Complex PTSD in Survivors of Prolonged and Repeated Trauma

Read more at http://www.experts.com/Articles/Complex-PTSD-in-Prolonged-Repeated-Trauma-Survivors-By-Michael-Perrotti#BIWUR06kh4wr8tO3.99 All too often one sees survivors of abuse all categorized under the rubric of posttraumatic stress disorder (PTSD). As Herman, in a paper on complex PTSD, notes (1992), PTSD formulation fails to capture the sequelae, acuity, and severity of prolonged, repeated trauma. This is trauma with respect to individuals who have been in a state of captivity or unable to flee and under the control of the perpetrator. It can apply to sexual and physical abuse as well as intimate-terror violence. Examples of such conditions include prisons, concentration camps, slave-labor camps. The factor of coercive control, which brings the victim into prolonged contact with the perpetrator, is very significant. One frequently sees this in cases of continuous sexual abuse. Gelinas (1983) talks about the disguise presentation of survivors of childhood sexual abuse as patients with chronic depression with dissociative symptoms, substance abuse, impulsivity, self-mutilation, and suicidality. Gelinas conceptualizes sequelae of prolonged childhood abuse as a severe posttraumatic syndrome including affect dysregulation, dissociative states, ego fragmentation , reenactment of revictimization, and suicidality.

Chronically traumatized individuals are hypervigilant, anxious, and agitated without any recognizable baseline state of calm or comfort. One frequently sees them in the office, and they present with chronic depression frequently unable to identify triggers. Moreover, they give a history of suicidal thoughts and/or homicidal thoughts. They are in distress and frequently at a loss in terms of their identity in terms of selfdefinition. Herman speaks of survivors of prolonged childhood abuse characterized as staggering psychological losses resulting in tenacious states of depression. These are individ als who prior to the trauma had been functioning well in school and with their families and in society. Subsequent to the PTSD, there is chronic hyperarousal and intrusive symptoms, in what Niederland calls the "survivor triad" of insomnia, nightmares, and psychosomatic complaints. Dissociative symptoms of PTSD merge with the concentrative difficulties of depression and the paralysis of initiative of chronic trauma combines with the apathy and helplessness of depression. The disruptions and attachments of chronic trauma reinforce the isolation and withdrawal of depression. The loss of faith suffered in chronic trauma merges with the hopelessness of depression.

This writer sees this symptomatology and syndromes as also applicable to the returning veterans from Iraq and Afghanistan as well as returning POWs. Epidemiological studies of returned POWs consistently document increased mortality as a result of homicide, suicide, and suspicious accidents (Segal et al. 1976). Studies of battered women similarly report a tenacious suicidality, and in one clinical series of 100 battered women, 42% had attempted suicide (Gayford 1975). Unfortunately, the connection with trauma is frequently lost and they are treated as primarily depressive patients.

The methods of coercive control destroy the victim 's sense of self in relation to others and foster a pathological at that time to the perpetrator who seeks to destroy the victims sense of autonomy.

Repetitive phenomena have been widely noted to be sequelae of severe trauma. This topic has been recently reviewed by van der Kolk (1989), who will be discussed later in this article. After prolonged and repeated trauma by contrast survivors may be at risk for repeated harm, either self-inflicted or at the hands of others. Victims of intimate terror or violence frequently return to the perpetrators. Children who have been victims of sexual abuse grow up and develop with nihilistic senses of self, of chronic

depression, of hopelessness and helplessness for their future and frequently are victims of attempted suicide and self-mutilation. The compulsive form of self-injury appears to be strongly associated with a history of prolonged and repeated trauma.

Van der Kolk (2001) discusses PTSD and notes that a majority of traumatized treatment-seeking patients suffer from a variety of psychological problems not included in the diagnosis of PTSD (i.e., depression, self-hatred, dissociation, depersonalization, aggressive behavior against self and others, problems with intimacy, and impairment in the capacity to experience pleasure, satisfaction, and "fun"). Van der Kolk (1996) discusses the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) field trials and notes that they demonstrated it was not the prevalence of PTSD symptoms themselves but depression, outbursts of anger, self-destructive behavior, feelings of shame and distrust that distinguished the treatment-seeking sample from the non-treatment-seeking community sample with PTSD. Seventy-seven percent of trauma-centered patients suffered from significant dysregulation of affects and impulses, including aggression against self and others, 84% suffered from depersonalization, and 75% were plagued by chronic feelings of shame. It is tragiC that the victims who have been victimized blame themselves, and they indeed are the repositories of unspeakable psychological damage.

Van der Kolk (2001) tells us that PTSD is a diagnosis that was constructed in response to a social demand-delineated syndrome to capture the psychological suffering experienced by many Vietnam combat veterans. Prior to creation of the diagnosis (PTSD), other posttraumatic syndromes have been proposed, such as "rape trauma syndrome" (Burgess and Holstrom 1974).

There is little indication that children outgrow these early problems. Indeed there is attachment disruption, and the damage done to interpersonal relationships plays a significant role in preventing the children from leading satisfying lives and engaging in competent social relationships.

Van der Kolk (2001) discusses the disorders of extreme stress, which have characteristics such as impairment of affect regulation and chronic self-destructive behavior, including eating disorders, drug abuse, amnesia, dissociation, alterations in relation to self, distorted relations with others, loss of sustaining beliefs. In individuals with disorders of extreme stress (DES NOS), the DSM-IV field trial of PTSD found that DES NOS 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 DES NOS diagnosis. Interpersonal trauma, especially childhood abuse, predicts a higher risk for developing DES NOS than accidents and disasters.

Recommendations for Assessment: It is strongly recommended to clinicians that they consider these factors in assessment of traumatized patients, realizing that these patients can frequently present for assessment with straight-up symptoms of depression and/or simple PTSD. Moreover, with treatment approaches, therapists who treat chronically traumatized patients need to develop a keen appreciation of how trauma is reenacted in these patients' lives. In contrast to trauma such as motor vehicle accidents (MVAs) and torture, childhood abuse occurs as a part of everyday life. Thus, for people who have been abused as children, seemingly innocuous experiences (i .e., harmless sounds) and physical sensations may become triggers of extreme emotional distress, especially when triggered by traumatic reminders from the past.

Van der Kolk (2001) recommended that all treatment of traumatized individuals needs to be paced according to the degree of involuntary intrusion of the trauma. Indeed, recent research in the area of PTSD and trauma notes that repeated-exposure therapy actually is harmful to individuals because it prevents them from reconsolidating and reintegrating .

Eighty percent of traumatized children have disorganized attachment patterns. This interferes with their capacity to regulate physiological states that manifest themselves in chronic patterns of hypo- and hyperarousal. Moreover, these individuals have poor experience in functioning in intimate relationships. The literature on sexual offending notes that later in their lives this proves to be a major impairment in that

these individuals relate to others physically because they do not know how to function in intimate relationships and thus end up getting into trouble in the legal system. These individuals tend to lack nuance responses to frustrations and go out of control in the face of stress with excess anger and impulsivity. This writer has seen individuals strike themselves and strike objects, inflicting great damage upon their bodies. They have little control over these reactions.

Need for Neurobiological Emphasis in Treatment: This writer proposes that protocols that address PTSD and childhood trauma and abuse draw more upon the fields of neurology and psychopharmacology. Indeed, neuroleptics need be considered in addition to psychiatric medicines. Neuroleptics would act on the neurobiological damage to the brain as evidenced by trauma and PTSD to brain functioning. Thus, it would more directly affect the sequelae stemming from neurobiological changes in brain functioning from PTSD and complex PTSD. All too frequently these individuals are seen as suffering from depression and a diagnosis is made solely of depression and major depression and individuals do not recognize other aspects of pathological functioning such as have been discussed in this paper on complex PTSD and DES NOS. Consideration of neuroleptic medications would more accurately "target" the areas of cognitive and neuropsychological deficits stemming from PTSD and complex PTSD and DES NOS.

Conclusions: There is a large population of individuals in society through slave trafficking, intimate terror violence, physical and sexual abuse, as well as individuals subjected to other forms of coercive control who have been treated under the diagnosis of major depression and/or simple PTSD. This paper proposes to educate practitioners about the need to address the neurobiological aspects of PTSD and, more importantly, complex PTSD and the vastly different symptom constellations stemming from these disorders as opposed to Simple PTSD and major depression. This may very well result in more robust treatment and offer hope and healing for victims of chronic, repetitive abuse as well as individuals who have been subject to coercive control. This is the very least that our profession can offer to these individuals who have been so damaged by traumatic experiences.

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