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From doctor to incendiary nun: the importance of analysing the pathways of trauma

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Abstract

Childhood traumatic experiences have often been associated with the development of severe psychiatric disorders or, at least, with serious impairment in the victims' developing personality. Emotional abuse and neglect can cause gradual damage to Self-image and to models of self-in-relation to Others. We report a case of a woman who underwent psychiatric evaluations for marriage annulment. The issues were the assessment of the outcomes of early psychic trauma and the examination of the remaining individual capacities from a judicial standpoint. The examiners found that the memories of the woman's history of childhood abuse had become integrated into her personality organization. The spheres most strongly influenced were those of psycho-sexual/affective maturation and a dysfunctional bond with religion. Psychodiagnostic evaluation diagnosed a Borderline Personality Disorder.

The complexity of the case suggests the need of a multi-dimensional analysis by an interdisciplinary team including experts in legal medicine, forensic psychiatry and psychology as well as clinical criminology. ***Clin Ter 2022; 173 (1):10-14. doi: 10.7417/CT.2022.2384***

Key words: *childhood trauma, borderline personality disorder, psychiatric disorders, emotional abuse, forensic psychiatry, religion, psychology.*

Introduction

According to Flannery (1,2), psychic trauma is the physical and psychological reaction of an individual to a sudden, overwhelming and usually unexpected event that is potentially life-threatening, over which the subject has no control because an adequate understanding of the experience demands analysis of all its characteristics (3). These include the origin (natural or human), nature and type (sexual or physical abuse), duration (this element raises the possibility of cumulative trauma), gravity and consequences of the traumatic experience; the extent of the spheres affected; the type of exposure to traumatic events; the relations with the people or things that perpetuate the trauma (4).

Exposure to childhood traumatic experiences (TEs) has frequently been linked to the development of severe psychiatric conditions, including mood disorders, somatoform and panic disorders, and serious impairment in several functional domains (5,6).

In the literature, a significant relationship has often been suggested between multiple forms of adverse childhood experiences such as emotional, physical, or sexual abuse and their long-lasting effects on the victims' developing personality, resulting in maladaptive traits or personality disorders (PD) in adulthood (7,8). For example, childhood maltreatment has been related to Schizotypal PD symptoms especially paranoia and unusual perceptions (9). Child abuse and witnessing domestic violence have been associated with self-reported antisocial behaviours in adolescence (10).

The borderline personality disorder (BPD) is certainly one of the most significant and frequent mental illnesses in psychiatric settings, whose aetiology and pathogenesis have long been under investigation. The main features are a pervasive pattern of emotional dysregulation, hyper-intense affect, unstable interpersonal relationships, and impulsive behavior (11). Patients who suffer from lack of impulse control and self-regulation tend to show poor social functioning, and are subject to angry outbursts, fear of loneliness, identity disturbance, and a profound sense of emptiness. According to current multifactorial models, many interactions of genetic, neurobiological and psychosocial elements are involved in the pathogenesis of BPD. Among the latter, several authors have described childhood TEs, insecure attachment and maladaptive emotion regulation as causal factors in the development of BPD (12,13).

A recent meta-analysis showed that these patients more commonly report childhood TEs than patients with other types of psychiatric disorders, and they were over 13 times more likely to refer a history of childhood trauma than nonclinical subjects (14). In addition, empirical research revealed that the trauma was related to the severity of BPD symptoms (15). On the other hand, according to the attachment theory (16), persistent problems in emotional regulation and interpersonal relationships in these patients can be explained as developing from difficulties in the early dyadic parent–child interactions with caregivers, from which "internal working models" or mental representations of self

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and others are derived in adulthood. Indeed, a close relationship with primary caregivers increases the likelihood of a secure attachment. Impaired attachment styles were highly correlated with a borderline personality disorder. These patients usually demonstrate unresolved, insecure or disorganized attachment styles, accompanied by interpersonal dysfunction (17).

These individuals cannot identify, manage, or regulate their emotions because nobody taught them to do so during childhood, and may experience constant fear of interpersonal rejection or abandonment (18).

Moreover, emotional abuse and emotional neglect can cause gradual damage to the self-image, defined as the perception and evaluation of oneself, and the development of maladaptive models of self, others, and self-in-relation to others. Therefore, it has been proposed that a disturbance in the sense of Self is a fundamental component of a personality disorder and an important predictor of social functioning (19). Individuals who have suffered childhood trauma, including abusive relationships between caregivers and children, are apt to employ a series of maladaptive ER strategies, including rumination, fantasizing about catastrophes, blaming others, which might contribute to strong negative emotions and extreme emotional instability (20).

Obviously, each child's temperament may predispose to certain difficulties, but that temperament coupled with experiences of loss, trauma, or neglect can cause such traits to become pathological (21).

Parents of future patients with BPD may themselves have personality disorders, they may be insensitive to the needs of their children or fail to provide an appropriate supportive environment (22). Non-optimal family environments (i.e., high levels of conflict and control, low levels of cohesion and organization) are related to borderline psychopathology. Parental neglect, unproductiveness or permanent loss of primary caretakers are important factors in the genesis of a personality disorder. It is possible that trauma is most pathogenic for children with vulnerable temperaments or for those most lacking in protective factors, such as positive relationships with other caretakers or siblings (23).

We report a case of a woman who underwent psychiatric evaluations for a lawsuit for marriage annulment. The most common reason used to declare a marriage null is the inability to fulfil the essential marital obligations due to causes of a psychiatric nature (Code of Canon Law Can. 1095 n. 3). The case is marked by a dual problem of interest, which concerns with the forensic psychiatry field, namely the assessment of early psychic trauma's outcomes and the examination of the remaining individual capacities judged from the judicial standpoint.

Case Report

The history was reconstructed based on the lawsuit proceedings and interviews with the 35-year-old woman. She had lived with her maternal grandparents until the age of five, since her parents had shown inadequate parental skills (her father was disabled, and her mother was devoted to satanic cults). After the death of her grandparents, she went back to live with her parents but was often involved by her mother in "sexual rituals" of satanic type. Her father died in a car accident. At the age of 10, the Juvenile Court placed her with a foster family. At the age of 13, she started to have homosexual relations with the family's biological daughter - also a minor but already with child . She was definitively adopted at the age of 14 by another couple, both doctors, with whose nephews the girl later had sexual relations between ages of 16 and 18. Aged 19, she enrolled at the School of Medicine because she had been "forced" to do so by her adoptive parents, that she sued 2 years later for "psychological maltreatment". At the age of 22, she began a relationship with a course mate but he left her after a few months because, she claimed, she had refused to consent to an act of sodomy. She felt "abandoned" and cut her wrists with a piece of glass.

It was at this point that she developed the idea of becoming a nun. She continued her studies but went to live in a convent, where she began a vocational explorative pathway. However, during that period, she claimed that another nun had tried to "exploit her for sex". She referred this to the Mother Superior, who tried to dissuade her from following the vocational pathway. She reacted by setting fire to the bed in her room. The fire spread to the whole convent and she ran away and later blamed the other nuns. After the bachelor's degree in medicine and Surgery, she firstly specialized in Gynaecology and Obstetrics and then took a research fellowship in Infectious Diseases, where she became the lover of the pro-Rector, a man much older than her. However, during the relationship, she forbade him to have complete sexual relations with her, in order to remain "chaste and pure" with the intention of returning to the religious life. When the pro-Rector proposed marriage she fled to another convent where, after "confessing" the events in her life to the Mother Superior, she was subjected to a number of exorcisms because she was believed to be "possessed by the devil". However, the various priests denied this possession by the devil and in the end she left the convent, feeling "disappointed and betrayed" by the abbess. After this, through a religious website, the woman came in contact with a man who had been a seminarist but he also had abandoned his vocation because he claimed he had been molested by an another seminarist. Six months later she married him to see if she was "better suited for marriage or for a religious life", but they separated after about one year, during which she had always refused any type of sexual relations. After the separation (decided by him), she had a rebound relationship lasting one month with a police officer because, she claimed, she felt once more "abandoned". After this, she applied for formal cancellation from the Medical Registry because she was convinced that "her pathway was a religious vocation". She moved to a home managed by friars where she met a bishop to whom she confided her story. She also expressed her intention of founding a new religious order with the aim of taking care of homeless minors, where she would act as the abbess. At this stage, the bishop advised her to seek the annulment of the marriage.

Forensic Psychiatric Assessment

During the psychiatric interview, she showed an excessive focus on Self, emotional detachment and instability,

oscillating between reticence and exhibitionism, victimhood and manipulation of the setting. Hypoaffectivity and dysempathy were manifest, in a context of pseudo-eroticized, conflicting and unstable interpersonal relationships. Her orientation about persons, place, and time was correct, and no formal psychiatric illness was found. Non-verbal communication appeared to be self-defensive (she remained at a certain distance from the interlocutor; she mostly stared at the wall while speaking and maintained carefully controlled gestures). It appeared that memories of her childhood abuse had become integrated into the total personality organization that had essentially become ego syntonic. Her formal thought was found to be unstable, and delusional and "victim-like" ideas surfaced. She showed both megalomaniac exaltation ("*... I preferred to die than sin, because I aspire to Christian perfection ...* "), and moments when she adopted a more critical attitude, but showing narcissistic traits ("*... I have only miseries to offer to Christ ... I want to become like Christ...*").

Aspects of a disordered personality were assessed using the Rorschach Test, which demonstrated inadequate emotional-affective regulation, an incomplete and disturbed self-identity due to lack of integration of the self-image, personality functioning bordering on the psychotic, poor reality testing with scarce insight. The MMPI-2 was not interpretable due to the unstable values obtained on validity scales.

According to the behavioural analysis and the clinical data, the expert indicated that the woman was suffering from a Borderline Personality Disorder (BPD), at least at the time of the wedding and since. The diagnosis of BPD consisted of: i) her traumatic psychosexual and psychoaffective maturation; ii) the structural and functional limits of her personality and identity (narcissistic-histrionic type); iii) emotional instability (in which reactive aggression and impulsiveness masked separation anxiety); iv) and a highly conflictual and dysfunctional bond with her husband.

In view of these features, the woman was unable to fulfil the essential obligations of marriage. This psychopathological condition bordering between the neurotic and the psychotic, in fact, adversely affected her psychic functioning as it precluded her from establishing and maintaining a solid interpersonal relationship over time, characterized by elements of adequate balance, integration and reciprocity. Noteworthy, she had never been seen by a mental health specialist despite her medical background.

Discussion

The reported woman's history suggests that traumas like those produced by abandonment, betrayal or violence, can cause the complete loss of faith in others and of certainties (symbolic) on which to find the subject's self-image and existence. The Other, previously seen as familiar, takes on a new, terrifying aspect and can no longer be used as a basis on which to build the necessary certainties. So that such subjects find themselves powerless when faced with the destructive force of the Other, and the impossibility of separating their view on life from their traumatic experiences. They are thus condemned to live in a world of wounded subjectivity, obliged to brood continually over the events without ever truly processing them because they are resistant to any possible processing in their mind (24).

In cases of very traumatic events the subjects are often unable to store the memory of the trauma in a precise area dedicated to processing it. Therefore, their living space is full of suppressed memories, flashbacks, fragments that they cannot consciously access. Their future is overshadowed by their present, which is a hostage of the past, and so both time and space are marked by their incommunicability (25,26).

The subject refers traumatic events related to their relationships and contacts that are dys-harmonic, dysfunctional and often violent. In general, in dyadic relationships this involves not just two subjects interacting at a physical level, but also the inner representations that each has of the other subject. The representations and emotional investment in the Other are not only complex but also distorted and spoiled by the previous traumas. It is inevitably dysfunctional in terms of the status and balance of the dyad, and their behavior will surely suffer from the negative reflections of this imbalance (26-30).

In stable relationships, the subjects need to have sufficient maturity to be able to compare their own representations with the concrete reality of the other. This must precede the construction of valid human relationships, especially those between couples.

In the presented case, a condition of defective maturity in relations with others, the Church, and religion was evident. In such cases there is a tendency to consider oneself or others in exclusively positive or else negative terms, thus activating the defensive schism mechanism that is typical of the early stages of mental development. The lack of integration among the split parts means that the representation of the other person oscillates between an ideal vision of the partner, and the reverse image of one considered to be the cause of one's own unhappiness. It becomes impossible to reconcile the feelings of attraction and repulsion, of seeking out and rejecting, of love and hate. In this way, they have no chance of accepting the other person as he/she really is, which is the essential condition for true love to develop, rather than just how much he/she is able to respond to their particular needs (31). Consequently, these types of subjects are influenced by a distorted cognitive balance and inadequate modulation of affect to reality, to themselves and others and so have dysfunctional powers of critical deliberation, behavioural planning and realistic forecasting. In fact, BPD was the final psychiatric diagnosis in the reported case.

Considering the entire woman's life experiences as recounted by herself, it is difficult to calculate how many episodes of trauma she really experienced.

There can be no doubt that the spheres most strongly influenced by her traumatic experiences are those of sexuality and religion:

1) sexuality:

- in childhood with her involvement in her mother's satanic rituals;
- in adolescence with the homophylic relations with a minor unmarried mother, and heterophylic relationships with the nephews of her adoptive parents;
- in adulthood when she claimed sexual victimization and self-harming acting-out dictated by anguished feelings of

abandonment, the sexual molestation by a nun, the matrimonial project with another claimed victim of sexual molestation, her refusal to have sex with the spouse and failure to consummate the marriage.

2) Religiosity:

- her first explorative vocational pathway was interrupted by the claimed sexual molestation, that ended in her setting the convent on fire and running away;
- her second vocational pathway was characterized by repeated failed exorcisms; her project to marry a man had also aspired to a religious vocation;
- her third attempt to enter a convent, preceded by her application for cancellation from the Medical Register; it was justified by her wish to find a new religious order of which she would become the abbess.

These two spheres are probably two sides of the same coin. The religious experience is that of a relationship with Another, that is completely Other (32).

Therefore, her religious experience was one of transcendence, in the sense of an intrinsic, impelling move toward a world of values in which the subject attempts to have a relationship with the Other, non-Self, but is unable to build one.

In this case, a study of the relations between religious ideals and the individual personality seems to be fundamental in order to gain a better understanding of the underlying mechanisms involved (33-36).

The religious experience becomes a manifestation of the Self-function, because the religious sphere is certainly not a sector apart from the mental sphere but is rather an integrated part of the individual psychic structure (37-39).

The healthier this is, the better able it will be to integrate, organize and harmonize the Past-Present-Future (space and time dimension), Self and non-Self (relational-objective dimension), Life and Death (anthropological dimension), Immanence and Transcendence (ontological dimension).

In any case, the concept of Self is defined in reference precisely to the relational construct, because all human beings exist as a part of a relationship with others. It is within the relationship that the distinction of Self and the Other is made, and the construction of Self-starting from the Other and through communication and exchange with the Other.

This is why our *Being*, as a *being-in-the-world*, is always a *being-in-relation* and a *being-in-a-situation.* This is also why, in this context, the religious experience contributes to found and organize the personal identity because it allows one to qualify the Self. This is as a polysemic construct – in relation to Transcendence – as a dimension that is not only anthropological but also ontological (40-45).

In the case reported, the woman's religiosity is pathological because it lacks any authentic transcendence, in other words a valid call for the sake of others and featuring empathy with others. This deficiency is because her body as a sexual element was never seen by her as able to mediate reciprocal relations and an alter-ego complementary exchange, owing to the destructuring effects of her perceptions of sexual experiences. This gave rise to pathological oscillations – typical of an extreme state on the borderline of a personality disorder– between a hysterical attitude (with ostentatious, exhibitionist manifestations of a religious vocation behind which the subject takes refuge to avoid sexual victimization), and a narcissistic attitude (in which religion can ensure that the subject reaches perfection by triumphing over sexuality itself).

The conclusion to be drawn from this case report is that the analysis of the pathways of trauma, as described by the subject, is important for the assessment of BPD whose multifactorial interactions have yet to be examined in depth. The complexity of the case especially those requiring an evaluation of individual capacities from judicial standpoint, warrants multi-dimensional analysis by an interdisciplinary team including contributions from experts in legal medicine, forensic psychiatry and psychology, and clinical criminology (46-49).

Ethical standards

Declaration of conflicts of interest

Cristiano Barbieri has declared no conflicts of interest
Lucia Tattoli has declared no conflicts of interest
Ignazio Grattagliano has declared no conflicts of interest
Caterina Bosco has declared no conflicts of interest
Giancarlo Di Vella has declared no conflicts of interest

Ethical approval

The article does not contain any studies with human participants or animals performed by any of the authors.

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