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“What doesn’t kill you makes you stronger”: micro-trauma and dyadic expansion of consciousness

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Abstract: It’s becoming even more widely recognized from neurosciences, epigenetics, and clinical research on observation of infant-caregiver interaction (Beebe & Lachmann, 2002; Tronick, 2007; Provenzi et al. 2016) that daily cumulated micro-traumatic experiences cause damages not only to one’s mental health and identity, but also to immune system, leading to metabolic, eating, sleeping, affective, behavioural, cognitive and linguistic, and social disorders in adults as well as in children and infants. From the other side, there are also extensive evidences that psychotherapy helps to change maladaptive patterns caused by traumatic experiences (Lingiardi et al., 2006; Fava et al. 2016, 2002).

Relational Psychoanalysis argues that human beings are complex living dynamic systems, so the therapeutic change is related to expanding levels of consciousness and exploring new ways of being in the world. Clinical examples are provided.

1. Trauma and micro-traumas

Trauma reminds to the old Greek concept of wound with laceration. Not only Medicine, but also Psychoanalysis has used this term to indicate psychological violent shocks and lacerations on the whole organism (Laplanche and Pontalis, 1981).

Beside of external accident and traumatic experiences such as sexual abuse (Freud, 1895; 1925; Brenner, 1973), domestic violence, psychological maltreatments, as well as living in or escaping from war conflicts producing predictable negative effects on individual mind and body, there are also other types of relational events causing same damaging impacts although such traumas may often be not noticed nor recognized as harmful, so they accumulate silently day by day. Crastnopol (2015) discussed such subtle and underhand stressful relational events as micro-traumas, pointing out they usually occur in the context of significant relationships, therefore in order to keep the connection with the parents, dissociated states undermining a coherent and valued sense of self may emerge. Additionally, the person inflicting the hurt usually preserves a facade of being neutral, even caring, as he/she is not aware of causing maltreatments.

Also, the victims feel ashamed, as they can’t identify a major trauma or a terrible personal story to justify and comprehend their psychological distress, leading to an even higher level of emotional suffering. So, micro-traumas can take place and have damaging consequences whenever, not only during early years of life as initially demonstrated by Freud (1895; 1923). This is consistent with viewing the human
beings as constantly evolving and changing through relational interactions, rather than shaped solely by childhood experiences.

Crastnopol (2015) identified seven types of micro-traumatic experiences. Just to mention some, “uneasy intimacy: a siren’s call” refers to daily situations where for example, a parent uses his/her ability or power to connect emotionally with the child in order to psychologically tie him/her in an emotional bond while devaluing the other parent. This type of interaction can be exciting and confusing at the same time, still causing psychic injuries particularly in infant and child.

Another type is “little murders and other everyday micro-assaults”, which refers to a large scale of micro-traumatic interactions such as insults, snubs, talking behind someone’s back, and back biting. The adjective “little” has been used here because these ways of interaction are just as prevalent in our modern society as they are underestimated in their damaging impact. More precisely, the oxymoron has been used with the purpose to emphasize that even if these acts can be identified as psychologically damaging, or even psychological abuses, they are often not recognized and are indeed trivialized and considered normal, even amusing, or simply a part of everyday relationships. Little murders may occur in the context of a parent-child relationship, for example when a parent openly criticizes the child in front of other people, creating a potentially humiliating effect.

Another type is “unkind cutting back”, it refers to interactions in which a partner suddenly and in an unexpected way withdraws from the other person, causing confusion, frustration, and pain. It can occur not only between adults, but also between caregiver and child. As the withdrawing person is actually still present in the partner’s life, this usually generates feeling of being betrayed and unsettled, particularly when a relationship is consolidated. Such type of micro-traumatic interactions may be caused by borderline personalities as well as insecure avoidant attachment style, or postpartum depression.

Furthermore, clinical research has widely demonstrated that the mother-infant insecure avoidant, insecure resistant, and insecure disorganized attachments cause severe affective and behavioral disorders in infants (Main & Hesse, 1990; Main et al. 2005; Cassidy, 1994; Beebe & Lachmann, 2002; Tronick, 2007; Seligman, 2017; Fivaz-Depeursinge & Philipp, 2014). For example, in mother-infant insecure avoidant attachment, as a result of being daily rejected and neglected especially at times of distress, infants show avoiding behaviors like minimizing their emotions and not seeking the parent during the reunion moments. And, as such dysfunctional interactions occur every day, depression or hyperactivity in infant and child emerge soon. Or, in mother-infant insecure resistant attachment, the caregiver is usually too preoccupied to be not a good-enough parent, acting over-caring, so infants become very distressed showing repeated expressions of anger, crying and petulance, and they seem heighten their emotional expressions in the hope to get response from the caregiver.

The caregiver-infant face-to-face communication plays indeed a fundamental role in developing an infant secure attachment as well as dysfunctional insecure attachment patterns, because it influences infant’s self-regulation of emotions, behaviors and intentions. Through the coordination and synchrony of facial expressions, behavioral correspondence, embodied simulation, and vocal rhythm coordination, the infant senses the quality of the occurring communicative and affective exchanges, particularly the emotional state of the caregiver (i.e. happiness, angriness, sadness, etc.), and the quality of what is happening between the caregiver and the infant (i.e. playing or staying with the caregiver is pleasant, distressful, frightening, etc.). And in such infant-caregiver dyad, meanings are being created, actually co-created together with the partner, on self-identity and own sense of being in the world (Tronick, 2007). Consequently, when the caregiver is angry with the infant, frightening, over-preoccupied, or neglecting, although expressing it merely nonverbally (by facial expressions, voice tone and volume, use of silence, and body movements), it creates microtraumatic experiences making the infant feeling disconnected, lost, refused, wrong. Among other scientists, in their extensive research Tronick (2007) and Montiroso’s team (see: Provenzi et al. 2016a, 2016b, 2016c) demonstrated and confirmed that repeated stressful experiences (such as prolonged pain in premature
newborns, artificial nutrition in intensive care units with limited access for mothers to handle their babies, affective deprivation, daily maltreatments, poverty, parents’ depression and mental illness) progressively and day-by-day weaken the infant making him/her even more vulnerable and less resilient to stress. Such cumulative negative experiences affect not only the psychological level (for example, leading to early depression, and later to personality disorders and relational problems), but also the biological one (weakening the immune system, causing cardiovascular problems, or/and eating and metabolic disorders, as well as impoverishing language and cognitive capacities, with then learning and performance difficulties). These evidences disconfirm the famous proverb “what doesn’t kill you makes you stronger”: micro-traumas actually weaken the body, psyche and relationships indeed. Moreover, when the human system can’t comprehend and make meanings on why traumatic experiences as well as maltreatments and abuses are occurring to him/her, particularly from beloved people, it leads to psychic and biological collapse (Tronick, 2007; Montirosso, 2016a, 2016b, 2016c).

In order to try reducing the negative impacts on infant and child caused by these daily repeated microtraumatic experiences, it’s now possible to detect and code the dysfunctional attachment styles even from the infant’s age of 4 months by the video-micro analysis of mother-infant interactions (Beebe et al. 2016; Tronick, 2007; Tronick et al. 1978). The earliest the dysfunctional interactive pattern is identified, the better it can be recovered.

2. Living systems moving forward

Symptoms and sufferance (i.e. depression, obsessive-compulsive problems) in adults are certainly the evidence of the psychological and physical wounds caused by traumas, particularly the micro-traumatic experiences accumulated silently day by day occurred in childhood.

From the other side, sufferance can also be seen as indicating the patient’s need to move out from consolidated traumatic relational patterns as well as a negative sense of self, to search and find new more adaptive ways of being in the world (Minolli, 2010; Cavelzani & Tronick, 2016b). This idea is consistent with the dynamic living systems theoretical framework (Harrison, 2009; Maturana & Varela, 1985; Sander, 2008) looking at the human beings as actively adapting in a specific context, and open to, indeed driven to, developing and exploring in a nonlinear and unpredictable fashion new more adaptive ways of being in the world (Tronick, 1978, 1980, 1982; Tronick et al., 1979; Cavelzani & Tronick, 2016a).

Self-developing and self-expanding necessarily leads, at the same time, to create, explore, and integrate new self-dimensions and organizational states that are initially different from those previously extant, as well as, from the other side, for some period of time, to a loss of coherence and complexity of the historical level of coherence that characterized the system. This loss is distressing, even generating an experience of annihilation, and resistance (Cavelzani & Tronick, 2016b), and more generally such process of change is very stressful and disorganizing one’s historical identity and organization. Consequently, as the dynamic living systems are indeed driven also by the need to maintain oneself by preserving one’s own historical and current organization and identity (Sander, 2008; Erikson, 1950/1963; Seligman & Shanok, 1995), the patient’s resistance to change is then comprehensible.

The struggle between the search for new ways of being in the world versus the need to maintain what was known until that moment, even though maladaptive, is particularly challenging and stressful when the historical experiences and coherence are daily micro-traumatized.

According to Minolli (2015; 2010), the first aim of a relational psychoanalytic treatment is to help the subject-system (the person) to become more self-present about his/her own functioning, historical identity and relational patterns. Also, to sustain the patient’s process to make meanings on the traumatic experiences occurred in his/her life. A second fundamental intention is to facilitate the patient in the processes he or she undergoes to self-develop, self-expand, and discover new and more complex desired and functional dimensions of the self that tend to be precluded by the lack of flexibility and
variability in his or her historical self-organization. Moreover, successful therapeutic interventions can be understood as perturbing the maladaptive, rigid dynamics of a patient’s state consciousness about himself/herself in the world (Harrison & Tronick, 2007). Along these lines, change and the expansion of states of consciousness are therefore a creative and constructive phenomenon, with the therapist acting as a dynamic scaffold of the patient that leads to emerging properties of the system, such as creating new experiences and ways of being in relationship in the world (Cavelzani & Tronick, 2016a).

Consequently, as indicated by Minolli (2015; 2010), the patient’s suffering can be viewed as the expression of the passage he or she is facing in the process of self-realizing, gaining more coherence, and evolving. The treatment does not necessarily aim at eliminating the suffering but at framing it in the context of the life process. Furthermore, the change can be facilitated by the therapeutic process but not determined by the analyst, as change ultimately depends on the internal coherence of the system and its regulatory process.

Change and the expansion of states of consciousness are therefore a creative and constructive phenomenon—an emerging property of the system (Cavelzani & Tronick, 2016a).

In conclusion, the previously mentioned proverb may be confirmed only through a new positive, mutual dyadic process that reactivates the patient’s self-reflexivity and self-presence, as well as sustaining the discovery of new and more functional ways of being in the world: dyadic expansion of states of consciousness, together with making new positive experiences about self and relationship may little by little, day by day play as “repairing process” (Cavelzani & Tronick, 2016b) by increasing the capacity of body and psyche to cope. In this way, the subject system has the chance to move forward from the past, so “what doesn’t kill you makes you stronger” could become true.

3. Clinical example: Max

Max is 50-years old, came to the therapy because of sufferance for obsessive thoughts and compulsive repetitions [for example, “did I by chance drink the WC water? Let’s wash my hands and the mouth to avoid any risk”, consequently he usually spends one hour washing his body, finally remaining stuck by complicated and bizarre calculations and repetitions that additional emerge. Or, when planning to check “only five times” the door to be sure is well locked, then a “negative number” (like the number of the day when his mother died, or the ambulance phone number) often occurs to his mind, consequently he has to restart checking the door five times again]. In addition, a severe depression was blocking Max at home in the past seven months, risking then to be fired (“I feel tired today, I cannot go to work”). He had a tendency indeed to call every day his boss to notice his “daily sickness” and postponing to the next day the return to workplace, however repeating this behavior for the past seven months so far was leading the patient to be fired.

Since his childhood, Max devoted his life to help the mother taking care of the sick grandmother and the uncle who were leaving in the same house. His father died when Max was 15 years old, so he decided to leave the school and find a job to be able to financially support the family. Max recalls countless nights spent in the hospital to assist his grandmother, alternatively the uncle, and later his mother when she also became sick. Max recalls also his mother crying every day silently in her room as the grandmother was never satisfied with the assistance provided by Max’s mother, and constantly blaming her every day with the same sentences (“the vegetables you bought for me are not beautiful enough, go back to the shop and find something better!”; “the house is not clean enough, clean it again!”; “there is not enough food for everyone, so give some of your dinner to your brother (Max’s uncle) as he needs to eat more than you”. When Max’s father was still alive, Max recalls also the daily tensions between his parents, as his father wanted to leave that “crazy house”, while Max’s mother was arguing she could not desert her mother and brother. Max was also used to spend the weekends and vacations at home just in case his grandmother would have needed some help. She was living in the part of the apartment at the ground floor, while Max and her mother at the first floor. In case of need, the grandmother was used to knock the ceiling with the
broom, consequently Max and her mother had to stay in silence and "no music could be played at all to avoid missing hearing the grandmother's call". After the grandmother died, Max's mother developed delusional thoughts on being poisoned through water and any beverages, as well as by her neighbors who wanted to enter secretly during the night in her apartment to poison her. Consequently, as she stopped drinking everything, an emergency recovery in hospital was finally necessary. And as the medical doctors did injections and forced alimentation to save Max's mother, her delusion to be persecuted increased, so that she was finally recovered in a psychiatric hospital. Max's mother died after a few years, and Max was visiting her three times every day (before going to work, then during lunch time, and for dinner) in the hope to help her recover. Max's unique remorse is indeed he didn't do enough to help his family, particularly his beloved mother.

Max's story contains lots of daily micro-traumas, consisting in particularly abrasive communicative and emotional exchanges as well as dysfunctional ways to stay together, accumulated silently and without any Max's critical thinking. Only after the last family member died, Max's depression and obsessive repetitions emerged, representing ultimately the opportunity for him to self-reflect, and change.

As said, Max considered his lifestyle "normal", and apparently, he was not expressing any frustration or critical reflection concerning his family, particularly his grandmother's behavior. Such dysfunctional interactions experienced daily inside one's own family, have shaped and built an identity full of sadness, powerlessness, cultural and cognitive poverty, weakening the body too: Max's severe obesity, diabetes, and cardiovascular problems can be seen the additional outcomes and evidences of his historical micro-traumas.

4. Clinical example: Alice

Alice is a 6 years old baby girl. After consulting many pediatricians either from private practice or public hospitals, her parents asked for an additional (the author's) clinical opinion. She had a relevant history of medical shopping in the emergency care units of Rome and Milano, and she had to endure many blood tests. Some of these consultations were positive for immunodeficiency; therefore the mother never let Alice attending the school. Alice's journey through medical care institutions started approximately when she was 2 years old, along with the inability of the mother to take responsibilities related to her caregiver role, probably causing the postpartum distress syndrome. At the same age (2 years old) she developed many interactional problems: she has a delay of speaking, moving and eating independently; she used to spend all the time with her parents, without complaining but just being silent and playing by herself or with her mother. None has ever suggested to the parents to consult a psychologist, while as a matter of fact it should have been one of the most important approaches to the problem.

Nowadays the situation is alarming, picturing a 6 years old young girl, struggling to develop her own identity and the basic functionalities of everyday life. The father seems estranged from the situation.

Consultation: Alice is 6 years old, 100cm, 12 kg, in normal condition but failure to thrive and a weight significantly less than 3rd centile. No siblings, she has a stay – at – home mum while the father works. No family history of significant illness was reported. Alice does not want to eat; she looks at her mother before answering to any of my questions looking for her approval. Alice seems completely dependent on her mother, always silent, she looks at her mother or at the floor, no eye contact with other individuals were recorded; she does not smile, even when the doctor tried to joke about something. The diagnosis was Munchausen Syndrome by proxy. Therefore the parents were noticed about the need to consult also a psychologist, and that legal actions to protect the little girl were needed. Finally, the parents were noticed that Alice needed to enroll in a school as soon as possible.

The main consideration is that this girl had many micro traumas due to the false relationship with her mother, although several physicians consulted in the past did not detect it. There is also a negative mental health and identity; this leads to a higher level of emotional distress and suffering.
Alice feels vulnerable, powerless, confused and overall ill. Such reiterated negative experiences, with no adequate treatments provided, can cause many health problems such as cognitive and language incapacities and immune disorders. Munchausen by proxy is a subtle form of child abuse that involves a parent or caregiver simulating or fabricating illness in a child, resulting in unnecessary examination, hospitalization or even death (Meadows, 1982; Schreie, 2002; Skau & Mouridsen, 1995). First described in 1977 by Roy Meadows, there are four types:

1) perceived illness;
2) medical shopping;
3) enforced invalidism;
4) fabricated illness – apnea/bleeding/vomiting/FTT/diarrhea.

The victim’s mother is usually the perpetrator. As additional hallmark, the child improves when removed from mother's influence/care. The judicial authorities and the child protecting services need to be involved. The mother needs also to be confronted directly and referred for help.

Warning signs:
1) Unexplained persistent/recurrent illnesses;
2) Investigation resulted in a worrisome situation regarding the general health of the child;
3) Opinion of professionals, such as pediatricians and other specialists, underlining the extraordinariness of the case;
4) Prolonged visits of the mother spending even hours in the ward;
5) Treatments that are not tolerated;
6) Despite being apparently a difficult medical situation, the mother shows no signs of over anxiety;
7) Seizure unresponsive to medication;
The mother may have had previous medical/nursing training or a history of similar illness herself.

5. Conclusions

The article pointed out that traumatic episodes refer not only to sexual abuse and physical violence, but also to subtle stressful cumulative experiences occurring daily, which are caused by insecure caregiver-infant attachment styles, post-partum depression, and caregiver's personality disorder. The provided clinical examples illustrate how such microtraumatic interactions and experiences occurred in the childhood have caused severe damages in all the lifespan to the sense of self as well as to the body.

With regard to these patients considered as dynamic systems, the psychoanalytic challenge is to help them moving forward from their past by expanding levels of consciousness and exploring new ways of being in the world.

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