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“WHAT’S OLD IS NEW AGAIN”
THE RE-EMERGENCE OF TRAUMA

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The re-emergence of trauma is a well known phenomenon having been reported in early psychoanalytic literature and thereafter in trauma studies across cultures and time. The events of 9/11 have provided fertile soil for the re-emergence of trauma in the lives of those who experienced the attack, not only those who were present at the WTC but those who witnessed it from near, from far, on TV, radio, telephone, those who were members of a victim's family or friends, caretakers, those who lived alone, etc. In essence, the re-emergence of past trauma was possible for all who were impacted by this event whether present at the scene, in New York City or elsewhere. It was palpable to all who found in this event some personal sense of a wounded self emerging from the rubble with a feeling of displacement or deja vu.

Re-emergence occurs when one or more psychological modalities exhume the past trauma that is believed by the patient to have been dormant or even to have been resolved. It often presents as an emotion or possibly a motoric process before it comes into analytic cognition and can be consciously interpreted. Conversely the fleeting thought, "oh my God this is just like…" can occasion the emergence of powerful emotions that only later can be interpreted cognitively and brought into psychological awareness.

In most cases the rapidity of the onset, as well as the proximity of the past trauma determines the primacy of the sensual versus the cognitive. One feels ripped from his/her fantasized world of protection, one's inner world is unveiled and uncertainty and fear emerge from the shell of one's cracked self.

The re-emergence of trauma is not stimulus-dependent. The circumstances that occasioned the first trauma need not be present in exact form for the second trauma to reemerge. Often only one sensory modality or a proximate circumstance powerfully introduced can elicit debilitating flashbacks. The failure of the primary defense allows the trauma to reemerge.

In analyzing the new trauma, one needs to consider the components of trauma: proximity, level of threat, extent of injury, nature of past trauma, unpredictability, sudden onset, and natural versus man-made.

To better comprehend the emergent trauma, one needs to grasp the nature of the trauma and one's role in trauma. It is in a narrative of self that one begins to diminish the power of trauma and elevate the primacy of self as a solid defense against the destructive and imprisoning nature of trauma.

Creating "The Narrative of Self": A Process Approach

The experience of trauma disrupts one's sense of self, one's sense of the world and ones sense of boundaries between self and the world. There is evidence that trauma memories tend to be fragmented, concrete and disorganized. At the same time trauma memories tend to be largely represented as intense emotion and this affects how the experience of trauma is processed and ultimately resolved. Initial cognitive processing tends to be episodic, disjointed and chronologically inaccurate. The degree of recovery from trauma is related to the creation of a coherent organized story or narrative about the trauma so that the emotional can be put into a cognitive frame that allows the traumatized individual to return to a sense security, well-being

and control. Studies show that a decrease in narrative fragmentation and an increase in narrative organization have been associated with a decrease in both anxiety and depression. The creation of an organized and coherent narrative is especially challenging for an individual with a traumatic brain injury where language, cognition, organizational ability and emotional processing may have been compromised.

1. Organizing "The Narrative of Self": This is an introspective process which requires the patient to collect in written or auditory form the reactions, emotions, behaviors, motoric activities, cognitions, linguistic communications and interpersonal relations that have marked a change in his/her functioning since the trauma and retrospectively compare those changes with pre-trauma functioning. Narratives are created within the context of the therapeutic process. In some cases the narrative is generated within a therapy session and in other cases the person is asked to prepare an initial narrative of his/her changes in one's daily functioning and perception of the world since the trauma.

2. Analyzing "The Narrative of Self": This is and ongoing process that takes place in therapy sessions over a period of several months. It involves retelling the trauma story, monitoring the level of discomfort during the retelling and re-examining emotional "hot spots". It also involves a process of successive approximations hierarchically-designed to desensitize the effects of the trauma. Guided imagery, cognitive restructuring and relaxation are all involved.

3. Internalizing "The Narrative of Self": This stage involves understanding our cognitions and emotions associated with the trauma and integrating them into a sense of oneself that allows one to reestablish a sense of well-being and wholeness. It is finding a place for the trauma within oneself so that we are in control of the trauma rather than the trauma controlling us.

4. Validating "The Narrative of Self": The validation process allows the individual to accept the reconfigured self and to formulate an improved self concept and sense of control over one's life. It paves the way for a more positive re-entry into the world and the establishment and/or reconstruction of inter personal relationships.

5. Integrating "The Narrative of Self": The integrating process allows the individual to establish a comfort with him/herself in relation to family, friends and community. It leads to new connections and the re-establishment of old ones. It reduces the sense of isolation and marginalization.

In the face of trauma, the creation of a narrative of self provides the individual with a voice to restore a sense of safety, well-being and control and to foster a sense of hope and optimism.

A WTC victim: Ms. X, a woman in her 40's, was in the WTC at the time of the first airplane attack. During her process of traversing the stairs she felt overcome with smoke but was encouraged by others to continue her descent. She explained that she felt that she would not make it, sure that she would die in the darkness of the smoke-filled stairs.

Ultimately, she was able to escape from the building and she began running, hoping to get away from the burning building. Then the first tower collapsed and smoke was everywhere. Caught in a cloud of smoke, she lost all direction. She started choking and fell to the ground as smoke and debris covered her. She recalls darkness enveloping her. "Everything was black, it was like night just descended and I was choking on smoke, I thought I was going to die." The time seemed purgatorial yet ultimately emerging light conditioned her eyes to life again.

She arose and walked in a daze not recalling where she was walking. She heard distant voices although she saw people walking beside her but did not equate them with the voices. She does not remember talking with anyone only hearing the murmur of voices muffled by the screaming sirens of fire, police and ambulances. The constant sound of an ambulance began to pulse in her head and a conscious cognitive thought occurred: "I need to go to a hospital," but she did not know where she was as she was still in a dazed state. Ultimately, the sirens stirred her consciousness and she saw St. Vincent's Hospital where she entered and was treated for smoke inhalation.

She remained in her home environment for several weeks and then returned to work. At work, she found it difficult to function in her bullpen atmosphere where she was encircled by partitioned walls. Furthermore, she experienced anxiety attacks about having to take the elevator to her office on the 4th floor; however the alternative of taking the stairs was unthinkable.

She began seeing a therapist in February 2002 on a weekly basis to deal with fears associated with multiple phobias including fear of darkness, claustrophobia and nightmares about smoke inhalation and choking (although she was a smoker herself). She continued in therapy until April 2003 and had felt that she had made significant progress. She was able to take elevators with almost no anxiety, although she still was unable to take stars except when she could see the ground floor in close proximity. Her nightmares of smoke inhalation and choking had lessened but she still felt claustrophobic.

On August 14 at approximately 4:20 p.m., New York City experienced a blackout. At that time Ms. X was in the ladies room at her office building. Seated in a stall, she started to feel overwhelmed with the emotion of being trapped. She started touching the stall walls and remembers starting to panic. She looked up and saw light coming over the door. This offered initial relief but she knew that she had to get out of there. Rushing to the door, she stopped and started to panic again wondering, "What's behind the door?" Opening the door, she found a corridor bathed in natural light and felt a sense of relief. That changed when she noticed that people were leaving their office spaces and although they spoke in animated fashion their voices seemed distant. She was struck suddenly by a clammy feeling as she realized that they were headed for the stairwell with the red "Exit" sign overhead. She went into her office to get her belongings and placed in her pocketbook a framed picture of her daughter that was on her desk. She kept sniffing the air for smoke and searched in her purse for her handkerchief. There was still light around her and she went back into the bathroom to wet the handkerchief. She took paper towels and wet them as well. Before exiting, she washed her face, hands and arms with cold water. Going back into the hallway, she saw a long line of people waiting to go down the stairs and remembers hearing something about a fire. She screamed, "No, No, Please No" and started shaking uncontrollably. She fell down but did not faint. Several people came to her aid

and tried to help her towards the exit. She told them she couldn't go, "Not again." They inquired what she meant, trying to make sense out of her utterances. She said something about the WTC and one of her colleagues explained that Ms. X had been in the WTC on September 11th.

Two women comforted her and talked her down the stairs, assisting her all the way. Still shaking uncontrollably, she did not utter a sound on the way down, only a slow purring of fear. When she reached the street she saw lines of people passing, talking in murmurs and the screaming sounds of sirens from police cars and fire trucks. She collapsed and for the next two hours was immobile. The women stayed with her and calmed her. One of the women was able to get a taxi driver to take her home. When she arrived home, Ms. X took an Ativan tablet that the doctor had prescribed after 9/11. The colleague remained with the woman until her daughter arrived home from school.

Since that time the woman has not been able to return to work and does not know if she can ever work in a building above the first floor. She does not like going out and begins to panic when she hears the sound of sirens. Recently, she left her house to go to the supermarket but on the way saw an industrial stack on a factory nearby emitting a large plume of smoke and she became so distraught that she went back to her house immediately and stayed there until her daughter arrived. She has since returned to therapy.

Traumatic Brain Injury: M.R. is a 50 year old woman from a well educated middle class family. She is one of four children. She has a Masters degree in Education. She had been a teacher and at the time of her accident was the Director of After School Programs for her school district. She is a writer with published poetry and short stories. She is also an artist and an avid organic gardener.

She enjoyed an active social life and has always been close to her family. At the time of her accident she was living on own in a Manhattan prewar building.

Late one evening in 1993 she was alone in her apartment. As was her habit, after a long day at work, she had settled into bed with a good book. Suddenly, the ceiling caved in and covered her with plaster and debris. She recalls pain but was unaware of any loss of consciousness. She was taken by ambulance to the hospital. X-rays of her back were normal and she was sent home.

One week later while walking on the street she experienced an episode she describes as feeling as if the floor was sinking and then quickly coming back up resulting in a loss of balance. She subsequently experienced other episodes where she felt as if she was on "fast forward and then suddenly stopping". Sometimes she felt an "electric jolt" in her head. These episodes were at times triggered by odors.

She was seen by a neurologist. An MRI at the time was negative and an EEG was equivocal. Results of repeated studies have been unclear. She was put under the care of a psychiatrist. She describes other episodes of finding herself somewhere and not realizing how she got there.

She reported persistent problems including headaches, dizziness, balance difficulties, poor concentration, memory problems, repeated episodes as described above and severe depression.

She remembers that at the time of her accident she was preparing a collection of short stories for publication. Overwhelmed by the need to write cover letters and organize a packet for her publisher she was forced to put the project aside. She found herself unable to continue in her job and believed that she had lost her skills. She felt “stupid.” She was frightened, confused, exhausted and depressed.

Overwhelmed by her trauma and unable to care for herself she moved into her mother’s home. She withdrew from life for seven years and spent much of her time in bed ignoring personal hygiene and personal needs. She reports excessive alcohol intake and a suicide attempt.

In the face of questionable EEG’s and imaging studies, her medical care focused on her depression and did not address the possibility of a traumatic brain injury. She recalls the pain of not being heard and the sensation of doors closed in her face. She was plagued by self doubt because no one would believe her. Each time she thought she was getting help she was disappointed and further traumatized. She lost trust in herself and in others and became more and more isolated.

Eight years after her injury she was given a diagnosis of Seizure Disorder and Organic Affective Disorder secondary to Traumatic Brain Injury. Subsequently, she was referred for a vocational evaluation and in the face of great difficulty completing the required tests was referred for a neuropsychological evaluation.

The evaluation documented impairments in: attention/concentration for visual and auditory information; perceptual motor functioning; visual and auditory memory; executive functioning; and evidence of severe depression.

She was enrolled in a cognitive rehabilitation program where she continues to participate. She has received individual and group cognitive remediation, individual and group psychotherapy and stress management training.

Six months ago she returned for a vocational evaluation which she successfully completed. She has spent the last two months in a work training program, meeting her responsibilities and taking great pride in her new accomplishments.

This history illustrates that trauma can be more than a traumatic event. It may also be the loss associated with that event and the continuing trauma endured in the aftermath of the event.

Treatment of this individual required the acknowledgment of the traumatic event as precipitating repeated trauma. The experience of repeated trauma had become embedded in her life and was accompanied by the loss of a sense of self, a loss of trust in others and the experience of isolation and disconnection.

Before she could understand the emotional impact of the trauma it was necessary to help her

construct a cognitive framework to process her emotions and help her make sense out of what had happened to her. The trauma had left her with a profound sense of loss: independence; sense of self; hope for the future; sense of the past ("the present has no context in the past or in the future); sense of security and safety; skills and abilities; sense of trust; seven years; social connections; a voice (unable to get help); and a place in the world (sense of being marginalized). Her injury had elicited anger and depression.

The accident could have been avoided if the landlord had put a new roof on the building. She felt betrayed, helpless and useless. Her future was uncertain. Her traumatic brain injury had left her body unreliable. Initial treatment addressed the disorganization and chaos in her thinking and in her life. It took her hours to get ready to leave the house because she was constantly distracted by her thoughts and her environment. She would begin an activity, become distracted and lose track of the next step. She would get lost on the way to appointments. She would arrive at the grocery store unable to find even one item. At the same time she found herself unable to tolerate being around people. She couldn't follow conversations. If she caught someone staring at her she experienced the person as assaulting her space. When waiting on line she would become enraged by what she experienced as an invasion of her physical space. She was easily provoked and anger quickly turned to rage and violent thoughts. Inevitably the anger would result in depression and withdrawal. She longed for a sense of safety and acceptance and found it no where. It was necessary to help to restore order in her life and to give her a greater sense of control over her emotional experiences.

Throughout Treatment there has been Evidence of Re-emergent Trauma: Startle responses; flashbacks; rage reactions; and depression.

1. Hearing the stories of other group therapy members elicited memories of her own trauma:
   a. She had asthma attacks
   b. She became depressed and anxious.

2. 9/11 precipitated flashbacks to her accident:
   a. She became depressed.
   b. She experienced an increase in seizures.
   c. She was afraid to leave her home.
   d. She and her family constructed a bunker in the basement and stocked it with supplies.
   e. Her healing was helped by bringing homemade cakes to the firemen at her local firehouse.

3. She built a high fence around her garden for greater security and became enraged when the space was repeatedly invaded by the neighbor's cat.

4. As a result of her poor attention and visual perceptual difficulties she fell through the floor at a neighbor's house.

5. August 2003 Blackout:
    a. She was aught at the hospital. It took her seven hours to get home.
    b. She remained calm by talking to herself.
    c. She helped other persons who were lost in the darkness.

Over the last two years she has been constructing the story of her trauma. Her narratives have become more detailed and more organized over time. She often asks if something we are talking about or working on is normal and uses that information to help make sense out of what has happened to her. She has created a cognitive framework in which to understand her story and to manage her emotional responses.

Education about stress management techniques has helped her to gain a greater understanding of the triggers of anger, anxiety and depression and of the use coping strategies to manage stressful situations in a way that has helped her to feel competent and in control.

She brought her poetry and short stories to sessions to help reconnect to herself. She began to write again and felt that she had started to "get my voice back." She has created a journal so that she has a story of her return to life. She started painting again. She is relearning how to make her voice heard and her needs known. She is now an active participant in therapy groups. She is now supportive of other group members, takes a leadership role and has made interesting and engaging presentations utilizing her excellent and re-emerging teaching skills. She has started spending time again with friends. She has slowly regained a sense of security, trust and self reliance. Her hope has returned.

Her trauma will always be with her and when she talks about her accident, her unheard voice and her lost years her eyes fill with tears. She remains sensitive to the experience of being misunderstood, of not being heard and is eager for acceptance and approval. As she said this week, "I know that if I don't panic and stay focused that I will survive."