

Trauma and resilience

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In this panel, which originates from the working group on trauma in EPF, we wish to broaden the scope of the understanding of the consequences of extreme or severe traumatisation. We have chosen a conceptual frame where the terms resilience and depletion/devitalisation reflect different courses in posttraumatic development, and which underscores the traumatized person's vulnerability and dependence on the environment especially for giving adequate responses to the complex and often enigmatic and contradictory messages emerging in a therapeutic or other contexts, expected to represent helping relationships.

While *resilience* points to the individual's ability to use resources in the environment, notably relationships with others and their internal resources and potentialities, the concepts *depletion/devitalisation* describe processes leading to a mental state of lack; lack of nourishment from good internal objects, lack of internal and external resources and energy and a state of deep and uttermost despair.

We will discuss the potentialities and possible usefulness of these concepts not only for understanding the traumatized patient, but also for their possible value in handling the therapeutic process. Since resilience designates progressive and potentially health promoting behaviour, countertransferential problems may emerge for clinicians used to focusing on vulnerability and pathology. It can be challenging to view what appears to be "acting out" as a positive attempt to restore agency.

Resilience in children has been defined as the capacity to negotiate ordinary developmental tasks, in spite of cumulative adversity (Eisold, 2005). Several protective factors are listed as important for the development of resilience, e.g. good intelligence, good communication and problem solving skills, the capacity to engage others in relationships, capacity for self regulation, and the ability to plan. According to Hauser and his group (Hauser, 2006, Hauser, 1999) based on a longitudinal study of early hospitalized youths, three general capacities characterized the group who as adults appeared to have achieved a relatively satisfying life in spite of serious family dysfunction (often abuse) and prolonged hospitalization; thus demonstrating resilient outcomes: the "belief that one can influence one's environment, the ability to handle one's thoughts and feelings, and the capacity to form caring relationships" (Hauser et al, 2005 p 262). These three capacities are by no mean separate factors and are, as we shall see,

expressions of underlying structures and processes about whose full nature and origins we still have limited knowledge. Hauser and others underline that these capacities represent processes rather than states and that “.. resilience does not lie in either the competence or relationship; it lies in the development of competence or relationship where they did not exist before” (Hauser et al 2006, p. 261). Alayarian emphasizes intrapsychic factors connected with resilience, such as the capacity to build a safe intrapsychic space where the person can: “ talk to themselves to regulate pain and protect themselves from too many vulnerable feelings” (Alayarian, 2007).

Depletion, on the other hand, has not been an explicit focus of research as has resilience. Adding the concept devitalisation, this dimension inscribes itself in the two structural dimensions of traumatisation, the psycho-economic dimension and the object relational dimension (Bohleber, 2000). Depletion and devitalisation can be described as process of gradual loss of energy. It is as if the mental apparatus is set on low burning barely able to sustain any wishes and vitality, and that it is furthermore depleted of any desire. From an object relational perspective this process can be described as a deficiency in the relation to caring, and nourishing inner objects. The traumatised person demonstrates less and less capacity to perform life tasks of care and self care, demonstrates a lack of inner resources and lack ability to use outer resources, i.e. other persons, for these purposes. We have important knowledge related to depletion/devitalisation from studies of Holocaust survivors and from studies of the life in concentration camps (Krystal, 2003, Krystal, 2001, Krystal, 1988, Krystal, 1971, Eitinger, 1973, Eitinger and Strøm, 1981, Levi, 1987, Niederland, 1981).

Resilience and depletion/devitalisation are concepts referring to visible characteristics of personality functioning and are concepts that do not directly relate to psychoanalytic concepts but nevertheless points to multiple determinants of processes, that is, overdetermination and the need for individual understanding of each person (Gabbard, 2006).

The phenomenology of posttraumatic states is, however, to a large degree characterised by the dialectic or the dynamic between “vitality” and “lack” that a discussion about whether these concepts can organise findings on traumatisation is justified.

In Hauser et al’s study it was apparent that the resilient youth did not show a normative development. Their lives had not been easy; they made

seemingly unwise choices and often faced troubles. What characterized these persons was, however, an ability to learn from experience.

In this panel we shall focus on the refugee population. We have found the concept couple resilience and depletion/devitalisation useful as a starting point for reflection on a group of patients who to an increasing degree knock on the door of western health systems, often receive minimal treatment, are as a rule not very well understood and are seldom seen by psychoanalysts. The sparse longitudinal studies of this population reveal a high prevalence of psychopathology (Lie, 2003, Lie, 2002, Lie, 2001, Dahl, 2001, Boehnlein, 2004) great risk for withdrawal and development of chronic conditions-- exemplified in, for example, enduring personality changes after extreme traumatising (World Health Organisation, 1993). On the other hand, clinicians working with this group have also seen astonishing positive changes even after long time of withdrawal, confusion and heavy symptom load; and research has shown that psychoanalytic psychotherapy may give positive results (Varvin, 2003).

Salient questions are: What characterizes those who are judged as resilient? Taking resilience research into consideration, which processes and kinds of interaction with the environment can influence development in the direction of resilience or depletion? We hold the view that resilience and depletion/devitalisation are outcome extremes; from a phenomenological perspective they may be on a continuum. And that dynamic forces are in play, which may shape the the nature of individual outcomes.

Do resilience and depletion refer to the same processes in the personality and its relation to the environment?

Depletion/devitalisation obviously refer to pathological processes. It is as if the struggle against the hopelessness of the traumatising experience is lost or about to be lost. The person withdraws and if there is no help or someone who cares, this withdrawal may be chronic, lead to diminished interaction with the world, disturbance in vital processes both psychic (lack of fantasies about a future) and somatic and eventually to disease and early death (Eitinger, 1964) (see the case presented by Gill Henschelwood in this panel). Resilience refers, on the other hand, to forces that seek to change, relate and learn. It may be reasonable to think that this refers to aspects of

the personality that are concerned with growth and development (Emde, 1991) and thus active inner dialogues and fantasies about a future.

In this connection it is pertinent to ask what role psychotherapy or psychoanalysis can play. Does psychoanalytic psychotherapy have what needs to make the difference? And what makes some patient able to use this opportunity to start anew relating, wishing to change and learn from experience?

We are interested in studying how psychotherapy can work for patients who are in an exile situation, often marked by adverse circumstances, poor living conditions, racism, loss and lack of familiar cultural environment. That is, many of the protective factors that have been connected with resilience are weak or absent.

What we can do in this panel is raise these questions, and begin discussing whether the concepts of resilience and depletion/devitaliation as used here can be fruitful.

We will use material from clinical practice and from a prospective single case treatment study of severely traumatized refugees (Varvin, 2003).

Vignette I

I have been able to follow this man for 16 years, seeing him through his adolescence and young adulthood, where he came for therapy in intervals but always keeping the contact:

He was from a country in the Middle East and arrived in Norway at 14 years old, together with his mother and two younger sisters. His father stayed in the region continuing the resistance fight. An older brother had been killed. His childhood from age 5 had been characterized by ongoing war; living clandestinely under dangerous conditions, frequent change of place of living and frequent interruptions at school. When he started treatment at the age of 15, he was a depressed and at times chaotic youth, living in a multi-problem family with a mentally ill mother, where he early had to take responsibility without having the capacities needed to fulfil the tasks laid upon him. He was at times severely suicidal.

He showed early emergent and often not very visible characteristics which have been pinpointed in resilience research. For example, he believed he was able to influence his surroundings; he tried to help the family in spite of lack of cooperation on their side; he struggled hard at school and managed

to accomplish well. He had ideas about relationships; and even though they were most of the time very few and not intense, he nevertheless tried.

Now, after 16 years, he has completed higher education and is about begin an academic professional engagement. He said he was in a fog for about ten years, not knowing what would become of him. When he was around 25, his trajectory dramatically changed, as he then determined to create a life for himself. We worked on some dreams in his therapy, where he connected with a deceased important relative. It was a transference dream where an uncle–doctor gave him the advice to pursue a peaceful path. He was at this time convinced that he should go back and fight the oppressive regime in his home country. It seemed as if the work with the dream made him halt and redirect his future plans. This was of course a culmination of earlier therapeutic work. His mind struggled with aggression and violence, and the need to take revenge. The reconnection, through the transference, with earlier good objects, representing relation in a peaceful part of his early life, seemed to help on a path towards health.

He thus seemed to benefit from the therapeutic relationship. The question is why he managed where so many others fail, and either withdraw or take on identities as aggressive victims.

Vignette II:

During an Adult Attachment interview, I asked a visibly depressed and devitalised refugee from Chechnya about his childhood experience. When asked about his relation to his father he suddenly burst out crying. He then told about early experiences with father and he markedly changed appearance, his face lightened up, his eyes glared and his gaze changed. He looked directly at me and smiled, although with sadness, revealing vital forces had been activated. This brief encounter with an early vitalising object relation activated a broad spectrum of emotions not previously apparent during the interview. The question is, again, what made for this inner change; and the change in the attitude of agency that it implied.

A similar sequence could be seen during a long psychotherapy with a woman much more devitalised and “depleted”.

Vignette III.

Elena was a thin, slightly bent woman, dressed in ordinary clothes and wearing a traditional Muslim scarf covering her hair. At the first meeting, she was

pale and talked in a low voice. Her eyes were much of the time fixed on the table or the floor, and from time to time she looked with a very direct gaze at the therapist. She gave an alarming impression of being not only very depressed; but a person who had almost given up life.

She came from a lower middle-class family in a large city in a middle-east country; the only girl with three brothers. She described her childhood as reasonably comfortable; except for her having to live in a crossfire between her conservative father, who believed girls could only take the Quran school and get married and a more modern mother who supported her wish for education. Early on she felt her father's attitude to be most unjust, but became accustomed to being quiet about her feelings while nevertheless pursuing her goals with a determined stubbornness. She was the one who took care of other people's problems, and she was extremely afraid of offending or hurting others.

While working in a legal political organisation, mass arrests began to take place shortly after her children were born. Her husband and several members of his extended family were arrested. Eight of them were soon killed or executed. Her husband survived heavily tortured. She was arrested with her two small children, then 4 months and 2 years old and they spent two years in the most inhuman prison.

First Elena and her two children had to live in a small cell, less than one square metre in size. As it was impossible to stretch out when sleeping, she developed a technique of bending her legs backwards in order to rest and to give the children more room. At the beginning of therapy (about ten years later), she was still obliged to sleep in that position to get some rest. Food was scarce and hygienic conditions were poor. At a time when her youngest child was about to die of hunger and thirst, the guard brought milk that contained a noxious substance that almost instantly made the child extremely sick and brought him nearer to death. For prolonged periods of time she had to stand, hooded, against the wall, not allowed to sit or take care of the children, who had to crawl on the floor. They could hear the screams of people being tortured, and the mother was hit while the children watched.

They were then moved to a larger prison where they were placed in a large, over-crowded cell. The fellow prisoners were regularly tortured, and bleeding and maltreated persons were a common sight. Many had their toes or fingers cut off, some became lame, and some were killed in front of her and the children.

The following are excerpts from her statements in therapy. The therapy was tape-recorded and I have reinterpreted the material with the perspective of resilience and depletion/devitalisation in mind.

P. Yes, because there we have seen so much, too much, we had never expected that human beings could do things like that.

Comment: she uses “we” and she says “we had never expected”, that is, there seemed to be a representation of a collective normality where things like that should not be done.

P. We have an old proverb saying that what you see is not the same as what you hear.

Comment: Analyst is an outsider, but nevertheless a potential witness in whom she can confide, one who can or cannot understand:

P. Yes, it was in the middle of the night, they had fetched one from the cell where I was and they raped her.

(Pause 10 seconds).

Yes, we were all in the same room, and they came, they could come 1, 2 or 3 men.

They were covered all over with black clothing so we could not see.

We could not see anything of those people, they were all covered.

And in every cell we were about 70 at the time. And then they came, placed themselves in the middle of the room, turned around several times pointing, and then suddenly stop, and the finger pointed at one of us.

The other of us had almost lost the breath while this man turned around, now it will be me, by coincidence.

When one was pointed at, we other could breath again, but we were desperate for the person who had been selected.

Because we did not know. Is it torture or execution?

(pause).

And I remember my friends, they were fetched at 4 o'clock in the night for execution and we were not allowed to raise

and say our thanks and say goodbye

And it was like that, if the fellow-prisoners took my children on the lap, they got whipped.

Comment: This is early in her therapy. She is talking about relations and feelings for others. The focus is equally on relations than on the atrocities done. She could speak about the survivor dilemma, the other and not me, and state the suffering in a way that could evoke empathic response in the listener. She was not, even at this point of exasperation, totally demoralised.

Thus, quite early in therapy when she was in a state of apparent depletion and seemed almost totally devitalised, emotion were present either represented as bodily pains, but also sometimes contained in herself or experienced projectively by the analyst. She later described her state of mind at this point in the following way: “Before I was afraid of everything, all the time. Now it is totally changed. I will never forget you.” Her conscious experience was thus mainly of fright and, as she said, she had not been aware it was fright.

Time does not allow telling her story of suffering here. Suffice it to say that the stay in prison was a malignant experience, where her main objective was to take care and protect of her children during the degrading conditions and stay alive during maltreatment. The five years she lived with her children and mother in her country after release from prison was a long fight for survival with repeated arrests, maltreatment and harassments of her and her family. She was suicidal and suffered sequelae after torture, and at times was totally lacking energy barely able to walk. “I had to crawl”. She later claimed that this was in many ways worse than being in prison. She lived in constant fear and the oppression did not stop when they had fled. The families remaining in the home country were and are constantly harassed; and the embassy kept exiles under surveillance and reported to authorities in the home country on their activities, and punished their families in different ways.

She suffered from a plethora of posttraumatic symptoms, bodily pains and depression and her emotional life was severely restricted. She was suspicious and withdrew from others. In therapy there was a first “honeymoon-like” phase where she could verbalise some of her experiences experiencing immediate improvement and trust in others, followed by a prolonged period lasting several years of mistrust and negativism, before a phase of integrating began where she was able to make mental

connections on her own; and work with what frightened her in her daily life, regaining her ability for reflecting and thus learning from experience and experiencing more agency in her life

Comment [sth1]: Sverre, Do you mean with respect to these feelings? To experiencing more agency over her life?, etc?

. Elena at first demonstrated a negativism characterised by withdrawal and suspicion, while at the same time showing a stubborn search for solutions with a lot of action, seeking alternative treatments, sabotaging sessions etc. For longer periods negative therapeutic reactions were regular and self-reflection and mentalising capacity was almost absent, making therapy tiresome and quite lonesome for the analyst. In hindsight, it was possible to see emergent signs of subsequent resilience, that is, signs of internal processes that to contribute to changes leading to resilience, which were present but in a brittle balance with traits of depletion and devitalisation.

Comment [sth2]: I wonder if you mean here signs of subsequent resilience; signs of internal protective processes, which might already be, or would, contribute to changes leading to resilience? I don't mean anything this wordy, but wanted to check on your meanings here

In one session she told about the torture and started to cry. She felt she had been *made* helpless and humiliated by the analyst, went home and isolated herself for two weeks before she returned to therapy. Her therapeutic experience was for her a long march towards something better. In spite of her tendency to negative therapeutic reactions and repeated breaches of the therapeutic frame (usually interpreted as “acting-out”), she stayed on in therapy and managed in the end to live a reasonable life although suffering from bodily sequelae after torture.

“Discovery” of early good objects played also here an important role in her recovery. In one session she was able to re-discover a good relationship to her grandmother. Grandmother had earlier in therapy been regarded as harsh and unempathic. It was obvious, however, that this mental picture of her grandmother had been coloured by later experiences of oppression, which thus had *nachträglich* destroyed a libidinal source for her.

Elena showed, then, a resilient pattern where she managed to she recover from her devitalised state, use relationships, especially the therapy relationship, where she never gave up the desire to make something of her life (the so-called “acting out” could, in this perspective, be seen as attempts and restoration and a sign of agency) and where she gradually became more reflective and thus able to learn from experience. She came thus out of a condition of almost total depletion and lack of vitality. Again the question is what made her benefit from the special relationship of psychoanalytic psychotherapy?

Bearing in mind the motherhood constellation (Stern, 1995), the theme of maintaining the life and growth of her child probably was an important factor

connected with her resilience. She knew that if she had given in, she would have failed her children. Keeping emotions inside and not react, had been a life saving strategy during her life under oppression, which led to severe bodily pains and probably was a background for many of her posttraumatic problems. In her therapy she had to learn in her own way how she could regain access to emotions and thus gain vitality.

Discussion

Depletion and devitalisation are concepts related to the effects of the internal struggle with the impacts of traumatising experiences. This internal struggle is, however, dependent on the emotional, relational and social context of the survivor. Numerous studies have shown that survival and resilience are dependent on how others meet the traumatised after the traumatising experience. I will mention only one, as this shows clearly what is at stake. Keilson and Sarpathie showed, in their study on Jewish children returning to Holland from the camps and from hiding after the Second World War, that traumatisation was sequential. Three sequences were identified: 1. the oppression in Holland; 2. the experiences in the camps and in hiding; and, 3. the return. The last sequence was most determining for health 25 years later and there were two aspects that was important: affirmation of experiences during the atrocities and affirmation of their identity as Jews (Keilson and Sarpathie, 1979).

This study, and others, shows that what happens after traumatisation is a complex process involving the subject's relation to others and the world on several levels. The posttraumatic process implies complex relationships where the development of resilience cannot only, or maybe primarily, be seen as dependent on individual factors be it personality or genetics. Resilience researchers agree about this point, and put weight on culture, ethnicity, social network, family relations etc (Harvey, 2007, Tummala-Narra, 2007, Eisold, 2005, Fonagy et al., 1994, Crittenden, 1985).

We could see in the vignettes presented above that the three factors summarised by Hauser; agency, capacity or interest in close relationships and reflexivity were present. I think, however, that one could identify these in all reasonably successful treatments. The question is what determines that these will develop into strategies for creating a better life *in spite of* previous hardship and

Comment [STH3]: "relationships is probably too general a terms, and I think we meant, but did not always specific, close constructive relationships (or at least close ones)

traumatisation? Agency, reflectivity and close relationships are dimensions involving several aspects of personality and its relation to others and the world. In my case vignettes good early relationships became apparent as a vitalising force possibly activating resilient ways of coping. Attachment research clearly shows the interconnectedness of relationships, capacity for self reflection and capacity for agency (Crittenden, 2002, Bowlby, 2001, Fonagy, 2001, Fonagy and Target, 1997, Crittenden, 1996, Fonagy et al., 1993, Crittenden, 1992, Crittenden, 1985). Other clinicians and researchers (e.g. Alayarian 2007) have also referred to the importance of early relationship experiences, which suggest conceptualizing and studying attachment as a possible mediating element in development of resilience. I say mediating factor, since the development of early good object relations may be exactly what characterises resilience. Schore claims, for example, that resilience against trauma or deleterious effects of trauma is founded in a good enough early attachment to the caregivers and that trauma or neglect in this phase makes a person vulnerable to later traumatic experiences and that this to a large degree can explain why only a portion of those exposed to traumatising experiences develop PTSD (Schore 2004).

In the following I briefly describe a model that can serve as a framework for the further development of our thinking in this field. In agreement with the view that social trauma and its after-effects are linked with the individual's relation to others and the social context, three levels of interaction can be identified:

1. *Subject/body-other relation*: This dimension concerns the individual's relation to the other on a dyadic level; this is the level of emotional bodily-mediated regulation of affective states. Emotional withdrawal will diminish the possibility to use others in the process of modulating negative affect. In disordered states, the person may be unable to concretise or symbolize the sensations. Within this dimension, important nonverbal emotional regulatory processes occur between self and others and there is a self-soothing reliance on internalised object relations. Research on affective self-regulatory processes (Schore, 1994) and interpersonal regulatory interactions has demonstrated that these self and relational processes are key for maintaining psychological safety. This is especially pertinent to the regulation of negative or unpleasant arousal, which depends on safe early attachment relationships and good enough early containment by mother/caregiver (Bion, 1967, Bion, 1962) These relationships, in turn, are dependent on a growth-promoting cultural and social context (Obeyesekere, 1990), including family and social network

support (Hauff and Vaglum, 1995). Moreover, it is reasonable to consider that what on a social psychological level is identified as the urge to create emotional bonds is contingent on a belief shared by the participants in a dyad and a group that emotions can be regulated at this level.

2. *The individual's relation to the group*: this is the level of identity formation where one finds one identity as both a member of a family, group, community and nation, but also as being different and unique. The group functions both as a safety background, an arena for intimate emotional relationships as in the family; but also as source to knowledge on what one is and what one should/could do. In the family and other close/intimate groups one learns from its members and acquires the ability to empathize and take the other's perspective.

A malfunctioning group creates a poor background for what may be a desire to change, to relate, and to reflect. In societies where the family and the related larger grouping (e.g., clan, tribe) are the most important organising units of society, and where belonging to such a group is of fundamental importance both for personal and social identity, disturbances in this dimension may have grave disorganising effects.

3. *Subject discourse dimension*: This dimension relates to the individual's relation to components of his or her culture--to religion, cultural narratives such as folktales, philosophical texts, moral codes, norms and so forth. It is this level where shared meanings are established; with this cultural level serving as a reservoir for finding ways of understanding existential themes, life-crises, developmental challenges, rite-de-passages etc.

[Binding and unbinding relates to all levels thus evoking concept of symbolisation on the hand and the functions of the drive on the other; the unbinding force of the Death drive the binding force of Eros with its connection to object cathexis. Repetition compulsion can function on several levels but without its bin ding up to the symbolic it tends to become pure repetition.](#)

Resilience must, from this perspective be studied, *not only* as personal characteristics or as a results of favourable circumstances, both called protective factors in resilience research (e.g. intelligence, good relations). Resilience is an outcome of a complex process *involving the individual's and the group's relations on several levels and also likely involving the interplay of these levels with each other..*

Depletion or devitalisation on the other hand seems to belong to the psychopathological processes and involves lack and draining of resources involving vital body-mind processes.

The question of why someone is able to take advantage of available resources be it in therapy or outside, remains still open. Maybe this is not the right question. Resilience as a set of many individual and relationship processes only describes a development over time seen from a social-developmental perspective. There are probably different answers for each individual regarding the bases of their resilient outcomes.. The three factors mentioned by Hauser, general as they are, represents to my mind a window through which each process can be studied in its individuality bearing in mind that there probably are general processes related to resilience to be identified. Attachment research may possibly open up for understanding of one set of mediating factors involved in the development of resilience. From a clinical and practical point of view it seems, taking the conditions refugees are offered in Europe today, we probably know a lot. Yet at the same time, we need to build more systematic interdisciplinary knowledge—which will include individual, interpersonal, family, and sociocultural domains---on how to avoid counteracting or destroying capacities for resilience. In the end, hope for a better future is built on the capacity to fantasise about and project on our inner screen, ourselves in a different situation. Totalitarian conditions destroy fantasy. It is sad to notice that many refugees coming from totalitarian regimes meet totalitarian conditions as asylum seekers.

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