ARTICLE

Micro-traumatic Experiences and Psychotherapeutic Treatment

Alessandro Cavelzani*1, Martina Trinchieri2, Maria Carlotta F. Gorio3, Lucia Romeo4

1. Psychotherapist IARPP, Buzzi Children’s Hospital of Milan, Italy
2. Candidate, Società Italiana di Psicoanalisi della Relazione, Milan, Italy
3. Department of Biomedical and Clinic Sciences, L Sacco University of Milan, Italy
4. Pediatrician, Buzzi Children’s Hospital of Milan, Italy

ARTICLE INFO

Received: 21st November 2018
Revised: 10th January 2019
Accepted: 11th March 2019
Published Online: 31st January 2019

Keywords:
Trauma
Maltreatment
Mother-infant attachment
Therapeutic change
Relational psychoanalysis

ABSTRACT

It’s becoming even more widely recognized from neurosciences, epigenetics, and clinical research on observation of infant-caregiver interaction 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. Relational Psychoanalytic treatment argues that 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) [12]. Beside of external accident and traumatic experiences such as sexual abuse (Freud, 1895; 1925; Brenner, 1973) [8][9][13], 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) [6] 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

*Corresponding Author:

Alessandro Cavelzani,
Psychoanalytic Psychotherapist for Adults and Children, Buzzi Children’s Hospital of Milan, Italy;
Email: alessandro.cavelzani@gmail.com.
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; 1925)\[^9\]. 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)\[^{[19]}\] 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 as well cause severe affective and behavioral disorders in infants (Beebe & Lachmann, 2002; Fivaz-Depeursinge & Philipp, 2014; Main et al. 2005; Tronick, 2007, 2017; Seligman, 2017).\[^{[12][13][26][27]}\] For example, in the mother-infant insecure avoidant attachment style, 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.

In the mother-infant insecure resistant attachment style instead, the caregiver is usually too preoccupied to not be a good-enough parent, consequently 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.

Research then widely demonstrated (Beebe et al. 2016; Seligman & Harrison, 2012; Tronick, 2017)\[^{[1][22]}\] that the infant senses the quality of the occurring communicative and affective exchanges, particularly the emotional state of the caregiver (i.e. happiness, anger, 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.) through the coordination and synchrony of facial expressions, behavioral correspondence, embodied simulation, and vocal rhythm coordination. 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, 2017, 2007)\[^{[26]}\]. So 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.

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)\[^{[27]}\] and Montiroso’s team (see: Provenzi et al. 2016a, 2016b, 2016c)\[^{[17][18]}\] demonstrated and confirmed that repeated stressful experiences (such as prolonged pain in premature newborns, artificial nutrition in intense care unit 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). So, micro-traumatic experiences 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, 2017, 2007; Montirosso, 2016a, 2016b, 2016c). [18][19].

In order to try reducing the negative impacts on infant and child caused by these daily repeated micro traumatic 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). [12][13] The earliest the dysfunctional interactive pattern is identified, the better it can be recovered.

2. Relational Psychoanalytic Treatment

Symptoms and sufferance (i.e. depression, obsessive-compulsive problems) in adults can be seen as 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. This idea is consistent with the dynamic living systems theoretical framework (Harrison, 2009; Sander, 2008) [11][20] adopted by the relational psychoanalytic psychotherapy 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, 2007; Cavelzani & Tronick, 2016a, 2016b; Minolli, 2015, 2010). [27][34][5][15][16]

Self-developing and self-expanding necessarily leads, at the same time, from one side to create, explore, and integrate new self-dimensions and organizational states that are initially different from those previously extant.

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, 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; Seligman & Shanok, 1995), [20][23] 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), [15][16] 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). [10] 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), [15][16] 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.

In conclusion, recovering from traumatic experiences...
would be possible through a new positive, mutual
dyadic psychotherapeutic 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” 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.

3. Clinical Example: Max

Max is 50-years old, came to the therapy because
of suff erance 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 rest start 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 fi ed.

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 fi nd a job be able to
fi nancially 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 satis fied 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 fi nd something better!”; “the house is not clean
eough, 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 fi rst fi oor. 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 fi nally 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 fi nally 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-traumatic
experiences, 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 ref ection 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 Milan, 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, while the doctor tried to joke about something.

The main consideration is that this girl had many micro traumatic experiences 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 may be caused by insecure caregiver-infant attachment styles, post-partum depression, and caregiver’s personality disorder. The provided clinical examples illustrate how such micro traumatic 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.

References

[14][24][25]