PJP

CASE REPORT

# TRAUMA FOR THE VULNERABLE: REAL OR IMAGINED?

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**ABSTRACT**

Linn is a twenty-year-old female who grew up silently competitive while feeling inferior, and still excelling academically in the background of bullying and social exclusion. This report proposes that the vulnerability to trauma or to the perception of being traumatized can be related to the individual's level of narcissism.

Trauma-associated narcissistic symptoms (TANS) are a result of experiencing a stressor as an affront to the grandiose self. A traumatic disequilibrium occurs in a narcissistically vulnerable self. In both TANS and posttraumatic stress disorder (PTSD), secondary symptoms of anxiety and depression can significantly color the patient's clinical presentation. Individuals can develop both TANS and PTSD, displaying a mixed clinical presentation. Psychotherapy with the primary goal to restore narcissistic equilibrium is recommended.

**KEYWORDS:** *Trauma, Trauma-Associated Narcissistic Symptoms, TANS, Post-Traumatic Stress Disorder, Narcissism, Vulnerable Patient*

## INTRODUCTION

To some degree, everyone is narcissistically vulnerable to trauma. Ordinary life traumas usually induce an element of injury to one's self-perception of invulnerability. However, individuals with narcissistic personality disorder or traits are especially vulnerable to life's traumas that threaten or overwhelm the grandiose self.

Trauma-associated narcissistic symptoms (TANS) is very similar to posttraumatic stress disorder (PTSD), with notable distinctions that may make the difference between clinical success or a clinical stalemate. This report describes a young woman who was initially for PTSD, and how the diagnosis was revised to TANS after integrating the patient's history as well as her biological, psychological and social characteristics.

## CASE REPORT

This is a case of Linn, 20-year-old female, single, Roman Catholic, from Iloilo City, who is currently a Chemical Engineering student. She sought teleconsultation with a chief complaint of "ni-refer ng Guidance".

History of Present Illness
Linn was born full-term to a 26-year-old primigravid mother via normal spontaneous delivery without perinatal complications.

It was a planned and wanted pregnancy. From the moment she was born, her parents would be mostly out of their home, working double-time to pay off a big business debt. They admittedly were more focused on finding the means to recover from their financial loss than with rearing their child. Her nanny and maternal grandparents consequently filled in the gaps. Linn grew up sheltered and isolated because they did not have neighbors. She grew up at par with her age, with no note of developmental delays.

She was able to gain a few friends during kindergarten and her first few years of elementary school. This was when she met her best friend, Faye, who later on turned against her. She described her classmates as belonging to the upper-middle to upper class of society and predominantly Chinese. She and her classmates grew up together and bonded warmly until Grade 3. As far as she could remember, she had felt inferior towards her classmates since Grade 3, making her very timid and guarded to speak her mind.

9 years PTC, when the patient was 10 years old, in Grade 4 she experienced bullying from her female classmates, who picked on her physical appearance, such as being the smallest in class and having two big moles on her face. One time, they also teased her as lesbian in front of the class. Embarrassed, she felt further humiliated when their teacher laughed along. Linn thinks the bullying began when the mother of her best friend, Faye, blamed her as the reason why Faye failed her Filipino subject. Since then, Faye and their classmates turned against Linn.

She described her experience at school as being in "Hunger Games" wherein her classmates were out to get each other to emerge as the best student in class. She claims that she was a silently competitive student then but anytime she would get ahead of her other classmates, they would pull her down. She also felt as if she was an outcast.

The verbal bullying happened occasionally then, which she did not initially mind, but later became more frequent. She also experienced indirect forms of bullying such as having nasty things said about her behind her back and being deliberately excluded from the rest of the class. These happened constantly, which gradually took a toll on her emotionally. She reported these a few times to their teacher who reprimanded the people involved. However, the bullying persisted. Linn felt it was futile to report the succeeding incidents and so just kept mum about them. According to her, one reason was that she seemed to be the odd one out—she was timid, introverted and had different interests as her other classmates such as reading books in the library and playing chess.

She coped by minimizing interactions with the bullies and ignoring their attacks. She could recall fighting back only a few times. When her other classmates saw these, they threatened Linn and ganged up on her. Since then, she thought that her actions did not stand a chance against them because they were still "superior" to her, and fighting back might further degrade her. Her parents knew of the bullying and its effects on her but they did not take any action.

8 years PTC, when Linn was 12 years old in Grade 6, she was seated next to one of their class' top students. Her seatmate insisted on copying her answers during tests. If she did not allow this, her seatmate would kick her chair, pinch her on the side and badmouth her. Linn felt she was just being used during these times but she gave in to the abuse anyway to avoid sparking trouble. Nonetheless, Linn graduated top 10 in elementary.

7 years PTC, the 13-year-old Linn had her moles removed. She felt good about herself but, when she returned to class, she was teased for having surgical wounds on her face. When they healed, some of her classmates teased her yet again for having braces. This made her feel that whatever she did, her classmates would not stop making fun of her. Linn described her time in school as miserable as she hated her classmates; like she was constantly living on edge. Linn felt resentful towards them because they did not seem to acknowledge her. She said she had very low self-esteem and became more withdrawn than before.

In the same year, she had frequent episodes of sadness and hopelessness. She would intentionally lose weight because she was conscious of her looks and her classmates' comments about the food she brought to school. She had passive suicidal thoughts and started inflicting harm on herself like cutting her wrist

with a pair of scissors, hitting her chest with her hands, stabbing her skin with a ballpen, and scratching her forearms. She also began to have nightmares, which gradually became more vivid and frequent as time went by—the theme of which was about being trapped in a room while being ridiculed by her bullies.

Amidst all these, Linn did not tell her parents about the bullying nor how it was affecting her, assuming that they would not understand her anyway. She claimed that her parents were clueless as she continued to have excellent grades in class and stoic affect at home. Thus, she was not brought for any mental health consultation. At home, she could not find any refuge because her parents were always fighting, which made her feel even more miserable. She also felt that her relatives from both sides were judging her whenever they met during family gatherings. She also felt overlooked compared to her brother and cousins.

6 years PTC, when Linn was 14 years old, in Grade 8, she decided to transfer to another school. During the first few days, she thought that her new classmates were all fake, befriending her only to exploit her family status and academic aptitude. She would recount putting up a trouble-free, people-pleaser façade so she would not be treated in a special manner and receive attention. Eventually, she was able to find three friends whom she described as "a bunch of nobodies" like her. She claimed they did not befriend her for her wealth and treated her like an ordinary person. She denied feeling bullied by her new classmates, but recalled having a terror dance teacher who would often got angry with her and humiliated her during dance practices. This also took a toll on her self-esteem.

5 years PTC, at 15 years old, Linn went back to her original school for the 9th grade of her own accord; a decision she later regretted. She transferred because she could not stand the strenuous extra-curricular activities in her new school, which physically drained her. Her decision was influenced by her old "friends" in the seventh grade who reached out to her saying how the school had changed since she left. She fantasized about the idea that these people, whom she believed were no longer outcast in their school, would accept her this time. To her dismay, her so-called friends had cliques that did not include her.

For the next two years, Linn returned to becoming "nonexistent" again—excluded in conversations, not being talked to, and her opinions during class discussion being brushed aside. It was only when she got into the honors' list did they start to actually listen to her and invite her out. Still, she would carry on with her day in school, burying herself excessively in schoolwork, acting as if everything was okay. However, when the day has ended, she would ruminate about what happened during the day and would feel sad and worthless. Despite all these, Linn excelled academically—she was part of the honor roll every year and graduated top 10 in junior high school (grade 10).

2 years PTC, when Linn was 18 years old in the middle of Grade 11, she found herself frequently ruminating about her day-to-day experiences in school and would feel sad, angry, tired, and sorry for herself all at the same time. Her suicidal thoughts and self-harming behavior recurred. The nightmares about her bullying persisted. She would wake up in a panicky state during those nights.

With her mom's suggestion, she decided to transfer from her original school to a third school in the second semester. She felt relieved to leave her previous school behind. However, she observed that she had difficulty forming relationships with her new classmates. She was hesitant to approach them at first because she felt unworthy or inadequate. Even so, she felt significantly better in this new school.

In the same year, she unfollowed all her former classmates on social media and created another account so as not to be reminded of them. She also recalled seeing one of her bullies in a mall and the sight of her made her feel so anxious as humiliating memories resurfaced. She ran to the restroom, crying and trembling. She also kept on hitting her head with her hand, trying to suppress the memories from coming back.

4 months PTC, one of their college classmates committed suicide. Although surprised by the news, she claimed it did not affect her personally, as she barely knew the victim. Following the news, Linn chanced upon one classmate's unusual social media posts and

reached out to him. This began a series of online conversations between them. Although John was only an acquaintance, he would express to Linn his depressive feelings and that particular sense of "feeling stuck and wanting to die". Linn felt like she had the same feelings as him and responded to John's existential queries.

As John's existential questions to Linn continued, she found herself eventually experiencing nightmares about her past bullying experiences. She frantically avoided her previous classmates and did not want to talk about anything related to bullying as she was afraid that such would trigger distressing and mortifying memories. The mere thought of mingling with them sickened her. Her frequent ruminations about her bullying experience resulted in difficulty sleeping and concentrating. She would then feel sad why this was happening to her. Bothered by it, she sought consult with their University's guidance counselor who recommended her to seek psychiatric consult. Linn claimed that the guidance counselor suspected her to have PTSD. She, however, did not seek psychiatric consult as she felt better after talking with the counselor.

3 days PTC, Linn had an argument with her father. She became angry with her dad because he repeated the same "cruel" behavior towards their dog. Thinking she cannot do anything about her dad's actions, she became increasingly anxious. She told her mom, demanding an explanation for her dad's behavior and a resolution regarding this. When her mom could not provide any and replied, "Just be thankful that this is your life", Linn felt invalidated, got angry with her and retreated to her room crying. She felt hopeless and had passive suicidal thoughts. She then remembered about the instructions of their guidance counselor to seek mental health consult.

Past Medical History
She was diagnosed with mitral valve prolapse (MVP) when she was 14. She had lactose intolerance when she was in elementary, and had been admitted several times in the hospital for diarrhea and dehydration. No other known medical illness, surgery or falls.

Family History
No known medical illnesses in the family.

Psychiatric History
The patient did not have any previous psychiatry consult. Her father had depression 20 years ago, characterized as having low mood, irritability, excessive worries about possible illnesses befalling him. Her paternal grandmother had stocks of alprazolam (Xanor) at home and was described as an anxious person though psychiatric consult was made.

Substance History
Linn did not drink any caffeine or alcoholic beverages nor did she smoke cigarettes or try any illicit drugs.

OB-GYN History
She had her menarche at 10 years old with regular intervals, 5 days duration, moderate amount, with occasional dysmenorrhea. G0.

Sexual/Legal History
She is attracted to the opposite sex. She has not had any intimate relationship. She had two previous suitors. She denied experiencing any form of sexual abuse. No pertinent legal history.

Family History
Linn grew up with absentee parents, both professionals and of Chinese descent.

Her mother, 46 years old, was mostly away for work and Linn characterized their relationship as detached. Linn described her as indifferent towards her and hardworking. Linn felt like she did not have the ideal mom- preparing food, choosing clothes for her, going to school and contests with her, etc. She was more like a material provider rather than an emotional one. Her mom disciplined her mostly through verbal reprimands, but when she answers back, her mom would either pinch or slap her. She also had the habit of comparing Linn to her peers in their society.

Linn's mother described her daughter as diligent, obedient, a good sister, resourceful, problem-solver, and persevering until she finds a solution. Though these are admirable traits, Linn's mother confessed that Linn seems to be too hard on herself. Her mom regrets not having helped the patient regarding her bullying experiences in school.

On the other hand, her father, 47 years old, started his professional career from scratch but allegedly pulled some strings in society to go up the social ladder as a businessman. Linn describes him as being sharp-tongued about her faults but quick to retrieve the harsh words he had said. She perceives him as more indifferent towards her and does not really care to listen to her opinions.

Linn is also more sensitive to her father's actions/reactions than she is towards her mom's. He would repeatedly tell her how she should behave in social gatherings or that she must achieve  something in the future. Linn believes she cannot meet her dad's expectations no matter how many awards she gets. She believes that she can only do so if she achieves a "socially likable" reputation; that is to amicably mingle or rub elbows with other influential persons in her parents' circle. When she is with her dad or his friends, she feels that she must be the perfect daughter.

Linn's brother is 11 years old, and has it much easier than when she was his age. Unlike Linn, he was not given any household chores nor did he have to hear their frequent fights. He is presently home-schooled. She also felt that her parents were more supportive of his endeavors than with hers while she was growing up. She said this without claiming any form grudge or envy towards her brother. Despite certain occasions where she felt compared to him, she denies any feeling insecurity or competitiveness between them.

Nanny Mary is a 40-year-old nursing aide who raised Linn when she was young. Linn considers her as part of the family and her stand-in parent. She was hands-on in almost all aspects of the patient's life. Linn said her nanny understands her more than her parents do and finds comfort in her talking to her or just being with her. Mary would be the one nudging Linn to study and exerting pressure on her to do well at school. She is also the one accompanying her during chess tournaments.

Her 74 -year-old maternal grandmother is a retail store owner. Like her parents, her maternal grandparents were mostly away for work yet still more "present" in her life than her parents.

Linn's maternal grandmother is particular with social etiquette and quite superstitious. Linn remembers her as someone who has stereotypes about gender norms. She would have a litany of how a girl should act and what kind of job a girl like Linn must have e.g., Secretarial course. It is from her whom she learned that people in their society are watching each other, hence the aspiration to be a perfect individual.

Her 79- year-old maternal grandfather is a businessman who loves gambling. Along with his friends, they would let their grandkids play in the bowling center and bet on who wins. She would feel pressured every time. Linn believes she can never meet his expectations as well, because while he is proud of her as a chess medalist, he also wanted her to excel in the kind of sports he likes such as bowling and billiards. But unlike her maternal grandmother, her maternal grandfather is more thoughtful and unconditional in giving her what she needs.

Developmental & Social History
Prenatal & Perinatal
She was a planned and wanted pregnancy from a 26-year-old primigravid. She was born full term, via normal delivery, in a hospital in Iloilo City without perinatal complications. She is one of the first grandkids in both the maternal and paternal side. She was bottle fed from the start because her mom could not express milk. She lived in the same household as her maternal grandparents for 16 years.

Early Childhood (0- 3 years old)
From the moment she was born, her parents would be mostly out of their home, working double-time to pay off a big debt in their business. Her parents seemed to be at a loss during this time. Despite being on maternity leave, her mother would only be at home for 3 to 4 days per week. The nanny and maternal grandparents consequently filled in the gaps of parenting Linn. She grew up at par with her age, with no note of developmental delays. She loved going to school from the day of preschool. In her second year of schooling, she found close friends. She started toilet training at the age of three and achieved bladder and bowel control at the age of four. Because she was not a messy kid, her toilet-training period was allegedly uneventful.

Middle Childhood (3-11 years old)
Linn claimed that the whole school was operating under a “caste system” where she was part of the outcast group. On the other hand, Linn grew up as a sickly child compared to her peers. She would frequently have stomachaches, diarrhea, easy fatigability, leading to hospitalizations. Because of this, she would miss important gatherings among her circle and have certain restrictions, preventing her from enjoying with other kids. She then would feel left out during conversations at school.

Late Childhood (≥12 – 21 years old)
She began being conscious about her position in the family during her adolescent years. Consequently, Linn would act carefully around people.

Linn has an achiever paternal cousin, Ika, whom Linn felt she needed to measure up to. Linn believes that as the eldest, she has to reach a certain standard to secure a stable position in the family. Amid such an aspiration, she is not used to her rich stature, thinking that her status does not coincide with her personality, like the expectation to be trendy and to behave like a socialite. "I feel like I just don't belong in this class." When she was 17 and reviewing for college entrance exams in Manila, she felt that when among students her age of higher status or intellect, she would feel inferior.

Adulthood (≥ 21 years old)
She decided to take Chemical Engineering in college, upon the nagging of her parents. She considers her acceptance in her present university as her proudest moment and associates college to a fresh start. She does not know anyone, and she can be her authentic self who paves her own way. She believes she was able to fit in and find contentment in her present school. But she would despise every occasion when she is put in the center of attention. She feels scared of committing mistakes because they could ruin her name and future, and she is fearful of being humiliated or exploited by others.

However, now that she is old enough to decide for herself, she feels conflicted whether to leave her life here in Iloilo City to seek for an independent life abroad or accept the grim reality of being an heir to an elite society, from which she does not feel she belongs.

Dreams and Fantasies

Linn wants to graduate, go abroad, find a job she wants (like being a researcher), and just live a “normal” life, without the influence of her family. She also wants to be left alone in choosing her friends and make it in life through her own efforts, even if it means experiencing hardships, and not just inherit the successes of her parents. She values hard work and fairness.

Physical & Neurological Exam
Unremarkable, except for her small stature (4’7”) and being overweight using the Asian criteria (BMI 23.6 kg/m2).

Mental Status Exam
Linn appears as her stated age, with erect posture, wearing blue t-shirt and black shorts. She is well-kempt and fair-skinned. She was calm, attentive, cooperative, with spontaneous, goal-directed movements and good eye contact. She has full command of the English and Hiligaynon language, which were intermixed during the interview. She speaks at a regular rate and tone, medium pitch, and moderate volume.

Linn has an alexithymic mood (“Hindi ako sure, I think I’m okay?”), with restricted affect. Her thinking process was coherent. There was no note of delusions, but she displayed preoccupations with her traumatic memories and intrusive thoughts about her bullying.

She denied suicidality, homicidality, obsessive-compulsive thoughts and perceptual disturbances during the interview. She was alert, fully oriented, with good concentration, calculation, memory recall, fund of knowledge, and abstraction.

Linn had poor impulse control, with level 3 insight. She has good test judgment but poor social judgment.

Diagnostic Assessment
Narcissistic Personality Disorder (Hypervigilant Type); Trauma-Associated Narcissistic Symptoms (TANS)

Therapeutic Intervention

Her management primarily consisted of cognitive-behavioral therapy (CBT). As several cognitive distortions were noted in this patient, CBT was chosen to encourage the development and application of adaptive thought processes such as rational thinking and problem solving. She was assisted in recognizing and change maladaptive thinking patterns in relation to her narcissistic and trauma-related behaviors. She was taught relaxation techniques and educated regarding her illness.

CASE DISCUSSION

In the literature review and meta-analysis by Nielsen et al. (2015), they defined bullying as a long-lasting and systematic form of interpersonal aggression where an individual is persistently and over time exposed to negative actions from superiors, co-workers or other students, and where the target finds it difficult to defend herself against these actions (1).

Following this definition, bullying can be described as a two-step process: The first step includes exposure to systematic bullying behavior over time, whereas the second step comprises a subjective interpretation of being victimized by these bullying behaviors (1).

To fully elucidate this common phenomenon, a child and environment model (Harris, 2009) posits that characteristics of the child and the child's environment operate together to cause peer victimization (2).

Before discussing the theoretical basis for, and empirical evidence in support of, child risk factors for peer victimization and rejection, it is important that we consider the role that children's sex plays in the emergence of bullying. Some studies suggest that girls are more likely to be victimized via indirect, or social forms, of aggression as in this patient (3).

The first child factor for bullying is social behavior. Victimized and rejected youth exhibit behaviors, such as social withdrawal, like in this case, that provoke or reinforce their negative peer status (2).

Second is emotional reactivity. Investigators find that emotional reactivity and regulation interact in such a way that children who experience intense negative emotionality and have difficulty regulating those emotions display less socially competent behavior with peers such as anger, fear, and embarrassment (2). The latter seems applicable to Linn.

Third is social cognition which includes social information-processing, self-perceptions, and attributions. Evidence supports the notion that poor self-regard, as in this patient, forecasts increase in victimization and rejection (4).

Moreover, studies where children blame themselves for being bullied are correlated with victimization because such self-blaming attribution influences how children cope with peer aggression (5).

Lastly, psychosocial vulnerability may also precede some children's experiences of peer victimization. Researchers have found that depressive symptoms are associated with increased peer victimization and rejection (6). While depressive symptoms were not present in this patient at the onset of bullying, her depressive manifestations few years later contributed to the continuation of the bullying.

Investigators have also examined how environmental or contextual factors may contribute to the emergence and stability of the bullying phenomenon (2).

First environmental factor centers around family relationships and parenting practices. It is argued that insecurely attached children, such as in this patient, come to school with internal working models derived from their attachment histories with caregivers which leave them either uncertain as to how peers will treat them or expecting to be treated poorly. In turn, such children display an anxious vulnerability around peers as well as a tendency to exhibit withdrawn behavior (7).

Next, peer culture revolves around the victim's status within their peer groups, the quality or quantity of the child's friends, and peers' roles may encourage or discourage bullying interactions (2). The patient's seemingly lower socio-economic status, compared to her wealthier classmates, may have led to lower peer group acceptance. The subsequent dislike for Linn's character may have provoked her bullies' desire to harm her, and her low status within the

group may have raised little concern for retaliation (8).

Finally, schools and teachers play an important role. By setting an antibullying tone in their classrooms and creating environments of care and respect, teachers can be especially influential in controlling the amount of peer-directed aggression (9). But with inconsistent and ineffective handling of bullying episodes and the lack of serious consequences for bullying behavior, many children, like this patient, suffer the consequences.

But is bullying a precursor to PTSD? DSM-5 emphasizes that the first criterion to the diagnosis of PTSD must be a single traumatic event which caused a threat of or actual death, serious injury or sexual violence to the person (10). But does this automatically mean that non-life-threatening acts of violence like bullying are not traumatizing?

In the literature review and meta-analysis by Nielsen et al. (2015), they revealed that bullying was associated with symptoms of post-traumatic stress, but that there was a shortage of clinical and prospective research on the association. Their findings showed that an average of 57% of victims of bullying reported symptom scores for PTSD above cut-off thresholds for caseness (1).

But, according to Gabbard, whereas the severity of posttraumatic symptoms was once thought to be directly proportional to the severity of the stressor, empirical studies suggest otherwise (11).

Events that seem to be relatively low in severity may trigger PTSD in certain individuals because of the subjective meaning assigned to the event. In fact, there is a growing consensus that PTSD is perhaps dependent more on subjective issues, such as individual meanings and the interaction of genetic and environmental factors in one's history, than on the actual severity of the stressor (11).

Finally, some authors claim that the distress many of the victims of bullying experience equalizes the stress associated with traumatic events. Building on Janoff-Bulman's theory of shattered assumptions, it has been suggested that bullying is a traumatic event in that prolonged exposure to the phenomenon shatters the target's most basic cognitive schemes about the world, other people, and ourselves (12).

So what might predispose this patient to developing PTSD and what factors led us to initially believe that this was the case?

First is inadequate family support. This can be gleaned in the form of general invalidation, the negating, ignoring or trivializing of emotions and thoughts by caregivers. General invalidation predicts emotional dysregulation, dissatisfaction and dysfunction in romantic relationships, more negative cognitive appraisal processes, interpersonal sensitivity, aggression, poor active coping, as well as psychopathologies such as anxiety, depression, and PTSD (13).

As trauma is subjective to the person who experiences it, the victim's characteristics are essential in the development of PTSD.

Personality traits, like neuroticism, are risk factors for developing PTSD. In fact, in one study, negative emotionality or neuroticism is the primary temperamental risk factor for PTSD (1).

Displayed by this patient, neuroticism is the trait disposition to experience negative affects, including anger, anxiety, self-consciousness, irritability, emotional instability, and depression. Persons with elevated levels of neuroticism respond poorly to environmental stress, interpret ordinary situations as threatening, and can experience minor frustrations as hopelessly overwhelming (14).

Moreover, neuroticism largely overlaps with and is a significant predictor of a form of narcissism, the vulnerable type. Narcissism is best understood as a multidimensional personality trait with two overarching themes: narcissistic grandiosity and narcissistic vulnerability (11).
On one end of the continuum, the grandiose narcissist, described by Kernberg, is typified by the envious, greedy individual who demands the attention and acclaim of others. This type closely matches the clinical picture described in the DSM-5 criteria and patients are relatively emotionally stable (15).

On the other hand, the hypervigilant type is highly neurotic and more vulnerable to slights and self-fragmentation, which was characterized by Kohut (16). While arrogance and open displays of dominance and grandiosity characterize grandiose narcissism, the vulnerable form is described by self-reported feelings of inferiority, depression, depletion, shame-proneness, and high reactivity to evaluative events (11).

Specifically, Kohut described hypervigilant narcissists as exquisitely sensitive to how others react to them. In fact, their attention is continually directed toward others, in contrast to the self-absorption of the oblivious narcissist. Like the paranoid patient, they listen to others carefully for evidence of any critical reaction, and they tend to feel slighted at every turn (11).

Kohut understood this state of affairs as the result of the parents' empathic failures. Specifically, the parents did not respond to the child's phase-appropriate displays of exhibitionism with validation and admiration (11).

Linn's entitled and reactive self-views indicate her narcissistic sensitivity, which may have been influenced by her parents' coldness and indifference. Subsequently, Linn tried to make up for her parents' lack of idealization and mirroring by developing self-centeredness and entitlement. Thus, she is constantly plagued by her continued struggle for approval and assurance from others. However, because of her negativistic and unstable ways of responding, secondary to her own unattainable relationship demands and self-aggrandizing goals, she pushes away the same people whom she seeks for validation and admiration.

In this case, the vulnerability to trauma or to the perception of being traumatized can be related to the individual's level of narcissism, as in this patient (17).

Narcissism was related with the onset of victimization during early adolescence, as in this case. Early adolescence is regarded as a more vulnerable developmental period, which might place individuals with narcissistic traits at greatest risk for being victimized. If highly narcissistic adolescents with low self-esteem fail to expand their social status and strengthen their self-image, they might place themselves in a negative situation of lower social standing and increased risk for peer victimization (17). This is one probable reason for the patient's constant feeling of being shamed or victimized in several of her past and present situations.

Although only limited work investigated associations with victimization, a study which collected data from college students reported that narcissistic individuals tend to perceive themselves as victims of others' interpersonal transgressions more so than other individuals. The narcissism-victimization relationship appears to result, at least in part, from biased recall or self-presentation (18).

So is this really a case of PTSD in a vulnerable narcissist or is this simply a case of vulnerable narcissism in a patient whose trauma was amplified and perpetuated by her own negativistic views of herself and others?

Looking closely at this case, we can agree that her presentation cannot meet the first DSM-5 criterion for PTSD. However, we can view the trauma components as belonging to a concept called Trauma-Associated Narcissistic Symptoms or TANS, which was first elucidated by psychiatrist Dr. Robert Simon in 2001 (19).

Although TANS has not been validated in empirical studies and does not constitute a formal diagnosis, being aware of it has important diagnostic and treatment implications as it can closely mimic PTSD.

TANS occurs when a traumatic stressor (which may be relatively small and insignificant) overwhelms the grandiose self, producing shame, humiliation, and rage that drive re-experiencing, avoidance, and arousal symptoms (19).
The underlying vulnerability to traumatic stress usually stems from the presence of a narcissistic personality disorder or narcissistic personality traits. Although TANS can closely mimic PTSD, it has a different etiology, course, and prognosis.
To some degree, everyone is narcissistically vulnerable to trauma. Ordinary life traumas usually induce an element of injury to one's self

perception of invulnerability. However, individuals with narcissistic personality disorder or traits are especially vulnerable to life's traumas that threaten or overwhelm the grandiose self. The narcissistically vulnerable individual may not experience a stressor as life-threatening but rather as an affront to the grandiose self (19). The bullying did not overcome Linn's survival coping mechanisms, but it threatened her sense of self-importance and entitlement.

Following exposure to trauma, the typical symptom response of a person with pathological narcissism is shame, humiliation, embarrassment and rage. The self is deflated. A traumatic disequilibrium occurs in a narcissistically vulnerable self (19).

While they are commonly mistaken, TANS and PTSD have clinical differences. The following are relevant to this case.

First, in individuals who develop TANS, the traumatic stressor usually is interpersonal or contains a strong interpersonal element, and can be mild to severe. There is direct confrontation with the individual who is inflicting the trauma. The trauma is "up close and personal" like in the form of bullying which was rather mild in this case. Typical interpersonal stressors involve exploitation, harassment, abuse, and humiliation (19).

This interpersonal stressor is perceived as a deliberate deprivation of desired narcissistic supplies, admiration, or mirroring, which results in painful mortification (19).

On the other hand, the traumatic stressor for PTSD is usually extreme, such as exposure to actual or threatened death, serious injury, or sexual violence. These events threaten the survival of self or others (10).

The psychological and physiological distress in a patient with TANS results from continually rehashing the humiliation and mortification induced by the traumatic event, which has caused narcissistic injury. In contrast, because of the severity of the trauma in PTSD, it elicits intense fear, helplessness and horror as a result (19).

The individual with TANS does not usually experience recurrent distressing dreams or nightmares of the event unlike in patients with PTSD. Instead, dreams with scenes of humiliation related to the current and/or earlier narcissistic injuries may emerge like in the case of Linn (19).

As for re-experiencing, the individual with TANS does not act or feel as if the traumatic event were being replayed; rather, he or she is greatly deflated and disturbed by re-experiencing the humiliation and consequent rage connected with the event. Behavioral reenactments do not occur. The person with TANS may feel shame thinking about their failure to live up to self-expectations (19).

On the other hand, in PTSD, the recurrent and distressing recollections of the event are largely intrusive and unbidden. Behavioral reenactments of the traumatic event may occur. PTSD victims frequently suffer guilt out of a troubled conscience (19).

In TANS, the person also avoids thoughts, feelings, conversations, and being around people, but for entirely different reasons. Like Linn, the narcissistically injured individual desperately wants to avoid shame and embarrassment. Revisiting the scene of the trauma also do not reawaken feelings of intense fear, horror, and helplessness (19). But for those with PTSD, the underlying reason for the avoidance is to prevent re-traumatization through distraction and thought suppression (20).

In terms of numbing, a TANS patient withdraws from relationships to protect the grandiose self from embarrassing inquiries. They may drive others away because of heightened demands for attention and solace and a constant display of embitterment and rage (19). On the other hand, in PTSD emotional numbing can also negatively impact relationships. Litz and Gray (2001) hypothesized that heightened arousal to unpleasant images and decreased arousal to pleasant images would mediate the relationship between PTSD symptoms and relationship dysfunction (21).
Individuals with TANS, unlike those with PTSD, do not usually experience hypervigilance or an exaggerated startle response.

Moreover, the individual experiences persistent, intense, seething outrage that "feels right." The wounded grandiose self ragingly asks "How could this happen to me?" I deserve better!" In contrast, PTSD patients exhibit hypervigilance and exaggerated startle response that is driven by the anxiety of re-experiencing the trauma (19).

In both TANS and PTSD, secondary symptoms of anxiety and depression can significantly color the patient's clinical presentation. After exposure to a severe or extreme traumatic stressor, individuals can develop both TANS and PTSD, displaying a mixed clinical presentation (19).

As for treatment, brief, focused psychotherapy can be done whose primary goal is to restore narcissistic equilibrium to the level that existed before exposure to the trauma, not to treat the underlying narcissistic vulnerability or disorder (19).

Psychotherapy that is empathic and supportive and that allows for emotive expression and for the clarification of options to restore narcissistic equilibrium can be helpful in increasing confidence and dissipating deflation (19).

While the course of PTSD tends to be chronic, the course of TANS is highly variable. In some individuals with uncomplicated TANS, the acute symptom response to a traumatic stressor may be quite alarming in intensity. In an individual with major narcissistic vulnerability, TANS may persist following exposure to even a relatively minor trauma, causing significant disability. The misdiagnosis of TANS as PTSD will probably lead to a treatment stalemate, adversely affecting recovery (19).

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**REFERENCES**

1.. Nielsen MB, Tangen T, Idsoe T, Matthiese SB, Mageroy N. Post-traumatic stress disorder as a consequence of bullying at work and at school. A literature review and meta-analysis. Aggression and Violent Behavior. 2015 Mar- Apr. 21: p17-24. Available from: https://doi.org/10.1016/j.avb.2015.01.001. (https://www.sciencedirect.com/science/article/pii/S1359178915000026)

2. Harris MJ, ed. Bullying, rejection, and peer victimization a social cognitive neuroscience perspective. 1st edition. NY, NY: Springer Publishing Co LLC; 2009.

3. Crick NR, Bigbee MA. Relational and overt forms of peer victimization: a multi-informant approach. Journal of Consulting and Clinical Psychology. 1998; 66, 337–347. Available from: https://doi.org/10.1037//0022-006x.66.2.337

4. Egan SE, Perry DG. Does low self-regard invite victimization? Developmental Psychology. 1998; 34, 299–309. Available from: https://doi.org/10.1037/0012-1649.34.2.299

5. Graham S, Juvonen J. Self-blame and peer victimization in middle school: an attributional analysis. Developmental Psychology. 1998; 34, 587–599. Available from: https://doi.org/10.1037/0012-1649.34.3.587

6. Sweeting H, Young R, West P, Der G. Peer victimization and depression in early-mid adolescence: a longitudinal study. British Journal of Educational Psychology. 2006; 76, 577–594. Available from: https://doi.org/10.1348/000709905X49890

7. Bowlby J. Attachment and loss: Vol. 2. Separation. New York: Basic Books; 1973.

8. Perry DG, Williard JC, Perry LC. Peers' perceptions of the consequences that victimized children provide aggressors. Child Development. 1990; 61, 1310–1325. Available from: https://doi.org/10.1111/j.1467-8624.1990.tb02863

9. Henry D, Guerra NG, Huesmann R, Tolan PH, Van Acker R, Eron L. Normative influences on aggression in urban elementary school classrooms. American Journal of Community Psychology. 2000; 28, 59–81. Available from: https://doi.org/10.1023/A:1005142429725

10. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th edition. Washington, DC: American Psychiatric Association Publishing; 2013.

11. Gabbard GO. Psychodynamic Psychiatry in Clinical Practice. 2nd edition. Washington, DC: American Psychiatric Press; 1994.

12. Janoff-Bulman R. Shattered assumptions. Towards a new psychology of trauma. New York: The Free Press. 1992.

13. Hong PY, Lishner DA. General invalidation and trauma-specific invalidation as predictors of personality and subclinical psychopathology. Personality and Individual Differences. 2016 Jan; 89:211-216. Available from: https://doi.org/10.1016/j.paid.2015.10.016. (https://www.sciencedirect.com/science/article/pii/S0191886915006509)

14. Widiger TA, Oltmanns JR. Neuroticism is a fundamental domain of personality with enormous public health implications. World Psychiatry. 2017 Jun;16(2): 144–145. doi: 10.1002/wps.20411.

15. Kernberg OF. Pathological narcissism and narcissistic personality disorder: theoretical background and diagnostic classification, in Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications. Edited by Ronningstam EF. Washington, DC: American Psychiatric Press; 1998.

16. Kohut H. The analysis of the self: a systematic approach to the psychoanalytic treatment of narcissistic personality disorders. New York: International Universities Press; 1971.

17. Hermann A, Brunell A, Foster J, editors. Handbook of trait narcissism: key advances, research methods and controversies. 1st edition. Cham, Switzerland: Springer International Publishing; 2018.

18. McCullough ME, Emmons RA, Kilpatrick SD, Mooney CN. Narcissists as “victims”: the role of narcissism in the perception of transgression. Personality and Social Psychology Bulletin. 2003; 29, 885–893. Available from: doi:10.1177/0146167203029007007
19. Simon RI. Distinguishing trauma-associated narcissistic symptoms from posttraumatic stress disorder: a diagnostic challenge. Harv Rev Psychiatry. 2002 Jan-Feb; 10 (1):28-36. Available from: doi: 10.1080/10673220216206. PMID: 11751643.
20. Ehlers A, Clark DM. Post-traumatic stress disorder: the development of effective psychological treatments. Nord J Psychiatry. 2008; 62 Suppl 47(Suppl 47):11-8. Available from: https://doi.org/10.1080/08039480802315608
21. Lytle K. PTSD symptomology and relationship dysfunction: is emotional reactivity the culprit? [dissertation on the Internet]. University of South Carolina-Aiken; 2014. Available from: https://scholarcommons.sc.edu/aiken_psychology_theses

## TRAUMA FOR THE VULNERABLE: REAL OR IMAGINED?

RYZAMEIL ANDREA F. UY, MD

This artwork would like to illustrate our patient's journey towards healing. Her life may currently be in the dark but there is always hope and light if one keeps on looking.

The ascending staircase represents the complexity and effort in her life's journey, which may seem to lead the patient to a dead end but there is actually a ray of light that can still be hopeful.

As she goes up towards the light, she comes across portraits of her goals and dreams marred by her troubles and fears. The glamorous things she envisioned were not exactly as she imagined them to be, thus the cracks in the glass. This caused her to endure feelings of self-doubt, low self-esteem and sensitivity to slights and criticisms.

But despite the difficulties, she still braved to take that first step towards the unknown. The light on the right side would hint that there is an opening, not a dead-end, which may lead towards many other possibilities.

Even if the end may not be clear or near at the moment, she will have to get there eventually, with her therapist guiding her with every step she takes; represented by the handrails and staircase lights. In the midst of all the darkness, she still strives to be better for better days are yet to come.