



Understanding psychological trauma

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The first thing to understand about trauma is that it is a unique personal experience: you can take a group of individuals exposed to the same stressor and find that the outcome for each varies considerably, according to pre-, peri- and post-trauma variables. These might include age, personality, prior trauma, cultural environment, circumstances of the index trauma event (ITE), disclosure, support and intervention. Thus, it is poor clinical practice to try and generalise the impact and outcome of psychological trauma across a given population of sufferers. Each case must be treated on its own merit according to the specific circumstances surrounding it.

Everyday life is rife with psychological or emotional trauma, such is the nature of life itself. However, unpleasant as they might be, most are relatively benign and we spontaneously recover from them in time and move on hopefully the wiser for them. But the most destructive traumas are interpersonal (i/p), as opposed to accidents or acts of nature, precisely because the victim has been dehumanised, used and abused. Further, their ordeal is unlikely to be a shared experience – like a natural disaster for example – meaning the victim is more often than not forced to endure their misery in secrecy with no support or intervention to mediate or ameliorate.

The victim will also try and make sense of their ordeal and their role in it. Thus, there is a considerable cognitive component to trauma in terms of how the person views him/herself as a human being. Age is a critical factor as children think egocentrically and are likely to place themselves at the centre of blame, being incapable of seeing the issue from any other perspective. Furthermore, the usual means of processing emotional trauma do not fully develop until age 25, so young people tend to employ ego defence mechanisms to cope with i/p trauma. These might include partial, or total, psychogenic amnesia (it never happened), or dissociation (it happened to someone else) for example and in time these become deeply entrenched and an automatic conditioned response to any external threat.

It is safe to assume that victims of domestic violence will have been traumatised to a greater or lesser extent by the index event (and subsequent traumas) and thus it is necessary to understand exactly what this means in terms of physiological and psychological damage or injury that adversely effects the victim's quality of life in terms of thinking patterns and behaviour. To do that, we need to look at the human brain – both its structure and function.

Like all mammals, we have a primitive 'reptilian' brain that is responsible for basic physical survival. Above this, lies the emotional brain, or Limbic System that contains numerous key substructures that maintain optimum physiological status or, if you prefer, the organism's survival. Immediately above the limbic system lies the corpus callosum that interconnects the two hemispheres of the neocortex which, in humans, is particularly large, hence its corrugated construction. Neurologists have broadly identified which areas do what and those that principally concern trauma are the frontal and pre-frontal lobes. Situated behind the forehead, these areas rationally process everyday experience and moderate thinking and behaviour. They do not become active or develop functionally until aged 7.



The neocortex is the source of our conscious thinking processes – that little voice inside your head, whereas the Limbic System (LS) is our unconscious brain with no means to directly express itself in our thoughts. This is crucial to understanding trauma. In terms of functioning, these two brains have been likened to an iceberg: the bit we can ‘see’, our conscious, is very small compared to the bit we can’t ‘see’, the subconscious which is constantly processing a phenomenal amount of sensory data, either from internal somatic sources or external stimuli. However, precisely because it is conscious, most people wrongly believe that the neocortex does the bulk of the brain’s work and, ergo, we have supreme control over thinking and behaviour.

All sensory data are initially experienced by the thalamus, a sort of processing station that diverts data to the appropriate substructure(s) for action. Below lie the hypothalamus and pituitary gland which are responsible for maintaining body chemical homeostasis. The hippocampus curves down and forward from the rear of the thalamus and is where long-term memories are stored. Attached to the front of that is the amygdala where fear is registered and generated. There are bundles of nerve axons varying in length, complexity and function that connect these two brains transferring vast quantities of data up and down; where these join a microscopic gap called a synapse exists. The impulse is transferred across this gap by chemical neurotransmitters and it is this process many pharmaceutical drugs target to either increase flow or suppress it all together (neuronal gating).

Severe trauma overloads this system entirely. The neocortex protects itself by gating the connections between the two brains thus confining the trauma ‘package’ to the limbic system which makes repeated attempts to get rid of it in the normal fashion as it cannot tolerate the emotional overload. Thus, the individual may have no conscious recollection or awareness of the index event, or only partial recollection. Meanwhile, the subconscious memory, residing in the hippocampus, remains highly active, triggering responses from the amygdala, hypothalamus and other connected structures with distressing and disastrous consequences.

The individual is in a constant state of arousal (hypervigilance) repeatedly triggering the so-called four F’s response: fight, flight, freeze, or fawn. This may occur in the complete absence of an external stressor or trigger. In any event, a trauma-conditioned response results which then drives an automatic behavioural response that may persist until satisfied or met. It is worth remembering at this point that the limbic system is the powerhouse of our motivation, signalling needs and desires to the conscious brain which then sets about satisfying those needs or, crucially, moderating them according to ingrained beliefs and attitudes.

Thus, it follows that trauma conditioned behaviours are more automatic in nature and may lack any intellectual intervention to moderate or extinguish them. They will also persist, unabated, until resolution of that trauma which, in the absence of any conscious awareness resulting from traumatic amnesia is not going to happen. With trauma, what cannot be remembered cannot be forgotten.

Clinical evidence of post traumatic stress disorder (PTSD) indicates physical consequences to neurological development including reduced volumes of hippocampus, left amygdala and anterior cingulate cortex (helps focus attention and ‘tune’ conscious thoughts). In children,



reduced volumes of the corpus callosum and frontal lobes were found compared to non-PTSD controls. Neurochemically, disproportionate cortisol and norepinephrine levels were recorded in response to stressors.

There is no doubt that domestic violence qualifies as interpersonal trauma and is therefore potentially highly damaging to the victim, according to the unique circumstances of their ITE and any subsequent trauma. Thus, it is likely that the victim will develop PTSD with concomitant brain dysfunction that will precipitate a raft of harmful thoughts and behaviours that continue to negatively reinforce the initial psychological injury which, according to its severity, must be classified and treated as a closed brain injury. Just because it can't be seen, it doesn't mean it doesn't exist.

One of the key problems with PTSD is that it is frequently comorbid with several other illnesses or conditions that are very serious in their own right. These might include depression, eating disorders, anxiety disorders, phobias, OCD and self-harming to name but a few. This makes accurate diagnosis difficult as medical practitioners and patients alike are distracted by peripheral presentations which will be resistant to any treatment if the underlying condition is PTSD and it remains unrecognised, diagnosed or treated. It isn't hard to imagine how successive failures of treatment plans would only add to a patient's misery and minimal sense of self, providing them with robust evidence it is simply 'who they are'.

But PTSD is not 'who you are'. Following trauma, the individual will develop a 'false-self' which will be in perpetual conflict with the 'true-self' to a greater or lesser extent according to ITE variables. Sufferers frequently report a catastrophic transformation in their personalities and their ability to cope with everyday life: where once they were confident and competent, now they are constantly on edge and in a state of disarray, no longer able to focus or manage their conscious mind in their accustomed manner.

Sufferers might also find themselves wanting to re-create or re-enact the initial trauma. This persistent need is often obsessive in nature and ritualised so as to be as identical to the ITE as possible. It is unlikely to be an everyday event, but cyclic and following a regular pattern. Once satisfied, all interest in repeating the behaviour will vanish until the cycle repeats itself. The individual 'copes' by shutting this latest experience away with all the preceding ones in the drawer marked 'psychogenic amnesia' such that it never happened. In reality, what has done is negatively reinforced the ITE and consequent traumatic conditioned behavioural patterns.

So why is the individual repeatedly exposing themselves to their trauma? To the rational, it doesn't make any sense. But that's the whole point, rationality doesn't come into their behaviour – it is being driven purely by the irrational subconscious brain much as one might eat a snack to satiate hunger pangs.

My explanation is this: the limbic system is functionally in disarray, threatening the physical survival of the individual and therefore desperate to offload the trauma package and restore order. The neocortex is doing much the same and thus saying 'no way', slamming the synaptic door shut. This is typical of medium grade trauma and explains the PTSD symptom of



Intrusion (spontaneous unbidden graphic recollections of ITE): the LS keeps bombarding the neocortex piecemeal allowing the individual to consciously confront their trauma, process it intellectually and rationally, and then accommodate and assimilate accordingly (amend or modify existing data or create new for future 'reference'). Thus, trauma resolution is eventually achieved.

But what happens in the absence of any conscious awareness or recollection? How can the individual mentally process something that doesn't exist? It can't. Another key diagnostic characteristic of PTSD is Avoidance where the individual will either consciously or subconsciously do anything they can to avoid any tangible reminder or trigger of their ITE. It doesn't take a genius to realise that here we have a complete paradox: Intrusion and Avoidance. No wonder we think we're mad!

So, in the totalitarian absence of the normal internal means of trauma resolution, the limbic system has little option but to physically recreate the ITE as faithfully as possible. Again, this is fundamentally paradoxical to re-enact a harmful scenario and yet that is exactly what happens and an indication of the severity of this affliction. Thus, victims of DV may subconsciously be drawn or attracted to dangerous men without understanding why. Furthermore, when their fear response is inevitably triggered they will automatically go into 'fawn' mode and not put up any effective resistance. This behaviour is not the product of rational conscious thought processes. Rather, it is a conditioned response driven by the dysfunctional LS.

This explanation is, of course, only one part of a much more complex phenomenon. The role of the perpetrator has yet to be considered, as have the cognitive processes involved on both sides and I intend to discuss these in separate submissions. For my part, as someone who existed in complete ignorance of my ITE for almost 3 decades, understanding the complexities of trauma was fundamental to my recovery as it gave me insight and that, in time, gave me control. Now, at last, I could understand why I had been driven to do the things I had – where after I no longer needed to. But, everyone is different: what worked for me might not work for someone else. I can only give you the benefit of my experience which, I am delighted to report, has had a positive outcome. A little late in the day, perhaps, but I no longer 'exist' in that particular hell.

If I have a new drive, it is to spare others a similar fate, ideally through proactive prevention but also in ameliorating suffering through greater knowledge and insight. It is worth the effort.

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