REDELVE INTERNATIONAL PUBLICATIONS

Journal of Psychiatry and Psychotherapy
Volume 2018, Issue 01
REVIEW ARTICLE: RD-PMH-10001

# The Effects of Trauma in Childhood and Adulthood: Clinical Discussion

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***Citation:** Goodwyn E (2018), The Effects of Trauma in Childhood and Adulthood: Clinical Discussion. J Psych Therapy: RD-PSY-10001.*

***Received Date:** 19 September 2018; **Accepted Date:** 17 October 2018; **Published Date:** 25 October 2018.*

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## Abstract

Clinical developmental theory proposes that early trauma indirectly causes attachment disturbances and dissociation tendencies by interrupting normal learning. At the same time, however, it is known that trauma can directly disrupt psychic integrity and attachment structure regardless of age at trauma, and patients without a history of childhood trauma can present with dissociation and attachment disturbance due to the trauma rather than the interruption of learning. The difference between predictions of these models should be evident in cases of adult trauma in the absence of childhood trauma. In this paper, some extant literature on trauma in childhood and adulthood is examined in the light of developmental considerations, and an illustrative Jungian-oriented therapy case of a twenty-year combat veteran with no history of childhood trauma, but extensive PTSD, is presented. Clinical implications are discussed.

**Keywords**: Attachment; Dissociation; Dreams; Jungian Therapy; PTSD; Risk Factors; Trauma.

## Introduction

Archetypal psychologist Adolf Guggenbuehl-Craig pointed out that though we often speak of early childhood trauma, we don't speak much about severe trauma in adulthood when there was a sustaining parental bond in childhood. His point was that it was the trauma that mattered and not so much when it happened (personal communication, Milena Sotirova-Kohli, Aug 31, 2011). The present article discusses this question and provides a case study for reflection as well as pertinent literature review.

Many patients present to therapy with a history of childhood trauma. This, along with data from developmental psychology, has led many to theorize that some of the symptoms of post-

traumatic stress-dissociation, narrative memory fragmentation, and problems with emotional regulation and attachments-are caused by an interruption of normal development and learning. There is less discussion, however, of patients who endured severe adult trauma that had supportive, trauma-free childhoods. The difference between these two cases is clinically significant, as we want to address the most pertinent disturbances of our patients' functioning in therapy.

It is commonly thought that early trauma can indirectly causes pathology of attachment and structural integrity due to its interruption of normal developmental learning in the abilities of self-integration or attachment formation. Theoretically, supportive enough parenting, however, will allow these skills to develop normally and serve to protect the child from maladaptive attachment patterns and structural dissociation. It is well known that childhood trauma predicts a vulnerability to developing PTSD following subsequent trauma [1-3], however, in addition to learning disruption, this effect could also be due to the dose-effect between cumulative traumas and PTSD severity that has been observed in numerous reviews [4-7], rather than because the early trauma occurred during a specific developmental window of vulnerability.

## Poor Attachment and Integration Skills-Learning Deficit and/or Injured by Trauma

Much clinical theory focuses on the effect of early trauma on a patient's ability to maintain a coherent sense of self and sustain healthy attachments due to its interrupting the normal learning of these skills. Several presumed requirements need to be met before such skills can be learned. Ferro, for example, states that patients traumatized in childhood are often unable to verbalize their experiences well because they did not have the opportunity to learn these skills:

The highest degree of trauma results, in childhood, from a defect in the function governing the development of the caregiver-object's capacity to transform protoemotions and protosensorality into images. It is in this context that the seeds are sown of extremely severe pathologies… (2006: 1045).

Theoretically when caregivers are abusive or neglectful, the children cannot mirror self-cohering skills from their caregiver. The trauma, therefore, may cause deficits in this ability because it interrupts normal learning of these skills from caregivers. Presumably, then, adult trauma without child trauma history should have less of an effect on patients who have acquired these skills by learning them from supportive caregivers.

Theorists also commonly attribute difficulties in adult attachment formation to deficits in attachment learning in early childhood:

A central issue for patients who have experienced early childhood trauma is that on one hand they can perceive attachment as threatening whilst at the same time they experience profound grief if they perceive that the analyst is absent. As with an infant who becomes distressed at the temporary absence of the mother, there is no previous experience to reassure the patient

that absence is a part of attachment, nor is there a foundation upon which to model appropriate attachment [8].

In this example, the patient's inability to form a stable attachment is compared to the effects of a poorly responsive mother. However, if trauma of enough severity can damage a previously untraumatized adult's ability to subsequently find or maintain a stable attachment, then mother-infant learning deficits are not to blame for attachment disruption so much as the trauma is to blame by some other (presently unknown) mechanism.

Carter (2011), to cite another example, quotes Herman (2007) [9] by stating that disorganized attachment patterns arise when the primary attachment figure is a source of fear or shame: "In this case the child is torn between the need for emotional attunement and fear of rejection or ridicule." [10]. Carter goes on to explain that the disorganized attachment is caused by the formation of a maladaptive internal working model, leading to a child who feels s/he is unworthy of help and comfort. Shame "result[s] from a failure of the attachment system to emerge and become more complex, cohesive or coherent; instead the mother and baby function in a state of mutual withdrawal…" (339).

Knox (2011) outlines further theory that proposes that disorganized attachment is caused by breakdowns in mother-infant relationships, starting at 4 months of age, which has long term consequences:

The infant's joyful agentive communications are met by an expression of disgust or fear on the mother's face. The infant's mirror-neuron system activates the corresponding networks in the baby's brain so that he or she also experiences disgust or fear at his or her core-SELF positive or negative emotional states [11].

This approach therefore could be construed to predict that those who have formed healthy internal working models and had adequate mirror-neuron reflection of joyful communications should not suffer from self-disgust or self-fear, once they achieve this skill. Presumably, the above kind of shame should not be a factor in cases of adult trauma. But as the above theorists would no doubt agree, it of course can be.

Dissociative tendencies are also attributed to early trauma. Waldron explains that complex trauma in childhood has different results from trauma experienced later, with respect to dissociative tendencies because of the primitive or inadequate state of the child when s/he was traumatized:

[in trauma] Reality and imagination do not meet in the same way that they meet in a child who has not experienced complex trauma…. In the primary stages of development, the object is not separated from the proto-ego, i.e., from the developing self of the infant. Persecution, experienced in this early stage, is apprehended as an internal persecutor, undifferentiated from the self. In the infant's perception, there is no separation between the persecutory object and the persecuted subject. At this stage the thinking function is not yet established and trauma at this formative stage disrupts the progression of the earliest form of thinking… [8].

Presumably, one might interpret these statements to predict that an adult with proper skill development should not suffer from this kind of blurring between persecutor and victim. This, however, will be discussed in the case study below.

Dissociation is finally linked to attachment formation in theory as well. Building on the work of Broussard and Cassidy (2010) [12], McFadden argues: "dysfunctional or pathological dissociation has its roots in very early development, relational dysfunction between the infant and mother or primary caregiver, resulting in the failure of a good-enough secure or protecting environment and leading to acute or chronic trauma." (2010: 348, emphasis mine). Quoting Liotti (1999), McFadden states that "Where this relationship has been reasonably secure, [Liotti] posits that pathological dissociation does not occur."

These statements might lead one to think that the explanation for dissociation/attachment disruption is caused by a lack of good enough mothering, rather that possibly caused simply by the trauma itself. But trauma symptoms can arise that do not have to do with mothering but look clinically the same as those with early childhood trauma. It appears that it some cases, not only can dissociation and attachment disruption manifest due to lack of skill development, but severe enough trauma can damage skills that were previously successfully achieved. In such cases, our focus would need to shift from mother-infant explanations for dissociation/attachment to trauma/non-trauma explanations. A non-traumatizing mother from this perspective would be 'good enough' by the absence of injury to the child's self/attachment, rather than by providing necessary skills or learning experiences. Put another way, in the case of adult trauma in the context of a supportive and sufficiently nurturing childhood, subsequent trauma can potentially be just as damaging to psychic integrity and attachment behavior as early trauma.

## Trauma-Indirect or Direct Cause of Symptoms?

That early prolonged trauma is associated with dysfunctional attachments and poor psychic integration is not in question. The question is rather what causes these symptoms. Is it because key learning experiences have not been achieved, and/or can trauma itself simply cause them regardless of age? The above developmental models argue that trauma can cause symptoms because it interrupts important cognitive/emotion regulation learning in infancy. Therefore, one might make the conclusion that anyone who successfully achieves these skills should be protected from having these symptoms if later traumatized. This, however, would be a mistaken conclusion.

Theorists in the Janetian dissociative model of trauma and the psyche, Van der Hart et al (2006: 59-60), for example, recognize that childhood trauma leads to structural dissociation and complex PTSD symptoms, but also state that adults can develop trauma-related structural dissociation when the trauma is prolonged and severe enough. They mention war, atrocities, captivity, and genocide as capable of producing such symptoms, but add that childhood trauma is a known risk factor for dissociation from subsequent adult trauma. As mentioned, poor attachment is also a known risk factor for adult trauma induced PTSD [1-3]. But these effects

would naturally also be observed if the increased vulnerability was simply an effect of repeat trauma, rather than because the early trauma occurred at a specific developmental window.

A meta-analysis [13] of 77 studies assessed which risk factors are most predictive of PTSD, and included age at trauma, social economic status, education, intelligence, race, previous psychiatric history, childhood abuse, prior adult trauma, non-abuse childhood hardship, family history of psychiatric illness, post-trauma social support, post-trauma life stress, and trauma severity. These risk factors were found to vary widely in effect size: the strongest risk factors found were severity of trauma, post-trauma life stress, and post-trauma lack of social support, whereas the weakest effects were race, gender, and age at trauma. This meta-analysis did not specifically assess attachment and dissociation directly, but measured PTSD symptoms, which include dissociation and poor trust. Nevertheless, the relatively small effect size of age at trauma argues against a major vulnerability point in early development.

Trauma has also been shown to cause dissociation and memory fragmentation in previously untraumatized adults [14-17], but little work has been done on the effects of adult trauma on personal relationships in the absence of childhood trauma-studies tend to focus on the effects of childhood trauma on adult attachment [18-20]. Clinical experience shows, however, that traumatized adults can suffer severe relationship difficulties following even a single trauma of enough intensity.

Two contributing factors, then, appear to be present in the foregoing: in the developmental learning model, severe trauma is proposed to indirectly causes symptoms via its interrupting effects on early cognitive and emotional learning, leading to an increase in dissociativity and attachment disruption. In this model, there is an early window of high vulnerability because critical learning must occur before healthy attachment and psychic integrity is possible. The second factor, however, I will call the "trauma primary" factor, trauma is proposed to directly cause symptoms of dissociation and attachment disturbance, through as-yet uncharacterized mechanisms, and the age at which it occurs is less important. In this model, early trauma is a risk for later trauma sensitivity not only because of learning disruption, but also simply because of the dose-effect relationship between trauma and symptoms independent of age.

This is an important distinction for clinicians because if the trauma primary model is prevalent in a clinical case, it means that patients who had trauma-free childhoods who later manifest PTSD symptoms following a trauma will not necessarily benefit from an in-depth exploration of early attachment patterns. The co-contribution of these two factors remind us that any trauma of enough intensity can cause the above breakdowns to occur, and the exact developmental timing of a trauma is not always as important as its intensity. Finally, it means we need to continue to develop models to explain why trauma causes dissociation and attachment disruption in adulthood even when firm and secure attachment patterns were achieved in development.

## Case Study: "Dan"[1]

Dan is a 20-year veteran who initiated therapy in December 2009. He is physically muscular and powerful appearing, with many tattoos of "Faith", "Honor", "Hope", or Christian religious images. He came from a stable, supportive family of 4. He spoke of his father with special tenderness, referring to him as his best friend and guide. He was also very positive in his description of his mother and younger sister, whom he said were "always there for me". He denied childhood abuse or neglect of any kind, after multiple explorations of childhood.

Dan joined the Air Force at age 18 and was involved in numerous deployments to hostile areas during his career. Before taking him as a therapy patient he had been referred to me one other time for a screening security evaluation. He had a long history of chronic back pain of six-year history, with multiple back surgeries which were minimally effective. He had been prescribed opiate pain medications and had been seen in pain clinics for several years. He described this time as extremely frustrating and expressed a great deal of anger towards "those doctors" which he felt had pressured him to keep taking opiates and "get hooked on them so I was doped up all the time". In September 2009 he decided to get off them on his own and go "cold turkey". Though he was successful in getting off opiates, he described withdrawal as "a miserable experience".

The purpose of our first visit was a brief mandatory screening examination to determine if he had a diagnosis of opiate dependence. This was part of military procedure and not voluntary, which put an immediate (though commonly encountered) barrier between doctor and patient. I determined that he did not meet criteria for opiate dependence, since there was no evidence of him using the medication for anything other than pain management, and he never deviated from what he had been prescribed. Furthermore, he had stopped them of his own volition, despite having withdrawal symptoms, rather than seek them out. Afterwards he referred positively to this initial visit by stating he felt like I was the first doctor to listen to him about his desire to get off opiate medication. Other doctors, he stated, had always pressured him to stay on them to control his pain-he experienced this as a lack of faith in his ability to cope. At this point he made no mention of his PTSD symptoms, and the session was focused on his opiate pain medication use. Having cleared him for his next assignment (a desk job), I did not see him again until December.

Dan's chronic post-traumatic symptoms continued to worsen, however, and were becoming overwhelming. Dan returned to the clinic on his own, finally opening to me with several symptoms that were consistent with chronic PTSD, including a long history of emotional numbing, angry outbursts, depressed mood, chronic back pain, and suicidal thoughts, the extent of which I did not learn until late in the therapy. Unbeknownst to me, prior to our first session, he had driven to the country with a 45 pistol, intent on suicide. He deliberately tried not to think about it so he "wouldn't get cold feet"[2]. He went to a secluded location and fired a test

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*[1] Identifying information has been altered or generalized to protect patient confidentiality. No effort to make details consistent with reported events in news media has been made. Patient provided permission to discuss his case and use his journal entries.*

*[2] Quotes are from journal entries and session notes.*

round into the ditch to ensure he wouldn't "botch it". He got out of his car and prepared to hit the emergency button on his car to report a suicide prior to doing it so there wouldn't be any search parties. He felt relief that he was "finally going to be free from all the pain and memories and fear", but then he stopped. "…suddenly images of my grandpa popped in my head along with my parents and my sister and nieces. At that point I thought what the fuck am I doing? I realized that I suddenly wanted to live and fight this thing at all costs…so I did the scariest thing I ever did in my life, I asked for help." Notably, the image of his deceased grandfather was the first counterbalancing factor. He said nothing of this interlude until our very last weekly session, one year later, stating that he had been afraid I would involuntarily admit him to "the nut hut". Developing and earning his trust was a major aspect of therapy that started with our first non-trauma related visit and had a rocky course until finally he was able to surmount the shame of his near suicide to disclose it to me.

But initially Dan could not share any of this with me due to his tremendous shame over this near suicide, and over his symptoms in general, which he stated made him feel "worthless and weak". He was able, however, to tell me of his first major trauma, which occurred in Panama during one of his first assignments in the mid-1990s. He was in his 20s. He was assigned refugee protection detail, and at one point a riot broke out during which time he was attacked by refugees repeatedly, which he reports was terrifying. During the chaos, some rioting Cubans had been bound and placed on the road, and Dan was ordered to remove them to protect them from incoming vehicles. He tried to save them all, but eventually was ordered to abandon many of them, then witnessed several of them be crushed to death-him expressed tremendous regret about this, but at the same time pleasure when watching helicopters gun down attacking Cubans. Already I was seeing the split in his psyche in the combination of guilt and regret on one hand, and rage at the enemy on the other. The rioting went on for 2 days with many injured on both sides.

This event was the first, and most important, trauma that affected Dan, but it was far from the last-he reported being in over 900 combat situations during his career. It is unclear at what point he began to suffer from PTSD symptoms, but he felt it was quite early on, only he had been able to hold himself together (barely) for years. It flooded him around Nov 2009.

## Dissociative Sequelae

Often Dan would fluctuate between the domination of what I came to call a "berserker" personality and a "prisoner" personality. In the dissociative model terminology of [21], these were fight and submissive Emotional Personalities (EP) overtaking the Apparently Normal Personality (ANP). The berserker in Dan frequently overtook the ego temporarily, as evidenced by this conflicted early dream he reported:

I was told to beat up my best friend by an unknown authority figure. I stuffed him in a drainage pipe and he was in a wheel chair. Shortly after I pulled him out and helped nurse his wounds. It felt AWFUL.

The "prisoner" personality, however, seemed dominant in this recurrent dream image:

I was at a river by the woods. I remembered that I used to have a good time there as a kid and that the water used to be blue and the grass and trees were green, and a lot of people used to go there. Now when I was there the water was brown and all the grass and trees were dead and there was nobody there except for myself and some elderly people. I woke up with a feeling of dread and soaked in sweat.

This dream recurred often initially-a part of him was imprisoned in a shack by this river, a hollow shadow of former happiness. Other dreams and journal entries showed Dan flipping between an angry, persecutory EP, self-punishing and self-loathing, criticizing his many "weaknesses", and a fearful EP, journaling about how he was "panicky", unable to go outside, and wanting only to stay home and clean his apartment for hours. Then, he would return to the ANP and comment on how emotional and extreme some of his prior entries seemed.

Examples of the fight EP: "I am starting to talk about my 'feelings' way too much and I am becoming a weak little woe is me piece of shit, well no more, I'm back!" Later, the submissive EP seemed to be talking: "I'm in a really dark place right now that I haven't been to in a long time. I feel utter hopelessness; it feels like I have no future or past, just now. Now I'm both physically and mentally weak…"

This sort of behavior has been described by Van der Hart et al (2006) [21]:

…a submissive EP will fear and avoid a fight EP that reflexively hates, insults or hurts this submissive EP. Such unjustified but understandably harsh feelings and ideas are hard to change, because the effects of evaluative conditioning are impervious to extinction or cognitive correction…. Effective therapy involves counterconditioning. For instance, the therapist helps the fight EP associate the submissive EP (negatively evaluated stimulus) with a realization that submission had survival value (positively evaluated stimulus). Thus, the fight EP eventually learns to associate empathy and appreciation with the previously despised submissive EP. The same process can occur in reverse, with the submissive EP learning to appreciate the survival value of fight EP. In this way, survivors can be supported to accept all aspects of themselves…. (204).

The "berserker" and "prisoner" EPs correspond well to the above "fight" and "submissive" EPs, the roots of which are identified by Van der Hart et al (2006) [21] as deriving from basic affective defense mechanisms we share with many animals. Notably, persecutory EPs are often devalued by the ANP and therapists and identified as "the problem" that needs to be eliminated [22]. As discussed, this merely serves to maintain the dissociation. We processed the fight EP, however, as not entirely negative-it was necessary for survival.

Dan's physical symptoms of back pain and leg pain fluctuated with his PTSD symptoms and appeared to be associated with his inability to view them psychologically as well as physically [23], with pain emerging along with the "prisoner" EP and disappearing with his "berserker" EP. As Jungian psychoanalyst, internist, immunologist, pathologist and researcher Richard Kradin (2008, 2011) has observed, psychosomatic symptoms are often the result of emotional

pain that has been improperly psychologized and/or symbolized-a state we often find in patients with severe childhood trauma. Since Dan suffered this effect in adulthood, however, and reported no evidence of childhood trauma, it appears symbolization may have been poor simply due to a constitutional trait that can vary at baseline and be injured by trauma at any age.

At one-point Dan was offered a civilian job in Afghanistan to follow his retirement from the military, and he was very conflicted about whether to take it. Once he started to seriously consider taking this job, his back and leg pain, panic attacks and depression became so severe he had to be seen in the local emergency department. He came to me very confused about whether to accept the job. I did not offer advice on which job to take, but continually returned to observe the tremendous conflict within him as a source of vital information to track closely. I pointed out how his symptoms emerged right as he began to contemplate the job in Afghanistan. Eventually he decided against taking the position, and the berserker EP rebelled: "I'm in an angry mood…I'm realizing I can have all the drive and determination in the world but my stupid body won't do what I tell it anymore, I'm so pissed at it right now that I want to push it until it completely breaks down, just to punish it and show it who's in charge, that makes no sense at all." We can see the berserker torturing the prisoner here-but with a new perspective, glimmering at the end, observing the process from a new vantage point with "that makes no sense at all". We reflected heavily upon this in session.

Not long after this decision, he reported the following dream:

There was a big guy with a knife that went up to this woman [she was tall, blonde, and pretty, about 20 years old] and tried to cut her so I ran to her, but it was like I was stuck in mud and it was hard to move but I still got to her in time. The bad guy had a huge knife [he cut her backpack with it], and I only had a little paring knife, but he left her alone and came after me and I was able to stab him in the stomach, so he ran away. After the bad guy went away, a female policeman arrived and took me to a bunker where a bunch of people decided I needed to be sacrificed on a stake, where I ended up in an old house flooding by a dark river and there were dead trees by the river.

In session, taking a Jungian approach, we dwelt upon these images for their notable intrapsychic conflict between the ego and the berserker, who attacked his intimate relationships. The woman's youth, brightness and beauty suggested an ideal kind of life-participation that was lost in this struggle. She is replaced by a policewoman-enforcing rules and law, not intimacy-and the ego is crucified and imprisoned in the deathly hell by the river. This dream is telling us the story of his psyche, as dreams often do, and what happened to the old Dan so long ago, and in session we amplified the rebirth that the "crucifixion" theme hinted at.

## Attachments

Dan's intimate relationships after Panama became greatly troubled as well. They were often plagued by a combination of fear of intimacy and sharp defensiveness. He stated many times that he could never get close to a woman and that he refused to share his experiences with them,

and that after Panama and his divorce he couldn't experience a healthy relationship. He said he would get into brief intense relationships that would usually end in breakup because he felt threatened and angry when it became more emotionally intimate, so he would flee from them. Dan's relationship with feminine images in dreams was also split between trying to rescue an idealized image from violent enemies, or being judged negatively, ridiculed, or shamed by them. He reported no history of this sort of behavior from his mother or sister. In session, though, he shared that after the first trauma in Panama, he tried to reach out to his ex-wife, but she was disgusted with him and criticized him for being "weak"; he later also found out his wife was cheating on him. He was devastated by this rejection, which was still alive in his psyche after almost two decades, as reflected in this dream:

I dreamt of my ex-wife, she was bitching me out over stupid stuff, what a surprise ha-ha. It made me think of one time when I cleaned our apartment when she was at work and she got mad at me that I cleaned so she threw an ashtray at me.

In the context of reporting this dream, he was attempting to re-enter a relationship with a woman he had known previously: "I broke up with my ex-girlfriend two years ago because I didn't think I deserved her, and she scared me because I felt vulnerable around her [fearful-avoidant behavior]." This attempt at a renewed relationship did not pan out, however, and once he started dating her again, he quickly became defensive and closed, and he broke up with her [dismissive-avoidant behavior].

His relationship with me was equally challenging, as he would often write things in his journal but erase them later-I found out about these events often months later as he began to slowly develop trust in me. Furthermore, he often expressed skepticism about the diagnosis of PTSD and we revisited this issue often; I had been alerted already to his distrust of doctors and medications, so I only suggested antidepressants with a great deal of reassurance that I would not pressure him to take them but respect his understandable-if perhaps unrealistic-wish to not need them. He did not believe me initially, and several times during treatment he stopped medication on his own, only to hint at it in session; when we processed this, I responded with understanding and respect for his desire for autonomy. He then would start them again. Over time, this pattern leveled off and he accepted the medication (venlafaxine and propranolol).

## Treatment Course

Therapy was Jungian-oriented in theme and technique. As discussed by Jung, therapy often involves an admixture of elements developed by both therapist and patient:

This bond is often of such intensity that we could almost speak of a 'combination.' When two chemical substances combine, both are altered. This is precisely what happens in the transference [24].

The images, stories, and symptoms Dan brought into the consulting room often prompted imagery to emerge in myself about warriors and, the descriptions of Northern European berserkers, which is why I termed Dan's fight EP that. In listening, I would often

spontaneously recall stories from Icelandic sagas that depicted men who would work themselves into a battle-frenzy and become unstoppable fighting machines, sometimes killing friend and foe. The emotion of "battle-gladness", or joy in the carnage, would also accompany these stories. This effect of course is discussed as part of the transference:

The greatest difficulty here is that contents are often activated in the doctor which might normally remain latent…psychic infections, however superfluous they seem to him, are in fact the predestined concomitants of his work… [24].

The warrior imagery was an area we could connect and was helpful in appreciating the fight EP that caused Dan so much difficulty with mood and relationships. Learning not to dismiss it wholesale but see its survival value despite its primitivity made it less terrifying to the submissive EP and facilitated integrative efforts. We pointed out, for example, that the fight EP was largely responsible for his getting himself off addicting pain medication, but at the same time would berate others in his life, especially romantic relationships.

I was reminded of the Irish story of CúChulainn [25], who after rampaging across Ireland against his foes, had to be re-integrated into Ulster society by three successive waves of nude women bringing large tubs of water. The first tub exploded from the heat of his rage when he jumped into it. The second tub remained intact, but the water all boiled away. Then the third cooled him off. This story seemed appropriate here, particularly because of the attachment-themed and sexually charged imagery of the women, in this case, symbols of reconnection, or Eros.

Jung's description of the enantiodromia ("cycling between extreme opposites") was vividly realized in Dan's continual switching between various EPs and the ANP:

The prodromal events signify the meeting or collision of various opposites and can therefore appropriately be called chaos and blackness. As mentioned above, this may occur at the beginning of the treatment, or it may have to be preceded by a lengthy analysis, a stage of rapprochement. Such is particularly the case when the patient shows violent resistances coupled with fear of the activated contents of the unconscious [24].

In discussing history and dreams, Cwik, building on Bion's (1962) [26] idea of "reverie" as a mother's capacity to make sense of her infant, proposed that projective identifications and countertransference's are emotional, unconscious communications that an attentive therapist can use therapeutically and diagnostically. He goes on to examine how dreaming is an aspect of this process: …even the dreams of the patient are no longer simply intrapsychic events, but possible manifestations of the analytic third [the healing resolution to extreme conflict]. This allows the analyst greater freedom to explore his/her own associations to the dream and bring them into the analytic space [27].

Cwik suggests that this process, through the transference as Jung described it, allows the therapy to progress toward greater integration:

In analysis and depth psychotherapy a capacity for reverie harvests and metabolizes the patient's projections and returns them through timely interpretive activity and/or comments that demonstrate that the therapist has understood deeply the current state of the analytic third [27].

In mid-March, Dan had a significant dream:

I dreamed of my grandfather who passed away in 98. This is the first time I dreamt about him since he died, and he and I were very close. In the dream I was standing in front of a low-crawl obstacle and he told me 'you're going to have to eventually crawl underneath all this shit' and then he was gone.

In session, we amplified the image of the Great Father ("grand-father") and discussed how various peoples worldwide believe their ancestors can help them from the Otherworld, giving stern advice (as here) and/or comfort. We also discussed how trauma survivors often experience helpful figures in dreams and fantasy [20,28,29]. But the image of wise, helpful grandfather resonated with me as well, since I saw my own grandfather as a guiding figure in my life, and he also died almost the same time as Dan's. This was a particularly fertile area to foster healing imagery for Dan. It was not until the last session that I learned the first protective image to emerge in Dan's head as he contemplated suicide was his grandfather[3].

By September 2010, he was talking about how he was much calmer and happier he was compared to the previous year-he was beginning to form a new life story. He dreamt that he was taking a shower with his ex-wife and two of her girlfriends, which we saw as a reflection of the archetypal CúChulainn story, with its imagery of water and nude feminine figures-we saw this as a reconciliation with the internal image of his ex-wife, a previously persecutory EP.

In November, 2010, Dan's insight, flexibility, integration and mastery continued to improve; his symptoms were attenuating and integration work continued: "had a great weekend with my family and nieces....I actually had some personality this time…I've also been having a lot of episodes of my past popping into my head all weekend, mostly about Iraq and Panama…I've also noticed that I have new memories of both popping in my head. Truth be told some of them bother me but I also kind of like it. It's like I'm living through some of the stuff again and I'm allowed to test myself again with the situations."

## Follow Up

I followed up with Dan 8 months after his last session with me by phone, and he reported continued improvement in re-experiencing, avoidance, anger, anxiety, and social attachments, though his chronic pain symptoms persisted. His severe anger had subsided completely, as had

[3] *An illuminating meditation on the grandfather was presented in a fascinating article by Jung's grandson Andreas (Jung, 2011) that demonstrates the powerful emotional resonance of the grandfather image.*

most of his anxiety. He had a job and (tellingly) was living with his sister and nieces, whom he described with great tenderness.

## Discussion

A significant number of the combat-traumatized patients I treated in my military practice, Dan included, reported secure, loving attachments in childhood; this did not to prevent severe adult trauma from creating a symptom set that was similar in many respects to that seen in childhood trauma. Dan is one example of many encountered in military practice. This, along with the above literature reviewed, draws into sharp relief the fact that early, stable attachment patterns can still be severely disrupted by later trauma of enough intensity.

In the developmental model, the patient never learned critical skills from caretakers to allow them to form a coherent self, or to form stable attachments. The trauma therefore partially caused symptoms because it disrupted learning during this critical window. In addition to these considerations, however, we must remember that the ability to cohere and form stable attachments-even when fully intact-can be injured by later psychological trauma, and the age of trauma in such cases may be less important, making developmental window explorations in therapy less relevant. The case study examined here, along with the reviewed literature, provides clues to this fact.

There are possible sources of error in the preceding discussion. First, it is possible that Dan, along with the others encountered in military practice that presented with fragmentation and attachment disruption, were traumatized in early childhood and simply did not remember it or refused to share it. In Dan's case, though, no matter how he was asked, he always denied any such history, and there was nothing in his presentation, body language, interactive style, or dream material to suggest otherwise. Given the many limitations of retrospective reporting [16], though, this possibility still cannot be definitively ruled out. Second, the literature reviewed focused primarily on the syndrome of PTSD; no rigorous, prospective, controlled studies exist to my knowledge that examine the difference between attachment patterns and dissociation tendencies in childhood trauma vs. adult trauma without childhood trauma. Some current medical models of PTSD [22,30,31] posit that subjects inherit a genetic vulnerability to developing PTSD that may or may not manifest depending on whether the subject is traumatized-little emphasis is made on age at trauma in this literature as an independent factor aside from the Brewin et al (2000) meta-analysis. Therefore, further studies need to be done to clarify such details. Until then, case material remains our best guide.

I am alone against hordes
I cannot stop nor let go.
I stand here in the long cold hours
Alone against every foe.

-CúChulainn, The Táin

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