Medical Trauma in Patients and Providers: Interpersonal Neurobiology and the Autonomic Nervous System
(SF Handbook Presentation 022616)

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Preface

Performing emotional triage on a young patient as she has gone through her medical residency has alerted me to some of the complexities on both sides of the white coat. The first one that comes vividly to mind was her call in her first year of residency about a patient who had been admitted with a serious but hardly life threatening condition whom her attending (supervisor) told her to give a (very necessary) blood transfusion and the patient ended up on life support the next day. It seemed related but she will never know if it was. Before she left for the night the patient had said "I trust you doctor." he was taken off life support by family later that week. "What did I know?", she wailed on the phone, "My attending has 30 years experience." Her supervisor made known that her treatment was the correct one, but that did not ameliorate her horror or the patient's family's grief.

A few months later, she came to a session at the end of a grueling 24-hour shift during which the adult children of a dying woman in her 90's insisted she order painful tests and procedures that she explained to them were unlikely to prolong their mother's life, but would certainly make it more painful. Legally, she explained to me, she had to follow the wishes of whoever was medical proxy in the absence of a living will signed by the patient. She was unnerved and devastated.

And then there was my doctor patient racked with guilt about a particular Ebola patient he felt he might have improperly medicated when his blogs from Sierra Leone had made it perfectly clear how little the staff, in their enormous safety gear could do except try to ease suffering by hydrating and hope the patient's

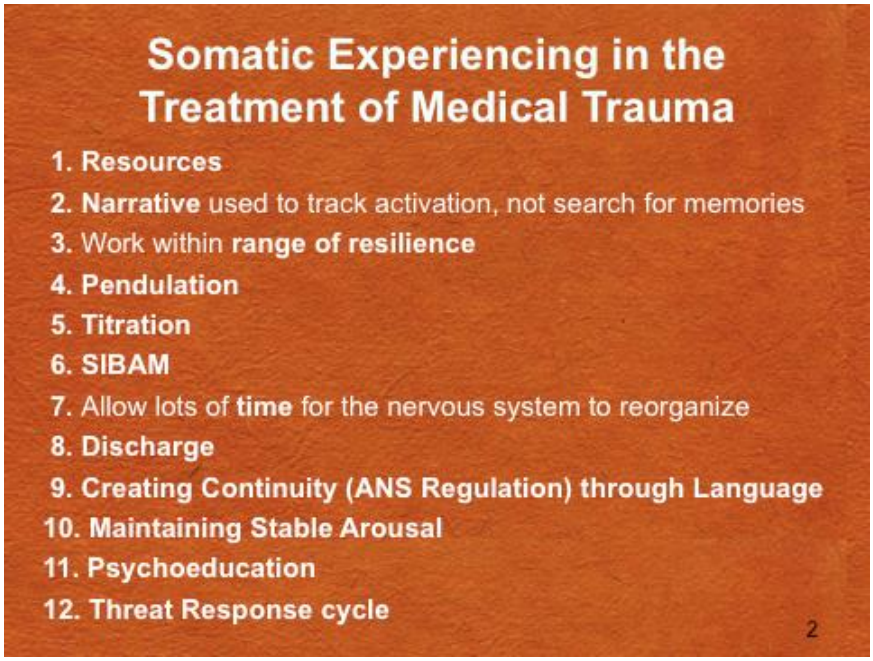
own body would rally. He ruminated for days about this particular man's family, children, place in the community…..

Finally, another doctor I have treated for trauma, working alone in a small, isolated community in Alaska, faced with a partial miscarriage in the middle of the night, found himself gazing into a fully formed face and tiny hand reaching toward him. The image haunted him for years.

Why do I preface with these vignettes? To make sense of what may sound like inhumane treatment of Celine, the patient whose somatic psychotherapy I will be discussing. That is not her real name, and other identifying details have been altered. So, I would like to make it clear at the outset that I do not question the medical necessity of what I will be describing, only its effects on a person's nervous system, her psyche. (Slide 1)

Blue Nude, Pablo Picasso 1

So, I continue to ask whether awareness of trauma to the ANS might have allowed the procedure to be managed differently. Would post-operative triage have helped? Probably, but we cannot know for sure. How can medical personnel be helped/trained to remain empathic and compassionate? I am not entirely sure, but they are vital and important questions to explore. The case I will present suggests that a tremendous amount of collateral damage to the autonomic nervous system can occur. In this case, it certainly did.



(Slide 2) In what follows, I will introduce the patient and then briefly describe and compare both the healthy ANS and the traumatized ANS. I will then describe the medical procedure that was so destabilizing and some aspects of how I have begun to try to help her heal. I will rely heavily on basic Somatic Experiencing techniques.

Introduction to Celine

"I want to kill myself, but I am a Muslim and it is *haram*, forbidden. And anyway I am living now in hell. If I kill myself I just go to another hell".

Christ's Descent into Hell, Hieronymus Bosch

(Slide 3) Her passionate face and voice speak from her small face, outlined in a rust colored band, edging a head cover of black. As I have gotten to know her,

she

On the Operating Table, Edvard Munch 4

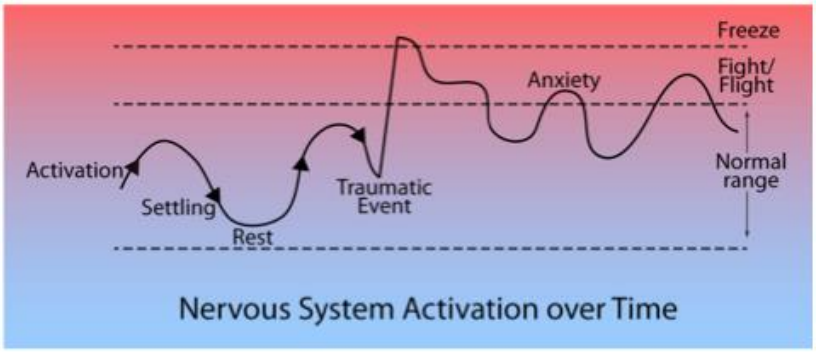
always wears black, frequently many layers, which she does not remove in office. Adorned only by a single broach or necklace. Eighteen months ago, her orderly world was shattered by a life-saving medical procedure: heart ablation. Eight hours, 116 electric shocks to her heart to interrupt the 4 arrhythmias that were making it harder and harder for her to function. Naked on an operating table, surrounded by a team of all men except for a single female nurse who occasionally held her hand.

my

(Slide 4) Cold. Shaking. Cold eyes looking over their surgical masks. Rape. Torture. Catheters are threaded up through veins/arteries to her heart, about which most patients complain bitterly, but she insists were “nothing”. “ I have a high pain threshold.” As we begin to unpack the whole thing, I wonder if pain or discomfort will surface in that area. It does.

We are circling gently. (Slide 5) She wants to dive, offers to bring her husband to wait nearby when we “begin”. I explain that we have

Allow lots of **time** for the nervous system to re-organize itself.



begun, that we are processing aspects of the trauma piece by piece. The whole thing, if we could even encompass it, would be re-traumatizing. And anyway,

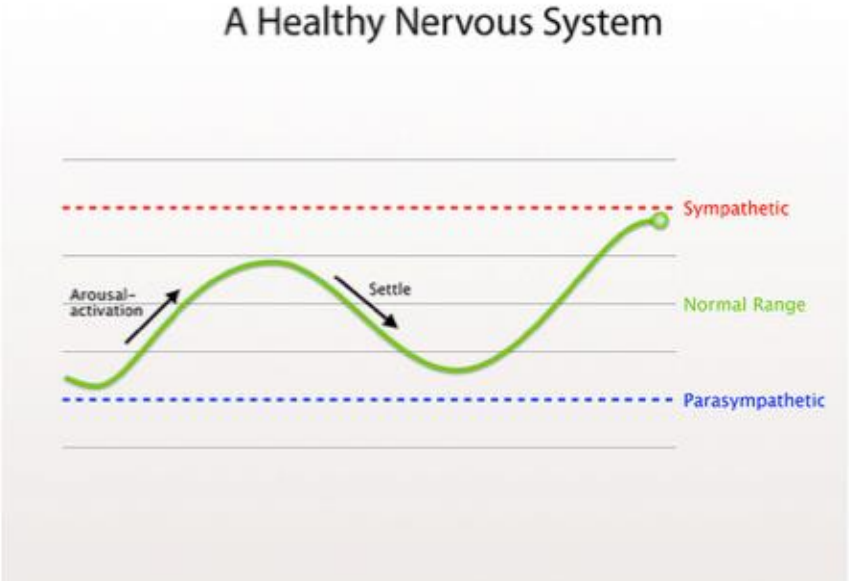
The Tree of Hope, Frida Kahlo 6

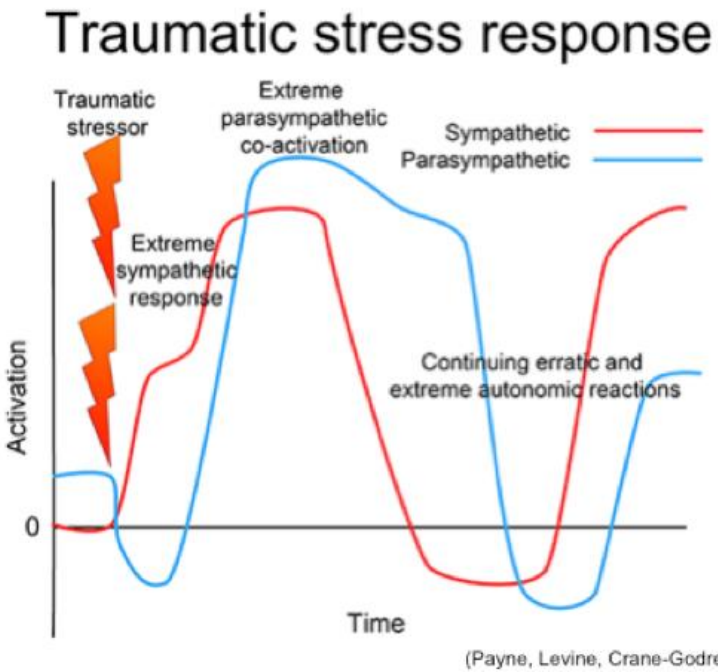
there are so many layers and levels. I become aware as she reminisces about the aftermath, that the relational piece is paramount. No one has acknowledged or understood what has happened to her. She speaks of her self-control, her apparent normality. (Slide 6)

She and her husband have taken sabbaticals and come to NY for her trauma treatment. At home, in their Midwestern university town, psychodynamic therapy didn't help, nor did CBT. Reading Ghislaine Boulanger's work, I understand why. Adult trauma of this sort is not assessed cognitively. Nor is it entirely related to psychodynamics as ordinarily pursued psychoanalytically. A relatively healthy, functional, adult self has been shattered. To paraphrase Boulanger, the trauma is "psychically indigestible…the self has collapsed.. in the face of an indelible memory." Everything has changed. So I begin with the relational piece, with the system Porges has labeled "social engagement." I listen. Closely. Precisely.

Sympathetic and Parasympathetic Nervous Systems (Slide 7)

For Body Psychotherapists, familiarity with the distinct and reciprocal roles of the two branches of the ANS is extremely helpful in assessing and treating psychological manifestations of ANS dysfunction frequently seen in mood disorders, including anxiety and depression, and traumatic stress disorders (among others). In the healthy human organism, they operate reciprocally and unconsciously. The function of the SNS is connected with fear or arousal and initiates instinctive emergency response activity as well as any conscious effort. In contrast, the function of the PNS supports processes such as normal digestion, deep relaxation and sleep. While the fight-or-flight response is associated almost totally with the SNS, the freeze response is associated with the PNS.





(Slide 8) In a recent article in the *Harvard Review of Psychiatry (23#4,July/August 2015, p.264),*

(Payne, Levine, Crane-Godreau, 2015)

Kozlowska et al. point out that “the responses that make up the defense cascade [freezing, fight or flight, tonic immobility and quiescent mobility] are primitive emotional states – coordinated patterns of motor-autonomic-sensory response – that are available to be automatically activated in the context of danger. Emotions are played out “in the theater of the body.” For humans, the activation of defense responses – the sudden change in motor and physiological state – may be experienced as overwhelming, and beyond conscious control….leading to PTSD, peritraumatic reactions, complex trauma, BPD, and states of intense distress potentially leading to self harm, that are difficult to diagnose and treat.”

Adrenaline, cortisol and cortico-steroids flood throughout the whole body: stimulating the heart rate and contractability of cardiac cells; closing down some of the blood-vessels in the periphery (skin) and making much more blood available for any intense muscular activity; All the external (skeletal) muscle systems become tense, ready to ‘fire’.

When the brain perceives a threat, it activates these physiological and behavioral responses. However, if stress is sustained or increases over time, the allostatic load causes damaging changes to the body that can lead to disease and long-term psychological or physiological imbalances (McEwen, 2006; 2007) During traumatic stress, the limbic system activates the SNS. When ‘fight or flight’ responses are not instantly possible, the limbic system activates the freeze response.

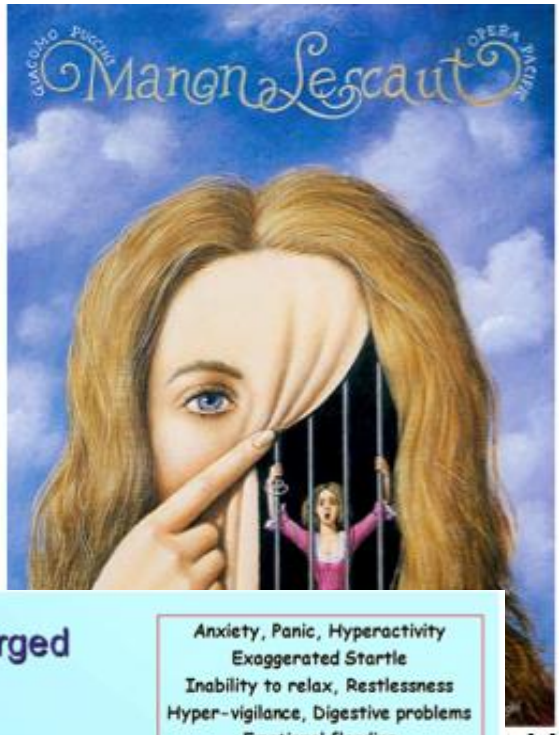
(Slide 9) This frozen or death-like state occurs in victims of rape and torture when they are unable to fight back or escape from physical violence. The nervous system stores undischarged energy experienced as a state of being overwhelmed and frozen in fear.

Levine (2010) points out that the “freeze response” immobilizes an individual in the face of trauma, which gives rise to debilitating

Blue Nude, Pablo Picasso

somatic symptoms such as numbing, shut-down, dissociation, feelings of entrapment and helplessness.

(Slide 10) During extreme arousal of the SNS, the PNS is also activated, slowing down or even shutting down bodily systems. When people are numb, they are dissociated and not "in" their bodies. Trauma manifests in the body as tightened, contracted energy, often locked into the muscles or viscera, which is similar to what ethologists call 'tonic-immobility' (Levine, 1997). This has been Celine's response. (Slide 11)



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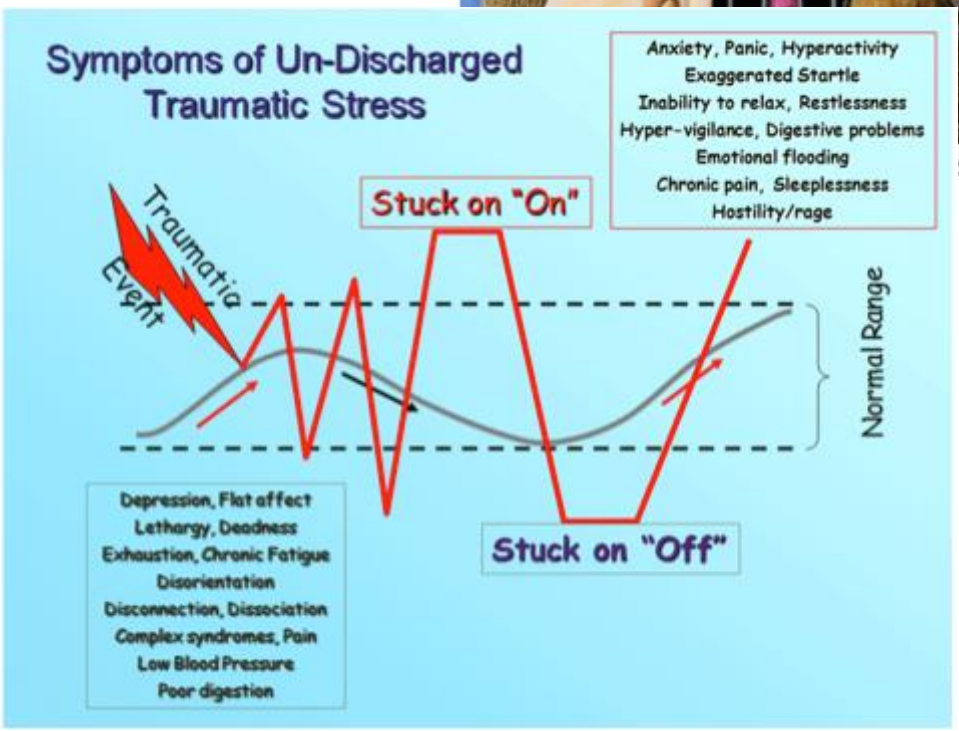
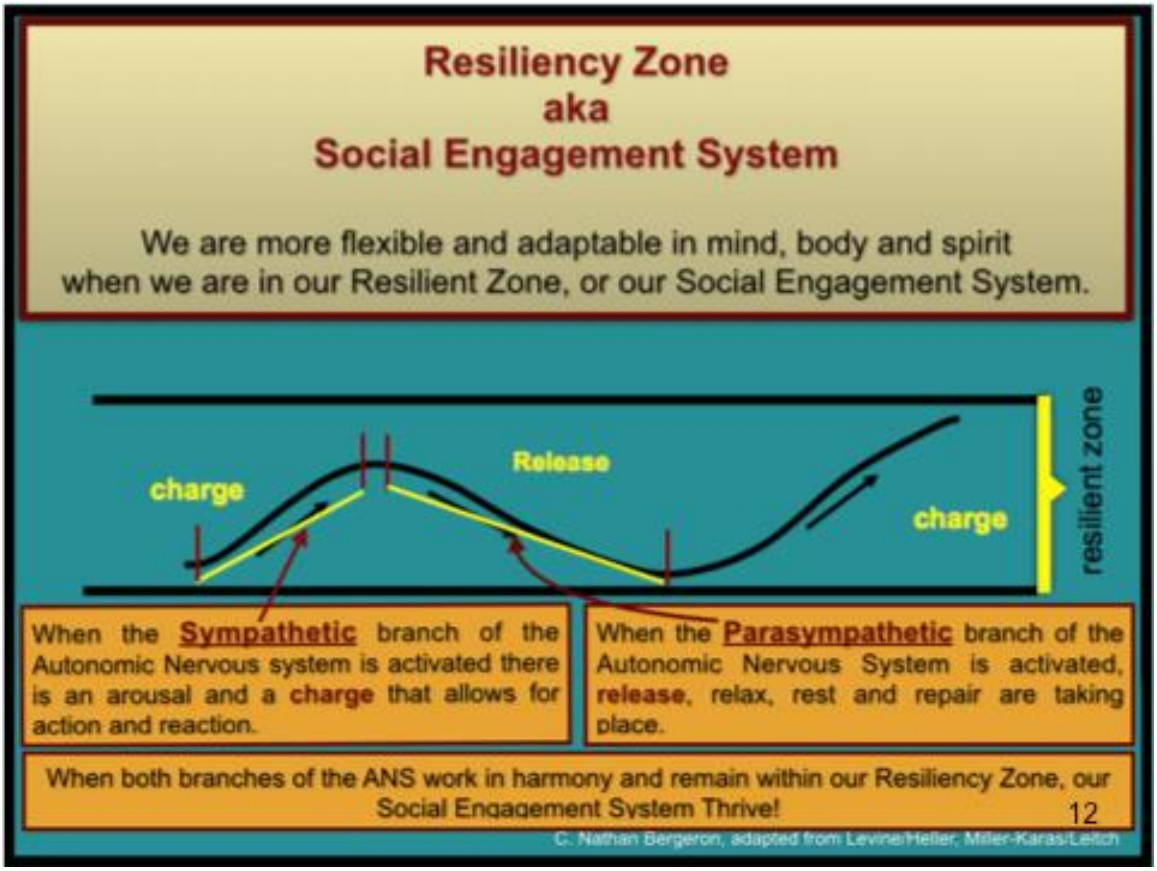
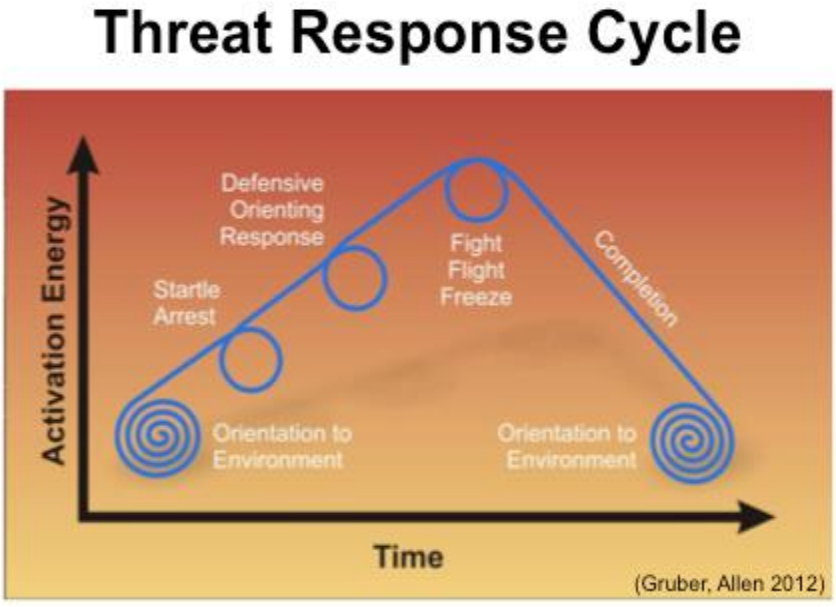


Under normal conditions, PNS regulates various everyday, healthy, relatively relaxed responses. Associated with activation of the PNS is the healthy relaxation response (relative to the activation response), or essentially the 'back-to-normal' response. (Slide 12)



Neural regulation of the heart rate is linked to the detection of fear and safety (Porges, 2011). When the environment is perceived as safe, cardiac output is inhibited, the parasympathetic nervous system is activated, and the organism perceives internal states as calm, enhancing social engagement. (Slide 13) When there is a perceived (real or unreal) environmental threat, cardiac output is disinhibited stimulating the heart via activation of the SNS in order to support adaptive survival functions mobilizing to fight or flee or immobilizing (i.e., playing dead). Therefore, any



medical procedure involving the heart would certainly benefit from ANS regulation.

The Traumatized Nervous System

Quoting Boulanger, “In recent years, neurologists have consistently noted the failure of the prefrontal cortex under extreme stress and the subsequent difficulties of laying down coherent explicit memories of traumatic events. Under normal conditions, the fluid ebb and flow of experience integrates a host of implicit and explicit memory systems; the senses come together with perception and with movement, with thought, and with affect. In one way or another…small adjustments occur in the brain and body as they interact with one another and with the environment, continuously maintaining homeostasis. (Slide 14)

But when the brain detects danger, there is a ‘profound departure from business as usual’ described as the ‘cascade of biobehavioral changes’ (van der Kolk, 1996, p. 218) that occurs in individuals exposed to trauma. Multiple levels of biological functioning, from the regulation of internal homeostasis to perceptual, higher cognitive, and analytical functions, are chronically affected.

The Dead Mother and Child, Edvard Munch

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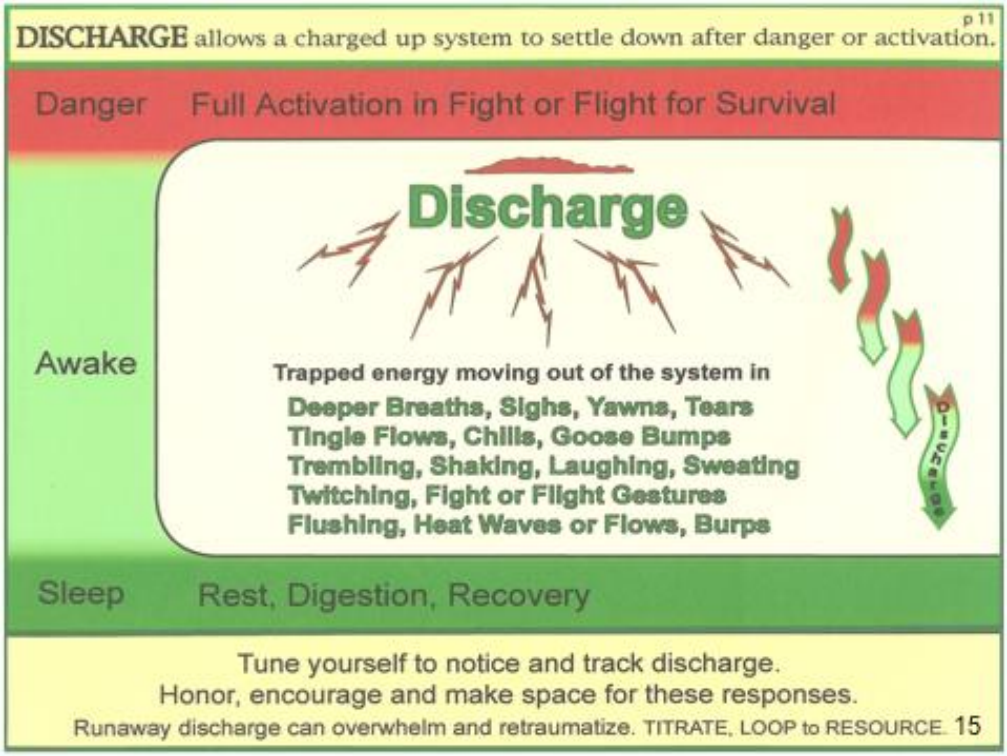
LeDoux (1996) describes two systems involved in traumatic memory: conscious or explicit memories linked to the hippocampus, and unconscious or implicit bodily memories mediated by the function of the amygdala.

In extreme stress, the increased secretion of norepinephrine disrupts the hippocampal functioning necessary for the consolidation of memory. Traumatic memories, therefore, are quite literally short circuited and stored as somatic sensations, visual images, and auditory traces in the amygdala rather than being integrated through the mediation of the hippocampus and prefrontal cortex. Linguistic memory is frequently inactivated during the



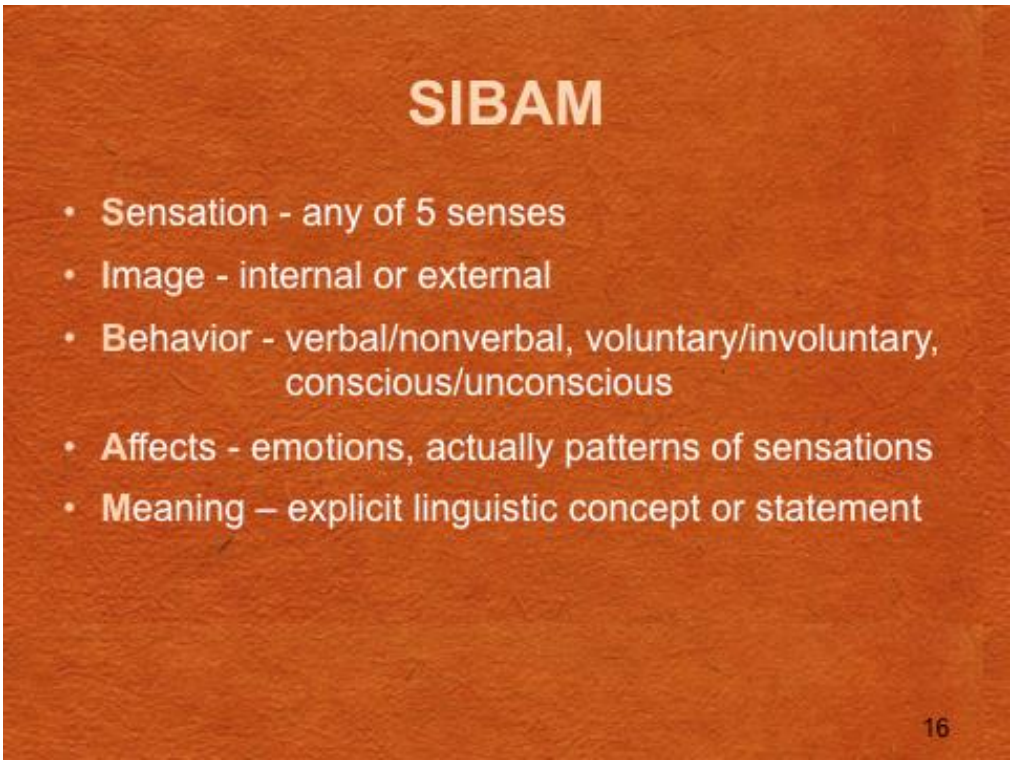
trauma; thus sensory, affective, and motor memories are often divorced from a conscious knowledge of what prompted them. These amygdala-based catastrophic memory fragments are much more easily aroused and, unmediated by the symbolic function of thought, they are frequently acted upon blindly, thus providing a biological explanation for the intrusive images common to posttraumatic states.

The survivor's memory can consist of moments of terrifying clarity and equally terrifying impressions of events that, on reflection, do not appear to hold together." (65-6)

The Procedure and Its Aftermath

It is a basic understanding in trauma treatment that the ANS processes information much slower than the neo-cortex. So, a large part of Celine's treatment has consisted of encouraging her to bring up details of the procedure one-by-one so they can be remembered in the context of present safety as her nervous system is first activated and then followed by discharge or "state change". (Slide 15)

To make the process as effective as possible, I invoke as many elements of experience as are relevant: sensations, images, movements, affects, and meaning. (Slide 16)



Celine was unprepared for many of the most difficult aspects of the procedure. Her aunt and grandmother had had ablation years before, resulting in immediate relief. She was told no more than 2-3 hours for the whole thing, including preparations with catheter and esophageal tube insertions. She would walk out of the hospital that day or the next with her pre-arrhythmia energy back and return to teach her university classes 3 days later. She arrived at the hospital accompanied by her husband, parents and extended family as is normal in Eastern culture. She knew there would be no anaesthetic because of her dangerously low blood pressure.

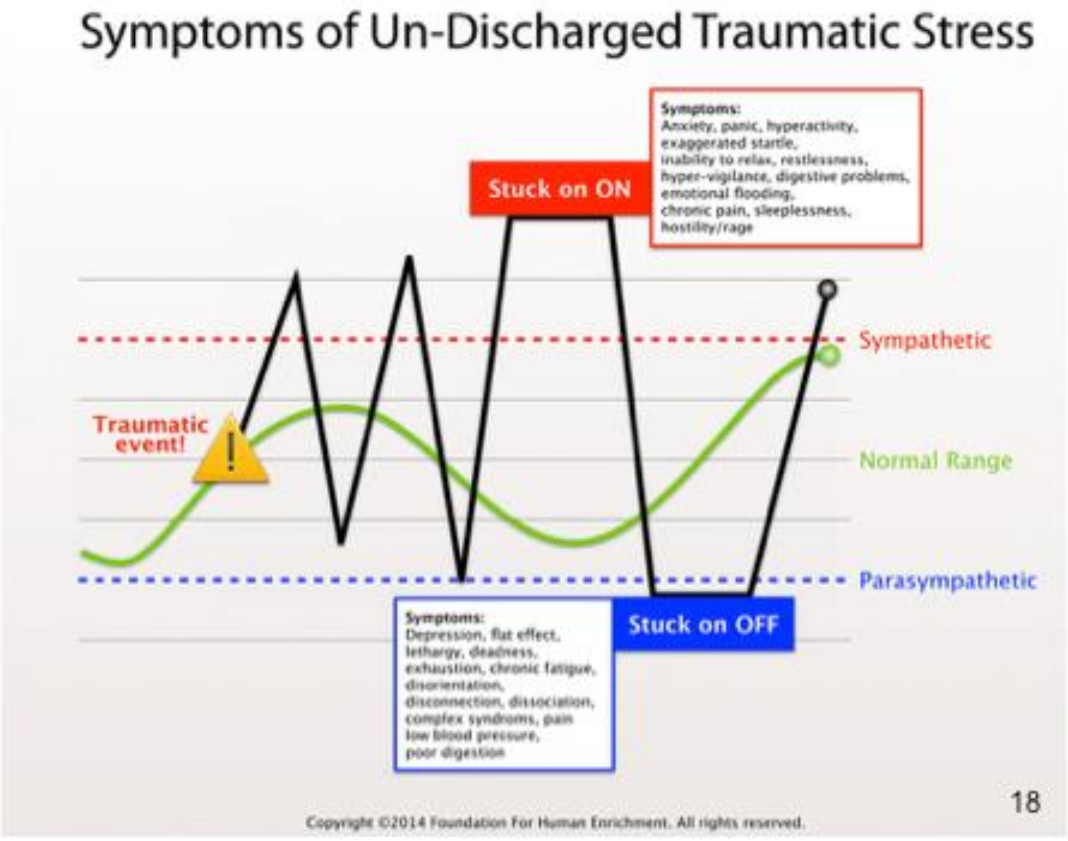
The catheter insertions were no problem, she insists, because of her high pain threshold. I think it is also partly because they were expected. From then on, surprises followed in rapid succession. She was tied down in multiple places, naked, and looked up at an all-male medical team, their faces half covered in surgical masks. (Slide 17) When the esophageal tube was inserted without anaesthetic, she was berated for gagging. When her body jumped at each electrical shock, she remembers being berated for that as well.

On the Operating Table, Edvard Munch 17

For 8 hours, she endured 116 electrical shocks administered by an apparently unfeeling team of medical professionals. She remembers passing out a few times and being revived. At one point a nurse held her hand for a few moments. And as the hours wore on, having fasted for 24 hours, she was enormously hungry and cold. She begged to be untied, to be fed, to be covered, and was met with a silence and faces of stone. (As she recounts this in a session, her eyes register again the panic and terror). She was never given any anesthetic but did remember a nurse imploring the surgeon to be allowed to give her some morphine but he said her blood pressure was too low (6/30?). She became a small child, whining, begging, pleading. Her characteristic stoicism vanished.

She emerged from the operating room on a stretcher, pale, weak and wordless. Back in her hospital room, she asked that her mother rather than husband stay with her. The request surprised both of them, but, she explained to me, she felt like a very small child who craved only its mother. The procedure was on a Thursday and she had been told she would walk out of the hospital that day and easily return to teaching her university classes the following Monday. Instead, she was taken out in a wheelchair and carried by her husband to a couch in her parents' living room, where she remained for the next 6 weeks.

Six weeks of rest would have been a much needed respite, but in Middle Eastern culture that was not to be. For Celine, who along with her mother was known in their social circles for always being available to help and support, it was definitely not an option. A new kind of torture ensued as extended family and friends came bearing gifts to celebrate the successful outcome of the ablation procedure. (Slide 18)



The surgeon, who was, of course, part of that milieu, had told her husband and parents as well as the wider community of how successful his heroic, 8-hour procedure had been and that she would soon be stronger and healthier than ever. Her experience, which she judged harshly, was different. How could she be such a weakling? She had always been so strong, unafraid of anything or anybody, totally "out there" with her opinions and certain of her point of view. Physically weak and shattered inside, she nevertheless rose to the social occasion and over and over recounted to visitors the cardiologist's version of the wonderful procedure that was to be life changing as soon as her strength returned. But, the "real" story, she told to no one, not even her husband and mother. She kept to herself her **experience** of 8 hours of what she ultimately characterized as trauma, rape and torture. For a year and a half she held her

mask in place, taught her classes, and smiled at her cardiologist when she met him socially. Inside, however, chaos and dissociation reigned. And, at least as important, her natural fight response was severed, both within the confines of the procedure, but continuing afterward, illustrated by 10-7,p.9 almost stepping in front of a car one evening after an argument with her parents who strongly discouraged her from confronting her cardiologist with her memory of the procedure.

Two Human Beings (The Lonely Ones), Edvard Munch 19

Then little by little she began to tell her husband, who had noticed and frequently commented on the differences between the wife who entered the procedure and the one who exited. (Slide 19)

A family systems therapist and academic, he began to do some research on trauma and they both read Bessel van der Kolk's latest book. From it, they gleaned that trauma treatment must include the body. They began to make plans. They took leaves/sabbaticals from the prestigious university at which they both teach and came to NY in September to stay with a relative in Queens while she sought treatment here and he commuted once a week to Boston to attend van der Kolk's trauma training. When she came to me in the middle of October, she had already enrolled in craft and painting classes at the 92nd St. Y, a cultural center half a block from my office.

She is 39 years old, grew up in a loving family in Beirut during the Lebanese War before the entire extended family emigrated to a large metropolitan area in the Midwest. At the age of 8, she rebelled against always being accompanied by a servant when she stepped out the front door. As she recounts it, she went into a bathroom, threw a tantrum and screamed and banged on the locked door until her parents were worn down and said, "All right, you win, please go out." Terrified, she did so from then on. I quote this because she recounted it to exhibit her concept of who she has always been. Freedom and independence

The Two Fridas, Frida Kahlo

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are defining values for her. She and her husband both have American Ph.D.'s. They have been married for 15 years, and do not intend to have children.

Following Ghislaine Boulanger's Wounded by Reality, as well as my own Somatic Experiencing training, I have not dwelt or forced focus on early childhood. Is it relevant that as a child and young adult she lived through a war? Yes! That she struggled with OCD and perfectionism leading her to overwork for many years? Definitely! But, her early years do not account for nor do they much inform treatment of the present state of her nervous system.

I am working very slowly and gently in ever narrowing concentric circles toward the trauma for which she came to me. I am conscious of being acutely present in the relational field. When any aspect of the trauma threatens to overwhelm her shattered ANS, we seek refuge in aesthetic interests we both share or other resources she has mentioned and I have carefully noted. Perhaps she takes comfort from the many images, artifacts, carpets and Arabic calligraphy that are part of the way I live. She is resilient, but simultaneously very fragile right now as we slowly and gently tease apart the many strands of what she has gone through. I encourage all her collateral activities, respecting her considerable intellect and framing her as my excellent co-therapist. Pursuing jewelry and painting and taking yoga classes, often with her husband, and taking long walks with him are important. As she searches for the self that was shattered, went into hiding, dissociated in the surgery, she tells me how she goes to clothing stores, first to seek outlets for her sophisticated crafts, then finds herself trying on clothing, dress after dress. At first confused by such proclivities as she had always hated shopping and anything else she defined as mundane, non-intellectual tasks. She soon became aware that she was searching for the boundaries of her dissociated body, of her very self.

We speak often of two parts of herself about which she has always known, but who have been polarized and painfully at war with each other since the surgery. (Slide 20) There is her rebel self whom she called “Nell,” and her OCD part, “the perfectionist.” Nell is furious, a “wild woman,” who can be mean, wants to lash out at everyone, especially her husband and mother for not realizing how shattered she was after the surgery. In the 6 weeks immediately following the procedure she now refers to as “the marathon” her mother entertained the visitors rather than sending them away and her husband went back to his very busy work schedule. In different ways, she felt/still feels abandoned by both.

How does one work with medical trauma if this sort?

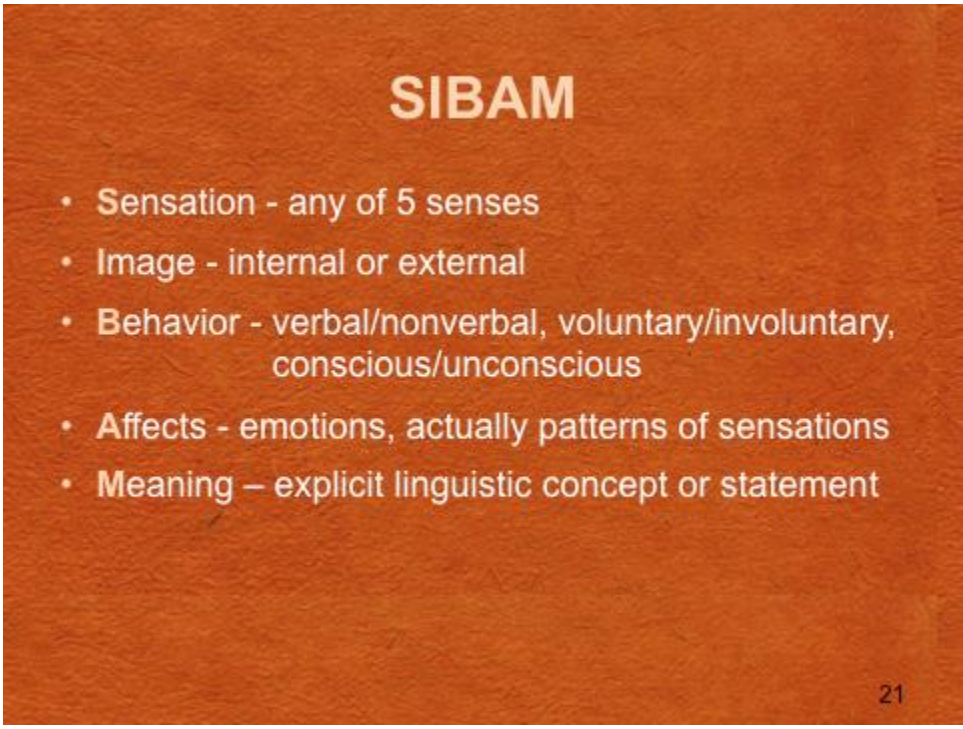
The damage was done to the bodymind in a bodily process in a reputable hospital, but the nervous system was ignored and sustains a good bit of the damage. It was exacerbated by subsequent relational trauma as her experience remained invalidated and, of course, by Celine’s own character, defenses and history: her highly intellectual, non-bodily focused family, plus living through a war as a child.

Celine slowly introduces Nell and Perfectionist beginning in 2nd session and tells of the “me” lost in the operation, mourned only by her because no one knows. But now I know. Her impatience in first two sessions to go to the heart of it in some way leads me to explain that memory retrieval cannot be the goal of our work. But the issue recurs again and again until I realize that (1) she thinks that is a cure and (2) she wants “evidence” for the lies she feels the doctor has told. This is her fight response beginning to surface. 10-21 She also introduces the analogy of her experience to rape and torture in Syrian prisons, pp.5-6ff.
She wants to know details of what happened during the 8 hours. “In an event that changed my life, I have big holes.” P.12
What is it like not to know? I wonder aloud. Perhaps never to know? This is the analytic, concrete part of her mind, her journalist self wanting to nail down the facts. But, there are no facts here. There is her experience, and that is all that matters.

She mentions that she has become aware that she habitually looks down when she is walking on the street, not wanting to encounter anything unknown, so we work with her orienting response, having her begin by looking around my office and noticing what happens in her body as she does so. When that becomes reasonably comfortable, I encourage her to see how it works outside.

I think of Reha, a construction engineer who wrote his dissertation on earthquake proof construction. After the last Istanbul earthquake, he climbed the 9 flights of stairs to sleep in his own bed. He had a cognitive filter to allay his anxiety and make the aftershock comprehensible.

Despite her identity rooted in her analytic ability, Celine had no such filter as she had expected a brief procedure of a couple of hours at most, with perhaps 3 and at most 4 shocks to her heart. And then, there was the denial of her doctor and therefore her family. They were told everything went fine, it just took a little longer than expected. After 6 weeks, she did go back to teaching and struggled through the next 18 months acutely aware that something was not right, but unable to unearth what it was. CBT and psychodynamic psychotherapy, which had helped her manage both depression and anxiety in the past, had no effect. She needed treatment that included her body. (Slide 21) From the beginning I have woven in awareness of sensation, but also of images, movement impulses, unconscious movement, feelings and the meaning or cognition of each issue/event she brings. Doing that enlarges her affective container and slows down the process so her nervous system has time to digest whatever we are dealing with.



By mid-November, her perfectionist part is beginning to lose a little hold: Allah, I point out, understands inability to follow rules, and all rules make her tired, “existentially tired” 11-11,4. Teaching for 18 months, beginning one month after the operation (as soon as she could walk), she compares to running a marathon on a broken leg. Her brain is tired, her cells are tired, and she is making little, “stupid” mistakes. Sustained attention and focus are difficult.

A session with her mother in the middle of November reaffirmed the shock of the procedure. They expected a brief procedure of a couple of hours, ¾ shocks, and she would feel immediately better as had her aunt and grandmother, walking out of the hospital the next day. They recount how the family waited with her for the procedure to begin, she was conscious of minor irritations: only a robe covered her, she had to remove her hair covering, an IV in her wrist was annoying, but she was buoyed, as she had been during the war, by her family around her. It was "annoying, undignifying, but communal. My whole family was there. I had support" (11-18,5)
With her mother present, we slowly processed what they remembered of the procedure and of the days afterward in the hospital. The terror in her eyes reminded me, if I even needed it, to go slowly, in small increments, asking her to breathe and check into her body frequently.

Everything shifted once she entered the operating room (11-18,5). As she recounts it with terror still in her eyes, she was cold, hungry and afraid. And mercilessly attacked by unfeeling medical staff chiding her for gagging when an esophageal tube was inserted, for reflexively jumping when the shocks were administered, and ultimately for trying to get out of the restraints on her wrists, ankles and torso.

Spring, Edvard Munch

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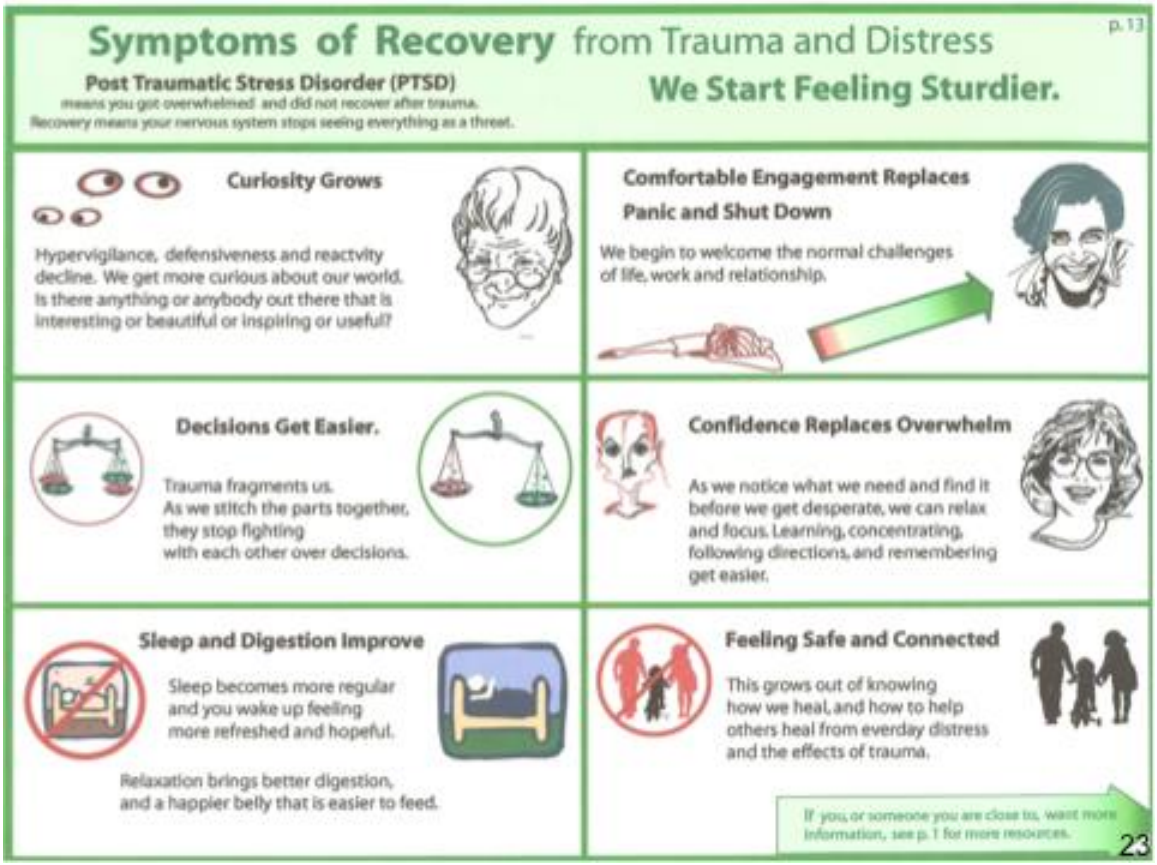
The doctor told the waiting family that it had gone very smoothly, was just a little longer than expected because they had to go slowly to take account of her constantly falling blood pressure. That narrative dominated the next 18 months. (Slide 22)
For the first month, she lay on her mother's couch receiving obligatory visits at which she repeated what she has come to call the official version: 8 hours, 116 ablations, no anesthetic, no problem, all went smoothly, she is just a little weak. She admitted to no one, including herself, how weak she felt, what she had experienced during those 8 hours and that she had died in the process. Her husband returned to his demanding psychotherapy

practice and consulting business and only slowly and dimly realized that the wife he knew no longer inhabited the body that emerged, pale and shaken, and terrorized from the procedure room.

Shame emerges as a factor in her inability to share her experience. She had had psychotherapy for depression and anxiety in the past and was totally socially open about it. No shame. But, she was overwhelmed with it here. She longs to find the outspoken, extroverted person she was before. A formerly extroverted, competent, outspoken professional, frequently referred to as Mother Theresa for her care-taking qualities, has become a frightened introvert.

We begin to work with her fight response: flinging things at the doctor, the staff, and the part of her she calls Nell came to the fore. In a few minutes she moves from chastising herself for weakness to realizing that she was incredibly strong to maintain her life, teach and hide the Hiroshima inside her for almost two years. She acknowledges that the arrhythmias were caused by overwork and stress; always at the top of her class, took on any responsibility proffered….She does not recognize the Celine who went from being fearless, as exemplified by the story of going out on the streets alone during the Lebanese War, to now being afraid of being attacked on the street, of people talking about her on the subway. A blurring of the distinction between real and unreal, what is in her head and what is in other people's is terrifying, along with no sense of an "I" and an unbridgeable gap between who she was and who she has become, while those around her only see who she was. 11-25,p.14-16



(Slide 23) By the beginning of December, she is reporting more self-compassion, less disjunction between the parts of herself she calls Nell and the Perfectionist, and increasingly deep communication with her mother and husband about what really happened in those eight hours as they sat in the waiting room assured everything was fine.

As we work, the tight lid that she had on the whole event begins to loosen, and fears she had denied plague her: being totally alone, being touched by anyone, fear of attack, especially from large groups of people. So she is hypervigilant to prevent another unexpected attack. 12-7,1. She is comforted by understanding this (Psychoeducation#11), especially how aspects of the trauma can be triggered when she least expects and cannot account for them.

In Conclusion

Intuitively, Celine has gravitated to mindfulness practices: the mundane household tasks she always eschewed, shopping. Watching and rewatching episodes of humorous sitcoms, and most important, the artistic and craft pursuits that have taken precedence over intellectual work and have flourished from a hitherto less creative expression. With this realization, she begins to think that perhaps all of her did not die in the operation, that perhaps parts got rearranged, and creativity was actually flourished. This is enormously reassuring, calming,

even intriguing. And with that comes the insight that her neo cortex, on which she has always relied so heavily with its penchant for analytic thought, had actually delayed healing by covering the complex emotions that have been locked in the pressure cooker sealed by her intellect (her image). Together in the session we play with that image: how scary the steam is when it first emerges, where exactly in her body she feels it, but how exhausting it has been to hold it all inside. I point out that intellectual analysis is positive, but not when used as the gasket on a pressure cooker for 18 months. That intellect has kept her both sane and insane. She agrees that for what is probably the first time in her life, her omnipresent intellect, her thoughts, cannot solve a dilemma. She again mentions the exhaustion and the realization for the first time that a Self is beginning to note how the two parts of herself, polarized in the months following the surgery, are beginning a rapprochement of sorts. With this, fear begins to diminish slightly. In a session late in December, she avows that even though the process is difficult and exhausting, for the first time, she has hope, can see a distant light.

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In this session, she avows that even though the process is difficult and exhausting, for the first time since she came to NY, she has hope, can see a distant light.
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