Contemporary Reichian Analysis and War Trauma

Edoardo Pera

ABSTRACT

This article is based on the author's experience, primarily in the Middle East, in post-emergency missions over the last 20 years. It is an exploration of war trauma, and how Contemporary Reichian Analysis can make sense of it and potentially help those afflicted, even in combination with other approaches. Given the complex social, cultural, and political landscape, our research is still only at its inception in seeking to better understand the elements of war trauma and suggest bodily interventions. However, in the field, there are certain steps that are possible to take and others that cannot be done.

Keywords: war trauma, Contemporary Reichian Analysis, post-traumatic symptoms, torture, arrow of time

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A Drop in the Desert

Syria, just before the outbreak of war. Tensions are high. For days, M, a young man, has been nearly tortured to death. He is finally released at the end of this torment, and, as he leaves the building where he has been detained, a sniper shoots and hits him three times. News of his death begins to spread, and reaches the media. At this time, in Syria, a single death still makes the news. His relatives come to collect the body, but someone notices that M is still alive. They immediately take him to Jordan, where he has several operations. He survives, but carries a number of wounds and scars. This is one of many stories we have come across in the past few years. I recount it because M is a patient of Hala, an inexperienced, 23-year-old Jordanian psychologist I am training, along with other psychologists and practitioners, during my assignments in the Middle East. It might seem to be a hopeless story; traumatic individual and collective experiences multiply and overlap, creating a thick fabric of suffering and post-traumatic symptoms.

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we can say is that those who work in these areas have come across minds and bodies that carry much of this suffering – lost or fearful minds, and hurt and tortured bodies, which all carry the painful memories of those experiences in their aching contractions.

Trauma and the Body

Trauma (from the Greek "wound", "breaking"), by definition occurs as an event, or a series of events, with characteristics that are exceedingly hard for the individual to integrate, overwhelm their ability to cope, and threaten the integrity and cohesion of their consciousness.

Thanks to extraordinary developments in neuroscience, studies on the effects of trauma have advanced considerably over the last few years. Functional magnetic resonance and other investigative techniques have highlighted the role of the body in traumatic experience, and evolved our understanding beyond previous maps that were rather disembodied. The principal studies on this subject (Van Der Kolk, 2014; Odgen & Fisher, 2015; Siegel, 2021) have highlighted how the body, being the first to "keep the score," is also the first to be involved in the therapeutic process. In *Refugee Trauma Clinic*, Vercillo and Guerra write:

> *The body, itself, is the main target of violence and trauma and the many possible assumptions derived from the experience can have a wide range of potentially debilitating, psychopathological impacts. These may arise at the moment of the traumatic event itself, or they can take hold afterwards, so they could be found immediately after the trauma, or in chronic forms later. In fact, it is precisely "the body that keeps the score"* (Van der Kolk, 2014) *and carries it forward. This is why today, by common agreement, we cannot conceive any form of trauma therapy that does not take somatic intervention into consideration in one of the three phases of common post-trauma treatment* (Vercillo & Guerra, 2019, p. 102).

The common agreement to which the authors refer can essentially be summarized as a three-phase process:

1. ***Stabilization***, during which we proceed by increasing emotional adjustment and reducing, as much as possible, situations of hyper- and hypoarousal, leading the person to stay within their window of tolerance. We try to resolve the more debilitating symptoms and behavior and, in particular, dissociative states. This allows us to establish, or reinforce, the therapeutic alliance.
2. ***Elaboration of the traumatic event***, with the chance to revisit those painful experiences while having already laid the groundwork for the patient to tolerate this re-emergence.
3. ***Integration*** of the elements of the patient's inner experience, as well as social and relational integration in their life.

These three phases are clearly interconnected. Certain aspects of one or another may emerge in different moments, but dividing the process into these stages is nonetheless very helpful.

This three-step approach has been widely applied in the field, and implies that for an individual to face the elaboration of traumatic memories, they must first be able to bring those memories closer without risking destabilizing themselves, or falling into negative therapeutic reactions.

Vercillo and Guerra again note that the concept of stabilization is drawn from the field of medicine – unless it is an emergency, before a patient undergoes surgery or any similar form of intervention, a patient must first be "stabilized." This fairly intuitive concept has long been neglected, but, over time, clinical experience has provided a solid basis supporting the need for this very phase.

The authors also point out that it is essential for the patient to begin overcoming their phobia of memories, emotions, and parts, as first defined by Janet and subsequently by others, during the first phase of treatment. Vercillo and Guerra note how each part feels repulsion towards the others, and tries to suppress them:

> *The treatment of this particular phobia, between the Parts, is a priority objective of the therapy to promote … an alliance of its subsystems that is profitable for the person, and to proceed towards future integration.* (Vercillo & Guerra, 2019, p. 135)

It can be seen how this approach is the opposite of attempts to eliminate the "bad" parts, and instead aligns with an interpretation that seeks to include the intelligence of symptoms and subsystems among the possible keys for therapeutic work.

In recent years, we have received valuable information from neuroscience on the central and autonomic nervous systems. From the point of view of the central nervous system, effective psychotherapy should operate by restoring both the limbic and neocortical structures to the homeostatic state that was present before onset. In studies on the neurobiological effects of some psychotherapeutic interventions, it has been seen that good outcomes show a reduction in the activity of the amygdala and insula, and an increase in activity of the anterior cingulate dorsal cortex and hippocampus (Pagani, Cavallo, & Carletto, 2019).

At the same time, we must evaluate the reactions of the autonomic nervous system, which, as Steven Porges' Polyvagal Theory has shown, responds to stress not only with the fight/flight response, as has long been believed by scientists and therapists. Facing danger and threats to one's life can activate the response of the dorsal vagal system, the oldest and most unmyelinated branch of the parasympathetic nervous system, leading to immobilization or collapse. These types of response occur outside the person's consciousness and control (Porges, 2017).

Contemporary Reichian Analysis and Trauma

What can Contemporary Reichian Analysis say about trauma? The introduction of the arrow of time into the model has allowed connection of the various bodily levels with their corresponding evolutionary stages. The development of the personality and its specific combination of character traits can be compared to the construction of a multi-story building. The various evolutionary phases make up its floors and apartments, each built one on top of the other. The intrauterine stage, the oral stage, the muscular stage, and, gradually, all the others, together constitute the construction of the building, which proceed along the arrow of time as ontogenesis. The relational body levels become successively dominant according to the functionality of each stage. Hence the sixth level, the abdomen, will be prevalent in the intrauterine phase; the second, the mouth, in the oral stage, and so on, in a sequence held together by the various steps of ontogenetic development. Experiences, the incised marks that occur during the various phases, will make each of those apartments more or less functional and harmonious, building up to a combination of absolutely unique, unrepeatable architecture. Events that unfold in the here and now, or "scene changes," can resonate with this or that stage, and reactivate certain patterns. Thus, what can the effect of a certain type of trauma be on this *unicum*, this unique combination? Is it sufficient to define the effects of trauma as very powerfully incised marks?

> *The arrow of internal time can be approached by, and can be identified with, the evolutionary negentropic arrow, so if a certain event produces vital alarm in the depths, or a lacerating wound connected with infinite, screaming impotence … then it is close to the entropic zero of the arrow and activates the pre-subjective areas and networks of the reptilian brain, which are responsible for survival. This type of event can be devastating and can activate the locus coeruleus, which is in charge of red-alert situations in the self, even going beyond-threshold* (Ferri, 2020, p. 79).

Hyperactivation of the locus coeruleus, in conjunction with a state of panic and deep anguish, therefore resonates with an interior time that precedes the development of the limbic system; it touches a layer prior to the development of affectivity and relationality. It follows that, even in the here and now, a devastating event can activate the sixth level of the abdomen at the bodily level, driving the depths of this system close to entropic zero, and reawakening historic relational and energetic patterns.

To use an analogy, the mass of a celestial body deforms the fabric of space-time, folding it around itself. Surrounding bodies are affected by this curvature and, depending on their mass, their movement along the space-time fabric is also deviated to a greater or lesser degree. Similarly, trauma bends and deforms inner space-time. It becomes an entropic attractor that suddenly seizes the other traits and imposes its weight on the general organization of the personality, effectively shifting its function towards those pre-subjective areas of the reptilian brain of which Ferri speaks.

In fact, fieldwork with highly traumatized people regularly reveals these deformations, which have been created within the personality and in the person's perceptions.

"However, in war – and in particular in related violence, including cases of torture – the limbic neural network, connected to relationships and affectivity, is often not easily reintegrated, precisely because of the profound distrust that these experiences generate towards human relationship."

> *Prior forms of knowledge, which is to say the typical prejudices with which we interpret our existence, are, in fact, substantially modified by the traumatic experience and influence the ways in which the subject suffering from post-traumatic pathology interprets his own existence (Vercillo &* Guerra, 2019, p. 79).

In these cases, the experience of time and space and of one's own body, as well as the concepts of self, the world, and human relationships can be substantially modified. For example, time may seem to expand, contract, or stop; it may lose its direction or linearity and become circular, or blocked, and its continuity may be interrupted. The body can be perceived as a place of danger, or not be perceived as one's own, etc.

War

Traumatic experiences related to war differ from those resulting from accidents or natural disasters, primarily because their causes include destructive human will. A catastrophic natural event or accident will certainly resonate in the reptilian areas of the brain, but the exclusion of the upper limbic areas is often temporary. An example was given to us after the earthquake in Nepal, where it was possible to see how networks of relationships and affection played a fundamental role in post-traumatic recovery. Having lived through an event with someone, and later being able to share emotions with significant people, were powerful factors assisting recovery. Their importance applies to all types of trauma, even those related to war. However, in war (and in particular, in war-related violence, including cases of torture), the limbic neural network, connected to relationships and affectivity, is often not easily reintegrated, precisely because of the profound distrust that these experiences generate towards human relationship. In this case, there is a collapse in relational ability, in addition to the impotence, vulnerability and difficulty of making sense of and deriving meaning from what has happened that are general characteristics of trauma. This has been systematically observed in veterans of various wars, beginning in Vietnam, and continuing to the most recent observations of survivors of conflicts in Syria and Iraq. It is also seen in displaced refugees.

Other elements, in addition to these characteristics, are apparently practical in nature, but, in reality, are linked to a deeply emotional dimension. For example, one of the main problems in treating trauma is that it is impossible to process it as long as the conditions of danger and alarm remain. This is a situation we have often encountered in refugees or war survivors. When refugees are gathered in camps, one could imagine that there would be newfound stability, but reality has taught us this is not the case. A high degree of alarm is still present, and their precarious condition remains, which prevents them from working through traumatic events while maintaining the right distance, which can occur only in a safe environment. In addition to the self-evident fact that a refugee camp does not restore the solidity of social networks, it must be said that violence quite frequently occurs in these camps – enough to note that we have repeatedly found that women avoided going to the bathroom after sunset due to the risk of being raped. All these factor keep people in a state of alert and perceived danger. The work performed in these contexts is, therefore, largely oriented towards supporting emotional stabilization, which is a necessary, primary condition in any intervention in this sector. Situations favoring increased resilience are sought, and "resilience groups" are created.

In working with refugees and survivors of wars, migrations, and natural disasters, we have seen that some factors influencing resilience can be increased, especially by rebuilding the network of relationships and the elements that confirm safety (in both a literal and broader sense). We must recreate a situation as close as possible to what was

normal for these people before the event. For example, for children, besides the resilience groups where they can play and express themselves, it is important to provide them with a "school experience." Of course, there are also factors relating to individual resilience; one fascinating hypothesis suggests there may be a form of trait resilience, meaning that each trait may have its own level of resilience and, therefore, the person will respond accordingly, depending on which "apartment" of the building is recruited by events.

Possible Activations

My colleagues and I, and Cristina Angelini in particular, have asked ourselves which bodily interventions are possible and, of course, useful, in specific, post-traumatic contexts. These are in no way comparable to the settings that we would provide in our European consulting rooms. We face two kinds of issues. The first relates to therapeutic appropriateness, which is a theme dear to Contemporary Reichian Analysis, according to which interventions should be oriented and calibrated to the specific combination of traits of the individual and to his or her personal history, as opposed to any standardized form of treatment ("aspirin for all"). The second relates to the specificity of the cultural and social context in which the intervention is carried out.

Both aspects are problematic and, in these circumstances, require some form of adaptation. I should mention that I have always worked in a post-emergency context, primarily in the Middle East, though also in Africa and Nepal. In this context, for example, there is strong inhibition to physical contact, especially between men and women. Furthermore, the use of a setting that includes a couch or mattress on which the patient can lie down is far from how psychotherapy or general interventions of a psychological nature can happen in these areas.

Years ago, when needing to choose bodily activations to be included in the work conducted in Syria and Jordan, we decided to focus on grounding and on the "nose-to-the-sky with stable object" activation, both being interventions which, if used properly, favor stabilization.

This is how Ferri describes this activation:

> *The analyst is stationary behind the person holding the pen-light perpendicularly above the glabella [the cavity between the forehead and the nose] at a distance of 30-40 cm. The patient is lying on the couch with their legs bent and actively experiences the reciprocity of the relationship. The person moves their eyes until they reach the object and then returns their focus to themselves and to their own nose before returning to the object again. This serves to emphasize identification, the here and there and the movement possible, but, above all, it emphasizes the returning to and the re-focusing on themselves "in the presence of the other who is there, stable, luminous and supportive for this pattern!"*
>
> *The bodily activation of "nose-to-the-sky and stable object" is a highly-negentropic acting.* (Ferri, 2020, pp. 41-42)

The activation was specifically adapted to the context in which it was applied – instead of lying on the bed, the person was seated, and the light was placed at a greater distance. Even some grounding exercises had to be adapted to the type of clothing worn, and physical contact has been limited. Both types of intervention have nonetheless received much positive feedback, and have been regularly used by local psychologists and their patients. Given the difficulties in obtaining the right conditions for longer-term interventions, it has often been necessary to integrate the mind-body approach with other tools and, in particular, with elements of psychoeducation, EMDR, mindfulness and narrative therapy. Nonetheless, in using these tools, attending to and emphasizing the rooting of emotions and experiences in the body has never been neglected.

What perspectives exist with regards to what Contemporary Reichian Analysis can offer in similar contexts? We have already said how, at a theoretical level, it helps us interpret what is happening in individuals and groups in the face of war trauma, but what can be done at a practical level?

This second question has not yet been explored fully in the field, and, for now, the context itself has limited interventions to those aimed principally at stabilization and strengthening the sense of self. In the future, I believe it will, however, be possible to introduce further activations to help strengthen the sense of self, despite the need to adapt to sociocultural conditions.

"We can see the light of a flame in the darkness that, however small it may be, is fiercely resisting, with the strength of life itself, and is helping us all to continue our shared journey"

What About the Drop?

I said at the outset that working in difficult contexts such as those mentioned here is a bit like carrying a drop of water across the desert. But what happens to that drop? M, with the help of Hala, is now feeling better, and helps other survivors of torture to recover. D, a woman who was gang raped and could no longer sleep, is now able to. War distresses us, but every time we manage to get that drop into a person's heart, we can also feel our own hearts opening up. We feel that our efforts have not been in vain. We can see the light of a flame in the darkness that, however small it may be, is fiercely resisting, with the strength of life itself, and is helping us all to continue our shared journey.

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