

Acute Trauma In Adulthood in The Context of Childhood Traumatic Experiences

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In this paper I will present the case of Paul, who survived an assault as a young adult, resulting in a traumatic brain injury and post-traumatic epilepsy. Paul's reactions to this traumatic event in adulthood are considered in the context of his earlier traumatic experiences, his psychodynamic conflicts, and his characteristic defense patterns. Transference and countertransference will be considered from the viewpoint of psychodynamic therapy with a traumatized patient who has been in a complex, dependent relationship with one of the perpetrators. Paul's progress in therapy will be reviewed, including his realization of the profound impact of trauma on his life and his strong will to work through his issues.

Keywords: abuse; predisposition; trauma; epilepsy; vulnerability; resiliency

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Introduction

Defined broadly as an overwhelming experience, resulting in a patient's sense of helplessness, loss of control and inability to adequately defend the psyche from stress, trauma is present in the lives of many people (Herman, 1992). Children are more vulnerable to trauma due to their underdeveloped defenses and overall lack of ego strength (Herman, 1992). Mature adults, on the other hand, live long enough to have an increased probability of encountering an overwhelming experience beyond their ability to manage it, despite having developed mature coping mechanisms.

Literature on the vulnerability, resilience and predisposition to trauma includes both neurobiological protective factors, such as increased hippocampus size (Higgins & George, 2007) and psychosocial protective factors, such as high sociability, thoughtful and active coping style, strong sense of agency and internal locus of control (Herman, 1992). Combined, these protective factors decrease the probability of a stressful life event becoming traumatizing for a specific individual. However, a purely quantitative approach to trauma – where the cumulative value of available resources is compared to the cumulative value of stressors – is a limited approach, as is the approach where a combination of prior internal predisposition and sufficient external stress necessarily results in trauma (Balint, 1969).

As Balint pointed out, trauma is a qualitatively different experience from those of everyday life; and various attempts to reduce trauma to a simple mathematical formula did not help improve the accuracy of the trauma diagnosis, nor make the diagnosis of trauma any less complex (Balint, 1969). One possible hypothesis about a qualitatively different experience in trauma is a neurobiological one formulated by Solms and Turnbull (2002). They suggested that during a traumatic experience a person's hippocampus fails to fully encode an explicit, autobiographical, "intrinsically

conscious” (p. 160) memory, known as episodic memory, while traces of procedural and semantic memories are formed. Procedural memory can be described as an implicit memory of “habitual *motor* skills” (p. 56), while semantic memory is “an objective, factual information about the world and its workings” (p.150).

As a consequence of the impaired episodic memory encoding by the hippocampus, one might state that a traumatic experience is not remembered in a fully conscious, emotionally-aware sense; there is no coherent subjective experience of a traumatic event encoded in an integrated manner with the idiosyncratic, affective perception of what has happened. Moreover, the subjective traumatic experience in that sense cannot be fully retrieved and relived, since there is no full episodic memory of it (Solms & Turnbull, 2002), but only the bits and pieces of procedural and semantic memories. (Solms and Turnbull suggest that traumatic events can sometimes be encoded in a “*degraded* episodic form, with a result that greater effort will be required to retrieve them, and the final product will be more or less unreliable” (p. 170)). Therefore, the traumatic experience often cannot be put into words of a first-person account; it is usually presented as a third-person narrative of some objective facts related to the experience (semantic memory traces). In essence then, a person’s traumatic experience is remembered as if he or she was not present at that moment as a reflexively conscious subject (Solms & Turnbull, 2002), but rather as if he or she were an objective neutral observer who had also developed automated unconscious responses to the traumatic stimuli. Such a combination can in fact be very confusing for a traumatized person, since there is no reflexive consciousness tying together the automated behaviors (procedural memories) and the fragmented pieces of factual (semantic) memories.

While these neurobiological aspects of traumatic memory can be very helpful in understanding the behavior and subjective experience of people with a history of trauma, an over-emphasis on the effects of trauma on memory also presents several diagnostic risks (Ingraham, personal communication, 2013; Poulos et al., 2013). On the one hand, the absence of a fully encoded episodic memory in trauma may lead one to the (possibly erroneous) conclusion that patients capable of describing specific past events coherently, emotionally and from the first person perspective were not traumatized during these events. On the other hand, assuming that a patient's inability to present a coherent, emotional, first-person narrative is the only sign of trauma may cause clinicians to disregard other important signs, such as hyperarousal, avoidance, dissociation, numbness, fixation on trauma, intrusion of memories, persistence of startle response, constriction of affect, and other symptoms (Herman, 1992; Van der Kolk, 1987).

Thus, it is important to note that trauma is more than just disturbed episodic memory encoding; that one symptom is insufficient to confirm the diagnosis of trauma; and, finally, that traumatic experiences vary considerably. In sum, despite the increased research interest into psychological trauma in the last twenty years, trauma is a complex biopsychosocial phenomenon and we should not attempt to reduce it to a simple formula. Despite these challenges, specific qualities of a patient's narrative are clinically meaningful data that can be considered in formulating a working hypothesis of trauma.

Statement of Question

Given the complexity of factors involved in the onset of trauma, it may be useful to consider one contributing factor at a time. While I fully appreciate the importance of

neurobiological and social factors in trauma etiology, in this paper I focus primarily on the psychodynamic context of an acute trauma in adulthood. Specifically, I will explore the following questions: How does a person's character structure (McWilliams, 1994), core conflicts and mental patterns influence his unique, idiosyncratic experience of trauma in adulthood? More importantly, how does such developmental context affect diagnosis and the course of therapy? I will use the case of Paul, presented below, to help elucidate these questions (the patient's name, as well as autobiographical details in the case have been changed to protect his confidentiality).

Case Material

Paul, a 37-year-old single college student, sought treatment due to feeling "empty." He stated that his goals in therapy were to feel more "whole and integrated." Paul was born in a European country; his family moved to the U.S. when he was four years old. He has a younger brother and a sister. As a seven-year-old boy Paul witnessed his father beating his mother. Paul wanted to help her, but wasn't able to do anything. He felt scared, helpless, and confused. Witnessing this episode of violence seriously disturbed Paul, and his parents arranged for him to see a therapist, who then called Child Protective Services. During the CPS investigation Paul's mother asked him not to tell CPS anything about the incident, as "it would not be good for the family." He complied with her request. Paul also stated that his father beat him from the age of eight into his twenties. His brother and sister also sustained physical abuse from their father.

Paul revealed a longstanding history of marijuana use, starting from the age of 15 years old. He experimented with other substances in his early twenties, including LSD, crack cocaine, heroin, and ecstasy. At the time when Paul presented for treatment he was smoking marijuana and tobacco, and drinking alcohol regularly.

Paul suffered a traumatic brain injury at age 24. He remembered that he was leaving a nightclub one night and suddenly two men approached him. One of them punched Paul. He fell down, his head landing on a curb during the fall. He lost consciousness. Paul was taken to an emergency room in a nearby hospital. He had a right temporal region hematoma, and was in a coma for a week. While some doctors expressed little hope of Paul's recovery, his father arranged for a complex craniotomy for him, which was successful. However, Paul was in an induced coma for three weeks after the operation.

Five years after his operation Paul experienced a sudden-onset generalized tonic-clonic seizure while walking through a parking lot. He was taken to the hospital and diagnosed with epilepsy. During the next several years Paul met with multiple neurologists at various clinics, who prescribed different anticonvulsant medications for him. However, he continued to experience partial and complex seizures, and he experienced hallucinations while being on one of these medications, which scared him. (Although he attributed having hallucinations to the medication's side effects, his hallucinations may have been related to epilepsy [Sacks, 2012]). Paul's seizures didn't stop until 2009, when the dose of his medication was substantially increased. An MRI conducted about a year after Paul had been diagnosed with epilepsy showed tissue loss in the bilateral anterior frontal lobes and in the right temporal lobe.

Paul had mixed feelings about taking anticonvulsive medication and wanted to stop taking it. He was concerned that the medication was sometimes used as a mood stabilizer and thus it could negatively affect his personality; he also complained about having low energy and feeling tired. When asked if he knew how alcohol interacted with his anticonvulsant, he stated that he had been drinking a lot longer than taking his medication for the epilepsy. I thought that his answer was defensive and that he was

aware of the risks of combining alcohol with anticonvulsive medication, especially when driving a car. Most importantly, Paul did not see a neurologist for two years prior to the intake in our clinic, despite the need to monitor his condition.

When I first met Paul, he attended college full-time and occasionally worked as a waiter. His father paid for his education, medical insurance and some other expenses. While Paul did talk about his traumatic experiences early on in treatment, he did not present with symptoms of acute PTSD. Moreover, he generally seemed to have metabolized his traumas when I first met him – he talked fluently, matter-of-factly, and without affect about the beatings he endured in his childhood.

Paul came to our first session in a torn T-shirt, shorts and sneakers, and he greeted me with: “Hey, man.” He was tall, handsome and intelligent. During the session he looked straight at me most of the time. I felt measured and tested. He presented himself as a poor but free-spirited artist, who felt contempt for the regular, boring “nine-to-five-type people.” In addition, he spoke with a tone of righteous indignation about the institutionalized authorities, such as the federal government and insurance companies; the “system” was hopelessly “screwed up.” (As I discovered later Paul’s exaggerated reactions to various authority figures were in stark contrast with his terrified and helpless compliance with his father. Thus, his repressed anger was likely displaced onto safer objects.)

Paul yawned widely during sessions and stretched as if he had just woken up. He would also routinely stand up in the middle of talking about something important and go to the bathroom quickly and decisively. After coming back, he would casually say “sorry” and immediately resume talking, as if nothing happened. I explored this pattern with him by observing that he was apologizing. I intended to use this comment as a close process monitoring intervention (Gray, 1973). He seemed surprised and responded

that he was sorry for interrupting the session. He said that his bathroom breaks were related to a natural physiological need. I agreed and pointed out that there was no harm done then, so I wasn't sure why he felt a need to apologize. In response, Paul stopped apologizing, but continued his mid-session bathroom breaks.

My supervisor suggested that Paul was showing me what he could not tell me – that our sessions were too intense for him (Ruth, personal communications, 2011). Subsequently, I focused more on empathic attunement (Rowe & Mac Isaac, 1991), as opposed to ego-psychological interventions, and Paul's repeated mid-session bathroom breaks gradually stopped.

He referred to me as a "kid" early on in treatment. During the course of treatment I was promoted to a "buddy," and occasionally even called a "bro." Any time we explored possible similarities in Paul's reactions to his father and to me in the transference, he strongly denied any such similarity – "You are not my father! Alright?"

My initial impressions of Paul were that his level of functioning was neurotic; his character style was primarily narcissistic; he had sufficient psychological mindedness. I also sensed that behind his "macho" façade was a man who felt insecure, empty and hurt.

During one of the early sessions Paul shared a memory of witnessing his father beating his mother when he was seven years old. Paul was telling me this story with little affect. I responded by stating that he might have felt helpless as a seven-year-old child seeing something terrible and being unable to intervene. I also said that there was no one there to protect him, nor to make sense of what had happened.

Paul came in an hour and a half early to the next appointment and slept in one of the rooms in our clinic. I thought that he started to feel safe in therapy. Below is a vignette from that session:

Paul: The last session. I felt difficult when I left here. I mean what good will it do if I tell my parents how I feel? They are old and they are not going to change. It won't change what happened.

Therapist: How do you feel?

Paul: I feel angry.

Therapist: With whom?

Paul: With myself first, then my father, then my mother.

Therapist: What makes you feel angry with yourself?

Paul: I really want to put all that behind me and I can't. I want it over with. This whole trauma, this little boy, he's inside me. I want to give him a hug and accept him and have it all over with. I don't want that little boy inside me anymore.

Paul developed a fantasy of magically reaching out across time, hugging the little boy and thus resolving the trauma. As a coping mechanism his fantasy of magic trauma dissolution was similar to the common post-traumatic fantasies of revenge and forgiveness, described by Judith Hermann (1992). Such fantasy would allow Paul to avoid the steps of expressing his anger and mourning. His wish to hug a little boy can be seen symbolically as an act of a Rescuer (Karpman, 1968), who was a missing character in Paul's traumatic memory. It is also meaningful that Paul was telling me the story of hugging "this little boy" from the third person perspective. This type of narration illustrates the point made by Solms and Turnbull (2002) – that Paul's traumatic narrative made from a third-person account was likely a combination of semantic memory traces with partially reconstructed memories from other people's stories (Solms & Turnbull, 2002). The session continued:

Therapist: Earlier you said that you are angry with yourself first, then with your father, than with your mother. What makes you put it in this order?

Paul: What good will it do if I feel angry with my father or my mother?

Therapist: Is it easier to feel angry with yourself, than to express your anger to them?

Paul: Yes. What good will it do if I'm angry with them? And they may die soon [his voice was breaking up].

Therapist: It seems that you care about them and you love them at the same time as feeling angry with them; it isn't just anger.

Paul: You are right. I do love them. For some reason, this is difficult for me to think that I can love someone and feel angry with that person at the same time. I used to be simple like that, categorical. I think you are exactly right, I love them and I'm angry with them at the same time, which is difficult for me to understand.

I was surprised to see Paul's emotions when he said that his parents might die soon. He shared earlier that they were both in good health. I also noticed his defense against his anger in seeing it as senseless. I tried to connect Paul's current experiences with his past ones in order to illustrate that his anger repression was a defensive pattern.

Paul's memory of his mother being beaten by his father seemed condensed and symbolic, as well as factual and traumatic; it possibly represented objects both from before this experience and after it, telescoped onto a memory of a single event. Further, this memory appeared somewhat detached from time and space. When we talked about this memory again after about a year of therapy, Paul shared that he wasn't sure if the event happened "at age seven or five, maybe twelve, but it definitely happened!" This

narrative was consistent with the qualities of a traumatic memory, which was timeless and detached from the context (Chefet, 2000; Brenneis, 1996).

When the treatment just started, Paul and I met once weekly. Therapy gradually progressed to twice- and then three times a week in a course of a year. Each of these changes in session frequency resulted in a qualitative change in our work together – there was less “reportage” of what had happened during the week and more work with Paul’s unconscious patterns.

Paul described his seventy-year-old father as a “powerhouse of a man.” While it was difficult for Paul to be assertive with his father, he could be overly assertive with other people, whom he generally considered to be less threatening. Despite that, during the moments when someone around Paul acted as a bully he felt as if “things were not real.” We processed his feeling as a defensive reaction of dissociation to the external cues evoking the memory of his past traumas. His automatic emotional and visceral reactions to cues reminding him of what had happened in his childhood were also consistent with the nature of a traumatic memory (Chefet, 2000; Brenneis, 1996). Further, it seemed that external cues were associatively linked to Paul’s expectation of his father’s upcoming blind rage, which reminded him of terror and evoked his defense of dissociation. Finally, Paul stated that interactions with his father were often marked by a presence of confusion and a surprising loss of authority.

Throughout the year of treatment I realized that Paul’s family was fragmented. First, there was a pattern of indirect or dysfunctional communications between family members. For example, Paul’s mother often relayed messages between Paul and his father. Second, the three children of the family chose to live as far away as possible from their parents when they grew up. Third, Paul shared in one of the sessions that he felt like “glue holding his family together.” Consequently, he felt guilty when his

parents argued and fought in front of him, because he was failing at his job then. In response to his insightful glue metaphor I remembered Paul telling me before how he himself often felt fragmented. I suggested that, perhaps, he was investing a lot of his “gluing energy” in holding his family together, while leaving little glue for himself. Further, this task of holding the family together seemed hard, since his parents had not only fought with each other for decades, but also normalized the violence. Paul agreed with me and followed up by sharing that he started to write every morning about his injury at age 24. Notably, while we were talking mostly about his childhood, Paul spontaneously made a connection to his adult traumatic experience.

He started telling me the story of his assault. During that session Paul repeatedly referred to what had happened to him as an “accident.” He would catch himself say “accident,” correct it to the “attack” and keep on telling the story. However, he was puzzled that he continued to make the slip over and over. I asked him if the attack were unprovoked. He said that it was and then started sharing the details.

According to Paul, the “fucking frat boys” who attacked him yelled that he was looking strangely at the girl they were with. Paul didn’t remember exactly what happened after that and said that he lost memory; he had to rely on what his friends and his mother told him later on. I commented that while it was useful to know some facts, his current subjective impressions of what had happened and his attempts to recall were more important for our work.

During that session I occasionally asked a clarifying question in an attempt to slow down his narrative and to facilitate the reconstruction. I felt that he was ready for it, because he started writing about the attack and spontaneously brought that up in a session. In addition, I sensed his ambivalence towards the perpetrators and his impulse to flight into forgiveness (Hermann, 1992), so I tried to show that I was firmly and

unambiguously against the men who did this to him. As Judith Herman has suggested, moral neutrality is not recommended for trauma work.

Paul was able to slow down his narrative. He was telling me the story ‘frame by frame.’ Below is a vignette from that session:

Therapist: So the injury happened when you hit the curb. What did they do? Did they call the ambulance or just leave you there?

Paul: They ran; they saw what bad shape I was in [Paul lost consciousness], they ran. And my friend called the ambulance. I was lucky my friend came outside, that was a miracle. So they were real, like ... assholes. But... um...I don't even know, like... my anger is coming up right now, because I'm really like... It's like thinking about it again... it's like a lot of mixed emotions in my head...but, these guys like, ran away after I am obviously really hurt. That's crazy, that's like nuts... [he paused briefly] But they don't deserve to go to prison, because I don't believe that's gonna rehab anyone [he started speaking faster]. I thought maybe if they went to the emergency room and thought of what violence does, you know, that would help a little bit.

Paul was aware of his mounting anger during the session. Nevertheless, his defense of flight into forgiveness came quickly and appeared “out of the blue” for me. It seems that his anxiety of being punished for expressing his anger was fully unconscious. While Paul presented rich material that I felt compelled to interpret, I decided to continue the reconstruction work and keep interpretations to a minimum. My main focus was to return Paul into the frame of what had actually happened, while trying to increase his awareness of the intolerable emotions coming up:

Therapist: And you were making that decision after you came out of the coma; that was the month after?

Paul: That was a month after.

Therapist: They did so much damage and it was so unfair, completely unjustified. They did a huge amount of damage.

Paul: Yea, I'm still feeling the damage.... Yes.

Therapist: The thought that came to you was rehabilitation. You were taking care of them in the middle of being hurt and recovering from the damages that they did.

Paul: Yea, so ...

Therapist: It seems that you are struggling with your anger with them. Because you are balancing between the words "accident" and "attack." Attack makes them more violent --

Paul: [interrupted me] I always struggle with anger, right? So it's just manifesting itself here in a very obvious way. That way I describe what happened. I always struggle with anger. I think it definitely comes from my father. You know... No doubt. So when I start to feel angry, I feel all this weird stuff.

I think that Paul's interruption of me illustrates that his anger was hard for him to tolerate during the session. Notably, the content of what he is saying – "when I start to feel angry, I feel all this weird stuff" was parallel to the psychodynamic process – his disorganization and his impulse to interrupt me (Hansell, personal communication, 2012). I continued:

Therapist: But also the word "accident" seems to put some meaning into the story, because accidents happen. It's sort of a force of nature; it's

not under anybody's control. But the word "attack" means malice; means they had a malicious intent. Which means that they are in fact criminals and deserve to be punished for what they did. So in a way the word "accident" kind of protects them as well.

Paul: Yea... yea. That's the intention of using the word – making them non-culpable.

Therapist: And maybe in a way it also protects you, because if you are a victim of attack, then it sort of puts you in more of a ... I don't know... if you wish, a submissive, or passive role. You suffered in the attack and you probably have some feelings about it?

Paul: [slowly starts talking after some silence, his tone is sad] I really didn't look at it this way. I think it's a good point. So I was a victim of a crime. [silence] That's a lot more... yea. [silence] ... yep.

Paul went on telling the story. He shared that when he regained consciousness in the hospital, police approached him and said that the young men who attacked him may have had homicidal intent and they attacked other people before in a similar fashion; the police asked Paul if he wanted to press charges. He requested that the perpetrators be assigned to a year of mandatory service on an emergency unit in a hospital.

I responded to Paul's sharing this with me by stating that we didn't know if the perpetrators had had homicidal intent for sure, but there was a possibility that one of these guys was indeed psychopathic, given that the attackers had done this to multiple people in the past. He responded with: "You can't speak to a psychopathic person, I guess, logically... and can't confront anger with logic either. That's what I'm trying to

do with my dad all the time. That's something that doesn't work. I'm only now learning it... and it's scary. It's even scarier to think what if one of these guys is really crazy and not really a stupid frat boy? Hopefully not and they learned something.”

Here again Paul made a connection from his adult trauma back to his father. He also talked about an overwhelming fear of the perpetrator. The thought that attackers might have been psychopathic possibly acted as a cue, which triggered Paul's memory of his father's blind rage. This traumatic reaction resulted in Paul's feeling of unbearable helplessness and loss of control. Thus, he defensively classified his attackers as misguided boys and rushed into mercy. Paul's repeated associative connections from his assault in adulthood back to his father illustrate that he may have experienced some of the same somatic and affective states during the traumatic events in his childhood. Paul's defensive reaction of quick forgiveness contained traces of his automatic reactions to his father's violence – in Paul's conversations with his dad he immediately felt sorry after he contradicted his father in the slightest way. Despite that, Paul's repressed anger at the attackers was slowly finding its way out during our session. I continued:

Therapist: [...] I have just another thought about it. It seems that your struggle around the word “accident” may be the evidence that it was in fact traumatic for you, as a psychological trauma, not just a neurological trauma. Part of what happens in trauma is a lack of words and disconnection. It's hard to name things for what they are. So the use of the words that describe what happened may be hard, because it's unspeakable. And maybe what you are doing now is you are fighting this unspeakability head on, you try to put

meaning to what happened, trying to choose words; and you seem to be choosing mild words and humane words.

Paul: I've used that accident word, as I said...since it happened. I think that is a definite, definite... Just that ... is a definite indication of a psychological trauma. I don't know the gravity of it, but...that's pretty... That may be connected to something else too, as well. Just that *incident* [he was still saying it, although changed the word slightly] didn't cause all that. It's extremely important that I kind of like get all this stuff out. You know... I'm... I'm angry ... [his voice was breaking up] I'm just angry in a lot of ways. I haven't really expressed it. I'm just like thinking maybe I want to throw a chair against this wall or something like that. That's the kind of energy that's coming right now. Obviously I won't do it. You know...

Therapist: Why not?

Paul: Because it'll damage the wall ... [laughs]. I have respect for this place. I won't do it... You know.

Therapist: You seem to be on the verge of tears.

Pau: I am. That's like confusion too. It's confusing. I'm angry and I'm sad all at the same time.

Therapist: Um-hum,

Paul: [he's crying] I think that's the little boy. He can't communicate [cries]... you know, can't communicate his feelings, watching his mom get beat up. My confusion is still there.

My initial intervention with the elements of psychoeducation on trauma could be seen as not supporting the development of mentalizing (Fonagy, 1989). Nevertheless, his response was a powerful emotional insight. In retrospect, I think that it was not just the content of what I was saying, but also my empathy with his traumatic experience that resonated with him. I followed up with affect naming “You seem to be on the verge of tears” (Katan, 1961), which led to Paul’s crying. I think that maintaining a close empathic bond with Paul in the here and now of the hour was all that I needed to do, while his strong emotions were rising to the surface and he was reconstructing his trauma. Effectively, we were constructing an episodic memory, tying together his affect during the session with his traces of semantic and procedural memories.

In the last part of that session I normalized Paul’s anger and then asked him if he could tell me what he was sad about. He responded by sharing that he thought he caused everything that happened to him. Notably, I asked him about his sadness and he responded with what seemed more like guilt, thus making an associative connection to one of the possible sources of his sadness.

During this session Paul repeated the same stable sequence we talked about on many occasions. Paul would feel angry with his father and wished to express his anger. However, he felt anxious that he might be punished. As a compromise formation (Brenner, 1979) he repressed his anger. In addition, as a way of coping with an uncomfortable helplessness and a feeling of confusion, he developed guilt, possibly as a way of taking responsibility for what was happening and gaining some control (Fritsch & Warrier, 2004). Specifically, he felt responsible for causing his father’s rage. As a last step in this sequence, Paul ended up feeling sad.

The session focusing on trauma reconstruction illustrates how Paul’s acute adult trauma was interacting with his core psychodynamic conflict and his childhood traumas.

Specifically, Paul's feeling of anger towards the perpetrator worked as a cue, which quickly and reliably invoked Paul's automatic response developed with his family – anger repression, confusion, guilt and sadness.

About a year into therapy Paul decided to confront both of his parents. When he shared how that happened, I was deeply moved. First, he looked his father in the eyes and told him how the beating of Paul's mother affected him greatly. Then, he looked at his mother and said that she did not allow him to tell CPS what had happened. Paul also told her that she did not protect him when his father was beating him. When I asked Paul what it was like for him to confront his parents, he said that he felt relief and pride. He felt energized. On the wave of this energy he called a neurologist, which he had been putting off for a long time. I felt proud of Paul and of our work together. This was indeed a significant achievement for him.

However, the euphoria of Paul's success made me somewhat less attuned to more subtle psychodynamic elements of what had happened. My supervisor pointed out that while Paul confronted his father, he also complied with me (Hansell, personal communications, 2012). Specifically, Paul's need to see a neurologist was a practical and important step, which we discussed numerous times. Paul had avoided doing a diagnostic EEG and seeing the doctor for more than a year; suddenly he overcame his resistance quickly and without reflection.

Paul's resistance to seeing a neurologist was complex and multiply determined. One of the reasons was his anxiety that he might find out that he still had seizures. He was also anxious about the possibility of finding out that he had none. Paul had adapted to the diagnosis of epilepsy by making it a part of his identity. While being genuinely afraid of having a seizure, which he described as a terrifying experience, he also found some predictability and meaning in his diagnosis. He coped with these complex

thoughts and feelings by avoiding seeing the doctor and facing the EEG results.

(Wilson, Bladin, & Saling (2001) describe these effects in more details in their insightful paper on psychological adaptation to the alleviation of epilepsy).

When after a few sessions I interpreted Paul's compliance with me on the subject of visiting the neurologist, he became angry. Apparently, he had an impression earlier that his trauma was fully "resolved," as were all his maladaptive mental patterns. He thought that he was moving forward at full throttle and was no longer stuck. It was a painful discovery for him to realize that he was still metaphorically speaking 'on the railway tracks,' although he moved from his father's track to mine; he was still not free to choose his own direction. As a 'knee-jerk reaction' to my interpretation, Paul enacted the reversal of his decision. The neurologist's secretary made a minor scheduling mistake and Paul used this mistake as an excuse not to go to the doctor.

I felt conflicted and sad. On a practical level I was frustrated that he changed his mind after almost a year of working though on this issue. He needed to follow up with his doctor, since he was on a high dose of an anticonvulsant medication for years without the appropriate monitoring of his condition and the side effects of the medication. Further, he could potentially wean off the medication gradually, given that he had had no seizures for several years. More importantly, he could get some clarity on his current diagnosis and on the treatment options. On the other hand, I felt that I did what was necessary from a psychodynamic standpoint. What kept me grounded was an understanding that the focus of my work was Paul's psychic life, his mental conflicts and patterns. Making life decisions was Paul's area entirely and was beyond the scope of my work with him in therapy, although it was most certainly intertwined with what transpired in therapy. I also remained hopeful that Paul's 'rebellion' was a temporary

regression and that he would eventually see a doctor, on his own terms, if and when he was ready.

Discussion

The transition in my psychodynamic formulation of Paul's issues from what I thought of originally as "characterological narcissism" to trauma at the core of his problems changed the course of Paul's treatment. This transition reminded me of Heinz Kohut's work. Kohut changed the analytic approach to therapy with narcissistic patients, who were traditionally considered to be unanalyzable in an ego psychological psychoanalytic tradition, due to their expected poor ability to develop transference (Mitchell & Black, 1996). Kohut introduced therapeutic use of empathic attunement with patients who are often hard to empathize with (Rowe & Mac Isaac, 1991). Similarly, my realization that Paul's past traumas played a significant part in his ongoing interpersonal and professional challenges opened up my eyes to possible underlying causes of his enactments early on in treatment.

Paul's "narcissism" stopped being a simplistic diagnostic label for me and became intertwined with his childhood and adult experiences in a complex way. I came to realize that he was not just "mirror-hungry" (Rowe & Mac Isaac, 1991, p.45), but he was also a person who sustained significant psychological injuries and who needed trauma therapy. However, I also gradually realized how Paul's childhood traumatic experiences and his adaptations created a context for the reactions – both conscious and unconscious - for his acute trauma as an adult. Specifically, his defensive flight into forgiveness, anger repression, feeling of confusion and helplessness, attempt to gain mastery through feeling guilty, pattern of dissociation when faced with imminent threat, his association with a role of a 'Rescuer,' were all patterns that likely developed long before the onset of his adult trauma.

With the foundation of these childhood adaptations, Paul experienced a series of acutely painful events as an adult. His assault at age 24, followed by a loss of consciousness, craniotomy, induced coma, and subsequent epileptic seizures were all events where he felt painfully helpless and intruded upon. These events were also significant losses for him. Experiencing these events over and over reinforced his maladaptive childhood adaptations and strongly influenced his identity formation.

It is also possible that his brain injury from the attack, and subsequent seizure activity, interacted with his defensive structure and personality style, and affected his experience of the treatment. Of course it is impossible to make any claims about any specific ways in which his brain injury, which likely had diffuse effects in addition to the localized tissue damage, as well as the seizures and medications, affected his personality and patterns of affect regulation. As clinical literature accumulates about psychodynamic work in the context of brain injury and neurological issues, we may be able to speculate further at a later date.

Another important question to consider in Paul's case is the assessment of therapy outcome. Was Paul's treatment successful? On the one hand, there is evidence of clear improvement in Paul's level of functioning. First, his ability to mentalize improved significantly (Fonagy, 1989). His level of awareness and his ability to self-monitor improved. In addition, he said he became a lot less "automatic" – he developed an ability to take a pause between an impulse and an action. Second, the painful feeling of emptiness Paul presented with initially was no longer haunting him. He also reported feeling confident and pleased with being mature. Finally, changes in Paul's mental functioning led to changes in his life. During the termination phase of treatment Paul was in a long-term, committed relationship. He stopped all substance use. Most importantly, he was able to finally complete an EEG and was told by the doctor that he

had no seizures. Subsequently, he weaned off the medication and reported having a lot more energy.

On the other hand, Paul was still financially dependent on his father and ambivalent about becoming independent. He still devalued me on occasion and experienced periodic outbursts of anger, although he was able to express it verbally.

The abovementioned positive effects of the treatment can be described as Paul's improved ego strength and reflexive consciousness, and it is tempting to speculate that this was associated with an increased influence of his ventromesial prefrontal cortex over his more implicit and automatic neuropsychological functions (Solms and Turnbull, 2002). However, even if post-treatment neuroimaging data were available, it would not of course be possible to correlate any specific neuroanatomical changes directly with his experience in intensive psychodynamic psychotherapy. We may speculate that neurobiological changes would include strengthened neuronal connections from Paul's vmPFC to his limbic system, as well as intra-right-hemisphere neuronal connections. It is useful to note that Paul is seizure-free without medication at the time of this writing, which he is proud of. His improved affect regulation, achieved at least in part through therapy, may have been a supportive factor in becoming seizure-free. In any case, Paul's level of adaptation and his level of comfort have improved significantly.

While reflecting on the course of treatment during the termination phase, I suggested to Paul that he was re-living his adolescence, although without the rush of hormones. He liked that metaphor. Paul enjoyed a combination of having the freedom to explore the world with a maturity of a nearly 40-year old man. Throughout the course of treatment he admitted on several occasions that he was quite impressionable, that he felt a fluidity and the absence of a stable sense of self. Paul's presentation at the beginning of the treatment corresponded with Erikson's definition of identity diffusion (Erikson,

1956). Specifically, Paul had a difficult time with intimacy, occupational choices, competition and, finally, his definition of himself was mostly a psychosocial one, rather than a stable self-definition. The metaphor of ‘adolescence without hormones,’ which resonated with Paul, suggests that the process of trauma reconstruction in therapy contributed to the resumed development and integration of Paul’s identity, which had been stymied by his chronic and acute traumas.

Another question to consider is the effectiveness of trauma-focused work in Paul’s case. Was it appropriate for me to focus on the reconstruction and to highlight trauma work about a year into Paul’s treatment, given that he did not present with symptoms of an acute PTSD early on?

I think that Paul’s childhood experiences can in fact be classified as strain trauma (Kris, 1956). I also think his assault was an acute psychological trauma as well as a neurological one. I believe that Paul had adapted impressively to these traumas and was functioning well on some level when I first met him. However, one might see traces of Paul’s repeating the traumatic scenario in his relationships, in the transference and in his compulsive proclivity to help others. Paul’s automatic reactions of dissociation and confusion in the face of unpredictable anger from others, his patterns of helpless passivity and compliance with his father, and, finally, his difficulty forming stable, intimate relationships, are all consistent with complex post-traumatic symptoms (Herman, 1992).

My early diagnostic impressions of trauma as not being at the forefront of Paul’s issues illustrate the difficulty of diagnosing trauma. To answer one of the questions posed earlier, it seems that Paul’s character style effectively masked his traumas and affected the course of his treatment. I incorrectly concluded early on that he had metabolized his traumatic experiences. Perhaps I was somewhat diagnostically skeptical

early on in treatment (which can be seen in part as the countertransference reaction to his devaluation of me). Thus, I may have initially considered Paul's narrative of his past traumas as being incongruent with the 'typical' quality of a traumatic narrative, as well as the symptoms of an acute PTSD. While I did not notice Paul dissociating during our therapy sessions, about a year into treatment he shared with me that he felt "as if things were not real" in the presence of an uncontrolled aggression from other people in various other settings. It is likely that Paul's pattern of dissociation from the painful stimuli also affected his narrative and, consequently, my ability to notice and prioritize his psychological traumas.

It seems that as a result of the focused trauma work in therapy, Paul was able to find some meaning in the tragic events that he endured. The unspeakable was turned into words. He constructed a cohesive narrative of what had happened and his story was no longer fragmented, timeless and context-free. He was able to feel the intense anger and sadness during therapy and to work through these feelings. In essence, Paul has re-lived his traumatic experience in a context of a safe therapeutic environment. Further, he has constructed new episodic memories, which also allowed him to introduce reflective consciousness where little was present before (Solms & Turnbull, 2002). Consequently, he improved his ability to modulate his strong feelings with thoughts and to better control his automated behavioral reactions. Finally, trauma reconstruction work seems to have led Paul to his confrontation with a person, who had been Paul's condensed symbol of the perpetrator. Notably, Paul made the associative connections between his adult perpetrators and his father, thus linking his various traumatic experiences and creating an integrated understanding of his patterns of reactions in similar contexts. By confronting his father, he also symbolically confronted the individuals who assaulted him in adulthood and changed his life so dramatically.

In conclusion, I would like to say that work with Paul has been rewarding, challenging and interesting. I feel proud of what he has accomplished and I am hopeful that his progress will continue in the future.

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