

Chapter 7 in: Traumatic Stress. Rachel Yehuda, ed. American Psychiatric Press, 2001

The Assessment and Treatment of Complex PTSD

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The author wishes to acknowledge the helpful comments and suggestions on this chapter by Drs. Janina Fisher, Debbie Korn, Onno van der Hart, Pat Ogden, Betta van der Kolk, Joseph Spinazzola and Peter Levine.

[Incest is thought to occur] in approximately 1 out of 1.1 million women. There is little agreement about the role of father-daughter incest as a source of serious subsequent psychopathology. The father-daughter liaison satisfies instinctual drives in a setting where mutual alliance with an omnipotent adult condones the transgression. .. The act offers an opportunity to test in reality an infantile fantasy whose consequences are found to be gratifying and pleasurable... The ego's capacity for sublimation is favored by the pleasure afforded by incest... such incestuous activity diminishes the subject's chance of psychosis and allows for a better adjustment to the external world.

There is often found little deleterious influence on the subsequent personality of the incestuous daughter...one study found that the vast majority of them were none the worse for the experience.

Freedman and Kaplan, Comprehensive Textbook of Psychiatry, 1972

Trauma as an etiological agent in the genesis of psychopathology was largely ignored from the end of the second world war till after the end of the Vietnam war, forty years later. During that time trauma-based psychiatric problems were generally trivialized, as exemplified by the above quote about the impact of childhood sexual abuse in the leading textbook of psychiatry in 1972. PTSD was created for inclusion in the DSM-III in order to capture the psychopathological effects of traumatization that was seen in hundreds of thousands of Vietnam veterans shortly after the end of that War.

However, over the years, it has become clear that in clinical settings the majority of traumatized treatment seeking patients suffer from a variety of psychological problems that are not included in the diagnosis of PTSD. These include depression and self-hatred, dissociation and depersonalization, aggressive behavior against self and others, problems with intimacy, and impairment in the capacity to experience pleasure, satisfaction and 'fun'. Many of these problems that are not categorized under the rubric of PTSD are often classified as "co-morbid conditions", rather than being recognized as part of a spectrum of trauma-related problems that occur as a function of the developmental level at which the trauma occurred, the relationship

between the victim and the agent responsible for the trauma, the duration of the traumatic experience(s) and the availability of social support

The DSM IV Field trial (van der Kolk et al, 1996) demonstrated that it was not the prevalence of PTSD symptoms themselves, but depression, outbursts of anger, self-destructive behavior, and feelings of shame, self-blame and distrust that distinguished a treatment seeking sample from a non-treatment seeking community sample with PTSD. The notion that the majority of people who seek treatment for trauma-related problems have histories of multiple traumas is exemplified in Table 1 which shows the trauma histories of 70 consecutive admissions to our Trauma Center outpatient clinic during April/ May, 1999.

Table 1

Percentage endorsement of different trauma types of 70 consecutive admissions to the Trauma Center

TRAUMA TYPE	AGE OF OCCURENCE				
	<u>0 to 6</u>	<u>7-12</u>	<u>13-18</u>	<u>19+</u>	<u>Lifetime</u>
Separation and loss	47.1	61.4	81.4	84.3	98.6
Neglect	58.2	71.4	81.1	80.0	91.4
Physical abuse	41.4	54.3	55.7	50.0	80.0
Sexual abuse	25.7	41.4	41.4	44.3	74.3
Emotional abuse	51.4	77.1	85.7	82.9	85.7
Other traumas	50.0	55.7	65.7	82.9	91.4
Witnessing violence	54.3	71.4	78.6	70.0	87.1
Familial substance abuse	40.0	50.0	67.1	65.7	75.7

While these Trauma Center patients had a mean PTSD score of 73, (equivalent to a CAPS score) they suffered from a variety of other psychological problems that in most cases were the chief presenting complaints: 77 % suffered from significant dysregulation of affects and impulses, including aggression against self and others, 84 % suffered from depersonalization and other dissociative symptoms, 75% were plagued by chronic feelings of shame, self-blame and feeling permanently damaged, 83 % complained of being unable to negotiate satisfactory relationships with others, and 73% said they had lost previously sustaining beliefs. Our patients reported that these problems, rather than the intrusive recollections characteristic of PTSD, made their lives unbearable.

PTSD has become a common diagnosis for psychiatric inpatients. For example, an examination of the records of the 384,000 Medicaid recipients in Massachusetts in 1997/98

(Macy, 1999) revealed that PTSD and depression were the most common psychiatric diagnoses. However, patients with a PTSD diagnosis spent 10 times as much time in the hospital than patients with the diagnosis of depression only. It is inconceivable that the 22,800 Medicaid recipients in Massachusetts who were hospitalized and diagnosed as suffering from PTSD between 1997 and 1998 were admitted following a one-time traumatic incident, such as a rape or motor vehicle accident. Most likely, they suffered from a complex constellation of symptoms, like those of the patients at the Trauma Center, which led to their requiring hospitalization.

However, since the long-term psychiatric impact of chronic, multiple traumas, is classified under the same rubric (PTSD) as would the sequelae of a one-time incident, we have no formal way of describing how convoluted the psychiatric presentations of these patients are, and how complex their treatment is. In Macy's Medicaid sample, a small group of 1200 patients with Dissociative Identity Disorder (DID) – a diagnosis associated with severe and prolonged interpersonal childhood trauma - had by far the highest utilization rate of any psychiatric diagnosis in Massachusetts during the years 1997/1998. Yet, there currently is not a single funded research program studying the phenomenology and treatment of this disorder in the United States.

PTSD as a diagnostic construct

PTSD as a diagnosis was constructed in response to a social demand to delineate a syndrome that captured the psychological suffering experienced by many Vietnam combat veterans at a time that the US was coping with millions of soldiers who had just returned from the war. Prior to the creation of the diagnosis "PTSD", other post-traumatic syndromes had been proposed, such as a "rape trauma syndrome" (Burgess & Holstrom, 1974) and a "battered women's syndrome" (Walker, 1977/78). Those syndromes highlighted the effects of those assaults on the victims' sense of safety, trust and self-worth, and their continued sense of terror. The DSM III definition of PTSD, guided by Kardiner's description of the "traumatic war neuroses of war" (1941) and Horowitz' biphasic stress response syndrome (1978) highlighted the physiological alterations that follow traumatization, and the co-existing traumatic intrusions and emotional numbing and avoidance.

While numerous studies have demonstrated that the diagnostic construct of PTSD captures essential elements of the suffering caused by such traumas as rape, torture, child abuse and motor vehicle accidents, no large factor analysis has been conducted across a variety of trauma populations to test whether the diagnostic criteria for PTSD uniquely capture

the psychological damage that occurs in response to psychologically overwhelming experiences. The PTSD Field Trial failed to measure other Axis I or Axis II disorders in its sample of 528 traumatized individuals. Therefore, the design of the Field Trial was unable to demonstrate that the criteria delineated in the diagnosis of PTSD capture the most essential elements of human suffering that occurs in the wake of trauma. However, the Field Trial did provide some information about how trauma at different ages contributes to the genesis of a complex constellation of symptoms that was called “Disorders of Extreme Stress - NOS” or “Complex PTSD” (van der Kolk et al, 1994).

Childhood Trauma and Complex PTSD

Most patients who seek treatment in our urban outpatient clinic that specializes in the treatment of traumatized children and adults have chronic histories of emotional, physical and sexual abuse. This is not surprising, since childhood trauma is very common in our society, and its effects are well-documented to persist over time. Each year over 3,000,000 children are reported for abuse and/or neglect in the United States (Wang & Daro, 1997). Only about a third of abused and neglected children in clinical settings meet diagnostic criteria for PTSD. For example, in one study of 364 abused children (Ackerman et al, 1998, Table 2) the most common diagnoses in order of frequency were separation anxiety disorder, oppositional defiant disorder, phobic disorders, PTSD and ADHD. So, while abused and neglected children may receive a variety of psychiatric labels, none of these diagnoses capture their profound developmental disturbances, nor the traumatic origins of their particular clinical presentations. Regardless of the diagnosis they receive, these children tend to be characterized by pervasive problems with attachment, attention and with managing physiological arousal.

Table 2.

Diagnoses	ABUSE GROUPS							
	Total %	Sexual (N=127)		Physical (N=43)		Both (N=34)		Control* %
		Boys %	Girls %	Boys %	Girls %	Boys %	Girls %	
ADHD	29	40	22	36	10	67	26	3-5
Oppositional Defiant Disorder	36	46	22	56	20	64	47	6.5
Conduct Disorder	21	44	11	21	10	67	21	3.9
Major Depression	13	12	11	12	20	8	32	0.4-8.3
Bipolar Disorders	9	4	9	9	20	0	21	1
Dysthymia	19	16	13	24	20	17	42	
Separation Anxiety/Overanxious	59	44	58	48	100	59	79	2.9-4.6
Phobic	36	44	36	24	30	25	58	2.4-9.2
Obsessive-Compulsive	14	0	14	18	20	8	27	0.5
PTSD	34	20	35	18	50	58	53	>6

*Based on various studies. Source: Ackerman et al., 1998. Subjects included 62% outpatients, 25% inpatients, and 13% were referrals from local agencies.

There is little indication that children “outgrow” these early problems: people with histories of early abuse and neglect have repeatedly been found to suffer from profound and pervasive psychiatric problems (McCord 1983; Roesler & McKenzie, 1994; McCauley et al, 1997.; Widom, 1997, Levitan, 1998). Their problems with negotiating satisfying interpersonal relationships seems to play a particularly significant role in preventing them from leading satisfying lives: being able to engage in competent social relationships has been shown to be an important prognostic factor in the capacity to recover from traumatic experiences (e.g. van der Kolk et al, 1991; Ford, Fisher & Larson, 1997).

Child abuse and neglect has been shown to profoundly impair the capacity for self-regulation (Cicchetti & Toth, 1995; Kendall-Tackett, Williams, & Finkelhor, 1993; Rodriguez et al., 1997; Westen, Lohr, Silk, Gold, & Kerber, 1990; Westen, Ludolph, Block, Wixom, & Wiss, 1990). Chronic affect dysregulation, in turn, is associated with substance use (Chilcoat & Breslau, 1998), chronic anxiety and depression (Beitchman et al., 1992; Felitti et al., 1998; Polusny & Follette, 1995), and increased use of medical and mental health services (Drossman et al., 1990; Golding et al., 1988; Moeller et al., 1993; Rapkin et al., 1990; Felitti et al, 1998).

In clinical settings the pervasive problem with self-regulation in these patients is most readily evident in their experiencing even minor objective stressors as overwhelming, and their managing the resulting overwhelming distress with self-destructive behaviors, such as self-

injury, substance use, eating disorders and suicide attempts (van der Kolk et al., 1991; Putnam et al., 1999; Felitti et al., 1998). Loss of self-regulation may be expressed on other levels as well: as a loss of ability to focus on relevant stimuli, as attentional problems and as an inability to inhibit action when aroused. Such problems with attention and stimulus discrimination may account for the high co-morbidity between PTSD and Attentional Deficit Hyperactivity Disorder (ADHD) in traumatized children, such as sexually abused girls (Putnam, 1997).

Having a history of childhood abuse and neglect pre-disposes individuals to develop PTSD to subsequent traumatic stressors (Bremner, 1993; Widom, 1999). Childhood trauma is also associated with the development of borderline personality disorder (e.g. Herman et al., 1989; Ogata et al., 1990), somatization disorder (e.g. Saxe et al., 1994), dissociative disorders (e.g. Ross et al., 1991, 1989; Saxe et al., 1993; Kluff, 1991; Putnam, 1989), eating disorders (Herzog et al., 1993; DeGroot et al., 1992; McFarlane, McFarlane, & Gilchrist, 1988).

To summarize: abused and neglected children, and many adults with histories of abuse and neglect, tend to suffer from 1) a lack of a predictable sense of self, with a poor sense of separateness, and a disturbed body image, 2) poorly modulated affect and impulse control, including aggression against self and others, and 3) uncertainty about the reliability and predictability of others. This accounts for the distrust, suspiciousness, problems with intimacy, and social isolation seen in many individuals with these histories. Cole & Putnam (1992) have proposed that people's core sense of self, is, to a substantial degree, defined by their capacity to regulate internal states and by how well they can predict and regulate their responses to stress. Hence, it is not surprising that the first order of therapeutic business with such individuals is the establishment of the capacity for affect regulation.

Trauma and Personality Development.

For children, the principal source of information about who they are is based on the quality of their relationships to their parents. Hence, it is not surprising that abused and neglected children are faced with enormous challenges to construct meaningful lives and safe interpersonal relationships. The combination of a lack of adequate self-regulatory processes, chronic dissociation, physical problems without a clear medical cause, and exposure to caregivers who are cruel, inconsistent, exploitative, unresponsive or violent are likely to have a profound impact on the sense of who one is, and is likely to lead to disturbances of body image, a view of oneself as helpless, damaged and ineffective, and in difficulties with trust, intimacy, and self-assertion (van der Kolk, 1987; Herman, 1992; van der Kolk & Fiesler, 1995; Cole & Putnam, 1992).

To a considerable degree, the effects of traumatic exposure depend the developmental level of the individual when the trauma occurs (Pynoos et al. 1996). However, it has been repeatedly noted that previously well-functioning traumatized adults often have a significant decline in their overall functioning, as well; that trauma may significantly erode ego capacities. Such “post-traumatic decline” following adult trauma was already well documented in the literature of the Second World War (e.g. Archibald & Tuddenham, 1965). Kardiner (1941, p. 82) noted that, once traumatized, “(t)he subject acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion. This means in effect that his conception of the outer world and his conception of himself have been permanently altered.” (1941, p. 249).

Trauma-based cognitive schemes come to organize their views of themselves and their surroundings. Often, parallel schemes co-exist, which are activated in a state-dependent manner: high levels of competence and interpersonal sensitivity can co-exist side-by-side with self-hatred, lack of self-care, and interpersonal cruelty (Crittenden, 1988). Many people who were traumatized in their own families have great difficulty taking care of their own basic needs: hygiene, rest, and protection, even as they may be exquisitely responsive to other people’s needs. Many repeat their family patterns in interpersonal relationships, in which they may alternate between playing the role of victim or of persecutor, often justifying their behavior by their feelings of betrayal and helplessness. The use of projective identification, attributing to others one’s own most despised attributes, and acting on the basis of that projection, without being able to acknowledge the existence those characteristics in oneself, has been thoroughly described by Kernberg (1975).

Disorders of Extreme Stress (DESNOS).

In preparation for a possible revision of the definition of PTSD in the DSM IV some members of the PTSD taskforce delineated a syndrome of psychological problems that have been shown to be frequently associated with histories of prolonged and severe interpersonal abuse. This conglomeration of symptoms has been called “Complex PTSD”, or “*Disorders of Extreme Stress Not Otherwise Specified*” (DESNOS) (Herman, 1992; van der Kolk et al., 1994, 1996). The diagnosis consisted of six different problems which research had shown to be associated with early interpersonal trauma: 1) alterations in the regulation of affective impulses, including difficulty with modulation of anger and being self destructive, 2) alterations in attention and consciousness leading to amnesias and dissociative episodes and depersonalizations, 3) alterations in self perception, such as a chronic sense of guilt and responsibility, chronically

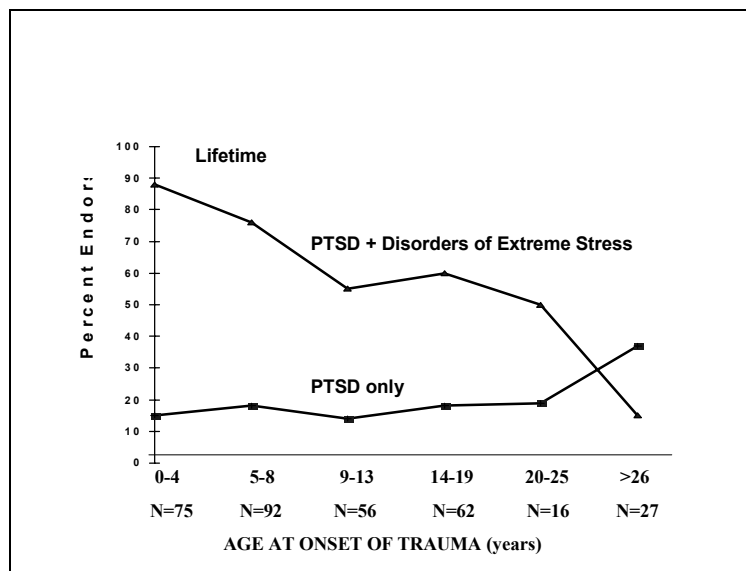
feeling ashamed, 4) alterations in relationship to others, such as not being able to trust, not being able to feel intimate with people, 5) somatization the problem of feeling symptoms on a somatic level for which no medical explanations can be found, and 6) alterations in systems of meaning (see Table 3).

Table 3

Disorders of Extreme Stress (DESNOS) or Complex PTSD

- Impairment of Affect Regulation
- Chronic destructive behavior
 - self-mutilation
 - eating disorders
 - drug abuse, etc.
- Amnesia and Dissociation
- Somatization
- Alterations in relationship to self
- Distorted relations with others
- Loss of sustaining beliefs

Figure 1



DSM IV Field Trial percent endorsement of all DESNOS categories by age of onset of trauma (van der Kolk et al, 1996)

The DSM IV Field Trial of PTSD found that DESNOS had a high construct validity (Pelcovitz et al., 1997). The earlier the onset of the trauma, and the longer the duration, the more likely people were to suffer from high degrees of all the symptoms that make up the DESNOS diagnosis (see figure 1). The DESNOS construct has been assessed in community

(Roth et al., 1997; van der Kolk et al., 1996) and specialized inpatient (Ford, 1999; Ford & Kidd, 1998) and outpatient mental health settings (Roth et al., 1997; van der Kolk et al., 1996). These studies showed that interpersonal trauma, especially childhood abuse, predicts a higher risk for developing DESNOS than accidents and disasters (Roth et al., 1997). Ford & Kidd (1998) found that meeting diagnostic criteria for DESNOS, and not a history of early developmental trauma *per se*, distinguished therapeutic outcome. Ford (1999) found that despite substantial overlap between PTSD and DESNOS, the two conditions had substantially different symptomatic and functional impairment features. In contrast with the DSM IV Field Trial which found a 92 % co-morbidity between DESNOS and PTSD, Ford (1998) found that DESNOS could occur in the absence of PTSD and that DESNOS was associated with particularly severe self-reported intrusive re-experiencing symptomatology, over and above that attributable to PTSD.

Why do we need DESNOS ?

PTSD patients with DESNOS are frequently refractory to conventional PTSD treatment and may, in fact, be harmed by it (Ford, 1999). McDonagh-Coyle & Ford (1999) conducted a randomized controlled trial of combined prolonged exposure and cognitive restructuring (PE/CR) versus “present-centered therapy” (PCT) that specifically did not involve either prolonged exposure or cognitive restructuring. Attrition was high in PE/CR (30%) but low in PCT (10%). PCT was equally effective in reducing PTSD and psychiatric symptomatology and in making clinically-significant reductions in research-diagnosed PTSD. These results suggest that some adults who were abused and neglected as children and who currently meet diagnostic criteria for PTSD may react adversely to PE/CR, and that effective treatment may need to focus self-regulatory deficits rather than PE/CR.

The literature on treatment failures with Prolonged Exposure suggests that patients who suffer from the DESNOS constellation of symptoms are the least responsive to that treatment, and that it may, in fact, aggravate their condition. Subjects with the poorest outcomes in PE/CR are characterized by: 1) high initial levels of anger (Foa et al., 1995); 2) memories during reliving of the trauma reflecting “mental defeat” or the absence of mental planning (Ehlers et al., 1998); 3) feeling alienated or permanently damaged by the trauma (Ehlers et al., 1998); 4) being unable to develop a non-fragmentary coherent narrative recounting of trauma experiences during reliving of the trauma in treatment (Foa et al., 1997).

A recent study by Ford & Kidd (1998) showed that PTSD subjects with DESNOS responded poorly to treatment in a multimodal milieu PTSD treatment program because of their

problems with self-regulation. Overall, subjects with DESNOS had a negative response to PE/CR. Those with the poorest outcomes in PE/CR had high initial levels of anger, memories during reliving of the trauma reflecting “mental defeat” or the absence of mental planning; a feeling of alienation or being permanently damaged by the trauma and an inability to develop a non-fragmentary coherent narrative recounting of trauma experiences during reliving of the trauma in treatment . The parallel in these features to DESNOS is quite striking. Moreover, a recent study showed that individuals with DESNOS tended to have deficits in developmentally-based self-regulatory capacities and were treatment refractory in a multimodal milieu PTSD treatment program (Ford & Kidd, 1998).

The Assessment of Traumatized Patients.

While PTSD has become the central organizing diagnosis for traumatized patients, it does not take into account the complexity of adaptation to trauma, nor does a patient’s PTSD score inform clinicians about such relevant issues as functional impairment, developmental aspects of the trauma, what resources the patient has available to deal with their PTSD symptoms, and how different traumatizing life events have coalesced to give rise to the current clinical picture.

In order to formulate a rational treatment plan it is critical to be aware of the patient’s pre-morbid history and available coping resources. To this end the Trauma Center has developed a computerized Traumatic Antecedents Questionnaire (TAQ) which gathers information both about the patients’ resources (having particular competencies and feeling safe with potentially protective people) during different stages of development: ages 0-6, 7-12, 13-18, and adulthood. In addition to measuring resources, it also assesses a variety of potentially traumatizing events over all developmental periods, including neglect, separations from significant others, secrets, emotional abuse, physical abuse, sexual abuse, witnessing, other traumas, and exposure to alcohol and drugs. A computer printout allows the clinician to gain a rapid overview both of the history of resources and of potentially traumatizing life events (see Table 4 for a sample printout).

Table 4.

Sample printout of Traumatic Antecedents Questionnaire

Name:
I.D. 2223fabs
Date: 10/23/9_

<i>Traumatic Antecedents Questionnaire</i>					
	<u>Young Child</u>	<u>School Age</u>	<u>Adolescence</u>	<u>Adulthood</u>	<u>Total</u>
	(0 – 6)	(7 – 12)	(13 – 18)		
RESOURCES					
Competence	3.0	3.0	2.0	2.5	10.5
Safety	3.0	2.0	0.0	0.0	5.0
TRAUMA AND NEGLECT					
Neglect	0.0	0.0	0.0	na	0.0
Separation	0.0	3.0	3.0	3.0	9.0
Secrets	2.0	0.0	2.0	0.0	4.0
Emotional Abuse	0.0	2.0	0.0	3.0	9.0
Physical Abuse	0.0	0.0	3.0	3.0	6.0
Sexual Abuse	0.0	0.0	0.0	3.0	0.0
Witnessing	3.0	0.0	2.0	3.0	8.0
Other Traumas	0.0	0.0	2.0	3.0	5.0
Alcohol & Drugs	3.0	0.0	2.0	3.0	8.0

key: 0 = Not at all; Never; A little bit; or rarely numbers between 2.0 and 3.0 are averages of endorsed items meaning moderately; Somewhat (2.0) to often; Very Much (3.0)

This is the TAQ profile of a 29 year old chronically battered woman, presenting in great distress. She had a violent alcoholic father, who left the family when patient was six years old. In adolescence she engaged in alcohol and drug abuse and married a violent, alcoholic man. Her memory of early safety and life long sense of competence are expected to positively affect her long term prognosis (see text).

Table 5

Sample scoring Report DES – NOS Results

Name
ID: 2223FABS
Date: 10/23/97

		<u>Present</u>	<u>Current Severity</u>
I.	Alteration in Regulation of Affect and Impulses		2.5
	la) Affect Regulation:	Yes	3.0
	lb) Modulation of Anger:	Yes	2.0
	lc) Self-destructive:	Yes	0.0
	ld) Suicidal Preoccupation:	Yes	3.0
	le) Difficulty Modulating Sexual Involvement Preoccupation:	Yes	0.0
	lf) Excessive Risk Taking:	No	0.0
II.	Alterations in Attention or Consciousness	Yes	1.5
	IIa) Amnesia	Yes	1.0
	IIb) Transient Dissociative Episodes and Depersonalization	Yes	2.0
III.	Alteration in Self-Perception		2.0
	IIIa) Ineffectiveness:	Yes	3.0
	IIIb) Permanent Damage:	Yes	2.0
	IIIc) Guilt and Responsibility:	No	0.0

	<i>III d)</i>	<i>Shame:</i>	Yes	3.0
	<i>III e)</i>	<i>Nobody can Understand:</i>	Yes	2.0
	<i>III f)</i>	<i>Minimizing:</i>	No	0.0
<hr/>				
<i>IV.</i>	<i>Alterations in Relationships with Others</i>			<i>1.5</i>
	<i>IV a)</i>	<i>Inability to Trust:</i>	Yes	3.0
	<i>IV b)</i>	<i>Revictimization:</i>	No	0.0
	<i>IV c)</i>	<i>Victimizing Others:</i>	No	0.0
<hr/>				
<i>V.</i>	<i>Somatization</i>			<i>0.6</i>
	<i>V a)</i>	<i>Digestive System:</i>	Yes	0.6
	<i>V b)</i>	<i>Chronic Pain:</i>	Yes	3.0
	<i>V c)</i>	<i>Cardiopulmonary Symptoms:</i>	Yes	0.0
	<i>V d)</i>	<i>Conversion Symptoms:</i>	Yes	0.0
	<i>V e)</i>	<i>Sexual Symptoms</i>	No	0.0
<hr/>				
<i>VI.</i>	<i>Alterations in Systems of Meaning</i>			<i>3.0</i>
	<i>VI a)</i>	<i>Foreshortened Future:</i>	Yes	3.0
	<i>VI b)</i>	<i>Loss of Previously Sustained Beliefs</i>	No	3.0

Patients also fill out a computerized PTSD rating scale and the computerized SIDES (Pelcovitz et al., 1997), which measures the items enumerated in DESNOS: 1) Alteration in regulation of affect and impulses 2) Alterations in attention of consciousness 3) Alterations in self-perceptions , 4) Alterations in relationship to others, 5) Somatization and 6) Alterations in belief systems (see Table 5 for a sample printout). Having thus obtained a developmental history of both coping resources and trauma-related symptomatology allows clinicians to prioritize the appropriate treatment interventions¹.

The most important issue we evaluate is the capacity of our patients to modulate their affective arousal: whether they are able to be emotionally upset without hurting themselves, becoming aggressive, or dissociating. As long as they cannot do this, addressing the trauma is likely to lead to negative therapeutic outcomes. Similarly, as long as they dissociate when they feel upset they will be unable to take charge of their lives and will be unable to “process” traumatic experiences. Hence, a substantial part of the treatment of our chronically traumatized patients consists of stabilization and the development of resources to cope with both the sequelae of their earlier trauma and with the challenges of day-to-day life.

Treatment approaches to chronically traumatized individuals.

Therapists who treat chronically traumatized patients need to develop a keen appreciation how trauma is re-enacted in these patients’ lives. They need to help them to

accurately evaluate and process their current situations and their physical and emotional responses to the present and avoid participating in any re-enactment of their patients' past dramas. Since interpersonal trauma tends to occur in contexts in which the rules are unclear, under circumstances that are secret, and in conditions where issues of responsibility are often murky, patients will be exquisitely sensitive to issues of rules, boundaries, contracts, and mutual responsibilities (Kluft, 1992; Herman, 1992) and often interpret minor frustrations as a return of past insults. Rather than understanding uncomfortable sensations as memories that are the result of having been triggered by some current event, they act as if restorative action in the present environment could alter the way they feel. Inexperienced therapists often take on the challenge to ameliorate the past by providing restorative experiences in the present. This usually leads to a repetition, rather than a resolution of the trauma.

In contrast to traumas such as motor vehicle accidents and torture, childhood abuse occurs as a part of ordinary everyday life. Hence, for people who have been abused as children seemingly innocuous experiences, ostensibly harmless sounds, the way light comes into a window, particular smells, and physical sensations, may become triggers of extreme emotional distress. When triggered by traumatic reminders the past becomes the present. Since they tend to have physiological reactions to triggers of traumatic reminders these patients are prone to experience slight irritations as emergencies and blame people in their surroundings for the way they feel. Hence, these patients, while numbing and dissociating in the face of real violations, often experience minor frustrations within the therapeutic relationship itself as a violation. As a consequence, these patients are most at risk of being abused by their therapists, and by the medical profession in general, and, reciprocally, to be experienced by them as abusive, ungrateful and manipulative.

Phase oriented treatment.

All treatment of traumatized individuals needs to be paced according to the degree of involuntary intrusion of the trauma, the individual's capacities to deal with intense affects, while understanding and respecting the various psychic defenses that are utilized to deal with the memories of traumatic material. For over a century, clinicians have advocated the application of phase-oriented treatment consisting of (1) establishing a diagnosis, including prioritizing the range of problems suffered by the individual, 2) designing a realistic phase-oriented treatment plan, consisting of:

¹ Copies of these assessment instruments can be obtained by visiting our Website at <http://www.traumacenter.org>.

1. stabilization, including identification of feelings by verbalizing somatic states.
2. deconditioning of traumatic memories and responses,
3. integration of traumatic personal schemes
4. re-establishing secure social connections and interpersonal efficacy
5. Accumulating restitutive emotional experiences.

(van der Hart et al 1989; Herman, 1992).

In the treatment of single incident trauma, it is often possible to move quickly from one phase to the next; in complex cases of chronic interpersonal abuse clinicians often need to refocus on stabilization (e.g. Janet, 1921; Brown & Fromm, 1986, Briere, 1998, Herman, 1992, van der Kolk et al, 1996, Chu, 1998, Courtois, 1999). Table 6. summarizes what appears to be the consensus by experts in this area about the appropriate stage-oriented treatment approach to patients with complex PTSD (van der Kolk, McFarlane & van der Hart, 1996).

Table 6.

Phase oriented treatment of Complex PTSD (DESNOS)

1. Symptom management: medications, Dialectical Behavior Therapy, Mindfulness training, Stress Inoculation Training
2. Create narratives
3. Realize repetitive patterns
4. Make connections between internal states and actions:
 - aggression,
 - sex,
 - eating,
 - gambling
 - cutting
5. Identify traumatic memory nodes, followed by
 - Exposure therapy
 - EMDR –
 - Body oriented work
6. Learn interpersonal connections – 12 steps, negotiation of sharing responsibility and intimacy. •

1. Trauma and the body.

The foundation of self-awareness and self-regulation rests on understanding the nuances and meaning of one's of physical sensations. The way people feel, and interpret the meaning of incoming information depends, to a large degree, to the meaning that they assign to their physical sensations (Schachtel, 1954). As people develop they learn how to interpret,

manage and act upon internal physical sensations. These can be generated internally (as in hunger, sleep and the need to urinate or defecate), or by interactions between the self and the surrounding world, as is the perception of fearful, soothing, or pleasurable stimuli. As children mature they gradually learn to interpret their bodily sensations, to attach emotional valence to them and to take appropriate action. It is thought that caregivers play a critical role in helping to modulate children's physiological arousal by providing a balance between soothing and stimulation. This "affect attunement" (Stern, 1983) between caregivers and infants regulates normal play and exploratory activity. By learning to coordinate physical sensations into a coherent whole, children develop a predictable sense of self (Crittenden, 1997). As children mature, they gradually become less vulnerable to over-stimulation and learn to tolerate higher levels of excitement. As long as the environment is more or less predictable, children gradually learn how to effectively take care of themselves. When that occurs they have less need for physical proximity of a caregiver to maintain comfort and they start spending more time playing by themselves and with their peers (Field, 1985). Secure children simultaneously learn how to get help when they are distressed (Crittenden, 1997). By accumulating a store of effective actions, they learn to predict the most appropriate response to most situations, and, failing that, when to look for outside help to cope.

Carlson and Cicchetti (1990) have shown that traumatized children follow different developmental routes: 80 % of them have disorganized attachment patterns. This interferes with their capacity to regulate physiological states and manifests itself in chronic patterns of hypo- and hyperarousal. This is likely to persist throughout the life cycle, and probably make these already traumatized individuals vulnerable to further traumatization. When children become overwhelmed by physiological arousal and caregivers fail to help them to re-regulate themselves, they fail to acquire the necessary capacity to use physical sensations as guides or effective action. Instead, they tend to become disorganized in response to minor stresses.

Porges et al (1998) have shown that the capacity to modulate arousal is, at least to some extent, genetically based, and that some children are much more vulnerable to lack of adequate parental care than others because of greater innate physiological reactivity. It has long been postulated that difficulty tolerating and interpreting somatic sensations tends to the development of alexythymia, which has been described to occur in traumatized individuals for over a century (Krystal, 1978). This inability to evaluate the emotional significance of somatic experience keeps these people from learning from experience, and prevents them from engaging in meaningful actions that can provide relief. Their disorganized states are merely

experienced as diffuse physical discomfort, emotional distress, lack of energy, or feelings of being dead. Reports of somatic symptoms for which no clear organic pathology can be found is ubiquitous in the psychiatric literature on traumatized children and adults (for a review, see Saxe et al, 1996) and include chronic back and neck pain, fibromyalgias, migraines, digestive problems, spastic colon/irritable bowel, allergies, thyroid and other endocrine disorders, anxiety, depression, chronic fatigue and some forms of asthma. Together these symptoms may explain some of the remarkable increase in medical morbidity, mortality and medical service utilization as documented by Felitti et al (1998).

When certain bodily signals become harbingers of helplessness and defeat, instead of subtle physical shifts that denote warning, satisfaction or pleasure, people often learn to avoid feeling them. As a result, these patients tend to lack nuanced responses to frustrations and go out of control in the face of stress with excessive anger and impulsivity, or by becoming depersonalized, “spaced out” or numb. Whatever the behavioral expression, they generally are unable to define the precise challenge they are facing. This not only may contribute to their well-documented lack of self-protection and high rates of re-victimization (Brown, Sheflin & Hammond, 1998), but also for their remarkable lack of capacity for feeling pleasure and meaning.

In order to overcome the effects of this physical hyperarousal and numbing it is critical for traumatized people is to find words to identify bodily sensations and to name emotional states. Knowing what one feels and allowing oneself to experience uncomfortable sensations and emotions is essential in planning how to cope with them. Freud (1911/1959) postulated that, in order to function properly, people need to be able to define their needs, and to entertain a range of options on how to meet them, without resorting to premature action to make those feelings go away. He called this: “thought as experimental action”. Being able to name and tolerate sensations, feelings and experiences gives people the capacity to “own” what they feel. Being “in touch’ with oneself is indispensable for mastery and for having the mental flexibility to contrast and compare, and to imagine a range alternative outcomes (aside from a recurrence of the trauma).

These skills need to be in place before people are ready to confront their traumatic memories. Without it, exposure is likely to be re-traumatizing because intense affects are likely to overwhelm the patient, just they did at the time of the original trauma. When traumatized individuals feel out of control and unable to modulate their distress they are vulnerable to resort to pathological self-soothing behaviors, such as substance abuse, binge eating, self-injury, or

clinging to potentially dangerous partners. As long as patients vacillate between extremes of under- and over-arousal it will be difficult to distinguish current frustrations from past trauma, and hence are prone to react to the present as a return of the past.

Trapped between feeling too much and feeling too little, many traumatized individuals devote their energy to avoiding the uncontrollable sensations associated with pain and helplessness. One way of doing this is by looking for a person, often in the form of a therapist, who can help them do what their early caregivers failed to provide at critical moments; supply them with comfort and safety. Others do this by seeking sensations and experiences that will keep them out of touch by means of engaging in compulsions, addictions and distractions that keep them from experiencing physical sensations associated with fear and helplessness.

Teaching terrified people to safely experience their sensations and emotions has not been given sufficient attention in mainstream trauma treatment. With the advent of effective medications, such as the serotonin reuptake blockers (e.g. van der Kolk et al, 1994), medications increasingly have taken the place of teaching people skills to deal with uncomfortable physical sensations. The most natural way that humans beings calm themselves down when feeling distressed and overwhelmed is by holding, hugging and rocking. This seems to allow them regain the capacity to overcome excessive arousal and return to feeling intact: capable of tolerating physical experience. This yearning for physical comfort usually is reactivated in relationships in which traumatized people re-examine their experiences with threat and abandonment. In traditional one-on-one therapeutic settings adults acting on those longings will tend to activate, rather than heal the confusion between safety and violation, particularly with patients with histories of physical invasion, though helping to feel and tolerate those sensations and fostering relationships in which they can be safely expressed should be a central therapeutic task.

However, there is a long standing tradition of specific body-oriented treatment techniques, first articulated by Wilhelm Reich (1937), and in modern times expanded to trauma-specific body-oriented work (e.g. Levine & Frederick, 1997, Gendlin, 1998), and psychodramatic techniques (e.g. Pesso & Crandell, 1991) focusing on experiencing, tolerating and transforming trauma-related physical sensations. Those traditions are widely practiced outside of academic and medical settings. Unfortunately, at present reimbursement for such techniques is difficult, and grants to study them impossible to come by.

2. Symptom management

Attending to issues of day-to-day safety, self-care, connections with other human beings, and competence are critical elements in the therapy of chronically traumatized individuals. The therapist's job is not just to focus on issues of sorrow, fear and pain, and to actively work on gaining some emotional distance from their overwhelming memories. Our research (van der Kolk & Ducey, 1989,) has shown that traumatized people have a decreased capacity for analyzing and planning. This may be related to a relative inactivity in the left hemisphere, particularly the language area, and heightened activity in the right limbic system in PTSD (Rauch et al., 1996). One can conceptualize the work of stabilization as helping maximize frontal lobe activity by learning to observe and attend, thereby diminishing the power of trauma-related physical sensations, emotions and perceptions.

Marsha Linehan (1996) has called the prime psychological resource that allows people mastery over physiological arousal "mindfulness". People need to learn to observe, describe their feelings and reactions without applying judgment (idealization or devaluation) or without immediately seeking relief. The task of development is what Jean Piaget used to call: "decentration": learning to attend to one's emotions, even if they are distressing and accepting feelings for what they are. Traumatized patients need to learn to uncouple trauma-related physical sensations from reactivating trauma-related emotion and perceptions. They need to learn to distinguish between how their internal sensations and the external events that precipitated them. In addition, they need to learn to articulate plans of action that can predictably help them to alter the way they feel.

As long as the trauma is experienced in the form of speechless terror, the body tends to continue to react to conditional stimuli as a return of the trauma, without the capacity to define alternative courses of action. However, when the triggers are identified and the individual gains the capacity to attach words to somatic experiences, these lose some of their terror (Harber & Pennebaker, 1992). Thus, the task of therapy is to both create a capacity to be mindful of current experience, and to create symbolic representations of past traumatic experiences with the goal of uncoupling physical sensations from trauma-based emotional responses, thereby taming the associated terror.

Any decrease in the intensity and duration of hyperarousal states (alarm or dissociation) will decrease the probability of experiencing trauma-related flashbacks and the resulting self-destructive acting out. For this stabilization to occur, safety and predictability are key elements.

Patients need to develop an internal locus of control by understanding and managing uncomfortable sensations and emotions and by learning effective plans of action.

Intrusive recollections of the trauma come in many different forms. Many people fail to realize that "flashbacks" are not just visual and often lack a narrative component. Flashbacks are fragmented sensory experiences involving affect, vision, tactile, taste, smell, auditory, and motor systems (van der Kolk & Fisler, 1995). Without a visual image to anchor an experience as belonging to the past tactile, affective, kinesthetic or olfactory sensory fragments, traumatized individuals are prone to experience the flashback as belonging to present . Stabilization consists of learning how to correctly interpret the intrusive sensory fragments of traumatic experience.

As long as patients are prone to dissociatively re-experience such fragments of their traumas, passively listening and meaning making can be counterproductive. It is critical to label what is going on and help patients understand and process these somatic experiences. In this context it is useful to reframe many of the patients' behaviors as symptoms of having felt overwhelmed by the physical sensations associated with their trauma; self-destructive impulses, hypervigilance, self-loathing and shame. They usually can be understood either as trauma-related physical or emotional states or as old , misguided, attempts to cope with overwhelming situations. Under stress, these patients tend to regress to how they felt at a time when the people who were supposed to take care of them actually were the sources of fear and anxiety. They cannot teach themselves how to be safe, because many of them simply lack a baseline understanding of what that means.

Affective hyperarousal can effectively be treated with the judicious use of serotonin reuptake blockers and emotion regulation training, which consists of identifying, labeling and altering emotional states. Patients are encouraged to attend to the sensory details of their experiences, locating where they feel the sensations associated with emotional states in their bodies. This supports them to learn to identify the internal sources of their distress and tolerate them ,as they observe tat bodily sensations change over time. Gradually, patients learn to observe, rather than running away from, the way they feel, and plan alternative coping strategies. As long as chronically traumatized people have not learned these skills, they tend to feel desperately dependent on people in their environment which makes it difficult for them to question and disagree with people they feel are essential for their survival.

All discussions between patients and therapists must include close attention to the effects of particular actions, such as work, relationships, and recreational activities, on their

capacity to feel in control and free from triggers for PTSD symptoms. Patient need to practice stabilization techniques which can help them ground themselves when they feel hyperaroused or dissociated, such as changing their posture and noticing the sensation of feeling one's feet on the floor, looking around the room and identifying familiar objects. It is useful to access several different sensory modalities: tactile, visual or auditory stimuli, touching cold objects like stones or ice cubes; smelling coffee or tea.

3. Resource identification and installation

PTSD symptoms should not be treated until the available internal and external resources have been identified and are in place: skills, hobbies, activities that calm the patient down, give satisfaction and a sense of competence. For most people feelings of interpersonal safety are essential to provide the sense of inner calm to make a distinction between current situations and the roots of current distress in the past. Fear needs to be tamed in order for people to be able to think clearly and be conscious of what they currently need. For this, it is necessary to have a body with predictable and controllable reactions to daily hassles. Developing a sense of bodily mastery and competence contradicts an identity of physical helplessness. In our program we actively encourage our patients to expose themselves to situations that precipitate a certain amount of controllable anxiety and which include a great deal of social support. Programs such as "model mugging" and Outward Bound can be immensely helpful to create physical and sensate memories of mastery. Having such experiences helps patients to associate certain anxiety provoking physical sensations not only with traumatic memories, but also with feelings of mastery, competence and triumph.

4. The use of language and the creation of narratives

Putting one's daily experiences, emotions and observations into words is one important element of post-traumatic therapy. Language creates the capacity to generate complex internal representations of one's reality. This promotes gaining a certain emotional distance from the trauma and observing the experiences from a variety of analytical vantage points. Language is indispensable for communicating the totality of one's experiences and distress.

Uncommunicated experience tends to lead to emotional isolation - a sense of being forsaken and no longer part of the human race. In contrast, feeling understood and amplifying what one knows and understands by communicating with others (in this case the therapist) is one of the great joys of being human.

Putting an experience into words is one way in which people can regain the capacity to imagine alternative outcomes, besides the disaster of the trauma. Of course, the study of how children process upsetting experiences has taught us that drawing and play acting are their preferred mode of coping with distressing experiences and child therapists have learned those lessons well and applied them in their consulting rooms. Some imaginative therapists who work with traumatized adults have successfully adapted those techniques for work with their adult patients.

Over time, as patients learn to recount what is happening in their lives and how they feel about it, they come to understand how they engage in repetitive patterns of distress, failure to communicate, and maladaptive behaviors such as self-mutilation, use of alcohol and drugs, impulsive aggressive and sexual behaviors as ways of dealing with specific trauma-related sensations, affects and impulses. Learning how to observe themselves, they come “own” these reactions as occurring in response to certain actions and reactions to and by bosses, co-workers, lovers, children and the therapist, but that changing the behaviors of the people who precipitate these reactions cannot set them free from their own exaggerated responses. Understanding these patterns of distress and making connections between internal states and self-destructive ways of coping with them is the essence of dynamic psychotherapy. Understanding how these patterns are often rooted in ways of coping with an unresolved past helps identify particular sensations which remain in need of further “processing.”

Trauma Processing

The key aspects of the treatment of traumatic memories are described differently by different therapeutic schools. Most clinicians and researchers believe that, in order for traumatic memories to lose their emotional valence, the patients must be confronted with new information that is incompatible with the rigid traumatic memory. According to Rothbaum and Foa (1996), two conditions are required for the reduction of fear, and hence for the treatment of PTSD: 1) The person must attend to trauma-related information in a manner that will activate his/her own traumatic memories and 2) the context needs to directly contradict major elements of the trauma, such as feeling safe. The decrease of fear or anxiety depends on the controlled and coordinated evocation of (a) environmental trauma-related cues, (b) the sensory and motoric responses, and (c) the meaning of the traumatic memory. Thus, the critical issue is to re-expose the patient to an experience that contains elements that are sufficiently similar to the trauma to activate it, and at the same time contains aspects that are incompatible enough to

change it. This eventually is supposed to lead to desensitization. Other chapters in this volume have demonstrated that this technique can be helpful for many traumatized individuals.

Exposing trauma victims too directly to their memories runs the risk of precipitating hyperarousal and sensitization, a common clinical occurrence that was well documented in Pitman et al's research on exposure treatment (1991). Thus, treatment should avoid the full-blown re-activation of the pain, dissociation and helplessness associated with the trauma, in general, and of earlier interpersonal betrayal within the therapeutic relationship, in particular. Effective treatment should minimize the time spent on re-living the past and its concomitant emotional devastation, and help patients to be fully present in the here now, without the residual dissociation and/or hyperarousal characteristic of PTSD.

In our Clinic we principally use EMDR to help patients "process" their traumatic memories. We also use EMDR for "resource installation", by amplifying memories and sensations of safe or pleasant experiences in the patient's mind. Despite its unconventional method, EMDR has been the subject of controlled studies involving well over 200 subjects, more than any single psychopharmacological or psychological intervention for PTSD (Chemtob et al., 2000). EMDR is predicated on the notion that experiences are stored in memory networks which are organized by affect, and which contain related memories, thoughts, images, emotions, and sensations. The storage of traumatic information is fragmentary and usually intensely distressing. It is thought that EMDR facilitates rapid adaptive, associative information processing by integrating sensations, affects and self-attributions. In this way, it may share some of the same qualities as REM sleep, which has been posited to help process distressing day-to-day experiences (Stickgold, 1999). However, at this point there is no scientific evidence of "why" EMDR works.

There are several advantages of using EMDR over the more conventional exposure techniques. These include the fact that it is easier to "dose": the moment that a patient experiences emotional arousal he or she is asked to "stay there", and "process" the memory while engaging in eye movements. This helps the patient avoid the extremes of physiological arousal which so often accompanies full blown exposure therapy. By tracking merely emotional shifts and asking the patient to name the somatic sensations that accompany those shifts, one permits the patient to not communicate precisely what is upsetting. Being able to avoid telling what is going on has major advantages. Trauma, by definition involves "speechless terror": patients often are simply unable to put what they feel into words, and are left with intense emotions simply without being able to articulate what is going on. For many traumatized

individuals the experience is contaminated by shame and guilt that may keep them from wanting to communicate what they are thinking. Respecting the patients' privacy while still being able to process the associated memories takes away the potential of an unnecessary voyeuristic element in the therapeutic relationship.

Flooding and exposure are by no means harmless treatment techniques: exposure to information consistent with a traumatic memory can be expected to strengthen anxiety (i.e. sensitize and thereby aggravating PTSD symptomatology). Excessive arousal may make the PTSD patient worse by interfering with the acquisition of new information (Strian & Klicpera, 1978). When that occurs, the traumatic memories will not be corrected, but merely confirmed: instead of promoting habituation, it may accidentally foster sensitization.

Conclusions

Given the prevalence of chronic complex trauma in psychiatric patients it is astounding how little research has been done on this population. Much of the existing knowledge comes from a re-framing of the diagnosis of Borderline Personality Disorder as a disorder related to childhood abuse and neglect (Herman et al., 1989; Zanarini et al., 1997). Most research on the treatment of that disorder, such as that conducted by Marsha Linehan, has largely ignored the traumatic origins of BPD, and, instead, focused on symptom stabilization. Research on BPD has carried much of the same stigma that has always accompanied research on hysteria, the historical precursor of both BPD and Complex PTSD. In fact, much of our current understanding of the treatment of this disorder has its origin in the writings on hysteria by Janet (1889, 1921) and Freud (1893, 1896). Both of these early clinicians placed the traumatic origins of this disorder central in their treatment approaches. Both ran onto considerable opposition and academic difficulties while studying the best treatments for these patients. Janet persisted and went into oblivion, Freud disavowed the study of trauma and became the defining figure of 20th century psychiatry. Clearly, while the study of war neuroses, motor vehicle accidents, hurricanes and other non-interpersonal traumas has become respectable, investigating that darkest side of human nature: our capacity to horribly abuse and neglect our own offspring and intimates, continues to be rife with controversy.

Because so little systematic research has been done on these patients, many questions remain about what constitutes optimal treatment. Some writers (McCann & *Pearlman*, 1992; Herman, 1992) emphasize the importance of a restorative therapeutic relationship, while others (e.g. van der Kolk, 1996) have been concerned about re-enactment of traumatic relationships within the therapy and emphasize building coping skills, the formation of loose associations (in

which a particular sensation loses its power to evoke entire traumatic scenes and the patient learns to attach new meanings to old sensations) and the “processing” of traumatic memories. Maybe what is most important for these patients is to learn to have a subjective sense of mastery and competence that will allow them to live in the present without being constantly pulled back into experiencing the present as a recurrence of the past.

Clearly, now that the long term psychological and biological consequences of early interpersonal trauma are beginning to be spelled out in as much detail as they have in the past few years, the need for adequate treatment outcome research has become critical. Up till now, very little funding has been available for such research, leaving the field to rely on clinical wisdom and vehement doctrinal disagreements.

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