by the

containment of having the relationship articulated the way they perceive it, they suddenly calm down, even if in an angry state of mind, and are able to start reflecting on what is happening.

Once the reflective functioning of the patient begins to improve – which can take quite a while - the task for the therapist is to *confront* the patient carefully with inconsistencies and oscillations between dyads, raising the patient's empathic curiosity for his own inner world. An example intervention would be, 'that is interesting, just a few minutes ago our conversation seemed quite intimate and you shared your sadness with me, apparently perceiving me as a safe and reliable listener, but suddenly it seemed that you perceived me as a threat you have to protect yourself against by reclaiming total power. How do you combine these two states of mind?'

And finally, when the patient is able to reflect and experience the therapeutic relationship as supportive at least some of the time, it is the task of the therapist to *interpret* the defensive layering of opposing dyads. 'Interpretation' in TFP is a process that leads to presenting the positive and negative dyads simultaneously to the patient, relating them. For example, 'could it be that on the one hand your anger is so extreme, distancing you from me, because on the other hand you feel so vulnerable when realizing that you long deeply for a safe relationship with a reliable parental figure?' or 'Could it be that you seem to prefer to see me as totally unreliable, because perceiving me as trustful and reliable makes you feel so terribly sad about your losses? Could it be that – by doing so - you protect your heart against losing a loved one for a second time?' So interpretation is about 'you and me' in the 'here and now'; it is not etiological.

This whole step-by-step interactional and interpretational process (Caligor, Diamond, Yeomans & Kernberg, 2008) results in the gradual mitigation of anger and rage, and eventually in the integration of the personality.

In TFP the patient is held responsible for his own recovery; this means that in the beginning of treatment a contract is made about (self) destructive acting out, explaining to the patient that this behavior is in opposition to a development towards health. When the patient might point out that he only knows one solution for conflict, to use violence, the therapist holds him responsible to prevent it: 'All feelings are welcome and respected, even murderous rage, as long as we can talk about it and not act on it.' When the patient has noticed a tendency to act out, or when he actually did, he is asked to mention it first thing in the next session. To prevent repetition of the cycle of abuse: 'The soldier needs to learn how to talk.'

#### **TFP illustrated in case material**

Ishmael is 24-year-old man from Sierra Leone who has been in the Netherlands since 2003. The first time the therapist met Ishmael, he had unsuccessfully been in psychotherapy for three years in which stabilization and support were the key focus. It soon became clear that he was highly ambivalent about treatment: motivated, but scared of the intimacy inherent in psychotherapy. Ishmael's biggest fear was losing control of his aggression when being triggered and harming an innocent person. He had gotten into fights with others, including his girlfriend.

He met criteria for DID, PTSD and depression, as well as personality disorder NOS. He suffered from amnesia, brief psychotic episodes including auditory comments and visual hallucinations. He had been suicidal occasionally and had been hospitalized once. He reported feelings of severe distrust, guilt and shame,

extreme loneliness, a sense of not belonging and of being dehumanized:

‘Sometimes I feel I am more an animal than a human being’.

Ishmael was born in Sierra Leone. He describes his early years as moderately happy. At the age of eight the rebels killed his mother in front of him and he was captured. He has never seen his father and sister since. Ishmael was forced by the rebels to stay with them in the jungle as a child-slave. There he experienced and witnessed innumerable cruelties and was forced to participate in them. After five years he was able to escape and managed to stay alive in Freetown. Momentarily he is in the middle of an asylum procedure.

The main problem in the first phase of psychotherapy was his inability to remain psychologically present while relating to others. This would manifest in the form of dissociation (e.g., switching into other states of mind, being ‘absent’) or in extreme dominance, aggression and oppression of the therapist. He reported paranoid feelings; having extreme fears of being abused, exploited, humiliated and not being cared for. He was unable to use the affect regulation techniques that were taught to him. When exposed to his aggression the therapist often felt overwhelmed by fear, struggling to reflect on what was going on. TFP offered a framework that made sense in understanding these confusing forces, the pushing and pulling, the reenactments.

Moving to TFP marked the transition from a one-person-model of understanding the patient and his symptoms, to a two-person-model of understanding the patient and the dynamic interpersonal forces he experiences. When asked about the differences in approach after this transition, the first thing that came to the therapist’s mind was: ‘So much more contact and understanding of what he is going through, since I empathically explore and see through his eyes the

person he is making of me. Dissociation and aggression became understandable as means to regulate distance and intimacy in our relationship.’

Using the overview of Clarkin et al. (2006) of the dominant ‘dyads’ in the transference and countertransference, we will illustrate some of them in this psychotherapy (Table 1):

<b>Table 1. Dominant ‘dyads’ in transference – countertransference</b>	
<b>Patient</b>	<b>Therapist</b>
Controlling, omnipotent self	Weak, slave-like other
Abused victim	Sadistic attacker/ persecutor
Out-of-control, angry child	Incompetent, useless parent
Dependent, gratified child	Perfect provider
Friendly, submissive self	Doting, admiring parent

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The following transference-countertransference interaction demonstrates the dynamic nature of dyadic relationships. In reaction to his vulnerability in sharing with the therapist one of his most traumatic experiences, and becoming sad, the patient suddenly switched into a different state. The therapist experienced the following:

*“I feel overwhelmed by his sudden shift to aggression. His eyes sharpen and in a derogative manner he says, ‘Can’t you see? There is fighting everywhere around you’. His gaze hardens and becomes indifferent. His lips slightly curl in a sadistic smile. It seems that I am part of the reliving of a violent and cruel traumatic experience in which we are facing each other in a combat situation. I no longer see the Ishmael I know; I see an extremely dangerous and threatening rebel who’s*

*capable of anything. I wonder if he sees the same threat in me. I feel confused. My body is warning me that there is danger and I am hyper-aroused. I catch myself looking at his hands, wondering if he could attack. Right now I want to stay sharp, but chaos takes hold of me. I am no longer able to reflect on what is going on and am drowning in a flood of fear. In the meantime I'm desperately searching for my therapeutic framework and tools but they seem to be washed away. I feel paralyzed and helpless. I can't win this battle, he's stronger, and I surrender to him...Is this what he wants to achieve with his aggression?*

*I point out his aggression and ask what is happening inside of him. He seems startled; his aggression suddenly disappears, he denies being angry or afraid; now he is the one who's confused and vulnerable. I am suddenly the perpetrator and he is the victim. I don't want to be the perpetrator. There's confusion again."*

Reconstructing what happened afterwards in supervision, we see an aggressive defense against sadness and vulnerability, as well as the reenactment of trauma, but in the reversed, dominant position, scaring the therapist to a terrifying submission and confusion. The patient seems to evoke in the therapist the extreme fear that he is unable to verbalize. There is an oscillation between the sadistic attacker / persecutor and the abused victim. The task of the therapist is to tolerate this almost unbearable fear.

If the therapist is able to 'survive' this fear and to keep reflecting on what is happening between her and the patient, taking a respectful and neutral stance, she is increasingly able to 'contain' the bad object projected onto her and to try to engage the patient in reflecting on/symbolically holding what had previously existed as a raw, unsymbolized affect state. The therapist's empathic curiosity engages the patient in seeing that the intense state that overwhelms him may exist in a broader

context of other internal states and thus not comprise the whole of reality or of the relationship, thus modifying the object, especially in its intensity and its one-dimensional quality. Room for reflection, be it just a second or two, and tolerance for affect are slowly but gradually growing, as all affects are accepted, tolerated and contained by the therapist. In the patient a process takes place in which he slowly brings together the attacker he fears and the empathic and reflecting other he experiences and may secretly long for – both of which are reflections of internal states within him. This is thought to be an integrative process. Thus, the persecutory objects and self-states in the patient become gradually ‘detoxified’ (Scharff & Tsigounis, 2003)

Some time later the therapist struggles with overwhelming feelings of powerlessness and sadness, empathizing with the patient. Now the patient seems to be more able to tolerate his vulnerable state as well as being connected with the therapist. Now the therapist notes:

*‘Ishmael expresses intense feelings of worthlessness, related to atrocities he experienced as a victim. He longs for peace of mind and death. I feel his self-loathing and pain. Unable to tolerate it, I try to change his guilty and shameful perspective on himself but notice it does not fit his needs. He lets me know that he has no room for it. I tell him that I understand that wanting to change his perspective was a futile attempt to deal with my own feelings of powerlessness that his sadness induced. I add: ‘We could let the sadness exist here as we sit together, without having to talk about it.’ He remarks that he would like that, especially because there is nowhere else where he can just let his sadness exist. Our eyes meet and his sadness hits me. He sees that my eyes become moist and I say that his sadness affects me. For a moment he turns his head away, but then*

*meets my gaze again and I can see that he allows his sadness to exist in my presence. There is an intense moment of meeting. At the end of the session, Ishmael tells me that through experiencing and sharing his sadness he feels 'more connected' and less lonely.*

From a dyadic perspective, the therapist feeling powerless and sad comes from how the patient is interacting with and perceiving her (i.e., projection and projective identification). In this instant the therapist first wanted to comfort the patient prematurely and get away from the sadness, 'acting out' the way the patient regularly does. Then the patient was aware of the sadness in the therapist, as she was willing to 'sit it out' with the patient, tolerating the sadness together. This 'being there in the sadness with him together' restored his tolerance for connection, for relatedness, for the 'mother' in him that he had lost.

After 18 months of TFP the therapist notices a remarkable increase in and tolerance for intimacy and vulnerability in the therapeutic relationship. This development represents access to the previously split-off libidinal segment of the patient's internal world. He is more able to verbalize and tolerate painful experiences and strong emotions. There are fewer oscillations between emotional states and there is less black and white thinking. The aggression has become less 'wild', destructive and scary, and seems to be gradually melting away. Aggressive feelings, thoughts and fantasies are openly shared in therapy. He is better able to regulate emotions and to assert himself non-violently.

At the symptom level there are fewer nightmares, flashbacks/reliving states of terror, dissociation, avoidance of traumatic material, less distrust, feelings of guilt and shame. Auditory comments and visual hallucinations have receded. With

respect to DID there is more differentiation between then and now. Emotional states are less fragmented and less separated by amnesia. Severe traumatic experiences concerning atrocities are no longer only told through the murderous self, but now are also told in sad and more reflective states. Ishmael lives a less isolated life; he has more contact with the outside world through his volunteer work, hobbies and even a budding friendship.

### **Discussion**

In the treatment of former child soldiers from Africa with DID, TFP helps to address the aggression of these patients and their tendency to seek total control and dominance over or oppression of the therapist. It is a helpful object-relational model to understand the severe problems with split off aggression, as well as the sudden and confusing switches in the mental states of the patient, addressing the transference-countertransference, the therapeutic ‘dance’ of push and pull interactions and re-enactments between patient and therapist, instead of addressing primarily symptoms situated in the patient.

This touches also on the discussion of working either from a one- or two-person psychology perspective in the understanding and treatment of extreme trauma. The case described moved from a one person perspective with limited success (focusing on symptoms and psychopathology, perceived solely *in* the patient), to a two-person-psychological model in which the focus was on the dynamics as perceived *between* the patient and the therapist in the form of splitting, projective identification and oscillating self –and other states. This helped the patient to emotionally regulate, to start mentalizing, to socialize and to integrate more, both internally and externally. Instead of following the traditional phase

oriented trauma therapy, affect regulation was strengthened by focusing on enhancing secure attachment in the therapeutic relationship.

This represents a move from PTSD primarily seen as an anxiety disorder towards (complex) PTSD (and DID) perceived as primarily relational disorders, characterized by isolation, loneliness (disconnection), distrust of others, lack of soothing, comforting inner relationships, rage towards mankind, shame and guilt. Complex stress-related disorders such as DID are disorders of personality, identity and affect regulation. Relational disorders altogether. Psychodynamic models work in the here and now of the therapeutic relationship.

After eighteen months of TFP we observed improved affect regulation as well as mentalization and relatedness in this patient. The mechanism of change in the improved affect regulation could be hypothesized in the fine attunement by the therapist to, and containment of, the dominant dyads and the emotional states linked to them in the here and now of the interaction. Supporting this hypothesis is the study of Levy et al. (2006) showing a development towards improved reflective functioning and security of attachment in borderline patients after one year of TFP. More secure attachment leads to better affect regulation (Schore, 2005). One could argue that TFP is similar to Mentalisation Based Therapy (MBT). The major difference is that in TFP the oscillation, the conflict between different dyads, is central. Secondly, the transference is addressed, the therapist takes part in the dance and is less of a coach; TFP is more experiential than cognitive. Finally, TFP respects aggression as a central dynamic force.

Views on aggression and how to treat it diverge considerably. Some treatment models do not address it at all (assume it comes from an 'alien' self), others solely try to control it (more CBT types of 'anger management'), or suppress it (e.g.,

medication), while in TFP it is considered essential and vital (and in a way 'healthy') in the inner dynamics.

We have the clinical impression, that in severely traumatized patients, in whom aggression does not surface in treatment directly, it may be channelled through nightmares and self harm, and in doing so it is projected onto (inner) 'perpetrators' as a 'safe way' to experience aggression ('externalizing' it internally). Such patients also have (aggressive) oppressive parts who want total control - arising from identification with their childhood aggressors. From a TFP perspective, in order to reach some form of integration, balance and health it is essential that the patient's aggression is addressed, acknowledging that it belongs to the patient him/herself. We observe that not all patients are able or willing to face this and they feel no way forward but to stay oppressed by holding onto their identity as a victim, perpetually attacked by projected aggression.

The TFP therapist takes part in the 'dance' on the one hand, but tries to keep reflecting on what happens between them. He does so in a respectful way, neutral towards the conflicts in the patient, accepting what is put forward into him. In the metaphor of a harbor: all ships are allowed in, no ship needs to stay at sea (i.e., all feelings and mental states, however negative they may be, are welcome into the relationship with the therapist). The therapist then acts as a reflecting mirror in which the patient sees a more integrated image of himself than what he is projecting. The containment of aggression and hatred are a precondition on the road towards integration of good and bad. The murderous self needs to be seen, respected, welcomed and appreciated for what it means to the entire person: it is the keeper of horrible memories and it watches over the patient to avoid being hurt again. This aspect of self is extremely lonely ('dehumanized') and convinced that

no-one will ever like him or be close to him. If this dangerous and hateful part of the patient feels that he is understood, respected and appreciated, his hate slowly starts to melt. Only then is there room for mourning and deep sadness. Patients who have killed need to mourn about it and rituals of mourning and regret may be introduced.

Finally, for the therapist to learn to make himself emotionally available for the inner world of the patient, to participate in this 'dance' and to recognize it and reflect on it in order to make an intervention, supervision is a 'conditio sine qua non.' To develop this emotional availability, this mental skill and awareness of induced feelings and processing them into an intervention, we need a safe and accepting relationship with a supervisor.

### **Conclusion**

Extreme aggression and a self state of a 'killer' - particularly in males - poses severe problems for patients with dissociative disorders, alienating them from other people, preventing intimacy, and inducing fear in their psychotherapists. This problem is hardly addressed in the theory or research on PTSD and treatment focuses primarily on anxiety.

Anger and aggression are central in severe traumatization, causing patients to feel guilty, 'bad' and isolated, struggling for control and alienating them from fellow humans. This is particularly the case when patients have been forced to kill. In the treatment of former child soldiers with DID, suffering from split off aggression, TFP helps to address these aggressive parts and their tendency to seek total control over, or oppression of, others including the therapist. It also helps free them from their internal oppression.

## Reference List

Betancourt, T.S., Borisova, I.I., Williams, T.P. et al. (2010). Sierra Leone's Former Child Soldiers: A Follow-up Study of Psychosocial Adjustment and Community Reintegration. *Child Development, 81* (4), 1077–1095.

Caligor, E., Diamond, D., Yeomans, F.E., & Kernberg, O.F. (2009). The Interpretive Process in the Psychoanalytic Psychotherapy of Borderline Personality Pathology. *Journal of the American Psychoanalytic Association, 57*, 271-301

Chemtob, C.M., Novaco, R.W., Hamada, R.S., Gross, D.M., & Smith, G. (1997). Anger Regulation Deficits in Combat-Related Posttraumatic Stress Disorder. *Journal of Traumatic Stress, 10* (1,) 17-36.

Chu, J.A. (1998). *Rebuilding Shattered Lives*. John Wiley & Sons, New York.

Clarkin, J.F., Yeomans, F.E., & Kernberg, O.F. (2006). *Psychotherapy for borderline personality. Focusing on object relations*. Arlington: American Psychiatric Publishing, Inc.

Clarkin, J.F., Levy, K.N., Lenzenweger, M., & Kernberg, O.F. (2007). Evaluating three treatments for borderline personality disorder. *American Journal of*

*Psychiatry*, 164, 922-928.

Cloitre, M. (2009). Effective Psychotherapies for Posttraumatic Stress Disorder: A Review and Critique. *CNS Spectrums*, 14 (1), 32-43.

Draijer, N. (1999). Pathologische haat en traumatisering; de worsteling met afstand, nabijheid en herinnering. (Pathological hatred and traumatization: the struggle with approach, avoid and memory). In Koerselman, G.F. & Tilburg W., Haat (p. 55-74). Tricht: Stichting Psychoanalyse en Psychiatrie.

Draijer, N. (2009). Pre-conference workshop 'Transference Focused Psychotherapy (TFP) techniques in the treatment of DID' (half day). International Conference of the ISSTD, Washington, November.

Idem (2010). (full day). 2<sup>nd</sup> International Conference of the European Society for Trauma and Dissociation, Belfast, April.

Draijer, N. (2010). Conference-workshop 'An object-relational approach to problematic (counter) transference, working with patients with severe trauma related disorders (DID, C-PTSD, BPD).' (90 minutes). International Conference of the ISSTD, Atlanta, Oktober.

Ehnholt, K.A., & Yule, W. (2006). Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry*, 47 (12), 1197-1210.

Glancy, G. & Saini, M.A. (2005). An Evidenced-Based Review of Psychological Treatments of Anger and Aggression. *Brief Treatment and Crisis Intervention, 5*(2), 229-248.

Klasen, F., Daniels, J., Oettingen, G., Post, M., & Hoyer, C. (2010). Posttraumatic Resilience in Former Ugandan Child Soldiers. *Child Development, 81*( 4), 1096–1113.

Levy, K.N., Clarkin, J.F., Yeomans, F.E., Scott, L.N., Wasserman, R.H., & Kernberg O.F. (2006). The mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. *Journal of Clinical Psychology, 62*(4), 481-501.

Mills, J. (2005). *Treating Attachment Pathology*. Oxford; Rowman & Littlefield Publishers, Inc.

Nicholl, C. & Thompson A. (2004). The psychological treatment of Post Traumatic Stress Disorder (PTSD) in adult refugees: A review of the current state of psychological therapies. *Journal of mental Health, 13* (4), 351-362.

Orth, U., & Wieland, E. (2006). Anger, hostility, and posttraumatic stress disorder in trauma-exposed adults: a meta-analysis. *Journal of Consulting and Clinical Psychology, 74*, 698-706.

Saini, M.A. (2009). Meta-analysis of the Psychological Treatment of Anger: Developing Guidelines for Evidence-Based Practice. *Journal of the American Academy of Psychiatry and The Law Online*, 37 (4), 473-488.

Scharff, J.S. & Tsigounis, S. A. (2003) Self-hatred in psychoanalysis: detoxifying the persecutory object. Brunner-Routledge, New York

Schore, A.N. (2005). Attachment, affect regulation, and the developing right brain: Linking developmental neuroscience to pediatrics. *Pediatrics In Review*, 26, 204–211.

Schauer, E. & Elbert, T. (2009). The Psychological Impact of Child Soldiering. Unpublished paper:  
[http://www.fotres.ch/index.cfm?action=act\\_getfile&doc\\_id=100518](http://www.fotres.ch/index.cfm?action=act_getfile&doc_id=100518)

UNICEF. Paris principles: Principles and guidelines on children associated with armed forces or armed conflict. UNICEF; New York: 2007.

Van der Hart, O., Nijenhuis, E.R.S, & Steele, K. (2006). Structural Dissociation and the Treatment of Chronic Traumatization. Norton & Company, New York

Van der Kolk, B.A. (2005). Developmental trauma disorder. Towards a rational diagnosis for chronically traumatized children. *Psychiatric Annals*, 35, 401–408.

Yehuda, R. (1999). Managing anger and aggression in patients with posttraumatic

stress disorder. *Journal of Clinical Psychiatry*, 60 (15),33-7.

Yeomans, F.E., Clarkin, J.F., & Kernberg, O.F. (2002). *A primer of transference focused psychotherapy for the borderline patient*. New Jersey, Northvale: Jason Aronson, Inc.