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Identity After Trauma

Thank you very much for inviting me to speak. Today, I want to explore the subjects of identity and the self. I will look at identity from a historical and development point of view, explaining terms such as "identity confusion" and "diffusion", which often confuses us. Then I will talk about the effects of trauma on the developing self, and on identity in the refugee population.

Lastly, I will speak about the stages of psychotherapy and the need to incorporate the psychotherapy of identity disorders. I do not mean dissociative identity disorder, but those who have difficulties with identity formation, identity confusion or identity diffusion.

Quite a number of those who suffer from identity diffusion often present with dissociative episodes and also with psychosis. These need to be differentiated from some of the other major psychotic disorders.

The pioneer of identity studies is Erik Erikson. Erikson said identity is: "A sense of personal sameness and continuity over time and across situations, a sense of having one's inner agency" – and what we do is trying to help our patients develop a sense of agency: "the acknowledgement of one's role, commitments and views of oneself in the broader community" was Erikson's 1952 definition.

So when we look at identity we actually have to, according to some authors, describe three dimensions: continuity, coherence and distinctiveness. Continuity is being the same person over time. Coherence is about being able to see ourselves in varied roles, beliefs, ideologies, and being part of an integrated whole.

While we are composed of many selves, we have a continuity and coherence between oneself and the other and a distinctiveness, each of us sees ourselves as being different or separate from the other. These dimensions are really important when we are attempting to assess people who come to us with various mental health issues.

We know that identity development is an important life phase of adolescence, and quite often I think in this day and age, we debate the formation of identity. And it is very common now to say that adolescents do not really achieve an identity at 18. Instead they tend to have a prolonged identity kind of state from 18 to about 28, when they still live at home, attend university and are dependent on parents. That is how we see the changing society of today.

But identity is a fluid process. Though it might develop around the ages of 16 to 18, 21, it continues to develop into adulthood. So when exploring alternate roles, beliefs and ideologies, these will differ from culture to culture. So we need to look at the social historical context in which these ideologies and beliefs occur.

We believe that among adolescents aged 18 and 21 or 22 years of age, each one tends to adapt and commit themselves to a particular role, belief or ideology in an integrated way. But we are seeing that it is not as easy as that. There is such a variety of options available to young people in terms of academic studies and work, that quite often students are beginning to work from early high school because of the availability of technology.

So when identity is disturbed in some way (identity being an integral part of the self) it leads to some impairment of the self and we know the self has a core, which is present at birth. So agency, ownership, sense of boundary and internal cohesion, are all affected by trauma of various types which, in turn, affect identity formation.

Trauma carries with it numerous factors that interfere and prevent an adolescent from achieving identity.

One of the most important things that we see in people who have been affected by trauma is their reduced capacity for self-reflectivity. Now, self-reflectivity is the capacity to reflect on oneself and the effect that one has on other people. So there is a bipartite system there. How I affect someone else and how someone else affects me is the capacity for self-reflectivity, otherwise called "theory of mind", and more recently, Fonagy and Bateman referred to it as "mentalisation". The capacity for self-reflectivity develops about the age of four, under normal circumstances.

Let us look at identity confusion, which is a multifaceted, rather complex system, where identity is consolidated, but in circumstances of trauma, and I am citing post-migration, that is, the refugee situation and we are seeing the after effects of it, the intergenerational transmission of trauma in Sydney.

So particularly in refugees coming to a foreign country, trauma carries with it numerous factors that interfere and prevent an adolescent from achieving identity. For those who have achieved identity, there could be a disruption of that identity and therefore, the arising of confusion when they are faced with circumstances that are way out of their control and often unpredictable.

There is considerable evidence that forced migration has far-reaching consequences for adults as well as for children and various adaptive mechanisms are used. So like in normal development, adaptive or coping mechanisms, known as defences, are used by people to deal with threats in the environment, such as rejection, terror, violence.

Those who are forced to migrate have to face not only the consequences of those threats but also have to accommodate to abnormal circumstances in the new country, therein once again the development of self is interrupted and their identity is quite confused.

Now, identity diffusion is quite different from identity confusion. Here you would find that people experience problems with interpersonal intimacy, and that is quite often due to relationships within families where there is an interpersonal fusion, or enmeshment. So there is a loss of mutuality. The time perspective, the perspective of self, the perspective of work views, choices, etc, are interrupted and you find quite often that people who are experiencing identity diffusion go through a phase that is very dissociative and sometimes might even seem psychotic.

There is regression and sometimes an older person might appear to be baby-like or feel baby-like. They feel despair, depression, suicidality, poor concentration at work, preoccupation with self-destruction, excessive awareness and the abhorrence of competitiveness. On the extreme part of identity diffusion, there is a choice of a negative identity where young people choose role models often that their parents consider destructive, undesirable or dangerous, and I guess that this seems to be happening more and more in the current climate. So when one is faced with traumatic situations, adapting to and adopting a foreign country, having to live in ways that are foreign to one, this will cause conflicts. In our day-to-day life, all of us experience conflicts about different things and by and large we can resolve conflicts.

But sometimes conflicts are quite difficult to resolve, particularly when the environment is not conducive. So you have conflicts like the need for autonomy versus the need to be dependent; the need for submission versus the need to take control. Often, there is a desire to be cared for, but then there is a fear about allowing oneself to be cared for. Then there are conflicts related to self-value and identity. And I am sure that all of you would see people with these types of conflicts, particularly with guilt and sexual conflicts, self-value and identity.

There are those people who have great difficulty perceiving themselves as being conflicted. Unable to get in touch with their feelings, let alone express emotion.

These are the people whose negative feelings, (guilt, shame, anger) tend to locate themselves in the body structures, in body organs. This is what is referred to as somatisation.

So these people tend to present in local emergency units of hospitals with various types of illnesses and pain syndromes, but quite often it is their emotional distress that is translated into body symptoms. And it is indicative of people with conflicts, but with no capacity to resolve them, often they have fear of those conflicts.

So what are the effects of trauma? Trauma causes stress to the mind-brain system. In those cases the past and the future are limited. People feel disconnected from others, often within themselves, and experience dissociation. They feel a diminished sense of freedom and alienation. They experience a loss of trust in the environment, because as we know, the environment is supposed to be sustaining us, particularly the environment within a family home and within a local community.

But when people are traumatised they call into question human relationships and experience a loss of trust in those who have the power to make their living situations or social environment better.

Trauma has a profound effect not only on the self, but also on the systems of attachment and meaning, and it is by attachment and meaning that individuals and communities are linked together. So each community is linked together by a feeling of trust. Finally, they experience a diminished sense of meaning of life.

So how does trauma affect refugees? Now, we know that many refugees have experienced depravation, injury, torture, incarceration, abuse of all kinds, sometimes one, sometimes many of these types of traumatic experiences. Often people are witnesses to abuse events. They may sometimes come to being near death, have experienced the separation and loss of loved ones and have an altered sense of relatedness.

This brings about a sense of an inordinate amount of shame and humiliation. Parents, elders and children are often separated from one another creating great fear and distress. Now we know that these types of emotions have a profound effect on the neurobiological systems of individuals; similarly, with incidents of kidnapping, people experience a sense of foreboding and extreme fear.

The traditional values, beliefs and principles are often violated and most people, as a result, go through enormous amounts of grief and loss.

Now, grief and loss when experienced by a developing child, adolescent or young adult, interfere with the process of achieving one's sense of self-identity.

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Resettlement in a new country can also be terribly traumatic, adding to the trauma that has already been experienced.

I cannot talk about separation and loss without quoting John Bowlby because he brought the idea of loss and the need to resolve loss, to grieve over loss and have secure attachments to others. His work has important implications for normal development, but also for psychopathology, particularly for children's reactions to loss.

So if the circumstances are not conducive to normal grief responses, anxiety develops and the child has to cope or learn to cope in various ways to deal with grief. An example is a family where there are two parents and a couple of kids where a parent dies and the other parent is unable to grieve, and shows no signs of grief. The children then learn that this is how you have to deal with life events by just continuing to do what you have done all along. So tears are not allowed, talking is not allowed, yet a pervasive gloom or sadness lingers in the home.

Normally if a parent is able to deal with the loss of a partner and can encourage children to talk about the parent who has died and then after some time life resumes its normal trajectory. That is better for children's growth, rather than what I described earlier on.

Quite often we see adults who have not grieved normally over earlier losses. And when one loss compounds another loss, I mean the loss of a family member or other types of losses, like the loss of a job, the loss of status in society, or the need to flee one's country, it is difficult. Even when people leave their country by choice, often they have difficulty in the country they migrated to.

So attachment is very important. People who are securely attached throughout their development tend to fare better than those who have not had that security in early life. The latter might succumb easier to distress and trauma.

But the reactions to trauma must be seen as quite normal, particularly when the circumstances surrounding the trauma are horrendous and well beyond what one would normally be able to put up with. And, of course, we have to take notice of the cultures of the people we see because mourning in one culture might be quite different from mourning in another.

Psychodynamic psychotherapy is appropriate for individuals who have problems with identity and therefore problems of self. It is advocated that any type of psychodynamic psychotherapy, no matter what the model is, must include a phasic approach.

So when meeting somebody we need to work towards establishing a safe, secure therapeutic relationship with that person. We need to focus on the provision of safety and trust and pay attention not only to how the patient presents, but also to the patient's language. By language I mean the way in which he talks to you, the way in which he describes his circumstances or describes himself, because trauma affects coherence, continuity and clarity.

Trauma can cause people to fragment and dissociate. Quite often the person may present in a dissociative state, talk in a fragmented way, loose the continuity of his story, which may be fragmented and you cannot make sense of what is being talked about.

So to talk to such a person in lengthy sentences will not be received well. In fact it will create a sense of alienation between yourself and the patient. So monosyllabic responses, reflective intonations from the therapist and non-verbal responses, these are what help us to form a good therapeutic relationship with those who have been severely traumatised, and do not have the language initially to talk about their experiences and their problems at great depth.

In the case of young children and some adolescents, we need to use other ways to work with them, like sand play, play therapy, or art and music therapy in some instances. Some people are uncomfortable talking about their experiences. Even with adults, starting off with some art and talking about their artwork often helps them to feel a sense of safety in the relationship which enables them to verbalise their difficulties.

So the first stage is developing a safe, secure therapeutic relationship. One has to use a bottom-up approach because when people dissociate, their level of consciousness is constricted and therefore the level of consciousness is lowered, their speech becomes incoherent, their clarity impaired and more often than not, they are hard to understand.

Sometimes they are also interspersed with being out of touch with reality. So you can have some psychotic symptoms. There are times when therapists may think patients have a major psychotic disorder, like schizophrenia, but we need to differentiate dissociative psychosis from the other psychosis.

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The second stage of my talk is about exploring the individual's current relations with significant others and then, if a transference relationship develops, to work on this. We should only attempt to process traumatic material after safety is created.

Quite often psychotherapy has started, the patient quickly starts to talk about their trauma and the therapist also talks about it. Quite often such patients end up calling the therapist frequently out of hours, self-harming by overdosing or by cutting, and presenting to emergency departments.

When a safe therapeutic relationship has been developed, the patient's sense of self is strengthened in that relationship and therefore they are better able to cope with talking about their traumatic experiences and go into more detail.

The third stage is integrating the trauma into the sense of self because, as we know, a lot of people who have been traumatised dissociate, disavow or deny their trauma. Every individual uses various coping mechanisms, so our role as therapists is to help them integrate the trauma. When patients dissociate it is almost as if they do not want to think about it, or deny it happened to them. Whereas in therapy when it does come out it has to be integrated into that fabric of the self and so they have to end up saying, "It happened to me", "I wish it didn't happen to me" or, "I need to accept that this is part of my life".

So this is what I mean by integrating into the sense of self because when integration takes place there is a widening of consciousness, the speech improves, what was once incoherent and fragmented starts to become quite normal, then the sense of self is strengthened and self-reflectivity develops.

Quite often one sees issues of separation anxiety in these types of patients, particularly those who have left their homeland, their home and family. These issues have to be considered when ending the therapy because separation is re-lived once again in this therapeutic relationship which they have begun to depend upon so much.

We also need to deal with the shame and guilt issues and these are often a result of survival. Shame has to be very deftly and carefully dealt with.

PHOTO: RICCARDO BRUNI

Similarly survival guilt is also commonly seen in the psychotherapy of such individuals - the fear that they might have caused a negative event.

Often children feel highly responsible when something happens to their parents or their family, they may say: "It was my fault, I should have died". There may be cognitive distortion or negative beliefs about oneself.

So when survival guilt and survival shame are present, if we do not deal with them carefully, they prevent progress in therapy. Shame is usually not expressed openly, but the therapist has to wonder if what is happening is the result of unexpressed shame, and try to facilitate the expression of shame and other affects. It is most important to identify and help our patients express their emotions, because quite often when emotions are in their depths and the patient is not conscious of them, it gives rise to problems, difficulties and symptoms.

Neurobiological and scientific research shows that when the therapist focuses on the affective processes - the emotions, patients are helped to tell their stories and are able to gain some support from the psychotherapy.

Allan Schore who writes about the brain and psychotherapy, stresses the need for psychotherapy to focus on the affects because it literally alters the orbital frontal system. The non-verbal transference and countertransference interaction that takes place at preconscious and unconscious levels represents a right hemisphere to right hemisphere communication.

He says that the prefrontal limbic cortex retains the plastic capacities of early development and the right hemisphere cycles into growth phases throughout the life span. Twenty-odd years ago it was thought that as we grow older we shed off neurones as we age.

That is no longer held to be true because neurones grow and multiply in old age and the brain is so plastic that it actually cycles into growth phases throughout the lifespan.

So psychotherapy, which was considered inappropriate for someone in their 70s, is now commonplace and older people do actually make very good psychotherapy patients also. I am telling you that from my personal experience with older patients.

In therapy the conversational model is an integration of what is best in a lot of other models. It pays attention to language. It pays attention to the collaboration between therapist and patient, allowing the patient to speak, asking what they want; talking about their difficulties. This is very important. It is also important not to over identify with the patient and to focus not only on problems and conflicts, but also on strengths and resilience.

So in the situation of forced migration it is crucial to encourage parents to foster their children's capabilities. Because in the gloom of forced migration families are often stunted, they are dulled into submission, and the sense of hopelessness and helplessness they feel prevents them from seeing that their young children can in fact be helped, that they can recover, that they are resilient, and that they can have a good life. Sometimes it is very hard for them to see that.

Therapy with individuals and families also must focus on the strengths and resilience that is inherent in a lot of people, both young and old.

Therapy with individuals and families also must focus on the strengths and resilience that is inherent in a lot of people, both young and old.

So we need to explore those facets of self; strengths that emerge but are not apparent at times of distress. We also need to access those personal qualities, particularly when we have a young patient who is witty or humorous, persevering and determined. By highlighting strengths in the therapy process we can not only help them to develop a better sense of self, but also a better sense of self in relation to the community and the larger environment

So to wrap up, we need to look at identity as being a part of the self. Sometimes identity is mistaken by the social aspect of self, but identity is that aspect of self that develops from quite a young age and usually completes development in adolescence.

But trauma has a deleterious effect on the development of identity. Trauma can range from abuse in one's family environment to abuse in the wider environment, to traumatic relocation, dislocation and forced migration.

So I think it beholds us to, even though we cannot make everyone better, at least we can help some people and those that we cannot help we can give them a sense of hope, a sense that life is worthwhile.

Because, as we are seeing increasingly, the world statistics show that 40 percent of refugees are children and so working with children can help prevent future generations being vicariously traumatised and can also prevent intergenerational transmissional trauma. Thank you. ꟿ