Depth Psychology and Acute Trauma

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Abstract. Understanding the acute response to severe and traumatic stress from a depth psychology perspective helps us understand the mechanisms of psychic response to trauma. The horror of trauma and its randomness deeply affects the psyche, creating feelings of helplessness, both internally and externally. Depth psychology offers unique strategies for dealing with acute trauma because it recognizes the archetypal aspects of the inner wounds of trauma. About half of trauma survivors experience what is called post-traumatic growth, or positive personal changes because of trauma (Tedeschi et al, 2018). Those who have stronger acute emotional responses to trauma are more likely to experience post-traumatic growth. Facing the emotional aspects of trauma early in recovery can lead to deeper personal growth. Depth psychology encourages a deep experience and exploration of emotional symptoms and may be an effective way of encouraging post-traumatic growth.

Keywords: trauma, post-traumatic growth, helplessness, nightmares, epoche, acute stress disorder

Introduction[1]

Acute trauma is an important public health issue. In 2020 there were more than 38 million injury-related emergency department visits in the United States (Cairns & Kang, 2022). Since the onset of the COVID-19 pandemic there has been a significant increase in exposure to trauma, with firearm injuries increased by more than 20% since 2019 (Zwald et al, 2023). Acute trauma deeply affects the survivor, 6 to 30% will develop acute stress disorder (Warren et al, 2016). A prior history of assault, as well as certain mechanisms of injury like stabbings, shootings, and intimate partner violence are risk factors for more severe emotional responses to trauma (Keane et al 2006).

Acute stress disorder is a severe, immediate psychological response to trauma. Depending on the severity and type of trauma 6-30% of trauma survivors will develop acute stress disorder (National Center Trauma Institute, 2023). Acute stress disorder is

[1] *All clinical material was obtained from research subjects with their written consent. according to institutional protocols. Clinical material has been modified to protect anonymity.*

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often a precursor to post-traumatic stress disorder (PTSD); about two thirds of acute stress disorder patients will develop PTSD. Acute stress disorder, like PTSD, is associated with nightmares, intrusive thoughts, affective numbing, and avoidance. Nightmares occur in about half of acute stress disorder patients. If severe symptoms persist for a month after trauma, patients are diagnosed with PTSD rather than acute stress disorder.

Depth psychology offers unique insights into the experience of acute trauma. Understanding acute stress disorder can help elucidate how the mind processes trauma. A depth psychology perspective can enrich this understanding.

What is trauma?

Laplanche & Pontalis (1973), in their classic text, *The Language of Psychoanalysis* (p.465), define trauma as "an event in the subject's life defined by its intensity, by the subject's incapacity to respond adequately to it, and by the upheaval and long-lasting effects it brings about in the psychical organization." Van der Kolk (2014), one of the great modern authorities on trauma, was trained in psychoanalysis. He describes trauma in similar language, as a terrible experience that cannot be integrated, so that it is relived rather than remembered.

Before the 1970s, it was felt that healthy individuals would simply recover naturally from trauma without long-term ill effects. The vulnerabilities of those who had problems after trauma were the focus of research; those who suffered long-term impacts of trauma were, in a sense, blamed for the impact of trauma on their lives. The modern paradigm shift in conceptualization of trauma focuses on the severity of the stressor rather than the perceived vulnerabilities of the victim (Jones & Wesseley, 2006).

Especially from a global perspective, trauma is nearly ubiquitous. Stories of wars, famines and refugees fill our headlines. It is estimated that 70% of the world's population is exposed to significant trauma. The are many types of traumas and important differences in the severity of traumatic injuries. Our clinical work focuses on the acute traumas that are common in urban settings in the US: namely, assaults, motor vehicle accidents and falls.

Depth psychology and trauma

The Jungian analyst Papadopoulos (2020) explored the painful depths of the traumatic experience. He identified two types of pain associated with trauma: the trauma pain and the "existential/ontological pain." Trauma pain is the physical pain associated with the adverse event, together with concomitant aspects of the traumatic injury, like loss of function, financial loss, and grief. Trauma also causes the pain associated with, in Papadopoulos's words, "the big unanswerable questions" (p. 3). These are the questions raised by the randomness and injustice of trauma, question like *Why me? Why did I lose everything? What is the point of life?* According to Papadopoulos, this aspect of traumatic injury is often more distressing to the trauma victim than trauma pain, but we lack the language and tools to conceptualize and address existential/ontological pain. Yet it is precisely this kind of pain that facilitates posttraumatic growth.

We, meaning the network of caregivers and victims, avoid this existential/ontological pain by reverting to what Papadopoulos calls "the societal discourse of the expert" (p.71). Human suffering is reconceptualized as psychological distress experts are assigned to treat that distress. The suffering associated with the

existential/ontological pain is avoided. We see this mechanism played out in our clinical work in the acute care surgical setting. The families of a trauma survivor or the surgical caregivers will request that psychiatry or psychology be present at the bedside when a patient is told the bad news that a loved one has died in the accident that injured them. They imagine that the presence of the "expert" will somehow make the bad news more tolerable. In fact, it "psychologizes" the bad news which diminishes the authenticity of the suffering (Papadopoulos, 2020, p.34) . While caregivers psychologize, trauma victims somatize; that is, they experience their distress in the somatic realm instead of in the existential/ontological realm. Unanswerable questions are experienced as medical problems with potential solutions. Trauma survivors are offered false narratives that provide comfort to their caregivers instead of facing squarely the painful issues trauma raises.

Related to the existential/ontological aspects of trauma is the concept of moral injury. This term originally was used in military contexts, where a soldier, in obedience to his superiors was forced to commit acts that violate his internal moral code. Shay (1994) called this aspect of trauma a "betrayal of what's right" (p.6) that transcends the usual description of PTSD. Trauma survivors must face a form of this moral injury. The injustice of an assault violates internal, universal moral standards and forces the victim to realize that the just world hypothesis by which they, like most of us, lived was not in fact valid.

Post-traumatic growth

Post-traumatic growth (PTG) refers to the surprising psychological improvements observed in individuals' recovery from acute trauma. PTG can occur in as many of a third of trauma survivors. Women are more likely to experience PTG, as are those with the personality trait of openness to new experiences. The kinds of psychological changes noted in PTG include deeper interpersonal relationships, greater resilience, and an increase in spirituality. Paradoxically, those individuals who suffer a higher degree of emotional distress in the period of acute trauma recovery are more likely to have PTG (Tedeschi et al, 2018).

While PTG is very real, an excessive focus on it can serve as a way of avoiding the pain, suffering and grief associated with trauma. Caregivers must not collude with families and patients by pretending the trauma "wasn't so bad" or that "good will come of it." There is no "brightside" to acute trauma. If PTG does come, it comes because of squarely and authentically facing the horror of the traumatic event. Historical and literary case examples can help illustrate the process of PTG.

Frida Kahlo

At age 14, Frida Kahlo was riding home with her schoolmates on a tram in Mexico City. In one horrible moment a city bus crashed into the tram. Seven people were killed. A four-foot metal spike penetrated Kahlo's pelvis from the back, emerging out the front. Her young boyfriend, brave beyond his years, saved her life by pulling the spike through her body and out of her as she screamed in excruciating pain.

Kahlo spent months recovering in the hospital, then months at home. To the surprise of her doctors, she was able to walk again, though always with a significant limp. Chronic pain plagued her all her life. During her recovery she began to paint, and with her painting she both expressed and transcended her pain. "My painting carries with it the message of

pain" (Kahlo 2008, p. 72) she wrote. She experienced post traumatic growth which expressed itself in her painting, and her painting helped her survive subsequent traumas, like a miscarriage that was nearly fatal.

Kahlo clearly experienced the moral injury associated with trauma and described it beautifully. In a letter to her friend Alejandro Gomez Arias a year after her accident she writes, "If you knew how terrible it is to know suddenly, as if a bolt of lightning elucidated the earth. Now I live in a painful planet, transparent as ice, but it is as if I had learned everything in a few seconds." (Kahlo, 2007, p.27)

Jung

In *Memories, dreams and reflections* Jung (1963) described a traumatic fall suffered in childhood. He experienced his trauma somatically and was disabled for several months with a variety of somatic symptoms. He and his father both ignored the psychological impacts of the trauma and viewed it purely medically, seeking the opinions of multiple specialists at great expense to the family. Jung finally realized that he had some voluntary control over his symptoms, then had a sudden flash of insight not unlike Kahlo's. ". . . suddenly for a single moment I had the overwhelming impression of having just emerged from a dense cloud. I knew all at once: *now I am myself!* It was as if a wall of mist were at my back, and behind that mist there was not yet an "I." But at that moment *I came upon myself*" (p.32). Jung's new identity included the experience of suffering and trauma.

Job

The story of Job begins with an offstage event in heaven, a wager between God and Satan. Because of this wager Job loses his flocks, his health, and his children. Job realizes that he is tormented because of events that he does not understand, that occur for no comprehensible reason. Like many trauma survivors, Job is isolated by his suffering. Job's friends are unsympathetic; they respond to Job's pain with blame and othering. They do not understand Job's insight and truth, that he is being punished for no reason. They try to convince Job that he must be to blame for his suffering because God only punishes sinners; they insist that unlike them he refuses to admit his sins and accept blame. Job's power is in his insistence on the truth that he has done nothing wrong. After many pages of dialogue with his unsupportive friends, God Himself intervenes, addressing Job from out of a whirlwind. God chastises Job's friends, saying that "they have not spoken rightly concerning me" (*English standard version Bible,* 2009, Job 42).

By insisting that God is always just Job's friends have not understood God. Job's friends also have not listened to Job, refusing to hear and accept his story. They have offered Job a false narrative and attempted to explain away his pain. God makes a dramatic entrance but offers no justification for his actions but insisting on his power and otherness.

Job is a heroic figure, realizing the deep truths about life and trauma. Job's suffering leads to post-traumatic growth, symbolized concretely in the fact that all his wealth is not only restored to him, but doubled. As Jung (1958) brilliantly pointed out in *Answer to Job,* it is a moment of insight for God as well; God realizes his own moral failing through Job's suffering.

Trauma treatment and research program

The authors have been involved in a large trauma treatment program in a Level 1 Trauma center in Detroit, the Henry Ford Trauma Recovery Center. The program treats about 3000 acute trauma survivors per year and includes a research component with both qualitative and quantitative aspects. In the research context, we have collected over 100 posttraumatic dreams from trauma survivors. The study's population is 72% Black, 76% male and mostly low income (44% had an annual income under $40,000). Important preliminary data from this study have included findings that nightmares predict subsequent suicidal ideation in trauma survivors (Seymour et al., 2023). In this paper we describe some of the qualitative results of our clinical and research work from the perspective of depth psychology.

Qualitative findings

Case Study: The phenomenological experience of trauma

Mary was a student in an apprenticeship program in Detroit, living off campus. Her favorite hobby was working on her old car. She usually repaired it in the street in front of her apartment because she did not have her own garage. She was friends with many of the neighbors, but one evening when Mary was outside a loud group of strangers carried on across the street. Mary yelled, "Quiet down! Kids live in this neighborhood!" and went back to working on her car. Unbeknownst to Mary, one member of the loud group pulled his car around the block, parked in the alley, and approached Mary from behind. When he was within a foot or two, he pulled out a handgun and began firing. Mary was taken by surprise. Despite being defenseless, she grabbed the gun and pushed it down as her assailant fired. About a dozen bullets entered Mary's abdomen and lower limbs, causing severe injuries. Mary also suffered a severe thermal burn on the palm of her right hand; a gun barrel becomes white hot as multiple rounds are fired.

Mary never lost consciousness and called 911. Surgeons stabilized her bleeding (she required the transfusion of 12 units of blood). They removed several bullets, including one lodged next to Mary's spine. Mary survived. She spent about a month in the hospital, where we saw her almost daily. We helped her deal with her pain, her nightmares, and her family. We validated her pain and suffering and acknowledged the permanent life changes that she faced. We talked about the surgeries she had recovered from and the surgeries she would face.

The assault changed Mary's life forever. She went back to school but chose a different career, one in a helping profession. Mary's family was supportive but was never able to acknowledge the severity of Mary's emotional pain and distress. Mary came to realize her family's emotional limitations and learned to relate to them in a much more assertive and mature way. Mary began to make the first steps toward post traumatic growth. She grieved all she had lost but celebrated that which she had gained. "I know now that anything can happen, at any moment," Mary said. That realization was horrifying but liberating. "I know that my life matters."

Case Study: Nightmares and acute trauma

David stepped out of his home one rainy afternoon and was accosted by two males. One demanded David's wallet, which he had left at home. When David explained this, the second man pulled out a gun and shot him three times in the abdomen. When the men

walked off, nonchalantly chatting, David attempted to crawl to another home but fainted. Luckily a passerby noticed David and called 911. David survived.

For a few weeks after his assault David was haunted by trauma-replicative nightmares. He slowly recovered physically, and he was treated in therapy by the trauma psychology service. Besides his nightmares, David struggled with the helplessness he felt trying to crawl to safety and the moral outrage he felt at the nonchalant indifference of his assailants. We explored his nightmares as internal experiences, as depictions of the traumatic experience running amok in his psyche. Spontaneously, David's nightmares began to change. The assailants were present, they pulled the same gun, but in his dreams he was able to flee or sometimes wrestle the gun from his assailant. The dreams no longer brought terror or woke him from sleep.

David made a good recovery, both physically and psychologically. After a year he was able to return to graduate school. His nightmares gradually disappeared, and he never developed symptoms of PTSD despite the severity of his trauma.

Discussion: Helplessness and moral injury

Detailed clinical interviews with trauma survivors revealed certain consistent patterns of trauma response. Mary's story is an example of moral injury and the questions it stirs, as well as a story of traumatic growth and recovery. Trauma stirs feelings of helplessness. In the words of our patient Mary, we realize that, through trauma, "anything can happen." The sudden awareness that momentous and permanent change can occur unpredictably violates the just-world hypothesis that informs our everyday lives; good actions are rewarded; bad actions are punished. Trauma is often random and unpredictable, affecting the lives of the guilty and the innocent, without regard for justice.

This helplessness is external, in relation to a world over which we suddenly realize we have no control, but also internal. Patients and families state that the grief, sadness, and anger is too much to bear. Initially at least, the pain genuinely cannot be processed. Trauma survivors feel despair about their own inability to cope. The ego comes face to face with its own limitations, helpless internally against feelings that it cannot contain.

To avoid those helpless feelings, trauma survivors blame themselves with "If only" thinking. Mary might think, *if only I hadn't been fixing my car*, *if only I hadn't called out to those people*. Terrible as that self-blame is, it is more tolerable than the feeling of helplessness in the face of a random world. This internal helplessness causes many of the cardinal symptoms that are symptomatic of trauma like dissociation, intrusive thoughts, avoidance, and affective numbing.

Aspects of the trauma experience are split off from consciousness because they are unbearable, becoming inaccessible to the ego. Dissociative mechanisms preclude the integration of traumatic experiences. Intrusive thoughts occur when unstable defenses against overwhelming affects like suppression and denial break down and the ego is forced to face unbearable feelings and memories. Avoidance can be external, like avoiding the corner where an assault occurred, but can be internal, like avoiding thoughts and memories that cause recollection of the traumatic event. Affective numbing is subtler, involving the avoidance of feelings in general, because to feel at all might expose the ego to a burden it cannot bear.

The families and loved ones of trauma survivors face their own feeling of helplessness. Many respond by minimizing the tragedy, offering the trauma survivor false

reassurance that "everything will be all right" and "everything will be back to normal." The trauma survivor sometimes feels very alone in his pain because those who love them cannot face the reality of the impact of the trauma.

The response to this awareness of helplessness is an important predictor of PTG and recovery. Acceptance also allows for the mysterious phenomenon of post-traumatic growth, where the trauma survivor makes important life changes because of the horrors of trauma. The historical examples cited, as well as the cases of Mary and David, show examples of post-traumatic growth. Post-traumatic growth can occur as a result of therapy or spontaneously.

Nightmares and recovery

Detailed clinical interviews with trauma survivors revealed certain consistent patterns of trauma response. Nightmares have an important role in processing trauma (Mahr & Drake, 2022) and about half of trauma survivors develop nightmares (Wittman et al., 2007). We collected a sample of almost a hundred post traumatic dreams. Patients were eager to share their dreams, even their nightmares. Using a sample of post-traumatic dreams, we made a phenomenological analysis of post-traumatic nightmare content.

We expected to find dreams that reproduced the trauma, since trauma-replicative nightmares are a common result of trauma. While we found many such nightmares, we realized that the concept of trauma replication is a complex one. Dreams tended to replicate the trauma but with significant and important variations. For instance, the trauma survivor dreamed of an episode in his past life when he was jilted. This dream replayed not the trauma itself but the feelings of helplessness and abandonment associated with the trauma.

David's dreams were initially trauma replicative, but later, as David improved, the dreams themselves changed. In his later dreams, he was no longer helpless but was able to flee or protect himself by grabbing his assailant's gun. As in Mary's case, David's helplessness was internal as well as external, and the dual nature of this helplessness is depicted in his dreams. His assailants ran amok in his dreams, just as they did in reality, but the assailants may represent the inner assailant of the traumatic experience itself. As David improves, he can flee and eventually master this inner assailant.

We found many examples of violent and frightening imagery, like violence and assault. We also found many examples, of dreams that provided insight and spiritual connection. These dreams of insight may suggest a foreshadowing of the PTG process.

Epoche

The historical and literary examples, as well as the clinical cases, suggest a unique kind of insight that can develop from the traumatic experience. What was it that Kahlo, Jung, and our patient Mary realized? This insight might go by many names. It involves the awareness that the world has its own plans, independent of our wishes. It involves a sense of moral injury, the insight that the world does not operate according to our ideas of right and wrong. Heidegger called it *Dasein*, the pre-personal, ontological "layer" *preceding* the ego (Heidegger, 2022, p.27). It could also be called epoche.

Epoche is a philosophical term referring to a suspension of biases and assumptions to understand the world in its own terms. For the trauma survivor, beliefs about a just world must be suspended so that the process of acceptance and a recovery of a sense of meaning can begin. Epoche involves the realization that the commonplace world of everyday

experience is an illusion and that this awareness is the beginning of true insight and wisdom. In the case of trauma recovery, it may be the first stage of posttraumatic growth.

A more succinct way of expressing the insight that can lead to PTG is as follows: "Yes, the world is random, but it is not meaningless." Awareness of the randomness that can occur in the world does not contradict the search for meaning that is central to depth psychology; nor does it contradict synchronicity, the concept of meaningful coincidence. The awareness that randomness and meaning exist simultaneously is at the core of PTG.

Conclusion

The qualitative study of acute trauma survivors reveals important aspects of the trauma response. Key elements of that response include feelings of helplessness and an insight into the randomness of the world and human experience. An examination of post-traumatic nightmares confirms some of these insights. Depth psychology, because it acknowledges the depth of human experience, can be an important treatment modality in trauma patients and can facilitate post- traumatic growth.

Contributors

Greg Mahr, MD, is director of Consultation Liaison Psychiatry at Henry Ford Hospital in Detroit and is on faculty at the Wayne State University and Michigan State University. He has a long-standing interest in depth psychology. He co-authored *The Wisdom of Dreams: Science, Synchronicity and the Language of the Soul* with Chris Drake, published in 2022 by Routledge. He has collaborated with Heather Taylor-Zimmerman on *Dream Wisdom Oracle*, a handbook and set of dream cards, which will be published in August 2025 by Inner Traditions.

Anthony N. Reffi, PhD, is a clinical psychologist with expertise in trauma and post-traumatic stress disorder (PTSD). He is a researcher at the Thomas Roth Sleep Disorders and Research Center in Michigan, as well as the Henry Ford Acute Trauma Recovery Center, and has received a NIH grant to study trauma.

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Christopher Drake, PhD, is a clinical psychologist and sleep researcher. He has authored over 200 scientific publications and is a section editor for *The Principles and Practice of Sleep Medicine*. He has received research grants from the NIH and is a former Chairman of the National Sleep Foundation.

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