Section 7. Trauma and the Individual 1 - Scope

This document is one of 24 sections that make up the proposal to form TRISI. The other sections can be found at: http://www.ptgrr.com/trisi/about/trisi

Reference: Brian Rogers. Trauma & Resilience-Informed Solutions Institute of Southern Africa – Proposal of a Trauma-Activist; PTG-RR; Sep 2015/7

This proposal is a living discussion platform. The answers do not lie in one person’s mind. Its objective is to attract enabling-capital which includes intellectual contribution and financial support. Should you wish to participate, please visit the TRISI webpage. Furthermore, it is not in any way intended to presume scientific validity. The style, or method, is argumentative and documentary. It lacks academic skills which include the traditional representation of sources. Full acknowledgement is given at the point of disclosure so that the reader can identify the source and seek its original in order to explore further.

Trauma and the Individual 1 - Scope

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10. Re-Traumatisation
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“The small little insect that works so tirelessly and quietly around us certainly is one of the reasons, if not a main reason, for the possibility of human development on earth.”
CC Pollen Co The Importance of Bees
http://www.beepollen.com/the-importance-of-bees/

‘The “night sea journey” is the journey into the parts of ourselves that are split off, disavowed, unknown, unwanted, cast out, and exiled to the various subterranean worlds of consciousness.... The goal of this journey is to reuniite ourselves. Such a homecoming can be surprisingly painful, even brutal. In order to undertake it, we must first agree to exile nothing.’ - Stephen Cope
Van der Kolk, B. M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking

“In a strange way, perpetual change brings its own rewards. You can be serene in the knowledge that while you are looking right, you will be smacked from the left. The time to be truly nervous is when things keep going exactly to plan.”
John Hunt and Sam Nhlengethwa; the art of an idea – and how it can change your life; Zebra Press; 2009
Notes:

1. This section, like all the others is prepared in such a way that the experts in their fields primarily tell the story. The sources are clearly displayed and the reader can seek them out for further interrogation of the subject matter.

2. For a more complete understanding of Trauma and the Individual this section should be read in conjunction with Section 8. Trauma and the Individual 2 – Diagnostics.

Trauma and Stress have become extremely complicated concepts in the psych fields. This is entirely unnecessary, a frustration to any customer wanting Trauma education and a barrier to public discourse. Sections 8 attempts to unravel the Gordian Knot. From Necessary Stress to Developmental Trauma and Dissociation, hopefully the reader will have a better understanding of how Trauma affects body, mind and brain. Thereafter the impact on people’s lives is explored through Re-Traumatisation and Masking Trauma.

The Biological Mechanisms of Stress & Trauma

The Brain

*The Committee on Nomenclature and Statistics of the American Psychiatric Association; Diagnostic And Statistical Manual, MENTAL DISORDERS; American Psychiatric Association Mental Hospital Service; 1952*

‘Despite resistances and long-lasting internal conflicts (about which Kandel has offered very lucid reflections (Kandel 1998)), the identity of American psychiatry has been constructed by reaffirming a very old conviction that appears throughout the history of psychiatry: mental disorders are first and foremost brain diseases. This is indeed how American psychiatry is most usually perceived in the rest of the world.’

*Michele Rosenthal; The Science Behind PTSD Symptoms: How Trauma Changes The Brain; PsychCentral; September, 2015*

‘After any type of trauma (from combat to car accidents, natural disasters to domestic violence, sexual assault to child abuse), the brain and body change. Every cell records memories and every embedded, trauma-related neuropathway has the opportunity to repeatedly reactivate. Sometimes the alterations these imprints create are transitory, the small glitch of disruptive dreams and moods that subside in a few weeks. In other situations the changes evolve into readily apparent symptoms that impair function and present in ways that interfere with jobs, friendships and relationships.

One of the most difficult aspects for survivors in the aftermath of trauma is understanding the changes that occur, plus integrating what they mean, how they affect a life and what can be done to ameliorate them. Launching the recovery process begins with normalizing post-trauma symptoms by investigating how trauma affects that brain and what symptoms these effects create.’

The 3-Part Brain

‘The Triune Brain model, introduced by physician and neuroscientist Paul D. MacLean, explains the brain in three parts:

- **Reptilian (brain stem):** This innermost part of the brain is responsible for survival instincts and autonomic body processes.
- **Mammalian (limbic, midbrain):** The midlevel of the brain, this part processes emotions and conveys sensory relays.
Neommalian (cortex, forebrain): The most highly evolved part of the brain, this area outer controls cognitive processing, decision-making, learning, memory and inhibitory functions.

‘During a traumatic experience, the reptilian brain takes control, shifting the body into reactive mode. Shutting down all non-essential body and mind processes, the brain stem orchestrates survival mode. During this time the sympathetic nervous system increases stress hormones and prepares the body to fight, flee or freeze.’

‘In a normal situation, when immediate threat ceases, the parasympathetic nervous system shifts the body into restorative mode. This process reduces stress hormones and allows the brain to shift back to the normal top-down structure of control.

However, for those 20 percent of trauma survivors who go on to develop symptoms of post-traumatic stress disorder (PTSD) — an unmitigated experience of anxiety related to the past trauma — the shift from reactive to responsive mode never occurs. Instead, the reptilian brain, primed to threat and supported by dysregulated activity in significant brain structures, holds the survivor in a constant reactive state.’

The Dysregulated Post-Trauma Brain

The four categories of PTSD symptoms include: intrusive thoughts (unwanted memories); mood alterations (shame, blame, persistent negativity); hypervigilance (exaggerated startle response); and avoidance (of all sensory and emotional trauma-related material). These cause confusing symptoms for survivors who don’t understand how they’ve suddenly become so out of control in their own minds and bodies.

Unexpected rage or tears, shortness of breath, increased heart rate, shaking, memory loss, concentration challenges, insomnia, nightmares and emotional numbing can hijack both an identity and a life. The problem isn’t that the survivor won’t “just get over it” but that she needs time, help and the opportunity to discover her own path to healing in order to do so.

Throughout the brain several chemical and biological imbalances can present after trauma. Their effects are especially exacerbated by three major brain function dysregulations:

- **Overstimulated amygdala:** An almond-shaped mass located deep in the brain, the amygdala is responsible for survival-related threat identification, plus tagging memories with emotion. After trauma the amygdala can get caught up in a highly alert and activated loop during which it looks for and perceives threat everywhere.

- **Underactive hippocampus:** An increase in the stress hormone glucocorticoid kills cells in the hippocampus, which renders it less effective in making synaptic connections necessary for memory consolidation. This interruption keeps both the body and mind stimulated in reactive mode as neither element receives the message that the threat has transformed into the past tense.

- **Ineffective variability:** The constant elevation of stress hormones interferes with the body’s ability to regulate itself. The sympathetic nervous system remains highly activated leading to fatigue of the body and many of its systems, most notably the adrenal.


‘Over the past two decades, researchers have used various kinds of imaging techniques to peer inside the brains of trauma victims. These studies report that in people with PTSD, two areas of the brain that are sensitive to stress shrink: the hippocampus, a deep region in the limbic system important for memory, and the anterior cingulate cortex (ACC), a part of the prefrontal cortex that is involved in reasoning and decision-making. Functional magnetic resonance imaging (fMRI), which tracks blood flow in the brain, has revealed that when people who have PTSD are reminded of the trauma, they tend to have an underactive prefrontal cortex and an overactive amygdala, another limbic brain region, which processes fear and emotion.’

‘People who experience trauma but do not develop PTSD, on the other hand, show more activity in the prefrontal cortex. In August, Kerry Ressler, a neuroscientist at Emory University in Atlanta, Georgia, and his colleagues showed that these resilient individuals have stronger physical connections between the ACC and the hippocampus. This suggests that resilience depends partly on communication between the reasoning circuitry in the cortex and the
emotional circuitry of the limbic system. “It’s as if [resilient people] can have a very healthy response to negative stimuli,” says Dennis Charney, a psychiatrist at the Mount Sinai School of Medicine in New York, who has conducted several brain-imaging studies of rape victims, soldiers and other trauma survivors.’

University Of Oxford; Traumatic experiences change the brain — even in those without PTSD; PSYPOST; AUGUST 4, 2015
‘Trauma may cause distinct and long-lasting effects even in people who do not develop PTSD (post-traumatic stress disorder), according to research by scientists working at the University of Oxford’s Department of Psychiatry. It is already known that stress affects brain function and may lead to PTSD, but until now the underlying brain networks have proven elusive. Led by Prof Morten Kringelbach, the Oxford team’s systematic meta-analysis of all brain research on PTSD is published in the journal Neuroscience and Biobehavioural Reviews.’

E.A. Stark, C.E. Parsons, T.J. Van Hartevelt, M. Charquero-Ballester, H. McManners, A. Ehlers, A. Stein, M.L. Kringelbach; Post-traumatic stress influences the brain even in the absence of symptoms: A systematic, quantitative meta-analysis of neuroimaging studies)
‘The team separated studies by type of control group: trauma-exposed (those who had experienced trauma but did not have a diagnosis of PTSD) and trauma-naive (those who had not experienced trauma), and compared the individuals with PTSD to both groups. This yielded an insight into how the abnormalities in functional brain activity in PTSD comprise a whole-brain network.’

‘The analysis showed that there were differences between the brain activity of individuals with PTSD and that of the groups of both trauma-exposed and trauma-naive participants.’

‘This suggests that even in the absence of symptoms, trauma may have an enduring effect on brain function. Critically, the research found that in parts of a region of the brain called the basal ganglia, brain activity was different when comparing people with PTSD to the trauma-exposed group.’

“Crucially, the meta-analysis has identified the need to directly compare trauma-exposed and trauma-naive groups to identify potential biomarkers that could help early diagnosis and potentially novel treatments for PTSD.’

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 20
‘The brain-disease model overlooks four fundamental truths:
1. Our capacity to destroy one another is matched by our capacity to heal one another; Restoring relationships and community is central to restoring well-being;
2. Language gives us to the power to change ourselves and others by communicating our experiences, helping us to define what we know, and finding a common sense of meaning;
3. We have the ability to regulate our own physiology, including some of the so called involuntary functions of the body and the brain, through such basic activities such as breathing, moving, and touching; and
4. We can change the social conditions to create environments in which children and adults can feel safe and where they can thrive.’

Patience Mason; A Short History of PTSD; http://www.patiencepress.com/documents/A%20short%20History%20of%20PTSD.pdf
‘The current fad for brain chemistry explanations of everything is a pet peeve of mine particularly as it relates to PTSD. Although soldiers have been saying for centuries that war changed them, the American Psychiatric Association used to say, "No it didn’t!" Now the conventional wisdom is "It changes you, and you’ll have to take these pills forever." I can’t agree. New discoveries in brain plasticity show you can develop new skills, new neurons, and probably change your brain chemistry.’

‘Trauma physically changes the structure of your brain. Recent studies show your brain can change and grow at any age. Being in an unfamiliar environment and learning new things helps your brain grow. So getting into a new kind of therapy and/or learning new tools may be just what you need.’

Pat Brocken; Towards a hermeneutic shift in psychiatry; World Psychiatry 13:3 - October 2014
‘I do not believe that we will ever be able to explain the meaningful world of human thought, emotion and behaviour reductively, using the “tools of clinical neuroscience”. This world is simply not located inside the brain. Neuroscience offers us powerful insights, but it will never be able to ground a psychiatry that is focused on
interpretation and meaning. Indeed, it is clear that there is a major hermeneutic dimension to neuroscience itself. A mature psychiatry will embrace neuroscience but it will also accept that “the neurobiological project in psychiatry finds its limit in the simple and often repeated fact: mental disorders are problems of persons, not of brains. Mental disorders are not problems of brains in labs, but of human beings in time, space, culture, and history.”

**Neuro-Plasticity**

“The brain is neither predetermined nor unchanging, But rather is an organ of adaptation”. Louis Cozolino

Kezelman, C., Stavropoulos, P. Adults Surviving Child Abuse (ASCA) 2012; Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘Understanding of brain neuroplasticity reveals the devastating and long-term effects of unresolved trauma. This is for individuals, families and society as a whole. But it also reveals the corollary of this – that new, different, and positive experiences can activate positive neurological change and pathways to recovery. As Bloom and Farragher argue, understanding the psychobiology of trauma ‘restores context to what has increasingly become a decontextualised meaning framework in mental health, substance abuse, and other service practice’. If the sources of so much dysfunction and distress lie in adverse childhood experiences which are highly prevalent, this requires reconfiguration of both our conceptual frameworks and current ways of operating.

‘The exciting corollary of the now recognised neuroplasticity of the brain is that neural growth and change can occur across the lifespan. This possibility was precluded by previous readings of the ‘fixed’ brain, according to which less than optimal brain functioning might be compensated for but could not be modified. What is now termed ‘the social brain’ is built over time. But a ‘critical’ or ‘sensitive’ period occurs very early in life, between the ages of eighteen and twenty four months, via attunement between the right brain hemisphere of the caregiver and the right brain hemisphere of the child.’

‘The right hemisphere of the brain (variously termed the ‘right’ or ‘emotional’ brain) is contrasted with the left hemisphere (popularly known as the ‘left’, ‘cognitive’ or ‘thinking’ brain). Dominant in the early years of life, the right brain hemisphere is also linked to pre-verbal experience. Right-brain functioning is critical in ways that extend well beyond initial understandings of it, and which can Insights from the new field of affective neuroscience (‘interpersonal neurobiology’; ‘the neurobiology of attachment’) which focus specifically on development of self and identity in the context of early emotional (attachment) relationships need to inform all current work in relation to complex trauma. This includes updated understanding of the legacy of child abuse, and revised guidelines for service-provision to survivors of it. The extent to which emotional and psychological experience can now be physiologically correlated with neurological functioning represents enormous opportunities for revised practice across a range of disciplines and services. Yet it needs to be reiterated that while novel in its utilisation of technological advances unavailable to previous eras, contemporary neuro-scientific research also bears out key insights of early work on trauma. This includes aspects of the pioneering and multi-layered work of Freud, who is now credited as having laid important scientific and neurological groundwork. That subjective experience can now be objectively correlated in the brain constitutes a research innovation of major proportions, the many implications of which are now beginning to unfold.

**Beyond the Brain**

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 20

After trauma the world is experienced with a different nervous system. The survivor’s energy now becomes focused on suppressing inner chaos, at the expense of spontaneous involvement in their lives. These attempts to maintain control over unbearable physiological reactions can result in a whole range of physical symptoms, including fibromyalgia, chronic fatigue, and other autoimmune diseases. This explains why it is critical for trauma treatment to engage the entire orgasm, body, mind and brain.
Our work has obliged us to study emotions in depth. When one is sad, it’s not something that affects an ear or a foot; it runs through the whole body. Emotion is energy in motion. That’s why fury can make the entire body go rigid. The emotions resulting from being wounded, from trauma, which are rage, sadness, fear and guilt, automatically generate bodily changes. The body is wise and uses these changes to invite us to express the emotion. Emotion is a sign that we’re alive. When we feel sad about having lost something or someone, that sadness is a sign of life. When people acknowledge pain, sadness or some other profound emotion, they usually give themselves the time needed to digest it, and when they express and reflect on it, the emotion continues its normal course, eventually dissipating. But when that acknowledgement is blocked for whatever reason, the emotions—which have an impact on the immune system, the neurological system, the circulatory system, the whole body—trigger physiological changes in blood pressure, temperature, digestion, and end up making us ill. There’s always a tight relationship between the illnesses we suffer and the emotions we repress.’

The biological mechanisms that help us in the short run, it turns out, aren’t so useful when the stress grinds on for weeks or months.

McEwen, who wrote The End of Stress As We Know It, says often people find ways to tolerate that stress. But it can also be overwhelming, "and then, we have something that’s been called toxic stress," he says.

The stress system gone awry can literally make you sick.

"When stress is sustained or repeating or extreme, then all [the usual systems] gets disrupted," says Huda Akil, co-director of the Molecular and Behavioral Neuroscience Institute at the University of Michigan. "And eventually, you do it long enough and it starts impacting other systems ... immune responses; it can affect the heart; it affects brain cells. It depends how long we’re talking about."

A lot of stress can be very disruptive," Akil says. "But a little bit of stress is kind of like working your muscles, your emotional muscles. And you build them up and you learn how to cope. So this is not something that’s irretrievably wired to be bad or good. It can be retuned and fine-tuned, and it’s never too late."

Stress is, at root, a mechanism for adapting to changing circumstances. So when a challenging situation inevitably appears, the trick is to get the stress reaction to work to your advantage.

Stress is the process through which environmental demands tax or exceed the adaptive capacity of an organism, resulting in distress. Distress may manifest as psychological and/or biological changes that place individuals at risk for disease. Hans Selye defined stress as “the nonspecific response of the body to any demand,” and stated that distress occurs when stress is overwhelming or persistent and not dealt with in a positive manner. Related to stress is the stress response, described by Walter B. Cannon as the “fight-or-flight” response, which is a cascade of coordinated physiological changes that occur when animals, including humans, perceive threat.’

‘It is helpful to understand the biological mechanics of stress or trauma in order to understand their nature and impact. How does trauma affect our body and why? Given the same situation, why is one person traumatized but another is not? When a person has stress or experiences a traumatic event, chemical and biological processes take place.’

Our stress response is controlled by our Autonomic Nervous System (ANS). The ANS is in charge of preparing our body for flight, fight or freezing when there is a perceived threat. Imagine yourself in a stressful situation. What are some of the body changes that occur? Increased heartbeat, cold hands, dry mouth and tensing of muscles are all directed by your ANS.

During a traumatic event the ANS activates the victim towards fight, flight or freeze. Service providers working with highly stressed or traumatized individuals are also vulnerable to an ANS response (Rothschild, 2006).
Our ANS has two branches, the Sympathetic Nervous System (SNS) and the Parasympathetic Nervous System (PNS). They work together to promote survival of the individual and to maintain balance in the body. The SNS activates under conditions of stress, such as traumatic stress at the most extreme. The PNS is activated during rest and relaxation, and during distress such as sadness (Rothschild, 2006).

When a threat is perceived, the SNS is the primary system aroused and the body reacts quickly. Pupils dilate, heartbeat increases and blood flow is redirected from the skin to the muscle, digestion stops, oxygen supply increases and the body readies for fight or flight. When the threat is over, the PNS takes over helping the body return to a calm relaxed state.

When there is extreme life-threatening danger, the SNS and PNS can both be activated to their highest level, causing the body to freeze, like a deer caught in the headlights. The person experiencing freezing has an altered perception of time and space, and feels less pain and emotion. Time slows down and they are no longer afraid. Freezing can be viewed as an extremely valuable survival defense in some conditions (Rothschild, 2006).

This threat perception and response occurs at the unconscious level and is not subject to a cognitive or rational process. Personality, emotional content, experiential background, beliefs and internal resources play a large role in determining the perception of threat or danger. This explains why two people in the same situation can have very different reactions.’

Dr. Kauffmann, CCFP, FCFP; Strategies for coping with stress and building personal resilience for physicians; OMA Physician Health Programme;

“B” is for Body Homeostasis. “B” might also stand for biology, and the biology of stress is interesting. Consider first the concept of homeostasis, the maintenance of the internal physiological environment of an organism within healthy limits.

Homeostasis means that we eat when hungry, drink when thirsty, sleep when tired, and so on. Thus we are restored. This is the physiology of our regular patterns, routines and diurnal variations — the baseline biochemical “hum” of existence. Homeostatic processes and mechanisms have been long studied and are well understood.’

**Allostasis**

‘But what happens when we don’t eat when hungry, or fail to sleep when tired?’

A newer concept is that of allostasis. The body adapts to potentially diverse and dangerous situations through the activation of neural, hormonal, or immunological mechanisms. Liberation of cortisol and adrenaline are just two such stress responses. The problem is that the organism is fatigued and otherwise stressed by such an attempt to deal with “danger” (which might be only skipping meals on a very busy day).

Allostasis is the combined physiological and psychological adaptation to adversity and threats which creates wear and tear upon the organism. Allostatic responses are mediated by the brain and nervous system, but probably affect every cell and system within the body. When allostatic challenges are few, the body has time to recover and return to a healthy homeostatic state. When the individual is challenged repeatedly, or when the allostatic systems remain turned on when no longer needed, the mediators of allostasis can produce a wear and tear on the body that has been termed “allostatic load.”


‘Although most people, () recover from trauma, some never do. Some scientists are seeking explanations for such differences in the epigenome, the chemical modifications that help to switch genes on and off (). Others are looking in the genes themselves. Take, for example, FKBP5, a gene involved in hormonal feedback loops in the brain that drive the stress response. In 2008, Ressler and his colleagues showed that in low-income, inner-city residents who had been physically or sexually abused as children, certain variants in FKBP5 predisposed them to developing PTSD symptoms in adulthood. Other variants offered protection.’

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 20

‘The body keeps the score. If the memory of trauma is encoded in the viscera, in heart-breaking and gut wrenching emotions, in autoimmune disorders and skeletal/muscular problems, and if mind/brain/visceral communication is the royal road to emotion regulation, this demands a radical shift in our therapeutic assumptions.’
Good Stress, Bad Stress

“The forces of fate that bear down on man and threaten to break him also have the capacity to ennable him” Victor Frankl

Robert-Paul Juster; From Stressed Neurons to Resilient Neighborhoods: Discussion with Drs. Ilia N. Karatsoreos and Bruce S. McEwen; Mammoth Magazine; Issue 13; Summer 2013.

‘Stress is notoriously unpopular. It is generally expressed or exclaimed negatively and almost never espoused or embraced positively. Can stress be good for us? After all, an adrenalin rush has its’ advantages, sometimes even delightfully so for daredevils and sensation-seekers. Stress also kept our ancestors sharp so they could continue breathing and breeding. Today, we no longer ‘fight-or-flee’ from mammoths like we used to, and yet here we are stressing out about our hostile boss, saved or spent money, conflicts and clashes, economic crises, and countless varieties of relatively mundane stressors. In the grand scheme of things, such stressors rarely threaten our survival, so why are we still so stressed out? Maybe stress in today’s modern societies is merely an evolutionary hick-up leftover from our ancestral programming. True, our brain has not changed much in the last 10,000 years, so perhaps we’re just wired to react as if saber-toothed tigers were still around. Is stress merely a repugnant residue forever part of our biological baggage? Or maybe stress has stuck around for the right reasons so we can thrive. Could stress therefore be our ally rather than our enemy?’

@INeedMotivation 4 Reasons Why You Need Stress!

‘So much has been said about how stress is like the black plague, and it’s all bad and we should all do whatever is necessary to get rid of all stress from our lives. Truth is, stress can be a vital benefit to your life. Under the right circumstances, stress can be your best friend!’

Productivity

‘Short bursts of stress can really lit a fire under you! Whenever you feel some stress about finishing a certain task, it can create the right inspiration to get you going.’

Competition

‘Anyone that’s ever played a sport knows that feeling those butterflies in your stomach and feeling anxious to getting out there and win is absolutely necessary to succeed. If you don’t get those butterflies, you don’t belong in the game!’

Health

‘We all know the damage that long bouts of stress can do to one’s life. It’s the cause of a vast array of cancers and diseases, as well as making us age faster. However, short bursts of stress can actually be good for your health. As a matter of fact, it is vital to your well being. Research has shown that it can strengthen your immune system and prevent against such diseases as Alzheimer’s, in that it keeps your brain cells working at peak capacities. It has also been shown that patients who experience moderate levels of stress recover faster after surgery than patients experiencing higher or lower levels of stress. The key term here is “moderate”. We require stress for our bodies to function properly, physiologically speaking, but just like with anything, too much of it and the opposite effect takes place.’

Richard Harris Like All Animals, We Need Stress. Just Not Too Much; npr; JULY 09, 2014; HTTP://WWW.NPR.ORG/SECTIONS/HEALTH-SHOTS/2014/07/09/325216030/LIKE-ALL-ANIMALS-WE-NEED-STRESS-JUST-NOT-TOO-MUCH

‘Ask somebody about stress, and you’re likely to hear an outpouring about all the bad things that cause it — and the bad things that result. But if you ask a biologist, you’ll hear that stress can be good. In fact, it’s essential.'
For example, the adrenal glands of all animals have evolved to pump out stress hormones in unexpected situations — the hormones spur action and increase fuel to the brain, helping the animal react to danger appropriately. Those hormones also flow to memory centers in the brain, to help the critter remember those notable moments and places.


‘The term stress can be used to refer to either a stressful stimulus, the organism’s response to a stressful stimulus, or the consequences of this response (Levine, 2005). By contrast, the term stressor has been more consistently used to denote the physical and emotional challenges that threaten organismal homeostasis, and stress response denotes the organism’s behavior in the face of such challenges (Chrousos and Gold, 1992, Karatsoreos and McEwen, 2011). Because stressors are physiologically coupled to stress responses, some researchers have advocated for use of the more holistic term allostatic to describe the process by which variations in internal function allow an organism to achieve stability in the face of constantly changing environments (Karatsoreos and McEwen, 2011).’

‘Although the terms stressor and stress response commonly carry negative connotations, stress responses can be either adaptive or maladaptive and even similar responses can have different adaptive value in distinct environmental contexts. For example, combat veterans exhibit vigilance and fear responses that are adaptive in the combat zone because they decrease the likelihood of injury and death. However, these same responses become maladaptive if they generalize to other settings and persist after return to civilian life. Other determinants of the adaptive value of the stress response include the intensity, type, and timing of the stressor. Stressors that occur early in development have greater and more enduring effects than stressors that occur in adulthood, effects that vary depending on stressor intensity, duration and frequency (Hoffmann and Spengler, 2012, Russo et al., 2012). Chronic excessive stress carries a high risk of detrimental consequences, whereas acute intermittent stress may be essential for successful adaptation to changing natural and social environments (McEwen, 2008). Mild to moderate stress may enhance cognitive and emotional learning via the induction of neural plasticity and the adaptive remodeling of neural circuits, and may thus be a necessary component of learning and successful psychotherapy (Cozolino, 2010). The importance of stressor intensity for determining stress response has been further highlighted over the years by the definition of Post-Traumatic Stress Disorder (PTSD) in the Diagnostic and Statistical Manual for Mental Disorders (DSM). In the 4th edition of DSM, a stressful event has been traditionally considered capable of causing PTSD only if it involves the “actual or threatened death or serious injury, or a threat to the physical integrity of self or others” and induces “intense fear, helplessness, or horror” (American Psychiatric Association, 2000). Although this criterion was recently revised in the 5th edition of DSM, intensity remains an important characteristic of traumatic events, which should involve “death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence.” (American Psychiatric Association, 2013).’
Toxic Stress

‘Toxic stress is the bad apple that gives the whole stress orchard a bad reputation.

‘Like stress itself, stress responses are diverse and span the spectrum from adaption to maladaptation.’

Robert-Paul Juster; From Stressed Neurons to Resilient Neighborhoods: Discussion with Drs. Ilia N. Karatsoreos and Bruce S. McEwen; Mammoth Magazine; Issue 13; Summer 2013.

Imperial College of London; Resilience and Stress Management; http://www3.imperial.ac.uk/staffdevelopment/lcd/workshops/prof_dev/stressmanagement

‘Stress is now directly named as the biggest cause of work-related absence, and indirectly responsible for many other causes including mental health illnesses and musculoskeletal disorders.

It has also been proven to have a negative impact on performance, decision making and creativity. This means that there are long-term, negative, implications for both individuals, and organisations. However, there are skills and behaviours that we can adopt to help manage stress and develop resilience, and these form the basis of our range of workshops and support for all staff’


‘Children exposed to prolonged adversity, such as physical or emotional abuse or chronic neglect, caregiver substance abuse or mental illness, are at greater risk for cancer, diabetes and other diseases. Toxic stress increases their risks for smoking, drug abuse, suicide, teen pregnancy, STD’s, domestic violence and depression. Simultaneously, toxic stress can reduce children’s ongoing chances of success in school, holding jobs and maintaining stable relationships.’

Carol Gerwin; Pediatricians Take On Toxic Stress; Center on the Developing Child; Harvard University; Tackling Toxic Stress; toxicstressresponse/developingchild.harvard.edu/key_concepts/toxic_stress_response/

‘A growing body of scientific evidence about the power of severe childhood stress to weaken brain architecture and damage lifelong health is prompting leading pediatricians to call for a seismic shift in pediatric primary care. The American Academy of Pediatrics (AAP), which represents 60,000 physicians, is planning a comprehensive public health strategy to identify and reduce toxic stress in their youngest patients. They see this not only as a way to improve their patients’ health across the lifespan, but also as a means of improving the nation’s health—and economy.’

“Unfortunately, as a country we’ve ignored all those things. But it’s time to stop ignoring them,” says Robert W. Block, M.D., of Tulsa, Okla., the AAP’s immediate past president and a champion of the new approach. “As these kids [facing toxic stress] grow older, there become more and more issues that become more expensive to fix. And often they’re not fixed at all, because they’ve become too advanced.”

‘Extensive biological research shows that severe, chronic stress can become toxic to developing brains and biological systems when a child suffers significant adversity, such as poverty, abuse, neglect, neighborhood violence, or the substance abuse or mental illness of a caregiver. In the absence of responsive relationships with adult caregivers, a child’s stress response systems go on high alert and stay there, like a car engine revving for hours, days, even weeks. The cumulative toll increases the likelihood of developmental delays, learning disabilities, and childhood behavior problems, as well as diabetes, heart disease, depression, drug abuse, alcoholism, and other major health problems in adults.’

Center on the Developing Child; Harvard University; Toxic Stress; developingchild.harvard.edu/key_concepts/toxic_stress_response/

‘Toxic stress response can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support.’

‘The future of any society depends on its ability to foster the healthy development of the next generation. Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body (especially the brain), with damaging effects on learning, behavior, and health across the lifespan.’
'When a young child’s stress response systems are activated within an environment of supportive relationships with adults, these physiological effects are buffered and brought back down to baseline. The result is the development of healthy stress response systems. However, if the stress response is extreme and long-lasting, and buffering relationships are unavailable to the child, the result can be damaged, weakened systems and brain architecture, with lifelong repercussions.'

'It’s important to distinguish among three kinds of responses to stress: positive, tolerable, and toxic. As described below, these three terms refer to the stress response systems’ effects on the body, not to the stressful event or experience itself:

**Positive stress response** is a normal and essential part of healthy development, characterized by brief increases in heart rate and mild elevations in hormone levels. Some situations that might trigger a positive stress response are the first day with a new caregiver or receiving an injected immunization.

**Tolerable stress response** activates the body’s alert systems to a greater degree as a result of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time-limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might otherwise be damaging effects.

**Toxic stress response** can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years.'

‘When toxic stress response occurs continually, or is triggered by multiple sources, it can have a cumulative toll on an individual’s physical and mental health—for a lifetime. The more adverse experiences in childhood, the greater the likelihood of developmental delays and later health problems, including heart disease, diabetes, substance abuse, and depression. Research also indicates that supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response.’

Carol Gerwin; *Pushing Toward Breakthroughs: Using Innovative Practice to Address Toxic Stress*; Center on the Developing Child; Harvard University; Tackling Toxic Stress;

‘Using the expanding scientific evidence about the long-term, damaging effects of toxic stress, a small but growing group of forward-thinking social service practitioners are trying innovative approaches that target its root causes and could lead to breakthroughs in the effectiveness of interventions—for both children and their caregivers.’

‘The practitioners lead a diverse set of organizations serving infants, toddlers, and preschoolers nationwide, but they share a fierce commitment to finding more effective ways to enhance the capabilities of everyone who cares for children, at home and in the community. They are all members of the Center on the Developing Child’s Frontiers of Innovation (FOI) community, which comprises researchers, practitioners, policymakers, philanthropists, and experts in systems change from across North America.’
What is Trauma?

“One of the last frontiers of our society is the lack of realisation about the extent of trauma”.

Prof Warwick Middleton

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

“There are several things you should consider before you become a beekeeper, but they are no different than if you were going to begin caring for any other animal... dogs, cats, chickens or lamas.”


‘Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography or sexual orientation. It is an almost universal experience of people with mental and substance use disorders.’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

‘At one time, trauma was considered an abnormal experience. Contrary to this myth, the first National Comorbidity Study (NCS), a large national survey designed to study the prevalence and effects of mental disorders in the United States, established how prevalent traumas are in the lives of the general U.S. population (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Presented with a list of 11 types of traumatic experiences and a 12th “other” category, 60.7 percent of men and 51.2 percent of women reported experiencing at least one trauma in their lifetime (Kessler, 2000; Kessler et al. 1995; 1999):

- The most common trauma was witnessing someone being badly injured or killed (cited by 35.6 percent of men and 14.5 percent of women).
- The second most common trauma was being involved in a fire, flood, or other natural disaster (cited by 18.9 percent of men and 15.2 percent of women).
- The third most common trauma was a life-threatening accident/attack, such as from an automobile accident, a gunshot, or a fall (cited by 25 percent of men and 13.8 percent of women).

THE MORRIS CENTER; for healing from child abuse; Survivor to Thriver; Revised 7/99, www.ascasupport.org

‘Psychic trauma is a psychological condition caused by overwhelming stress that cannot be controlled by normal coping mechanisms. It can result from a number of situations in addition to child abuse, including war or battlefront experience, natural disasters, being held hostage and being in the middle of a bombing, hijacking or shootout. Perhaps the most common symptom of such traumatic exposure is panic attacks involving hyperventilation and severe anxiety. These can be triggered by anything your senses associate with your past abuse. Insomnia, sleepwalking, nightmares and night terrors (a more extreme type of nightmare occurring during non-dreaming sleep cycles) are other signs of unresolved trauma of some sort.

Many adult survivors don’t show signs of psychic trauma until years after the abuse ends. When they do show signs, survivors often report feelings of extreme anxiety, panic, general fearfulness and disorientation. In the most extreme cases, survivors may evidence dissociation (splitting of mind and body), numbing of the body and intrusive, repetitive thoughts and flashbacks to the abuse episode(s). The appearance of these symptoms lets you know that your psyche is still trying to resolve conflicts associated with your past abuse. There is growing evidence that survivors of extreme and prolonged child abuse are susceptible to developing multiple personalities as a means of self-protection and that child abuse may be the major cause of multiple personality disorders.’

Wisconsin; USA; A Practical Guide for Creating Trauma-Informed Disability, Domestic Violence and Sexual Assault Organizations – 2011

‘One definition of trauma () was developed by Judith Herman in her ground breaking book, Trauma and Recovery. Herman described events that are traumatic because they:
1. Render victims helpless by overwhelming force;
2. Involve threats to life or bodily integrity, or close personal encounters with violence and death;
3. Disrupt a sense of control, connection and meaning;
4. Confront human beings with the extremities of helplessness and terror; and,
5. Evoke the responses of catastrophe.’

This is a slow start to a very big subject, but the picture needs to be carefully built because Trauma started to disappear from our South African “Mental Health” discourse in the late 1990’s.

The “event” itself often gains prominence in unpacking trauma:

‘Psychological trauma is a type of damage to the psyche that occurs as a result of a severely distressing event.’ Wikipedia

Substance Abuse and Mental Health Services Administration, Trauma and Justice Strategic Initiative. SAMHSA’s working definition of trauma and guidance for trauma-informed approach. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2012.

‘Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being.’

The American Psychological Association current website definition expands a bit for us:

The American Psychological Association http://www.apa.org/topics/trauma/

‘Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.”

‘The events or circumstances may be the result of, but are not limited to witnessing, experiencing or exposure to:

- Violence in the home, workplace, school, community or relationships,
- Maltreatment or abuse; emotional, verbal, physical or sexual,
- Exploitation; sexual, financial or psychological,
- Change in living situation such as eviction or move to nursing home,
- Neglect,
- Deprivation,
- Physical or psychological injury, either intentional or unintentional,
- War or armed conflict,
- Natural or human caused disaster’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

“Although many individuals report a single specific traumatic event, others, especially those seeking mental health or substance abuse services, have been exposed to multiple or chronic traumatic events.”

Lane Benjamin and Sarah Crawford Brown (South Africa); The psychological impact of continuous traumatic stress -- limitations of existing diagnostic frameworks

‘The South African Stress and Health Survey (SASH), Williams, Williams, Stein, Seedat, Jackson and Moorman (2007) found that 56.1% percent of South Africans had experienced more than one traumatic event and a quarter of the population had experienced four or more traumatic events during their lifetimes. The SASH study is the most comprehensive psychiatric epidemiological study using national prevalence data through a representative sample of 4351 South African adults.’
Andrea Blanch, “The impact of violence is never restricted to individuals; it always affects groups and communities,” for US Department of Health and Human Services

‘The cumulative impact of traumatic events and experiences needs to be acknowledged and measured, rather than having each event or manifestation treated separately. Consequences for physical and mental health should always be considered simultaneously.’

As we shall see, understanding that events may mean several events and not just a single event is often a cause of contention.

The “experience” ability to “cope” with the experience comes up time and again in the literature.

The Canadian Network of Substance Abuse. Essentials of Trauma Informed Care. 2012

‘Trauma is defined as experience that overwhelms an individual’s capacity to cope. Whether it is experienced early in life—for example, as a result of child abuse, neglect, witnessing violence and disrupted attachment—or later in life due to violence, accidents, natural disasters, war, sudden unexpected loss and other life events that are out of one’s control, trauma can be devastating.’

Alameda County Trauma Informed Care - http://alamedacountytraumainformedcare.org/

‘We refer to trauma from a psychological perspective to describe experiences that are emotionally painful and distressing and that overwhelm an individual’s capacity to cope. Although there has been some debate about how to define a traumatic event, most definitions agree that when internal and external resources are inadequate to cope with external threat, the experience is one of trauma.’ The powerlessness that a person experiences is a primary trait of traumatization (Van der Kolk 2005).

Esther Giller, President of the Sidran Institute takes it a bit further.

Esther Giller; President, Sidran Institute; What is Psychological Trauma 1999

‘We all use the word “trauma” in everyday language to mean a highly stressful event. But the key to understanding traumatic events is that it refers to extreme stress that overwhelms a person’s ability to cope. There are no clear divisions between stress, trauma, and adaptation. Although I am writing about psychological trauma, it is also important to keep in mind that stress reactions are clearly physiological as well. Different experts in the field define psychological trauma in different ways. What I want to emphasize is that it is an individual’s subjective experience that determines whether an event is or is not traumatic.

Psychological trauma is the unique individual experience of an event or enduring conditions, in which:

- The individual’s ability to integrate his/her emotional experience is overwhelmed, or
- The individual experiences (subjectively) a threat to life, bodily integrity, or sanity. (Pearlman & Saakvitne, 1995, p. 60)

Thus, a traumatic event or situation creates psychological trauma when it overwhelms the individual’s ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss.’

Esther Giller; President, Sidran Institute; What is Psychological Trauma 1999

‘Jon Allen, a psychologist at the Menninger Clinic in Houston, Texas and author of Coping with Trauma: A Guide to Self-Understanding (1995) reminds us that there are two components to a traumatic experience: the objective and the subjective:

“It is the subjective experience of the objective events that constitutes the trauma...The more you believe you are endangered, the more traumatized you will be...Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness. There may or may not be bodily injury, but psychological trauma is coupled with physiological upheaval that plays a leading role in the long-range effects” (p.14).’
Which then comes ‘first’, the “experience” or the “event”?


‘My dictionary defines trauma as a deeply distressing or disturbing experience. Defined like that the events which can be considered traumatic are wide ranging indeed - from what might be considered the stuff of ordinary life such as divorce, illness, accidents and bereavement to extreme experiences of war, torture, rape and genocide. Insofar as we adopt this wide ranging definition, trauma is the stuff of everyday life.’

The Trauma-Informed way is to look beyond the “event” itself and give more emphasis to the “experience”...

“It is not the event that determines whether something is traumatic to someone, but the individual’s experience of the event.”

ITTIC – The Institute of Trauma and Trauma Informed Care; Buffalo Center for Social Research; School of Social Work; University at Buffalo; The State University of New York. http://socialwork.buffalo.edu/social-research/about-us.html

When an event is traumatic to children and adults they may be negatively impacted emotionally, physically, and spiritually by these adverse life events. – ITTIC, 2014

Trauma-Informed Care is about ensuring ALL individuals feel physically and emotionally safe, are noticed and listened to, and given a voice. – ITTIC, 2014

Adapted from ITTIC Models. http://socialwork.boffalo.edu/social-research/about-us.html

SAMHSA neatly explains why ...

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

‘It is not just the event itself that determines whether something is traumatic, but also the individual’s experience of the event. Two people may be exposed to the same event or series of events but experience and interpret these events in vastly different ways. Various biopsychosocial and cultural factors influence an individual’s immediate response and long term reactions to trauma.’

Which has brought about this SAMHSA view:


‘The Three “E’s” of Trauma: Event(S), Experience Of Event(S), And Effect - Individual Trauma results from an Event, series of events, or set of circumstances that is Experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse Effects on the individuals functioning and mental, physical, social, emotional or spiritual well-being.’

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

‘Nobody can “treat” a war, or abuse, rape, molestation, or any other horrendous event, for that matter; what has happened cannot be undone. But what can be dealt with are the imprints of trauma on body, mind and soul; the crushing sensations in your chest that you may label as anxiety or depression; the fear of losing control; always being on alert for danger or rejection; the self-loathing; the nightmares and flashbacks; the fog that keeps you from staying on task and from engaging full in what you are doing; being unable to fully open your heart to another human being.
SAMHSA’s Trauma and Justice Strategic Initiative; SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach; July 2014

‘Recognizing the absence of a universally accepted, trauma-informed definition in the literature, SAMHSA commissioned a panel of experts to develop a concept of trauma that would be pertinent across disciplines and constituencies. SAMHSA’s resulting definition of trauma encompasses its causes and effects as it relates to individuals:

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.’

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘It would be wrong to imply, ([], that there was no research base on trauma prior to the current period, or that the need to address the combination of dimensions involved in complex trauma renders research into trauma per se irrelevant. In fact not only has trauma been addressed by a number of clinicians and theorists at various historical points, but key findings of the ‘early’ trauma research are now being validated. Striking illustration of this is van der Kolk’s discussion of the 1889 observations of French pioneer Pierre Janet, which are supported by the current research, and which ‘confirm the notion that what makes memories traumatic is a failure of the CNS [central nervous system] to synthesise the sensations related to the trauma memory into an integrated memory’.

‘Current research suggests potential need for psychotherapy to supplement its established modalities with ways of working which more directly engage bodily experience. In stark repudiation of the mind/body dichotomy, new research is confirming the extent to which ‘physical, bodily feelings’ underlie and shape not only the process of decision-making, but attempts to address problems of all kinds. Indeed, as van der Kolk underlines, it is becoming increasingly clear that ‘response refers to an action we are impelled to take – that is, how we are physically inclined to move after receiving any particular stimulus’. Such findings have particular application to enhanced understanding of trauma, and to potential new interventions in its healing.’

‘The relationship between child abuse and compromised adult well-being is now well established. But currently unfolding research, specifically in the field of affective neuroscience (‘the neurobiology of attachment’) is providing new insights in relation to it. This includes enhanced understanding of the effects of trauma on the developing brain, the implications across the life-cycle, and even the impacts on the next generation. For these reasons, it is crucial that the main tenets of this research are delineated, and that they inform the care, treatment and service-provision guidelines which must evolve correspondingly. It is also imperative that they inform policy construction and development.

Before consideration of the new research, however, a striking anomaly needs to be noted. Increased recognition of child abuse is not the same as effective and systematic addressing of it. The extent to which the reality, prevalence and effects of child abuse pose ongoing challenges at all levels (ie not only to those who directly experience such abuse, but to health systems, governments and society as a whole) must be confronted at the outset.’

‘Capacity to respond with flexibility occurs gradually in human development, and as van der Kolk explains, is ‘easily disrupted’. Just as young children are limited in their ability to control their emotional responses when upset or excited, so adults revert to automatic responses when experiencing strong emotion. Significantly, we tend to ‘execute whatever ‘action-tendency’ is associated with any particular emotion’, whether this be the joyful impulse to embrace a loved one or to become paralysed with fear. Moreover, van der Kolk notes that since the work of Janet in 1889, it has been observed ‘that traumatised individuals are prone to respond to reminders of the past by automatically engaging in physical actions’ that must have been appropriate at the time of the trauma but that are now irrelevant’. Irrelevant in the present, but which – prevented from physical expression at the time of the trauma - remain dormant. And which are inappropriately expressed in the present, via unwitting reactions and enactments which express implicit memories.’
**PTSD – Post-traumatic Stress Disorder**

“There is more to trauma than PTSD” Robin Shapiro

Please refer to section 8 for diagnostic information.

Steven M. Southwick, George A. Bonanno, Ann S. Masten, Catherine Panter-Brick and Rachel Yehuda; RESILIENCE AND TRAUMA; Resilience definitions, theory, and challenges: interdisciplinary perspectives; European Journal of Psychotraumatology

‘For decades, the fields of neuroscience, mental health, medicine, psychology, and sociology have been collectively focused on the short-term and long-term consequences of stress, and more recently, extreme stress. Stress is a reality of our daily lives. At some point, most people will be exposed to one (or more) potentially life-threatening traumatic experiences that can influence mental health and result in conditions such as post-traumatic stress disorder (PTSD) (Karam et al., 2014).’

Carly Parnitzke Smith and Jennifer J. Freyd University of Oregon; Institutional Betrayal; September 2014; American Psychologist

‘Historically, definitions of traumatic experiences have tended to be narrow and in keeping with publicly accepted ideas of what might lead to disruptive levels of distress (Courtois & Ford, 2009). Typically, these identified experiences—combat, natural disasters, and violent crimes, for example—have been associated with intense fear and horror. In early editions of the American Psychiatric Association’s (2000) Diagnostic and Statistical Manual of Mental Disorders (DSM), this meant that valid traumatic experiences were largely limited to military combat, life-threatening disasters or accidents, or violent rape. Over time, the field of trauma psychology has grown to accommodate a shift in the understanding of traumatic events from one in which they are regarded as “unusual experiences” as defined by earlier editions of the DSM to one in which they are seen to include all-too-common experiences of many members of society (e.g., incest, child sexual abuse, domestic violence; American Psychiatric Association, 2013). This shift often required advocacy by outspoken critics of typical psychological practices in order to expand the field’s understanding and convince it to look at uncomfortable truths.’

‘Efforts aimed at alleviating distress associated with traumatic experiences are typically focused on individuals rather than systems and are usually reactive rather than preventative (Hertzog & Yeilding, 2009). However, new research has begun to focus on events that are clearly traumatic and yet historically have not fit neatly within the individually focused model that has dominated the field of traumatic stress. What effect does experiencing chronic fear, stress, or mistreatment have on psychological well-being? What does it mean to find danger in a place where one expected to find safety? These questions mark a notable departure from descriptions of traumatic experiences as flashpoints of danger in an otherwise safe world.’

National Center for PTSD; DSM-5 Criteria for PTSD, US Department of Veterans Affairs.

‘Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition.’

The History of ‘PTSD’

“There’s nothing that would help the young psychiatrist who has never faced a gun or a rapist understand what other people have been through. Of course numbing is encouraged in the medical professions.”

Patience Mason; A Short History of PTSD; http://www.patiencepress.com/documents/A%20short%20History%20of%20PTSD.pdf
The risk of exposure to trauma has been a part of the human condition since we evolved as a species. Attacks by saber tooth tigers or twenty-first century terrorists have probably produced similar psychological sequelae in the survivors of such violence.’

Edward Tick; War and the Soul, 2005 Quest Books.
‘Post-traumatic Stress Disorder (PTSD) is the psychiatric name which became current in 1980 for a condition that has existed for as long as human history. Survivors of tragic events such as rape, concentration camps, combat, hurricanes and many others – all share a common set of reactions...’

PTSD – The warrior origins...

‘Three thousand years ago, an Egyptian combat veteran named Hori wrote about the feelings he experienced before going into battle: “You determine to go forward. . . . Shuddering seizes you, the hair on your head stands on end, your soul lies in your hand.”

History tells us that among the Egyptians, Romans, and Greeks, men broke and ran in combat circumstances—in other words, the soldiers of antiquity were no less afraid of dying.

For instance, the Greek historian Herodotus, in writing of the battle of Marathon in 490 B.C., cites an Athenian warrior who went permanently blind when the soldier standing next to him was killed, although the blinded soldier “was wounded in no part of his body.” So, too, blindness, deafness, and paralysis, among other conditions, are common forms of “conversion reactions” experienced and well-documented among soldiers today.

Herodotus also writes of the Spartan commander Leonidas, who, at the battle of Thermopylae Pass in 480 B.C., dismissed his men from joining the combat because he clearly recognized they were psychologically spent from previous battles. “They had no heart for the fight and were unwilling to take their share of the danger.” (Herodotus tells of another Spartan named Aristodemus who was so shaken by battle he was nicknamed “the Trembler”—he later hanged himself in shame.)

One thousand years later, things had changed very little at the front. The Anglo Saxon Chronicle recounts a battle in 1003 A.D. between the English and the Danes in which the English commander Alfred reportedly became so violently ill that he began to vomit and was not able to lead his men.’

During the siege of Gibraltar in 1727, a soldier who was part of the defense of the city kept a diary. In it, there is mention of incidents in which soldiers killed or wounded themselves. He also describes a state of extreme physical fatigue which had caused soldiers to lose their ability to understand or process even the simplest instructions. In this state, the soldiers would refuse to eat, drink, work, or fight in defense of the city, even though they would be repeatedly whipped for not doing so.

Many consider the Civil War the first step on the road to modern warfare. Civil War soldiers made the first frontal assaults into repeating rifles and pistols, as well as the Gatling gun and delayed-time artillery rounds that allowed air bursts. Civil War technology also included telescopic sights and rifles with spiral barrels that greatly increased their accuracy and destructiveness in battle.

The immediate result was that psychological symptoms became so common, field commanders as well as medical doctors pleaded with the War Department to provide some type of screening to eliminate recruits susceptible to psychiatric breakdown. Military physicians, at a loss to treat the problems, simply mustered the extreme cases out during the first three years of the war. “They were put on trains with no supervision, the name of their home town or state pinned to their tunics, others were left to wander about the countryside until they died from exposure or starvation,” reports Richard A. Gabriel, a consultant to the Senate and House Armed Services Committees and one of the foremost chroniclers of PTSD.
Gabriel's research tells us that in 1863 the number of insane soldiers simply wandering around was so great, there was a public outcry. Because of this, and at the urging of surgeons, the first military hospital for the insane was established in 1863. The most common diagnosis was nostalgia. The government made no effort to deal with the psychiatrically wounded after the war and the hospital was closed. There was, however, a system of soldiers' homes set up around the country. Togus, Maine, was designated as the eastern branch of this system, and in 1875, its director noted that, strangely enough, the need for the hospital's services seemed to increase rather than decrease.'

'The first army in history to determine that mental collapse was a direct consequence of the stress of war and to regard it as a legitimate medical condition was the Russian Army of 1905 in their war with the Japanese. Gabriel states that Russian attempts to diagnose and treat battle shock represent the birth of military psychiatry. The Russians' major contribution was their recognition of the principle of proximity, or forward treatment. Although it's believed by most armies today that the Russians were right in treating psychiatric casualties close to the front, with the goal of returning them to the fight, the recorded rate of those who returned to battle suggests the method was not very successful. In actuality, less than 20 percent were able to return to the front.'

'By the end of World War I, the United States had hundreds of psychiatrists overseas who were beginning to realize that psychiatric casualties were not suffering from "shell shock." These psychiatrists came to comprehend it was emotions and not physiological brain damage that was most often causing soldiers to collapse under a wide range of symptoms. Unfortunately, they continued to believe this collapse came about primarily in men who were weak in character.'

The brutalities of WWI produced large numbers of the psychologically wounded. Unfortunately, what little had been learned up to then was forgotten. The only American experience with psychiatric casualties that anyone remembered was when American soldiers under the command of Gen. John J. Pershing in Mexico exhibited an abnormally high rate of mental illness. Consequently, the medical establishment set out once again to recreate the wheel. This time, they began by attributing the high psychiatric casualties to the new weapons of war; specifically, the large-caliber artillery.

It was believed the impact of the shells produced a concussion that disrupted the physiology of the brain; thus the term "shell shock" came into fashion.

Although WWI generated stress theories based on models of the mind, such as Freud's "war neurosis," these theories never gained wide acceptance. Quite simply, Freud postulated "war neurosis" was brought about by the inner conflict between a soldier's "war ego" and his "peace ego."

'During WWI, almost two million men were sent overseas to fight in Europe. Deaths were put at 116,516, while 204,000 were wounded. During the same period, 159,000 soldiers were out of action for psychiatric problems, with nearly half of these (70,000) permanently discharged.

Harking back to military medicine during the Civil War, psychiatrists concluded that the answer to psychological casualties was to more thoroughly screen those entering the military. Based on this, the main effort to reduce WWII psychological casualties was to focus on sifting through draftees in order to weed out those predisposed to break down in combat. The military used the best available psychiatric testing and rejected no fewer than five million men for military service.

In World War II, the ratio of rear-area support troops to combat troops was twelve to one. In the four years of war, no more than 800,000 soldiers saw direct combat, and of these, 37.5 percent became such serious psychiatric cases, they were permanently discharged. In the U.S. Army alone (not counting Army air crews), 504,000 men were lost to the fight for psychiatric reasons. Another 1,393,000 suffered symptoms serious enough to debilitate them for some period.

It became clear it was not just the "weak" in character who were breaking down. This is reflected in the subtle change in terminology that took place near the end of World War II when "combat neurosis" began to give way to the term "combat exhaustion." Author Paul Fussell says that term as well as the term "battle fatigue" suggest "a little rest would be enough to restore to useful duty a soldier who would be more honestly designated as insane."
While the name change showed movement away from psychopathology, it didn’t keep the military model of “predisposition plus stress equals collapse” from working its way back into military medicine.

Fussell was a 20-year-old Army lieutenant and the leader of a rifle platoon in France. He was severely wounded in 1945 and came home to earn a Ph.D. from Harvard. In the preface to his highly acclaimed book, *Wartime*, he writes, “For the past 50 years the allied war has been sanitized and romanticized almost beyond recognition by the sentimental, the loony patriotic, the ignorant, and the bloodthirsty—I have tried to balance the scales.’

‘In Korea, 1,587,040 served—33,629 were killed in combat and 103,284 were wounded. Of the 198,380 who were actually in combat, 24.2 percent were psychiatric casualties. In other words, the chances of being a psychiatric casualty in Korea was 143 percent better than the chances of being killed.

In Vietnam, 2.8 million served. Given the nature of guerrilla warfare, it is hard to estimate the number exposed to hostile fire. However, the Research Triangle Institute’s Vietnam readjustment study concludes 480,000 have full-blown PTSD and another 350,000 have partial PTSD.’

‘The dynamics were different in Vietnam, where conditions of the war were such that moral revulsion combined with psychological conflict lead to both acute and delayed reactions. Lifton writes, “[M]onths or even years after their return to this country, many Vietnam vets combined features of the Traumatic Stress Syndrome with preoccupation with questions of meaning—concerning life, and ultimately, all other areas of living.”

(Robert J.) Lifton argues that in the search to understand the soldiers’ traumatic stress reaction, doctors should focus on the death and destruction that actually took place and its related questions of meaning, rather than invoke the idea of “neurosis.”’

‘Having closed off and numbed themselves in order to survive, soldiers are then faced with the task of working their way back toward humanity. The struggle is to “re-experience himself as a vital human being.” However, it is not all that easy, for “one’s human web has been all too readily shattered, and in rearranging one’s self-image and feelings, one is on guard against false promises of protection, vitality, or even modest assistance. One fends off not only new threats of annihilation but gestures of love or help.”’

PTSD - the civilian origins...


‘PTSD shows up in the *Epic of Gilgamesh* (about 2000 BC). The *Bible* has multiple incidents which describe PTSD reactions, particularly the PTSD Psalm, Number 137”

‘Later PTSD shows up in Shakespeare in *Henry the IV, Part I*. I’ve put the modern names of these symptoms in a column beside Lady Percy’s speech:

<table>
<thead>
<tr>
<th>Emotional Isolation</th>
<th>Sexual Dysfunction</th>
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</thead>
<tbody>
<tr>
<td>Emotional Numbing</td>
<td>Intrusive Thoughts</td>
</tr>
<tr>
<td>Anxiety, and Startle Reaction</td>
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‘*The Narrative of the Captivity and Restoration of Mrs. Mary Rowlandson*, 1682, Boston, describes her sleeplessness after her rescue.’

‘Although no one describes the complete diagnosable syndrome, there is evidence of PTSD everywhere if you look for it.’
Steve Bentley; A Short History of PTSD: From Thermopylae to Hue Soldiers Have Always Had A Disturbing Reaction To War; Veteran, The Official Voice of Vietnam Veterans of America, Inc. ®An organization chartered by the U.S. Congress; Article Reprint Date, January 1991

‘Samuel Pepys was an Englishman who lived in London during the 1600s. His surviving diary provides an excellent record of the development of PTSD. In writing of the Great Fire of London in 1666, Pepys recounts people’s terror and frustration at being unable to protect their property or stop the fire. Pepys writes: “A most horrid, malicious, blood fire. . . . So great was our fear. . . . It was enough to put us out of our wits.”

Although his own home was untouched, Pepys was unable to sleep for days after the fire. He scrawls: “Both sleeping and waking, and such fear of fire in my heart, that I took little rest.” Two weeks later, Pepys writes: “[M]uch terrified in the nights nowadays, with dreams of fire and falling down of houses.” The diary reports general feelings of anger and discontent over the next four months. Pepys then records that news of a chimney fire some distance away “put me into much fear and trouble.”

‘For civilians in the 1800s, the growth of the industrial era created large companies with machinery operated by workers who often had injury-producing accidents. Train wrecks became common.

Author Charles Dickens was involved in a railway accident at Staplehurst in Kent, England, on June 9, 1865. He suffered symptoms which today would be diagnosed as PTSD. Dickens described the horrifying scene in a letter: “[T]wo or three hours work . . . amongst the dead and dying surrounded by terrific sights...” Sometime after, he wrote he was “unsteady” and said, “I am not quite right within, but believe it to be an effect of the railway shaking.”

Railway accident victims began suing the railroads. Lawyers for the railway companies fought back with the term “compensation neurosis,” which charged that litigants were trying to get something for nothing.


‘Research on PTSD in victims of civilian trauma has only recently begun. Rape is the most extensively studied civilian trauma. Most studies reported that PTSD following rape is common. Further, characteristics of the rape event, such as rape by a stranger, use of physical force, display of weapons, and victim injury, are associated with a greater likelihood of PTSD, and symptoms at 3 months after the rape are predictive of a chronic course. Interest in the consequences of MVAs has increased dramatically, perhaps owing to the frequency of such accidents and the large number of PTSD damage claims. There is a great need to understand work environments better and the special risks associated with dangerous occupations, such as police, firefighters, rescue workers, and body handlers. Clinicians commonly attribute symptoms to a particular stressor, usually the most recent stressor or the stressor that represents the content of the symptoms. For example, nightmares about a recent auto accident and avoidance of expressways are interpreted as evidence that a recent auto accident is the cause of PTSD symptoms.’

Matthew Tull, PhD; Rates of PTSD in Non-military Groups; About Health

1. **General Population**: ‘In one of the most comprehensive studies conducted to date, 5,877 people from communities across the United States were interviewed in order to determine how many had a diagnosis of PTSD at some point in their lifetime. If you lump everyone together (regardless of age or sex), it was found that approximately 7.8% of the people interviewed had PTSD at some point in their lifetime.’

   ‘PTSD is quite common in the general population. PTSD can affect people of all ages and does not discriminate based on sex or marital status. The high rates of PTSD found in this study suggest the need for people to become more aware of the disorder and its symptoms. Knowing what PTSD is can lead to early identification of it when it occurs, and consequently, early intervention.’

2. **Children**: ‘The consequences of being exposed to a traumatic event including PTSD are more commonly studied among adults; however, traumatic exposure and symptoms of PTSD in children can also occur. Yet, less is known about the rates of traumatic exposure and PTSD in children. To address this issue, researchers at the Center for Developmental Epidemiology in the Department of Psychiatry and Behavioral Sciences at Duke University Medical Center looked at rates of traumatic exposure and the experience of PTSD symptoms in a large sample of children under the age of 16 from western North Carolina.’
The rates of traumatic exposure in children found in this study are shocking, and their findings show that children are particularly vulnerable for a number of negative consequences stemming from traumatic exposure.

3. **Sexual Assault:** ‘PTSD from rape and other forms of sexual assault occurs with high frequency. The term "sexual assault” refers to a range of behaviors that involve unwanted sexual contact, such as sexual molestation or rape. Unfortunately, sexual assault is quite common in our society....Large surveys of the general population have found that anywhere between 13% to 34% of women will experience a sexual assault at some point in their life.’

‘The experience of sexual assault is connected with a number of negative consequences. People who have experienced a sexual assault are more likely to develop depression, an anxiety disorder, suicidal thoughts, and alcohol and drug problems. High rates of PTSD are also found among people who have experienced rape. Studies have found that 31% to 57% of women who had experienced a rape also have PTSD at some point after the rape.’

4. **HIV/Aids:** Despite significant advances in prevention efforts, more than one million individuals in the U.S. are living with HIV/AIDS, and an estimated 42,959 more continue to contract the disease each year. There is no question that the physical consequences of having HIV are great. In addition, mental health professionals are beginning to realize that being diagnosed with HIV can also result in a number of mental health problems, including posttraumatic stress disorder (PTSD).

Although research on HIV-related PTSD is rare, some studies of HIV patients have found high rates of HIV-related PTSD. Specifically, rates of HIV-related PTSD have ranged from 30 to 40%, a rate much higher than what is found in the general population.

5. **First Responders:** Some professions may place people at higher risk for experiencing a traumatic event, and consequently, the development of PTSD. First responders, such as firefighters, are more likely to be exposed to life-threatening situations, death, and dying. Therefore, it’s not surprising that higher rates of PTSD are found among firefighters.

Given that traumatic exposure is common among firefighters, it is not surprising that high rates of PTSD have been found. Studies have found that anywhere between approximately 7% and 37% of firefighters meet criteria for a current diagnosis of PTSD.’

_Lane Benjamin and Sarah Crawford Brown; The psychological impact of continuous traumatic stress -- limitations of existing diagnostic frameworks_

‘Thus, the data on the prevalence is very varied, with a focus on PTSD as the assessment framework. The levels of current PTSD vary between 2, 8% (Stein, et al., 2007) and 55% (Dinan, McCall & Gibson, 2004), despite all four of these studies using measures based on clinical assessment rather than pure self-report. The SASH study describes national data, rather than an examination of the mental health within a violent community -- yet these scores seem extremely low given the wide experience of multiple traumas also identified within this study.’

‘For people within vulnerable neighbourhoods in South Africa, experiences of violence may be one event of many within a lifetime of threatened community and criminal violence....PTSD does not adequately capture the pattern of symptom presentation by people who live in contexts of continuous violence. The majority of people living in violent contexts do not become violent. However, these individuals may carry their scars in other ways, stoically living their lives disconnected from themselves and others.’

PTSD - the history of diagnostics...
It appears Swiss military physicians in 1678 were among the first to identify and name that constellation of behaviors that make up acute combat reaction or PTSD. “Nostalgia” was the term they used to define a condition characterized by melancholy, incessant thinking of home, disturbed sleep or insomnia, weakness, loss of appetite, anxiety, cardiac palpitations, stupor, and fever.

German doctors diagnosed the problem among their troops at about the same time as the Swiss. They referred to the condition as *heimweh* (homesickness). Obviously, it was strongly believed the symptoms came about from the soldiers longing to return home.

In time, French doctors termed the same symptoms *maladie du pays*, and the Spanish, confronted with the same reactions among their soldiers, called it *estar roto* (literally, “to be broken”).

The French surgeon Larrey described the disorder—what we now call PTSD—as having three different stages. The first is heightened excitement and imagination; the second is a period of fever and prominent gastrointestinal symptoms; the final stage is one of frustration and depression.

During the American Civil War, military physicians diagnosed many cases of functional disability as the result of fear of battle and the stresses of military life. This included a wide range of illnesses now known to be caused by emotional turbulence, including paralysis, tremors, self-inflicted wounds, nostalgia, and severe palpitations—also called “soldier’s heart” and “exhausted heart.” It was reportedly surprising to some Civil War physicians that soldiers on normal leave often collapsed with emotional illness at home, even when they had shown no symptoms of mental debilitation before they had left the fighting.

Pierre Janet, 1904, began reviewing others information on trauma; Charcot, 1887, Bergson, 1896, and with his own work believed that with one’s personal past, combined with accurate perceptions of current surroundings, determined the capacity to respond appropriately to stress. Janet coined the term “subconscious” to describe the collection of memories forming the mental schemes that guide a persons’ interaction with the environment.

Janet proposed that when people experience “vehement emotions,” the mind might not be able to match what is going on with existing cognitive schemes. As a result, memories of the experience cannot be integrated into personal awareness. Instead, they are split off (dissociated) from conscious awareness and from voluntary control. Thus the first comprehensive formulation of the effects of trauma on the mind was recorded. This was based on the notion that failure to integrate traumatic memories due to extreme emotional arousal results in the symptoms of what we today, call PTSD.

The Swiss psychiatrist Edouard Stierlin, 1909, can be considered the first researcher in disaster psychiatry, with his study of nonclinical populations from the Messina earthquake in 1907, and a mining disaster. Stierlin found that a substantial proportion of victims developed long-lasting posttraumatic stress symptoms; for example, after the Messina earthquake killed 70,000 of the town’s inhabitants, 25% of the survivors suffered from sleep disturbances, including nightmares.

Although posttraumatic stress disorder (PTSD) is sometimes considered to be a relatively new diagnosis, as the name first appeared in 1980, the concept of the disorder has a very long history. That history has often been linked to the history of war, but the disorder has also been frequently described in civilian settings involving natural disasters, mass catastrophes, and serious accidental injuries. The diagnosis first appeared in the official nomenclature when *Diagnostic and Statistical Manual of Mental Disorders* (DSM)-I was published in 1952 under the name gross stress reaction. It was omitted, however, in the next edition in 1968, after a long period of relative peace. When DSM-III was developed in the mid-1980s the recent occurrence of the Vietnam War provoked a more thorough examination of the disorder. PTSD was defined as a stress disorder that is a final common pathway occurring as a consequence of many different types of stressors, including both combat and civilian stress.
definition of PTSD has filled an important niche in clinical psychiatry. Its definition continues to raise important questions about the relationship between a stressor, the individual experiencing it, and the characteristic symptoms.’

‘When DSM-III-R appeared just 7 years later, in 1987, many of these unintended modifications were reified in new diagnostic criteria. It was now 42 years after the conclusion of World War II and 24 years after the end of the Vietnam War, both of which had shaped the conceptualization of PTSD in DSM-III. Clinicians were more interested in the problems of here-and-now, and so the diagnosis of PTSD was steadily changing in that direction.’

‘DSM-III-R broadened the definition of the stressor; it was no longer defined as so severe that it would produce symptoms in almost anyone. It emphasized the psychological nature of the stressor and minimized physical components. It expanded the range of symptoms to include a stronger emphasis on dissociation, and it eliminated the acute form of the disorder. These revisions raised several concerns about the degree and rapidity of the change in conceptualization. The plight of Nazi death camp victims and the combat stress of Normandy or Iwo Jima had been the prototype for the DSM-III definition of PTSD. Had the diagnosis become too broad? Had the diagnosis become too psychodynamic at the expense of its biological underpinnings? Does using the same diagnosis for death camp survivors and victims of auto accidents trivialize the diagnosis?’

‘The process of change continued when DSM-IV was completed in 1994. It too was written in a time of relative peace, and this was reflected in the modifications made to the definition of PTSD. The definition of the stressor was further modified, but still open to a broad interpretation; for example, it was expanded so that the stress was no longer limited to one experienced by the patient himself; it could be “a threat to the physical integrity of self or others” (p. 427). Acute stress disorder was added, but with an emphasis on dissociative symptoms. Consequently, these changes raised concerns similar to those created by DSM-III-R.’

‘The occurrence of 9/11 and other acts of international terrorism have changed the context for conceptualizing stressors. The United States is now at war again in both Iraq and Afghanistan, and consequently combat-induced PTSD is now very much on the public and psychiatric radar screen. The biological aspects of the disorder have also reemerged in importance. For example, the relationship between TBI and PTSD requires exploration. Furthermore, advances in neuroscience have facilitated the identification of stress circuitry in the brain through neuroimaging and animal studies. The rising rates of PTSD in military personnel have set off alarm bells, and they have also caused some to question the validity of the diagnosis. Others point to valid reasons for the rise, such as prolonged deployments, the frustrations inherent in counterterrorist warfare, and the recruitment of reservists and National Guard members who did not expect to engage in combat when they joined. The burden on VA Hospitals has become so heavy that an Institute of Medicine study was requested and completed. This study, in three volumes, supports the validity of the diagnosis and the increased need for services.’

Trauma & Dissociation; Complex Post-traumatic Stress Disorder; http://traumadissociation.com/complexptsd

‘Complex Post-traumatic Stress Disorder, also known as "complex trauma", is the result of multiple traumatic events occurring over a period of time, for example caused by multiple incidents of child abuse. Complex Post-traumatic Stress Disorder is not a diagnosis in the DSM-5 psychiatric manual, released in 2013,[5] but is proposed to be included in the ICD-11 diagnostic manual, due for release in 2017.’

‘Complex PTSD was considered to be included within "associated features of PTSD" for the DSM-IV under the name Disorders of Extreme Stress Not Otherwise Specified (DESNOS), but this was not included in either the DSM-IV or DSM-V.[8]:23 See also: Enduring Personality Change After Catastrophic Event ICD 11 draft - Complex Post-traumatic Stress disorder The ICD-11, which is currently a draft document, includes the diagnosis of Complex Post-traumatic Stress Disorder in the Disorders specifically associated with stress section, immediately after Post-traumatic Stress Disorder. [3] Code 7B21’


'The syndrome has been alternately named Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Herman, 1992; Pelcovitz, Van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997), PTSD and its Associated Features in the DSM-IV
(APA, 2000), and Enduring Personality Change after Catastrophic Events (EPCACE) in the ICD (WHO, 1992). The selected definition included a range of symptoms organized into conceptually coherent and frequently used categories derived from the diagnostic descriptions cited above.’

Marylene Cloitre, Donn W. Garvert, Chris R. Brewin, Richard A. Bryant and Andreas Maercker; Evidence for proposed ICD-11 PTSD and complex PTSD: a latent profile analysis; European Journal of Psychotraumatology 2013, 4: 20706 - http://dx.doi.org/10.3402/ejpt.v4i0.20706
‘The World Health Organization (WHO) is responsible for developing the International Classification of Diseases, 11th version (ICD-11), which is expected to be completed in 2015. Within the spectrum of stress and trauma disorders, the WHO ICD-11 has proposed two related diagnoses, posttraumatic stress disorder (PTSD) and complex PTSD (Maercker et al., 2013). WHO has emphasized clinical utility as the organizing principle in classification development. This means that diagnoses should be consistent with clinicians’ mental health taxonomies, limited in number of symptoms, and based on distinctions important for management and treatment (Reed, 2010). These recommendations guided the organization of the PTSD and complex PTSD diagnoses as well as their relationship to each other. This study provides the first empirical support for a separation of these two conditions.’

Matthias Knefel and Brigitte Lueger-Schuster; An evaluation of ICD-11 PTSD and complex PTSD criteria in a sample of adult survivors of childhood institutional abuse; European Journal of Psychotraumatology 2013, 4: 22608 - http://dx.doi.org/10.3402/ejpt.v4i0.22608; August 2014.
‘In ICD-11, PTSD will be redefined and CPTSD will probably be introduced. From the present study on adult survivors of complex interpersonal child abuse, we conclude that CPTSD seems to be an important clinically relevant diagnosis, which should be considered in ICD-11 and in treatment research (Cloitre et al., 2011)’

PTSD thoughts and debates

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012
‘Inadequate classification and diagnosis, failure to routinely screen for prior, underlying trauma, and lack of understanding and preparedness to address `past’ adverse experience are powerful impediments to effective treatment and care. It is reassuring, however, that innovative interdisciplinary research directly relevant to complex trauma is expanding rapidly. Not only do we now know that adverse childhood experiences are directly linked to compromised adult health and functioning (as distinct from widely operationalising this knowledge). New insights into how (ie the processes by which) this occurs are now being generated. The findings of such research are crucial to effectively address the needs of adult survivors of child abuse, and to formulation of effective guidelines which can assist in this regard.’

Steve Bentley; A Short History of PTSD: From Thermopylae to Hue Soldiers Have Always Had A Disturbing Reaction To War; Veteran, The Official Voice of Vietnam Veterans of America, Inc. ©An organization chartered by the U.S. Congress; Article Reprint Date, January 1991
‘As we know it today, Post-traumatic Stress Disorder is marked by a re-experiencing of the trauma in thought, feeling, or dream content, which is in turn evidenced by emotional and psychological numbing. Today, PTSD is characterized by depression, loss of interest in work or activities, psychic and emotional numbing, anger, anxiety, cynicism and distrust, memory loss and alienation, and other symptoms. And why not?

Who would not be alienated from the scenes of death witnessed by soldiers? The point is that throughout history, men and women have acted to suppress the horrors that they’ve seen. It’s time we recognize that for what it is—as not only the outward manifestation of PTSD, but the clearest evidence we have that wars are destructive in other ways than in body counts. It takes many years for even the most sane among us to arrive at what we have seen and wanted to forget.

Psychiatrist Victor Frankel survived internment in four Nazi concentration camps during WWII. It would be quite a few years before he wrote his book, Man’s Search for Meaning. In the book, he states clearly that “an abnormal response to an abnormal situation is normal behavior.” In other words, if some things don’t make you crazy, then you aren’t very sane to begin with.
Unfortunately, it’s an idea whose time has not yet come.’

Dr Pam Stavropoulos Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.

‘Trauma stems from a normal response to overwhelming stress. We are innately equipped with ‘survival’ mechanisms which only become pathological if traumatic experience remains unresolved after the precipitating event/s have passed. But the effects of unresolved trauma are pervasive and cannot be compartmentalised. If unresolved, trauma becomes ‘a central reality around which profound neurobiological adaptations occur’. Pioneering research also tells us that many psychological and physical health problems in adults are the negative outgrowth of childhood coping mechanisms which initially served a protective function. This research has major implications for a revised reading of ‘symptoms’ as coping mechanisms which have ceased to protect and have become injurious to health.’

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘Trauma of any kind is serious, and its effects are damaging and need to be addressed. While various expressions of it may not necessarily be easily recognised or understood, trauma is never ‘simple’ in the minimising sense that this term might imply. What is increasingly called complex trauma, however – of which child abuse is a particularly insidious form – has different antecedents, evolution and potential effects than trauma in the unqualified sense. This is notwithstanding the fact that it may share features with other varieties of trauma and conditions.

We in South Africa received this insightful warning back in 1997 that we should be more open minded as to what constitutes trauma than the shoe horn effect of the DSM PTSD...


A continued focus on the psychological distress of individuals can also promote the stereotypical view that survivors of violence are irreparably damaged. As a result, the ways in which individuals cope with trauma and in many cases master its impact, can be overlooked. For example, the media, at times, fails to report on the complexities and differing reactions to the social phenomenon of rape. Instead they tend to focus on the "drama" of serial rape or choose to report on - and have frequently sensationalised - the human dramas of the victims. This often involves painting doomsday scenarios of victims who are irreparably damaged and for whom there appears to be no solution and no future. These are precisely the wrong messages to convey to the 20 or so other women whose rapes go unreported for every reported rape case. These scenarios promote maladaptive rape myths, and deny the experiences of the women and children who have survived the ordeal of rape and who have embarked on a process of healing.


‘A significant body of South African research is built around the prevalence of PTSD symptoms and strongly suggests that they constitute a significant public health concern. The emotional and behavioural problems associated with PTSD can have serious consequences for work and relationships. In severe cases, individuals may not be able to maintain their occupations and, if in formal employment, have to be medically boarded. In addition, the disorder takes a severe toll on relationships especially with intimates and in the family.’

‘Taken together, these interlinking sources provide incontrovertible evidence that traumatic stress syndromes are very real, and that large numbers of South African adults and children are affected on a chronic basis, only a small percentage of whom receive any form of counselling or professional help. They show that the sequelae of traumatising events constitute a significant public health problem in South Africa and that attention needs to be given to providing clinical services to those affected.’

Lane Benjamin and Sarah Crawford Brown (South Africa); The psychological impact of continuous traumatic stress – limitations of existing diagnostic frameworks

‘With a few exceptions, the South African literature concerning the psychological impact of violence focuses on PTSD as its key reference point. Concern is raised about the impact of ongoing violence and cumulative trauma (here discussing criminal, community and complex trauma) (Williams, Williams, Stein, Seedat, Jackson and Moorman, 2007; Gibson, 2001; Edwards, 2005; Dinan, McCall & Gibson, 2004).’
The SASH data indicate a significant association between the number of traumatic events experienced and levels of global distress (including symptoms of anxiety and depression) (Williams et al., 2007), suggesting that PTSD may not be the best or only diagnostic framework for capturing the impact of multiple trauma exposure in the South African population. This study found that people who have experienced more than six traumatic events were at five times greater risk for high distress. From the same data Myer, Stein, Grimsrud, Seedat and Williams (2008) found associations between higher levels of psychological distress amongst those with lower levels of social economic status and social support – where the increased exposure to traumatic events only partially explained these associations.

Lukoye Atwoli, Dan J. Stein, Karestan C. Koenen, and Katie A. McLaughlin; Epidemiology of posttraumatic stress disorder: prevalence, correlates and consequences; PubMed, 2015 July 01

‘The manner in which subtle methodological shifts give rise to different PTSD prevalence estimates in epidemiological studies is emphasized in the work by Beals et al. [16]. In their study of two Native American reservation communities, using the ‘single worst trauma’ method, lifetime PTSD prevalence rates ranged from 5.9 to 14.8%, while using questions asking about the ‘three worst traumas’ yielded higher PTSD prevalence rates of 8.9 to 19.5%. Breslau et al., in comparing the ‘worst event’ method and the ‘random event’ method in determining conditional prevalence of PTSD, concluded that ‘focus on the worst traumas overestimates the probability of PTSD associated with the entire class of PTSD-level traumas’ in a community sample. In this study, the conditional prevalence of PTSD using the ‘random event’ method was 9.2% while using the ‘worst event’ method it was 13.6.’

**PTSD - The way forward**

“We must become the change we want to see.” – Mahatma Gandhi

Edward Tick; War and the Soul, 2005 Quest Books.

‘...rather than shrink PTSD into the narrow category of stress disorder, we need complex, multi-levelled understanding of it that includes seeing it as a normative response to extraordinary conditions’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), trauma is defined as when an individual person is exposed “to actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association [APA], 2013, p. 271).

The definition of psychological trauma is not limited to diagnostic criteria, however. In fact, some clinicians have moved away from considering trauma-related symptoms as indicators of a mental disorder and instead view them as part of the normal human survival instinct or as “adaptive mental processes involved in the assimilation and integration of new information with intense survival emphasis which exposure to the trauma has provided” (Turnbull, 1998, p. 88). These normal adaptive processes only become pathological if they are inhibited in some way (Turnbull, 1998), or if they are left unacknowledged and therefore untreated (Scott, 1990).

Professor Warwick Middleton, MBBS, FRANZCP, MD Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery. Adults Surviving Child Abuse (ASCA) Authors: Dr Cathy Kezelman and Dr Pam Stavropoulos Funded by the Australian Government Department of Health and Ageing

‘Complex and ongoing developmental traumas not unnaturally produce psychological conditions that likewise are complex and ongoing. Yet throughout the history of psychiatry, it is both fascinating and alarming that individuals with such conditions have been prominently subjected to invalidating or incorrect diagnoses.

The issues have little to do with science: there are many excellent studies which demonstrate the consistent high association between childhood trauma and these outcomes, and which describe in detail the abuse histories and clinical phenomenology of the many so abused. The issue is much more about society’s willingness to know, and our at times extraordinary need to believe something other than the unsettling truth.’
Lane Benjamin and Sarah Crawford Brown (South Africa); The psychological impact of continuous traumatic stress – limitations of existing diagnostic frameworks

‘Researchers and clinicians draw on PTSD as the fundamental framework for thinking about the impact of experiencing or witnessing a life-threatening event on people. Perhaps this has arisen because PTSD is the only psychiatric disorder within the DSM-IV (APA, 1994) that includes the cause or precipitant as a criterion within the diagnostic category. This may reinforce an assumption that PTSD is the likely diagnosis after an experience of trauma. When undertaking epidemiological research, assessment or interventions concerning the psychological impact of violence, the DSM-IV PTSD core symptoms are usually the central focus. These are:

A) experiencing a traumatic stressor;
B) repeatedly re-experiencing the trauma;
C) avoiding activities and stimuli associated with the trauma and emotional numbing; and
D) heightened arousal (APA, 1994).

Yet, as the primary lens through which psychological trauma is perceived, PSTD is particularly problematic. The disorder does not fully capture the range of psychiatric or psychological response to trauma – particularly when the experience of violence is of a chronic and continuing nature.’

Somasundaram and Sivayokan; Rebuilding community resilience in a post-war context: developing insight and recommendations - a qualitative study in Northern Sri Lanka; International Journal of Mental Health Systems 2013, 7:3

… modern psychology and psychiatry, as it has developed, has had a western medical illness model perspective that is primarily individualistic in orientation. Geertz describes the Western concept of the individual self as “…a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgment, and action organized into a distinctive whole and set contrastively both against other such wholes and against its social and cultural background….is a peculiar idea within the context of world cultures”. PTSD is constructed as a condition that exclusively afflicts the individual self, the traumatic event impacting on the individual psyche to produce the PTSD. The World Health Report 2001, while pointing out that there is considerable mental morbidity among those exposed to severe trauma, warns that there is controversy regarding the cross-cultural validity of PTSD. It has been argued that PTSD is a recent western construct that does not apply in non-western societies. It is being increasingly recognized generally that we need to go beyond the individual to the family, group, village, community and social levels if we are to more fully understand what is going on in the individual, whether it be his/her development, behaviour, perceptions, consciousness, experiences or responses to stress and trauma as well as design effective interventions to help in the recovery and rehabilitation of not only the affected individuals but also their families and community.


‘Abstract

Background—The development of the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) and ICD-11 has led to reconsideration of diagnostic criteria for posttraumatic stress disorder (PTSD). The World Mental Health (WMH) Surveys allow investigation of the implications of the changing criteria compared to DSM-IV and ICD-10.

Methods—WMH Surveys in 13 countries asked respondents to enumerate all their lifetime traumatic events (TEs) and randomly selected one TE per respondent for PTSD assessment. DSMIV and ICD-10 PTSD were assessed for the 23,936 respondents who reported lifetime TEs in these surveys with the fully structured Composite International Diagnostic Interview (CIDI). DSM-5 and proposed ICD-11 criteria were approximated. Associations of the different criteria sets with indicators of clinical severity (distress-impairment, suicidality, comorbid fear-distress disorders, PTSD symptom duration) were examined to investigate the implications of using the different systems.

Results—A total of 5.6% of respondents met criteria for “broadly defined” PTSD (i.e., full criteria in at least one diagnostic system), with prevalence ranging from 3.0% with DSM-5 to 4.4% with ICD-10. Only one-third of broadly defined cases met criteria in all four systems and another one third in only one system (narrowly defined cases). Between-system differences in indicators of clinical severity suggest that ICD-10 criteria are least strict and DSM-IV
criteria most strict. The more striking result, though, is that significantly elevated indicators of clinical significance were found even for narrowly defined cases for each of the four diagnostic systems.

**Conclusions**—These results argue for a broad definition of PTSD defined by any one of the different systems to capture all clinically significant cases of PTSD in future studies.’

‘Discussion: Fifth, little evidence could be found for significant differences in socio-demographic, trauma-related, or prior lifetime psychopathological (including both fear/distress and behavioral/substance disorders) predictors of PTSD across the different systems, indicating that there is a similar underlying risk profile for PTSD irrespective of the definition. This general pattern, and especially the finding that the associations of prior psychopathology with PTSD are indistinguishable across the four diagnostic systems, adds support to the argument above that all four definitions are providing information on unique clinically significant cases that are omitted from the other systems.

These findings extend previous work comparing different diagnostic criteria sets for PTSD, and are consistent with the argument that refinements to DSMIV aimed at removing symptoms that overlap with those of other mood and anxiety disorders, are not associated with a major change in prevalence of PTSD, nor with evidence of a change in disability, comorbidity, or structural validity. Based on these findings, we suggest that broadly defined PTSD may be a particularly useful additional construct in future epidemiological studies of PTSD.’

**Galia Plotkin Amrami; Genealogy of 'national trauma', looping effect and different circles of recognition of new professional category; National Trauma Discourse in Israel; ethics.tau.ac.il/en/wp-content/uploads/.../national-trauma-gp.docx**

‘It is reasonable to assume that the development and 'social validation' of the narrative of collective trauma reflects more than changes in trauma theory (the appearance of “distant trauma” and its “raw material” - partial PTSD). It might be also evidence of moral and political assumptions that have become part of the current "trauma culture" (Brunner 2002, 2004). In inspiration of Brunner’s distinction between the "culture of suspicion" and "culture of compassion", it’s possible to define the trauma culture, developed in the Western therapeutic field, as a "culture of compassion". In this case, "compassion" refers to the expansion/adaptation/ transformation of the iconic (DSM) version of mental trauma so that it can include many psychologically normal individuals who were not directly exposed to the traumatic event.’

**Complex Trauma**

*Both Thinking and facts are changeable, if only because changes in thinking manifest themselves n changed facts. Conversely, fundamentally new facts can be discovered only through new thinking.*

*Ludwick Fleck; Genesis and development of a scientific fact.*

**Trauma & Dissociation; Complex Post-traumatic Stress Disorder; http://traumadissociation.com/complexptsd**

‘Judith Lewis-Herman, who first proposed Complex PTSD as a separate diagnosis, stated: Observers who have never experienced prolonged terror, and who have no understanding of coercive methods of control, often presume that they would show greater psychological resistance than the victim in similar circumstances. The survivor’s difficulties are all too easily attributed to underlying character problems, even when the trauma is known. When the trauma is kept secret, as is frequently the case in sexual and domestic violence, the survivor’s symptoms and behavior may appear quite baffling, not only to lay people but also to mental health professionals.’

**Van der Kolk, Bessel A. MD; Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories.**

‘The traumatic stress field has adopted the term “Complex Trauma” to describe the experience of multiple and/or chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early-life onset. These exposures often occur within the child’s caregiving system and include physical, emotional, and educational neglect and child maltreatment beginning in early childhood (see Cook et al, this issue, Spinazzola et al this issue).’
'Complex PTSD is typically the result of exposure to repeated or prolonged instances or multiple forms of interpersonal trauma, often occurring under circumstances where escape is not possible due to physical, psychological, maturational, family/environmental, or social constraints (Herman, 1992). Such traumatic stressors include childhood physical and sexual abuse, recruitment into armed conflict as a child, being a victim of domestic violence, sex trafficking or slave trade; experiencing torture, and exposure to genocide campaigns or other forms of organized violence.'

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

'It is a continuing anomaly that current established guidelines for the treatment of trauma relate to post-traumatic stress disorder (PTSD) are inadequate to address the many dimensions of complex trauma. The differences between complex (cumulative, interpersonally generated) trauma and `single-incident’ trauma (PTSD) are significant.’

Understanding of complex trauma as interpersonally generated and cumulative (as distinct from ‘single-incident’) reveals the scope of the challenges at issue. Such challenges relate not only to the many people who experience and are affected by complex trauma, but to public health systems per se. Bessel van der Kolk notes that ‘[t]he majority of people who seek treatment for trauma-related problems have histories of multiple traumas’. This underlines the current disparity between the prevalence of complex trauma, and the risks of its lack of detection (and thus compounding effects).

'The current research pertaining to complex trauma has major implications both for treatment of the diversity of trauma-related presentations and general service-delivery. Specifically, the practical potential of the research base in the neurobiology of attachment necessitates revised practice in two major regards. These are updated treatment of trauma in its many presentations (trauma-specific) and (2) comprehensive implementation of service-wide principles which are underpinned by the new insights (trauma-informed). Guidelines are required for both these areas if the insights of this pioneering research are to be applied.’

NCTSN: Assessment of Complex Trauma; http://www.nctsn.org/trauma-types/complex-trauma/assessment

'Developing a comprehensive framework for assessing both the exposure to, and impact of, complex trauma is vital. Complex trauma can have such pervasive impact on developmental trajectories that children often end up with problems across many domains of functioning. A child’s self-image is also profoundly affected. Many of these children end up feeling like they are “bad kids” who just can’t change no matter what they try. These children may be diagnosed with a range of disorders, and consequently treated with multiple medications and therapies that are ultimately ineffective because they fail to address the underlying problem and do not reflect a trauma-informed approach to assessment and treatment.'

Trauma & Dissociation; Complex Post-traumatic Stress Disorder; http://traumadissociation.com/complexptsd

‘The diagram shows the additional symptoms present in Complex PTSD, compared to PTSD, and is based on research from 2013.’
‘The urgency and horror of acute psychological trauma often beguiles practitioners and researchers into focusing on the impact of a single event within the person’s current life experience. Yet for many victims of violence, this single event may be one event of many traumatic experiences.’

- **Complex or repetitive trauma** is related to ongoing abuse, domestic violence, war, ongoing betrayal, often involving being trapped emotionally and/or physically.
- **Developmental trauma** results from exposure to early ongoing or repetitive trauma (as infants, children and youth) involving neglect, abandonment, physical abuse or assault, sexual abuse or assault, emotional abuse, witnessing violence or death, and/or coercion or betrayal. This often occurs within the child’s care giving system and interferes with healthy attachment and development.
- **Intergenerational trauma** describes the psychological or emotional effects that can be experienced by people who live with trauma survivors. Coping and adaptation patterns developed in response to trauma can be passed from one generation to the next.
- **Historical trauma** is a cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma. These collective traumas are inflicted by a subjugating, dominant population. Examples of historical trauma include genocide, colonialism (for example, Indian hospitals and residential schools), slavery and war. Intergenerational trauma is an aspect of historical trauma.”
‘It is now well established that the majority of people who report exposure to trauma have experienced multiple traumas rather than a single incident or event (Kessler, 2000). A subset of these individuals experience circumstances such as childhood abuse or genocide campaigns under which they are exposed for a sustained period to repeated instances or multiple forms of trauma. This type of experience, called complex trauma, creates risk for a symptom profile distinguishable from posttraumatic stress disorder (PTSD), commonly referred to as complex PTSD (Herman, 1992).’

‘The symptom profile of Complex PTSD recognizes the loss of emotional, social, cognitive and psychological competencies that either failed to develop properly or that deteriorated due to prolonged exposure to complex trauma. The treatment for Complex PTSD, then, emphasizes not only the reduction of psychiatric symptoms, but equally, improvement in key functional capacities for self-regulation and strengthening of psychosocial and environmental resources.’

‘Believing yourself to be “contaminated, guilty, and evil” is commonly reported by survivors of Complex PTSD. A fragmented identity is common, with Dissociative Identity Disorder occurring in some people. Interpersonal sensitivity includes having feelings which are easily hurt, anger/temper outbursts. Complex PTSD is normally the result of interpersonal trauma, the long duration of the trauma and the control of the perpetrator(s) prevents people from expressing anger or rape at the perpetrator(s) during the trauma; anger and rage both at perpetrators and the self can only be expressed after the trauma ends. Prolonged abuse normally leads to a loss of previously-held beliefs, with feelings of "being forsaken by both society and God".

Being unable to manage your own emotions is known as affect dysregulation, and often referred to as difficulties with emotion regulation. The unexpressed anger and internalized rage may lead to self-harm, a sense of self-hatred, and/or suicide attempts. Survivors of prolonged child abuse have an increased risk of self-injury, and the risk "repeated victimization" (e.g., relationships with abusive people, sexual harassment and rape) is significantly higher.’

‘The clinical picture of a person who has been reduced to elemental concerns of survival is still frequently mistaken for a portrait of the survivor's underlying character." Complex PTSD, BPD and Personality Disorders Recent research has produced detailed analysis of the symptoms of Complex PTSD, PTSD and Borderline Personality Disorder (BPD). Many people with BPD have either PTSD, or meet the proposed criteria for Complex PTSD, but Complex PTSD was shown to be a separate diagnosis because a significant number did not meet the BPD criteria (and vice versa).

In 1992, when first proposing Complex PTSD, Judith Lewis-Herman stated: Concepts of personality developed in ordinary circumstances are frequently applied to survivors, without an understanding of the deformations of personality which occur under conditions of coercive control. Thus, patients who suffer from the complex sequelae of chronic trauma commonly risk being misdiagnosed as having personality disorders. They may be described as "dependent," "masochistic," or "self-deceiving."’

‘The assessment of complex trauma is by definition “complex” as it involves both assessing children’s exposure to multiple traumatic events, as well as the wide-ranging and severe impact of this trauma exposure across domains of development. It is important that mental health providers, family members, and other caregivers become aware of specific questions to ask when seeking the most effective services for these children.

The following are some key steps for conducting a comprehensive assessment of complex trauma:

1. Assess for a wide range of traumatic events. Determine when they occurred so that they can be linked to developmental stages.
2. Assess for a wide range of symptoms (beyond PTSD), risk behaviors, functional impairments, and developmental derailments.
3. Gather information using a variety of techniques (clinical interviews, standardized measures, and behavioral observations.
4. Gather information from a variety of perspectives (child, caregivers, teachers, other providers, etc).
5. Try to make sense of how each traumatic event might have impacted developmental tasks and derailed future development. Note: this may be challenging given the number of pervasive and chronic traumatic events a child may have experienced throughout his or her young life.

6. Try to link traumatic events to trauma reminders that may trigger symptoms or avoidant behavior. Remember that trauma reminders can be remembered both in explicit memory and out of awareness in the child’s body and emotions.

The assessment should be conducted by a clinically trained provider who understands child development and complex trauma. Ideally, the assessment should involve a multi-disciplinary team. An ideal team would include a pediatrician, mental health professional, educational specialist, and, where appropriate, an occupational therapist. In residential, day treatment, and juvenile justice settings, a multi-disciplinary team might also include direct care staff familiar with the child."


‘The recommended treatment model involves three stages or phases of treatment, each with a distinct function. Phase 1 focuses on ensuring the individual’s safety, reducing symptoms, and increasing important emotional, social and psychological competencies. Phase 2 focuses on processing the unresolved aspects of the individual’s memories of traumatic experiences. This phase emphasizes the review and re-appraisal of traumatic memories so that they are integrated into an adaptive representation of self, relationships and the world. Phase 3, the final phase of treatment, involves consolidation of treatment gains to facilitate the transition from the end of the treatment to greater engagement in relationships, work or education, and community life.’

‘The recommendation of a phase-based approach as the optimal treatment strategy for Complex PTSD is consistent with those offered by other expert bodies focusing on trauma spectrum disorders (e.g., the Australian Center for Posttraumatic Mental Health, 2007; the International Society for the Study of Trauma and Dissociation, 2011; and the National Institute for Clinical Excellence, 2005; American Psychological Association Division 56 (Trauma Psychology) and International Society for the Study of Trauma and Dissociation, in preparation), suggesting uniformity of opinion on best practices, broadly conceived, for the effects of complex trauma.’

Optimization of outcomes also includes exploration of novel treatment approaches such as complementary medicine strategies that focus on somatosensory experience and the mind-body relationship, for which there is emerging evidence regarding efficacy (e.g., Telles, Singh, & Balkrishna, 2012). Lastly, the development of clinician-friendly algorithms that identify preferential treatments based on patient symptom presentation (see e.g., Baars, Van der Hart, Nijenhuis, Chu, Glas, & Draijer, 2011) would facilitate effective treatment matching in community clinics.

‘At the present time, the use of a phase-based treatment approach for adults with Complex PTSD has excellent consensus as well as two Level A (randomized controlled) studies supporting its use. Evidence supports the benefit of this treatment approach in enhancing outcomes related to PTSD symptoms, and equally importantly, in resolving other key aspects of this disorder, including persistent and pervasive emotion regulation problems, disturbances in relational capacities, alterations in attention and consciousness (e.g., dissociation), adversely affected belief systems, and somatic distress or disorganization. In addition, the guidelines recognize and highlight the importance of flexible, patient-tailored treatments where interventions are matched to prominent symptoms.’

Maryle ne Cloitre, Donn W. Garvert, Chris R. Brewin, Richard A. Bryant and Andreas Maercker; Evidence for proposed ICD-11 PTSD and complex PTSD: a latent profile analysis; European Journal of Psychotraumatology 2013, 4: 20706 - http://dx.doi.org/10.3402/ejpt.v4i0.20706

Some concern has been expressed about the overlap of symptoms that occurs between the complex PTSD and BPD diagnoses (e.g., Resick et al., 2012). From a clinical utility perspective, the disorders are quite distinct. Complex PTSD focuses on the effects of trauma, has PTSD symptoms as a core element of the disorder, and is associated with a treatment plan that includes the relatively rapid treatment of PTSD symptoms through trauma-focused interventions. The most salient and clinically relevant features of BPD are high risk of suicide, suicide attempts and self-injurious behavior and the diagnosis and its effective treatment has been organized around these issues (Linehan, 1993). In addition, the nature of self-concept and interpersonal difficulties in BPD emphasize problems with a lack of a stable selfconcept and fears of abandonment. In contrast, complex PTSD is defined by the presence of a stable negative selfconcept and avoidance of relationships. These differences have significant implications for treatment.
'The research base in complex trauma is substantial. At this point there is sufficient evidence to constitute what Courtois, Ford & Cloitre call an ‘evolving evidence-base for preliminary treatment recommendations and provisional best practices for complex traumatic stress disorders’. In this context, it is also important to emphasise that while dynamically evolving, the foundational principles for effective treatment of complex trauma are now solid – the core problems of affect dysregulation, structural dissociation, somatic dysregulation, impaired self-development and disorganised attachment are likely to remain the foundation for clinicians working with survivors of complex trauma, regardless of the specific diagnosis or assessment and treatment methodologies in use.

The approach of Courtois, Ford & Cloitre is to present ‘preliminary best practice guidelines based on [the]growing evidence base’. This involves ‘an array of approaches to clinical assessment and treatment that includes carefully designed adaptations of familiar evidence-based protocols’ as well as ‘novel assessment tools and therapeutic models’ specifically designed to address the multiple dimensions of complex trauma.’


‘The gap between the evidence and expert opinion about the presence of and interventions for complex PTSD provides a strong rationale for research about complex trauma populations and their treatment. We have three specific recommendations for future research:

(a) the development and routine use of brief, reliable measures that assess the full range of symptoms described in PTSD and complex PTSD;
(b) evaluation of the relative merits of single-stage trauma-focused therapies versus multicomponent and/or sequential therapies for different symptom sets and different patient populations; and
(c) sustained monitoring of symptoms during the course of treatment and during extended follow-up phases in order to identify the speed and durability of treatment effects.’

‘Identification of the optimal treatments for different trauma-related syndromes and disorders is a critical next step in the trauma research agenda. Systematic research is necessary to determine what kinds of therapeutic strategies and interventions maximize benefits for specific patient populations. This includes tests of the current paradigm such as direct comparison of sequential versus single mode trauma-focused therapies, testing the order of the components in phase-based therapies (e.g., skills-to-exposure versus exposure-to-skills), and evaluating rate of change to identify the length of treatment that yields maximum benefit.’

Matthias Knefel and Brigitte Lueger-Schuster; An evaluation of ICD-11 PTSD and complex PTSD criteria in a sample of adult survivors of childhood institutional abuse; European Journal of Psychotraumatology 2013, 4: 22608 - http://dx.doi.org/10.3402/ejpt.v4i0.22608; August 2014.

‘The gender-specific evaluation for ICD-10 PTSD shows the typically observed higher prevalence of PTSD in women (Brewin et al., 2000; Ozer et al., 2003; Tolin & Foa, 2006). The prevalence of ICD-11 PTSD and CPTSD together shows the same unbalanced distribution. Interestingly, this imbalance disappears in ICD-11 PTSD, and seems to shift towards CPTSD: no gender difference was observed in ICD-11 PTSD, but it was observed in CPTSD. Experiencing CPTSD symptoms such as affect dysregulation, negative self-concept, interpersonal problems, and higher arousal, seems to be more representative of females. The question that arises is: where does this gender bias come from?’

‘Does this symptom representation border on a stereotypical role definition that considers women generally weaker and more emotionally focused than men? Costa, Terracciano, and McCrae (2001) found very robust empirical
support for gender stereotypes across cultures: women report higher values in neuroticism, agreeableness, warmth, and openness to feelings, while men scored higher in assertiveness and openness to ideas. Moreover, Kimerling, Ouimette, and Weitlauf (2007) hint at the issue that social roles may moderate the impact of posttrauma responses (e.g., helplessness and emotional distress), as posttrauma cognitions are more consonant for women (Baker et al., 2005). Based on these findings, a female stereotype of posttrauma symptoms might also include lamenting, irritability or nervousness, a tendency to be reluctant to confront issues, and problems concerning self-concept. It appears that CPTSD is a female-dominated disorder. Further replication of this result is needed and future research should address the specific mechanisms underlying a potential gender bias in CPTSD. Reliable and valid instruments for screening and clinical diagnostics based on the proposed criteria should be developed and tested.

‘The structure of CPTSD repeatedly shows good construct validity, although further research should address the question of gender-specific construct validity. The question whether CPTSD represents a distinct or a sibling disorder is not yet clear; nevertheless, the present results suggest that both approaches are promising. We therefore conclude that in addition to the CPTSD specific symptoms, the inclusion of some PTSD symptoms might be the best way to define CPTSD.’

NCTSN: Assessment of Complex Trauma; http://www.nctsn.org/trauma-types/complex-trauma/assessment

‘Children with complex trauma often end up in multiple child-serving systems (e.g., mental health, child welfare, education, juvenile justice) with needs that are both complex and severe. These children may carry multiple diagnoses (e.g., bipolar disorder, attention deficit hyperactivity disorder, etc.) and may be taking various types of medications to address their symptoms, especially when the professional making the diagnoses is unaware of their trauma histories. Furthermore, professionals in each system may use different frameworks to understand children and have varying degrees of understanding of complex trauma. This situation leaves children with complex trauma at risk of being misunderstood, misdiagnosed, and thus “mis-treated.” Child-serving systems must work together to develop a common framework for assessment of complex trauma that can still work within the context of each particular system. Such a comprehensive framework can improve communication across providers and caregivers, and ultimately improve the care of the children and families entrusted to these systems.’

Continuous Trauma

“Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control – precisely the beliefs that were shattered by the original traumatic experiences”.-Judith Herman, 1992

Lane Benjamin and Sarah Crawford Brown (South Africa); The psychological impact of continuous traumatic stress -- limitations of existing diagnostic frameworks

‘(!), we define continuous trauma as a pattern of mental health presentation arising from living within a neighbourhood with high levels of community, gang and criminal violence from an early age, where violence has been witnessed or experienced repeatedly, and where the person recovers within this context of ongoing threat.’

Romeo Vitelli; When the Trauma Doesn’t End; Psychology Today, 2013.

‘Though exposure to traumatic events such as natural and man-made disasters can damage mental and physical health, what happens when the trauma never ends? When we talk about posttraumatic stress disorder (PTSD), it usually means people dealing with traumatic experiences in their past. Still, some trauma victims may find themselves trapped in dangerous environments where they can easily become re-victimized. And they often have little choice but to face that risk for years, or even decades.'
Back in the 1980s before apartheid was abolished, mental health professionals dealing with victims of political repression in South Africa found that the usual treatment for PTSD provided little help for people living in fear that the victimization could happen again at any time. According to Gillian Straker and her colleagues at South Africa’s Sanctuaries Counseling Team, helping people heal after trauma often focused on providing them with a safe haven where that healing could take place. ‘In countries where the ever-present threat of arrest or violence continues to exist, dealing with *continuous traumatic stress*(CTS) posed unique problems for therapists.’

*Trauma Abuse Treatment; CTSD, (Continuous Traumatic Stress Disorder) [http://traumaabusetreatment.com/ctsd-continuous-traumatic-stress-disorder](http://traumaabusetreatment.com/ctsd-continuous-traumatic-stress-disorder)*

‘To process trauma, patients need help, which often involves a combination of counseling and medical care. However, when trauma occurs on a continual basis, the results can be even more devastating and challenging to treat. South African writer Frank Chikane in 1986 first used the term CTSD as he explored how apartheid affected a generation of children. He noticed that people can suffer from CTSD due to the following experiences:

- Long-term bullying
- Being raised by an alcoholic parent
- Constant exposure to violence
- Poverty
- Police brutality
- Workplace inequality
- Homelessness
- Food insecurity and malnutrition

While similar to PTSD, this condition has its unique causes, so people will need specialized treatment to recover.

While adults can certainly experience continual trauma, children are especially vulnerable to its effects. The brains of children and infants are constantly creating new neurological connections, so trauma will force their brains to form in abnormal ways. The cumulative effect of CTSD leads to the following symptoms:

- Learning disabilities
- Panic attacks
- Dissociative disorders
- General sickness and immune deficiency
- Violent and impulsive behavior
- Insomnia
- Substance abuse and addiction later in life

Young people affected by CTSD are more likely to be incarcerated as adults, and they are more likely to die at a younger age due to violence, substance abuse or suicide.’

*Gillian Eagle & Debra Kaminer; Continuous Traumatic Stress: Expanding the Lexicon of Traumatic Stress; Peace and Conflict: Journal of Peace Psychology; 2013, Vol. 19, No. 2, 85–99*

‘Despite substantial theoretical and empirical advances in the field of traumatic stress since the introduction of the diagnosis of posttraumatic stress disorder (PTSD) into the mental health nomenclature, existing conceptualizations of traumatic stress retain the assumption that traumatic experiences have occurred in the past. We propose continuous traumatic stress (CTS) as a supplementary construct within the lexicon of traumatic stress, to describe the experience and impact of living in contexts of realistic current and ongoing danger, such as protracted political or civil conflict or pervasive community violence.’

‘Herman’s (1992) conceptualization of CPTSD is a formulation that has gained increasing purchase in the trauma literature, despite the likelihood that it will not become included as a formal diagnostic category in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, in press; see Resick et al., 2012). Herman (1992) introduced the idea of C-PTSD into the literature specifically to describe the clinical presentation of persons who had been exposed to prolonged and repeated traumatic stressors, most often in situations that were inescapable. She proposed that adults with histories of childhood abuse, survivors of intimate partner violence, prisoners of war, concentration camp survivors, and girls forced into sex slavery, among others,'
were likely to present quite differently from those who had experienced single-event traumas. Drawing upon her own observations and the work of a range of other theorists and researchers, she proposed that there are specific symptomatic, characterological, and relational patterns that can be identified in these kinds of populations (Herman, 1992).

Reading Herman’s original 1992 paper on C-PTSD, it is evident that much of the theorization pertains to conditions of pathological bondage to a powerful, persecutory object stimulated by prolonged, forced interaction with, and dependence upon, such a personage. She writes in the introductory section of the paper, “Captivity, which brings the victim into prolonged contact with the perpetrator, creates a special type of relationship, one of coercive control” (Herman, 1992, p. 377), and further argues that this control is “based upon the systematic, repetitive infliction of psychological trauma. These methods are designed to instil terror and helplessness, to destroy the victim’s sense of self in relation to others, and to foster a pathologic attachment to the perpetrator” (p. 384).

‘As opposed to C-PTSD or developmental trauma disorder, which occur in the context of more intimate or established relationships (such as between prison guard and prisoner, or between abusive parent and child), CTS is understood to occur in contexts in which danger and threat are largely faceless and unpredictable, yet pervasive and substantive. The first kind of context in which CTS is likely to be observed is in conflict-affected zones, such as those in which there is low intensity warfare, in which there are frequent terrorist attacks, including upon civilian targets, or in which repressive state forces operate with impunity. In relation to war and political conflict, Summerfield (1999) observes, “it becomes a permanent emergency, something constant and internal that colors the whole web of relations across the society and the daily calculations of its citizens”

The second common context for CTS is that of chronic community violence, especially where gangs are dominant and state security forces are unable to intervene to protect community members. Such circumstances have been observed in Mexico City (Etter, 2011), in the favelas of Brazil (Arias & Davis Rodrigues, 2006), and in the Cape Flats communities of South Africa (Shields, Nadasen, & Pierce, 2008). A third context in which we have observed that CTS may be prominent is in respect of people who have been displaced by virtue of persecution or warfare who find themselves living in xenophobic contexts in which they are preyed upon by others in society. For example, in South Africa, refugees, asylum seekers, and immigrants who have fled violence-torn countries on the African continent are disproportionately subject to harassment, muggings, and criminal attack (Landau, 2006).’

‘...the notion of CTS assumes a different temporal focus, one that appears to require alternative or supplementary theorization of mechanisms of traumatization. Whereas those living in contexts of ongoing threat have often experienced prior exposure to traumatic events, and often multiple prior exposures, the primary preoccupation in CTS is with their current and future safety, rather than with past events.’

‘It is evident that even if one chooses not to ascribe pathology to CTS-related responses in the more pejorative sense of disability or malfunction, these responses may nonetheless be understood as running counter to well-being and optimal mental and psychosocial health.’

**Developmental Trauma**

“If clinicians fail to look through a trauma lens and to conceptualize client problems as related possibly to current or past trauma, they may fail to see that trauma victims, young and old, organize much of their lives around repetitive patterns of reliving and warding off traumatic memories, reminders, and affects.”

Moroz, K. The Effects of Psychological Trauma on Children and Adolescents; 2005
‘Definition: DTD is a diagnostic proposal for DSM-5, authored by Bessel van der Kolk and colleagues. The concept of DTD is based on a wide array of research data that comprises tens of thousands of children across multiple research studies. DTD results from growing up in an interpersonal context of ongoing danger, maltreatment, unpredictability, and/or neglect. 80% of all child maltreatment is at the hands of children’s own parents. Maltreatment embeds “hidden traumas” in infant - caregiver interactions that are neglectful, intrusive, unpredictable, threatening, aggressive, rejecting, or exploitive. These interactions convey that the world is a dangerous, unreliable, and/or indifferent place that offers little or no safety. Given the highly limited capacities of infants / young children to assess risk, this lack of physical and/or emotional safety quickly rises to the level of a subjective survival threat (annihilation anxiety) even though the objective nature of the event may not actually be at that level. For this reason, such events do not warrant a diagnosis of PTSD because the events are not “imminently life threatening”, a criteria for PTSD. However, it is subjective perception, and not objective lethality, that determines trauma. Using PTSD criteria, the element of trauma gets missed, and the erroneous diagnostic process has begun.’

Major diagnostic criteria for DTD: There are seven major diagnostic criteria for DTD.

1. Witnessing or experiencing multiple adverse interpersonal events involving caretaker(s) for at least one year.
2. Affective and physiological dysregulation.
3. Attentional and behavioral dysregulation.
4. Self and relational dysregulation.
5. Chronically altered perception and expectations.
6. At least two posttraumatic symptoms.
7. Functional impairment- at least two of the following areas: academic, family, peers, legal, health.
8. Duration of disorder is at least 6 months.

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘Long-term biological and psychosocial stress can occur even in the absence of a threat to life or violation of bodily integrity (‘complex trauma constitutes objective threats not only to physical survival – but also to the development and survival of the self’). Such threats to self-development are especially dangerous and damaging in the context of young children, for whom the self is fragile because still developing.

In order to more accurately describe this trajectory, Bessel van der Kolk has proposed a new diagnosis of Developmental Trauma Disorder (DTD).80 Criteria for DTD stem from exposure to ‘developmentally adverse interpersonal trauma’ (eg abuse, betrayal and abandonment) and provide a diagnostic category for children which mirrors the complex trauma incorporated in the DESNOS (DSM) criteria for adults (subsequently included as associated features of PTSD). Significantly, DESNOS has been empirically shown to be linked to childhood exposure to interpersonal psychological trauma.

Building on these findings, ‘[t]he proposed DTD diagnosis for children with complex traumatic stress symptoms is even more specific in identifying ‘rage, betrayal, fear, resignation, defeat and shame’ as the subjective (A2) criterion for childhood complex traumatic stress disorders’.82 This new elaboration of the subjective dimensions of complex trauma presents a more nuanced account of what is at issue than currently figures in the standard classification of PTSD. But it also goes further. As Ford and Courtois discuss, inclusion within the DTD diagnosis of such dimensions as ‘shame’, ‘rage’ and ‘betrayal’ simultaneously widens clinical focus from the traditional emphasis on ‘fear’ and ‘anxiety’ to ‘the sense of a damaged self.’

‘Dissociation involves complex neural processes, and occurs beyond conscious awareness and control. It is a defensive response to what is unbearable (‘the escape when there is no escape’). It can also be reflexively deployed subsequent to the trauma in the absence of apparent threat (ie it can be activated by seemingly innocuous cues which serve as ‘reminders’ of the trauma). Effective treatment of complex trauma requires knowledge of dissociation, ability to recognise it, and skilful means of intercepting and working with it. As with attachment issues and ‘the window of tolerance’, the earlier it can be attuned to – including within the initial assessment – the better.'
Screening for dissociative tendencies, whether formally or informally, is optimal. This does not necessarily mean via administration of specific ‘tools’ (of which there are several, and not all of which, for a range of reasons, it may be appropriate to use). *Attunement* and *attentiveness* – as well as general openness to the possibility – is the therapeutic orientation to cultivate. As Shapiro relates, ‘[t]he more you know about dissociation, the more you automatically watch for its markers’. In addition to her ‘Affect Tolerance Assessment’, she provides a general ‘Dissociation Assessment’ which is likewise an informal means by which clinicians can begin to attune to potential signs. Therapists, she suggests, will ‘notice’ if, for example, a new client:

- Spaces out easily.
- Loses coherency when speaking about childhood events (Main, 1991; Siegel, 1999, 2007)
- Can’t remember much of childhood years
- Abruptly switches from calm discussion to a hostile, terrified, shut-down, or disorganised state
- Shows inappropriate affect when discussing distressing events
- Speaks in the third person about the self.’

‘In addition to the new conceptualisations of DTD (developmental trauma disorder) and ‘developmentally adverse interpersonal trauma’, references to ‘betrayal trauma’ and ‘relational trauma’ (particularly in the context of the now frequent references to ‘attachment disorders’) are increasingly common. These attempt to elucidate and convey the multi-facettedness and enormity of complex trauma, and the massive, wide-ranging impairments with which it is associated. Some respected trauma specialists explicitly utilise the new conceptualizations.’

Marc Schmid, Franz Petermann and Joerg M Fegert; *Developmental trauma disorder: pros and cons of including formal criteria in the psychiatric diagnostic systems*; Schmid et al. BMC Psychiatry 2013, 13:3 http://www.biomedcentral.com/1471-244X/13/3

‘Traumatized individuals are difficult to treat, but clinical experience has shown that they tend to benefit from specific trauma therapy. A main argument against inclusion of formal DTD criteria into existing diagnostic systems is that emphasis on the etiology of the disorder might force current diagnostic systems to deviate from their purely descriptive nature. Furthermore, comorbidities and biological aspects of the disorder may be underdiagnosed using the DTD criteria.’

![Developmental heterotopia of trauma](image-url)
Arguments in favor of formalized DTD diagnostic criteria. The following arguments support the initiative to include DTD as a distinct mental disorder in diagnostic systems:

- **More specific diagnosis**: The diagnosis of PTSD does not sufficiently take into account the symptoms of traumatized patients. The postulated DTD diagnostic criteria comprise a range of symptoms seen to occur after complex and repeated traumatization. For the diagnosis of DTD, traumatic experience is essential but not exclusive, and genetic and biopsychosocial origins of the disorder must be ruled out to specify the interaction between neurobiology, epigenetics and transgenerational traumatic life events and their consequences for the development of mental disorders. The existence of specific and validated DTD diagnostic criteria may sensitize professionals and the general public to the drastic consequences of child abuse, neglect, and traumatization. Moreover, the establishment of measures for e.g. child protection, policy making would be expedited.

- **Course of mental disorders**: The supporters of this initiative argue that more emphasis should be placed on developmental aspects of disorders caused by traumatization. The few longitudinal studies available indicate that more than 60% of adults with psychiatric disorders suffered from psychopathological symptoms during adolescence, and 77% exhibited symptoms before the age of 18 years. Furthermore, PTSD frequently becomes chronic. In a longitudinal study in adolescents with PTSD, 48% of patients still met the criteria for PTSD three to four years later.

- **Enhance research**: Establishment of formal diagnostic criteria for DTD is expected to stimulate research efforts in this area (e.g., epidemiological studies, developmental-psychopathological research). Cross-sectional and longitudinal studies on psychosocial risks and comorbidities during childhood and adolescence should be encouraged.

- **Explain comorbidities**: From a clinical point of view, the diagnosis of DTD focuses on traumatization as the psychopathological trigger of mental disorders. Several well-designed studies clearly demonstrated such correlations. Post-traumatic symptoms may occur together with other mental disorders. As many as 80% of PTSD patients meet the criteria for another disorder. In an evaluation of the ‘Dunedin longitudinal study’, Koenen et al. showed that all subjects meeting the criteria for PTSD in young adulthood had suffered from mental disorders at a young age. Conversely, other mental disorders may be present before PTSD or may develop after its occurrence. In particular, victims of sequential traumatization have an inherently high risk of developing a complex syndrome of disorders that often go hand-in-hand with single symptoms of PTSD without fulfilling the complete clinical picture of PTSD. In children and adolescents, comorbidities with ADHD, anxiety disorder, suicidal thoughts, and a trend towards affective disorders is highly prevalent.

- **Enable effective treatment**: By selectively treating trauma symptoms, patients can be stabilized, and concomitant illnesses (like anxiety disorder or depression) can be addressed. The effectiveness of therapeutic interventions in traumatized children and adolescents has been well documented in recent years. Spinazzola et al. pointed out that more attention should be given to naturalistic studies in inpatients suffering from psychosocial stress being at risk of suicide. Patients with severe interpersonal traumatization in childhood are the hardest to treat and have the poorest prognosis. Treatment may be constrained by insufficient understanding of the underlying illness, and patients often
cannot be reached by the psychosocial care system. Moreover, the degree of traumatization affects treatment success. Therefore, it is important to take the nature and severity of traumatic experiences into account when developing a treatment plan. With a more specific diagnosis, treatment options can be tailor-made.

**Social and legal aspects:** Many victims of neglect, child abuse, and maltreatment live on the edge of society and depend on social services for most of their lives. Failures at school and in youth welfare institutions are common. Clear definition of trauma-related symptoms could help to change attitudes towards delinquent or aggressive adolescents and facilitate the initiation of treatment [106]. Several studies have addressed the enormous healthcare costs arising from traumatization, such as medical treatment costs, early retirement, inability to work, need for social benefits, and even imprisonment. If the consequences of childhood traumatization were officially recognized, patients would benefit from improved social acceptance of their difficulties. Moreover, inclusion of mental disorders arising from complex traumatization in the official diagnostic systems would assist patients in obtaining compensation and legal support (court, victim aid). Many traumatized patients develop chronic mental disorders with serious impairment of their working ability and social interactions. Early and effective intervention is necessary to help patients to maintain a normal life style.‘

Van der Kolk and Pynoos were unsuccessful in getting Developmental Trauma Disorder in DSM 5, but are not being stopped in their efforts to gets DTD accepted practice globally.

*Van der Kolk, Bessel A. MD Robert S. Pynoos, M; Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in DSM-V*

‘The goal of introducing the diagnosis of Developmental Trauma Disorder is to capture the reality of the clinical presentations of children and adolescents exposed to chronic interpersonal trauma and thereby guide clinicians to develop and utilize effective interventions and for researchers to study the neurobiology and transmission of chronic interpersonal violence. Whether or not they exhibit symptoms of PTSD, children who have developed in the context of ongoing danger, maltreatment, and inadequate caregiving systems are ill-served by the current diagnostic system, as it frequently leads to no diagnosis, multiple unrelated diagnoses, an emphasis on behavioral control without recognition of interpersonal trauma and lack of safety in the etiology of symptoms, and a lack of attention to ameliorating the developmental disruptions that underlie the symptoms.”73

‘The recognition of the profound difference between adult onset PTSD and the clinical effects of interpersonal violence on children, as well as the need to develop effective treatments for these children, were the principal reasons for the establishment of the National Child Traumatic Stress Network in 2001. Less than eight years later it has become evident that the current diagnostic classification system is inadequate for the tens of thousands of traumatized children receiving psychiatric care for trauma-related difficulties.’

In a private paper, *Developmental Trauma Disorder: Towards a rational diagnosis for children with complex trauma histories*, Van der Kolk pulls no punches:

*Bessel A. van der Kolk, MD; Developmental trauma disorder: Towards a rational diagnosis for children with complex trauma histories.*

‘Childhood trauma, including abuse and neglect, is probably our nation’s single most important public health challenge, a challenge that has the potential to be largely resolved by appropriate prevention and intervention. Each year over 3,000,000 children are reported to the authorities for abuse and/or neglect in the United States of which about one million are substantiated[^1]. Many thousands more undergo traumatic medical and surgical procedures, and are victims of accidents and of community violence (see Spinazzola et al, this issue). However, most trauma begins at home: the vast majority of people (about 80 %) responsible for child maltreatment are children’s own parents.’

‘The ACE study showed that adverse childhood experiences are vastly more common than recognized or acknowledged and that they have a powerful relation to adult health a half-century later. The study unequivocally confirmed earlier investigations that found a highly significant relationship between adverse childhood experiences and depression, suicide attempts, alcoholism, drug abuse, sexual promiscuity, domestic violence, cigarette smoking, obesity, physical inactivity, and sexually transmitted diseases. In addition, the more adverse childhood experiences reported, the more likely a person was to develop heart disease, cancer, stroke, diabetes, skeletal fractures, and liver disease.’
‘Isolated traumatic incidents tend to produce discrete conditioned behavioral and biological responses to reminders of the trauma, such as are captured in the PTSD diagnosis. In contrast, chronic maltreatment or inevitable repeated traumatization, such as occurs in children who are exposed to repeated medical or surgical procedures, have a pervasive effects on the development of mind and brain. Chronic trauma interferes with neurobiological development (see article by Ford, this issue) and the capacity to integrate sensory, emotional and cognitive information into a cohesive whole. Developmental trauma sets the stage for unfocused responses to subsequent stress leading to dramatic increases in the use of medical, correctional, social and mental health services. People with childhood histories of trauma, abuse and neglect make up almost our entire criminal justice population: physical abuse and neglect are associated with a very high rates of arrest for violent offenses.’

**Dissociation**

“Dissociation is often described as watching what is happening from a third person point of view. The face and eyes of the perpetrator pierce into the soul of the victim and haunt them forever.”

*Reb Buxton, LPC-MHSP THRIVE! A Patient’s Guide To Therapy; © 2012, Reb Buxton* Self-publishing Mental Architects Counseling

“...dissociation, the escape when there is no escape, is inscribed into the right hemisphere, which is specialised for withdrawal and avoidance.*Schore

*Kezelman, C., Stavropoulos, P. Adults Surviving Child Abuse (ASCA) 2012 Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery.

Kezelman, C., Stavropoulos, P.  *Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012*

‘In a recent text, Ross and Halpern explicitly emphasise the response of dissociation ‘because it is a core component of the trauma response, and because dissociation is not as widely understood and recognised as depression, anxiety, psychosis, substance abuse, eating and personality disorders’. Understanding of the diverse manifestations of complex trauma is crucial both to recognition and appropriate treatment of it. Yet such understanding is unassisted by the standard diagnostic categories which themselves fragment the pervasiveness and totality of the effects of complex trauma.’

*Onno Van Der Hart and Rutger Horst; The dissociation theory of Pierre Janet; ARTICLE in JOURNAL OF TRAUMATIC STRESS · SEPTEMBER 1989; Impact Factor: 2.72 · DOI: 10.1007/BF00974598*

‘Pierre Janet was the first to show clearly and systematically how it is the most direct psychological defense against overwhelming traumatic experiences. He demonstrated that dissociative phenomena play an important role in widely divergent post-traumatic stress responses which he included under the 19th-century diagnosis of hysteria.

According to a recent definition, "dissociation represents a process whereby certain mental functions which are ordinarily integrated with other functions presumably operate in a more compartmentalized or automatic way usually outside the sphere of conscious awareness or memory recall" (Ludwig, 1983, p. 93). A similar description of dissociation was given by Pierre Janet a century ago. He was not the first to introduce this concept, but was its most important student. Janet’s dissociation theory is once again receiving deserved attention. Because he focuses on the role of dissociation in traumatically induced disorders, Janet’s theory is particularly relevant for research into traumatic stress.’

‘Most modern studies of traumatic stress focus almost exclusively on post-traumatic stress disorder. Janet’s work encourages us to seek the traumatic origins of a much wider range of disorders. Some such developments are already under way. Several studies in the field of dissociative disorders, in particular work on multiple personality disorder, indicate the traumatic origins in childhood of dissociative symptoms (cf. Gliss, 1986; Putnam et al., 1986; Ross and Norton, 1987; Shultz et al., 1985). Similar data have recently been reported with regard to borderline personality disorder (Herman et al., 1989).’

Van der Kolk, M.D. *The Body Keeps the Score – Brain mind and body in the healing of trauma*, Viking 2014

‘Dissociation is the essence of trauma. The overwhelming experience is split off and fragmented, so that the emotions, sounds, images, thoughts and physical sensations related to the trauma take on a life of their own. The sensory fragments of memory intrude into the present, where they are literally relived. As long as the trauma is not resolved, the stress hormones that the body secretes to protect itself keep circulating, and the defensive movements and emotional responses keep being replayed.

Flashbacks and reliving are in some ways worse than the trauma itself. A traumatic event has a beginning and an end – at some point it is over. But for people with PTSD, a flashback can occur at any time, whether they are awake or asleep. People who suffer from flashbacks often organise their lives around trying to protect against them. They may compulsively go to the gym to pump iron (but finding that they are never strong enough), numb themselves with drugs or try to cultivate an illusory sense of control in highly dangerous situations (like motorcycle racing, bungee jumping, or working as an ambulance driver). Constantly fighting unseen dangers is exhausting and leave them fatigued, depressed and weary.

If elements of the trauma are replayed again and again, the accompanying stress hormones engrave those memories ever more deeply in the mind.’


‘Dissociation is a state. It’s a protective mechanism called up by the nervous system when it reaches its maximum capacity to process stimulation (both internally and externally).

Imagine having to interact with people all day and by the end of the day you can't speak another word. You go home to regroup, anxious to get into your latest book. But you can't concentrate. You keep "floating" away into a thoughtless and timeless void. Oddly enough, your favourite book seems boring.

Dissociation caps the keyed up and restless energy underneath. It numbs the body so that one feels less internal distress. It’s a good temporary back up plan devised by nature for coping when we feel overwhelmed. But it has its drawbacks.

To the degree that you are dissociative, will be the degree of impairment in your ability to take appropriate fight or flight responses (e.g. being physically threatened). You see, dissociation is a type of freeze state.

In other words, you are more likely to move into an acute freeze state whether you want to or not (e.g. freezing at gun point during a bank robbery).’

‘When dissociation becomes chronic, it can feel unbearable. Addictive or self-injurious behaviours are common ways in which people seek temporary “relief”.

Chronic dissociation severely limits our perceptions. At some level we sense we’re operating on a different plane than the rest of the world. Although we know something is amiss we can’t put a finger on it.

Dissociation can make us feel invisible and powerless. It impairs the ability to connect with others to such a degree that we are unable to care for ourselves or others (e.g. as a mother might care for an infant).’

International Society for the Study of Trauma and Dissociation; http://www.isst-d.org/?contentID=76

‘Dissociation is a word that is used to describe the disconnection or lack of connection between things usually associated with each other. Dissociated experiences are not integrated into the usual sense of self, resulting in discontinuities in conscious awareness (Anderson & Alexander, 1996; Frey, 2001; International Society for the Study of Dissociation, 2002; Maldonado, Butler, & Spiegel, 2002; Pascuzzi & Weber, 1997; Rauschenberger & Lynn, 1995; Simeon et al., 2001; Spiegel & Cardeña, 1991; Steinberg et al., 1990, 1993). In severe forms of dissociation,
disconnection occurs in the usually integrated functions of consciousness, memory, identity, or perception. For example, someone may think about an event that was tremendously upsetting yet have no feelings about it. Clinically, this is termed emotional numbing, one of the hallmarks of post-traumatic stress disorder. Dissociation is a psychological process commonly found in persons seeking mental health treatment (Maldonado et al., 2002).

‘Dissociation may affect a person subjectively in the form of “made” thoughts, feelings, and actions. These are thoughts or emotions seemingly coming out of nowhere, or finding oneself carrying out an action as if it were controlled by a force other than oneself (Dell, 2001). Typically, a person feels “taken over” by an emotion that does not seem to makes sense at the time. Feeling suddenly, unbearably sad, without an apparent reason, and then having the sadness leave in much the same manner as it came, is an example. Or someone may find himself or herself doing something that they would not normally do but unable to stop themselves, almost as if they are being compelled to do it. This is sometimes described as the experience of being a “passenger” in one’s body, rather than the driver.’

‘There are five main ways in which the dissociation of psychological processes changes the way a person experiences living: depersonalization, derealization, amnesia, identity confusion, and identity alteration. These are the main areas of investigation in the Structured Clinical Interview for Dissociative Disorders (SCID-D) (Steinberg, 1994a; Steinberg, Rounsaville, & Cicchetti, 1990). A dissociative disorder is suggested by the robust presence of any of the five features.’


‘We recommend that consideration be given to adding a dissociative subtype of PTSD in the revision of the DSM. This facilitates more accurate analysis of different phenotypes of PTSD, assist in treatment planning that is informed by considering the degree of patients’ dissociativity, will improve treatment outcome, and will lead to much-needed research about the prevalence, symptomatology, neurobiology, and treatment of individuals with the dissociative subtype of PTSD.’


‘Although the proposal for a dissociative subtype of PTSD in DSM-5 is supported by considerable clinical and neurobiological evidence, this evidence comes mostly from referred samples in Western countries. Cross-national population epidemiologic surveys were analyzed to evaluate generalizability of the subtype in more diverse samples.’

‘Dissociative symptoms were present in 14.4% of respondents with 12-month DSM-IV/Composite International Diagnostic Interview PTSD and did not differ between high and low/middle income countries. Symptoms of dissociation in PTSD were associated with high counts of re-experiencing symptoms and net of these symptom counts with male sex, childhood onset of PTSD, high exposure to prior (to the onset of PTSD) traumatic events and childhood adversities, prior histories of separation anxiety disorder and specific phobia, severe role impairment, and suicidality. Conclusion: These results provide community epidemiologic data documenting the value of the dissociative subtype in distinguishing a meaningful proportion of severe and impairing cases of PTSD that have distinct correlates across a diverse set of countries.’
Re-Traumatization

“A sense of control, volition, and self-confidence are methodically stripped away by pimps/traffickers who utilize fear, violence and mind-control techniques to keep girls loyal and compliant.”

Rachel Lloyd; Founder/Executive Director From Victim To Survivor, From Survivor To Leader. The importance of leadership programming and opportunities for commercially sexually exploited and trafficked young women & girls; Girls Educational and Mentoring Services, GEMS

Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012

‘While confronting to contemplate, the re-traumatisation of already traumatised people by and within diverse services of the health sector is highly prevalent. Research establishes that service practices which lead to retraumatisation rather than recovery are not exceptional, but pervasive and deeply entrenched. In fact research which supports this disturbing claim is growing. Recognition of the reality that ‘trauma has often occurred in the service context itself’ is a major impetus for introduction of ‘trauma-informed’ practice.’

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57, 2014

‘Re-traumatization: In its more literal translation, “re-traumatization” means the occurrence of traumatic stress reactions and symptoms after exposure to multiple events (Duckworth & Follette, 2011). This is a significant issue for trauma survivors, both because they are at increased risk for higher rates of re-traumatization, and because people who are traumatized multiple times often have more serious and chronic trauma-related symptoms than those with single traumas. In this manual, the term not only refers to the effect of being exposed to multiple events, but also implies the process of re-experiencing traumatic stress as a result of a current situation that mirrors or replicates in some way the prior traumatic experiences (e.g., specific smells or other sensory input; interactions with others; responses to one’s surroundings or interpersonal context, such as feeling emotionally or physically trapped).’

‘Even the most standard behavioral health practices can re-traumatize an individual exposed to prior traumatic experiences if the provider implements them without recognizing or considering that they may do harm…

...Re-traumatization occurs when clients experience something that makes them feel as though they are undergoing another trauma. Unfortunately, treatment settings and clinicians can create re-traumatizing experiences, often without being aware of it, and sometimes clients themselves are not consciously aware that a clinical situation has actually triggered a traumatic stress reaction.’

U.S. Department of Health and Human Services (DHHS); Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services (CMHS) How a Trauma-Informed Approach Can Make a Difference.

‘A state-wide effort should be made to reduce or eliminate any potentially re-traumatizing practices such as seclusion and restraint, involuntary medication, etc. Specific policies should be in place to acknowledge and minimize the potential for re-traumatization, assess relevant history, respect gender differences, and provide immediate intervention to mitigate effects should violence occur in care settings.’

William Steele, PsyD and Caelan Kuban, LMSW; Advancing Trauma-Informed Practices Bringing trauma-informed, resilience-focused care to children, adolescents, families, schools and communities. The National Institute for Trauma and Loss in Children.

‘If we only completed an assessment of a traumatized child and found, for example, that trauma had created sensory integration challenges, we would have a basis for treatment. However, if we design that treatment without being aware of the kinds of experiences that child actually faced, the treatment may further traumatize that child. If for example, a weighted blanket is recommended as part of the sensory integration treatment to help calm that activated child, but the child has been sexually abused and the full weight of an adult on top of them was part of that experience, that treatment, that blanket and the sensation of heaviness, could in fact re-traumatize that child. Not having information about the details of the experiences associated with trauma places that child at greater risk when determining treatment. What then are the primary experiences of trauma, and subsequent implications for treatment and intervention?’
The re-victimization of adults who have previously been traumatized as children appears to be an all-too-common occurrence. In clinical work with adults who have been severely abused as children, mental health professionals have repeatedly observed re-victimizations such as physical or sexual assault, some of which seem to mirror the traumatic childhood experiences. Research statistics support this apparent high incidence of re-victimization.

In addition to negative effects of the psychological (and perhaps biologic) need to rework early experiences, childhood abuse also has profound negative effects on individuals’ later adaptability to their environment and resilience with respect to aversive experiences. Unless the cycle of victimization is broken by effective treatment, people who have suffered childhood abuse continue to be at risk for the recurrence of traumatic and harmful experiences. Those who treat past victims of childhood trauma need to realize fully the extent to which these individuals are at risk for re-victimization.

Discussions of re-victimization are often controversial, particularly when they focus primarily on the victim and do not address issues related to the perpetrator. This discussion has outlined how survivors of abuse play a role in their own re-victimization and how the mechanisms of re-victimization need to be understood and overcome. Therapists need to work with patients so that they are able to take personal responsibility for their own safety, but this is not to imply that patients are to blame for being re-victimized. An understanding that people with histories of early abuse are intensely vulnerable to subsequent re-victimization should in fact only serve to underscore the responsibility of a perpetrator who intentionally inflicts harm on another.
**Masking Trauma**

“As I walked out the doors towards my freedom, I knew that if I did not leave all the anger, hatred and bitterness behind, I would still be in prison.” **NELSON MANDELA**

The literature on Masking does not come easy. It is therefore an invention of this document. There are, however, many references where the word Masking can easily be inserted and the purpose of the upfront challenge can be interpreted without too much test to the imagination. Let’s leave that to you the reader...

*Dan J Stein A New Mental Health policy for South Africa; HMPG Editorial;*

‘**Masking** (personality) is a process in which an individual changes or "masks" their natural personality to conform to social pressures, abuse, and or harassment. Some examples of masking are a single overly dominant temperament, or humour, two incongruent temperaments, or displaying three of the four main temperaments within the same individual. Masking can be strongly influenced by environmental factors such as authoritarian parents, rejection, and emotional, physical, or sexual abuse. An individual may not even know he or she is wearing a mask because it is a behaviour that can take many forms.’


‘The suicide rate has shot up in Nicaragua, but while suicide is yet another manifestation of the multiple wounds phenomenon, we shouldn’t center all reflection on it. There are other daily ways of avoiding pain that are slower forms of suicide and are much more common in our country. Alcoholism, as an example, is very widespread in Nicaragua and even in the organizations, but no one has really reflected on this problem.’

*Kezelman, C., Stavropoulos, P. Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery. Adults Surviving Child Abuse (ASCA) 2012*

‘A key and consistent finding, (), is the relationship between lack of processing and integration of traumatic memory and ongoing impairments across a wide range of functioning. Unable to process and ‘move on’ from the precipitating trauma(s), the traumatised person is incapacitated not only by the catalysing events or experiences (of which they may have no conscious recollection) but by various attempts to avoid potential reminders of what has been so injurious to them. Thus they are ‘caught in a loop’ in which attempts to escape the trauma amount to an unwitting revisiting of its effects. This occurs in the form of various debilitating symptoms and coping mechanisms, which massively affect not only the quality of life but which can endanger life itself.’

‘The point that problematic symptoms, behaviours and conditions can be the outgrowth of initially protective attempts to deal with trauma needs to be reiterated and emphasised. Such initial coping mechanisms may have been both resourceful and creative (as discussed in the previous chapter). But with the passage of time, they have ceased to serve a protective function, and themselves become undermining of health. This means that complex trauma can underlie a range of otherwise diverse presentations, which in turn receive diverse diagnoses that fail to account for the underlying trauma. This point is critical precisely because of the breadth of responses generated by the comprehensive nature of complex trauma.’

*William Steele, PsyD and Caelan Kuban, LMSW; Advancing Trauma-Informed Practices Bringing trauma-informed, resilience-focused care to children, adolescents, families, schools and communities. The National Institute for Trauma and Loss in Children.*

‘Neuroscience documents that children in trauma are governed predominately by the sensations associated with their traumatic memories – the sounds, smells, sensations of touch, and visual memories (NCTIC, 2011). When these senses are triggered or activated by similar sensations associated with a real or even a perceived sense of impending danger, they don’t think but simply act on their senses. This is why certain sounds, smells, environments, and even
people and the way they present themselves can activate primitive survival responses. We may be very caring and skilled practitioners but, if one of our physical features is similar to the person who did that “bad thing” to that child, he cannot feel safe with us and will immediately rely on his survival responses. Reason and logic are overruled. Survival behaviours are also formed, driven and repeated because of how children experienced past traumatic situations and how they are experiencing their current situation, environment and people in their environment. If they feel unsafe, threatened or powerless, their trauma related survival behaviours may be activated. When children are direct victims of repeated trauma, like abuse, or exposed to multiple traumas, survival behaviours become more acute and include primitive, survival directed, fight, flight and freeze behaviours.’

THE MORRIS CENTER; for healing from child abuse; Survivor to Thriver; Revised 7/99, www.ascasupport.org

‘Survivors often use a number of mechanisms to numb themselves when the feelings get too strong. Some may adopt a “workaholic” lifestyle in order to avoid the feelings. Others may try to “stuff” the feelings by compulsive eating or to anesthetize them by drinking or using drugs. Certain feelings such as anger and rage may be so strong that they dominate a survivor’s internal life and overshadow the other feelings that may also be there.’

Goldman, A. Ph.D. Behind the Corporate Mask Is a Traumatized Leader; Psychology Today Jan 31, 2012

‘Robin William’s isn’t the first comic to commit suicide. And, unfortunately, he won’t be the last. Many people mask their depression with humour. They learn early in life to hide their deepest, darkest feelings from others. Depressed people are not popular; they are encouraged to “lighten up.” And “lighten up” they do. They smile. They make others laugh. They make other people feel good. Sometimes in the process they can even experience their own humour and temporarily escape from their own pain. Not wanting to be a burden to others and believing that others do not want to hear their pain, they don’t turn to people for soothing and understanding. Instead, they internalize their pain often becoming loaners. Or they may turn to substance abuse.’

Reb Buxton, LPC-MHSP THRIVE! A Patient’s Guide To Therapy; © 2012, Reb Buxton’ Self-publishing Mental Architects Counseling

‘We typically avoid having deep and ongoing conversations with ourselves. We side-step this regular emotional maintenance by some form of distraction. It may be a football game or alcohol (or both!) four nights in a row then three hours of TV after dinner every other night. It may be shopping or going to bars after work most nights. We may avoid self-reflection by refusing to engage in meaningful dialogue with ourselves and our friends and family. We may use drugs or shopping or sex with strangers. Shopping, sex, and football are not inherently bad. Anything can be used to avoid the conversations that should be happening about our feelings. Others may try to “stuff” feelings by compulsive eating or to anesthetize them by drinking or using drugs. Certain feelings such as anger and rage may be so strong that they dominate a survivor’s internal life and overshadow the other feelings that may also be there.’

DORTHE BERNTSEN and DAVID C. RUBIN; When a Trauma Becomes a Key to Identity: Enhanced Integration of Trauma Memories Predicts Posttraumatic Stress Disorder Symptoms; Applied Cognitive Psychology Appl. Cognit. Psychol. 21: 417–431 (2007)

Many theories of how traumatic events affect memory and self-knowledge take their starting point in the idea that a trauma creates a profound imbalance in the mind of the victim. According to this widespread view, the trauma violates the schemata of the person, is therefore hard to process and as a result becomes poorly integrated into the self-narratives of the person (e.g. Ehlers & Clark, 2000; Horowitz, 1986; van der Kolk & Fisler, 1995; for a review, see Dalglish, 2004). In order to recover, the person has to accommodate his or her schemata to encompass the memory of the trauma.

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

‘... when Felitti (Vincent Felitti Kaiser Permanente’s Department of Preventative Medicine in San Diego – and initiator of the Adverse Childhood Experiences study) net saw her a few months later, she had regained more weight than he thought was biologically possible in such a short time. What had happened? It turned out that her newly svelte body had attracted a male co-worker, who started to flirt with her and then suggested sex. She went home and began to eat. She stuffed herself during the day and ate while sleepwalking at night. When Felitti probed this extreme reaction, she revealed a lengthy incest history with her grandfather.’

‘Twelve years after he originally treated her, Felitti again saw the woman...She told him that she’s subsequently had bariatric surgery but after she’d lost ninety-six pounds she’d become suicidal. It had taken five psychiatric hospitalisations and three courses of electroshock to control suicidality. Felitti points out that obesity, which is considered a major health problem, may in fact be a personal solution for many. Consider the implications: If you
mistake someone’s solution for a problem to be eliminated, not only are they likely to fail treatment, as often happens in addiction programs, but other problems may emerge.’

Reb Buxton, LPC-MHSP THRIVE! A Patient’s Guide To Therapy; © 2012, Reb Buxton’ Self-publishing Mental Architects Counseling

‘What is fear? Fear is the worst of the worst case scenario. If our fear is loneliness, our greatest fear is living a solitary life and dying alone. If our greatest fear is futility, failure and meaninglessness lurk around every corner. If our greatest fear is our own power, beauty, and strength, we will do anything to destroy what is good and lovely about ourselves and elevate our failings to validate the lie.’

‘The unforgiving messages generated by our fears permeate the depths of our heart, mind, soul and inevitably influence our day-to-day decisions. They emerge from the dark corners of our psyche at the most inconvenient times whispering the same vicious lies coated in a veneer of truth. These half-truths prevent us from embracing our lives and celebrating our individuality. In short, they zap our vitality by choking us with shame, discouragement, and yes, more fear. In this downward spiral our fear perpetuates more fear. If this is the atmosphere in which all that prevents us from thriving originates, it is no surprise then that this unholy space is not easily accessible nor prone to change without intense, intentional effort.’

Klinik Community Health Centre – Canada; Trauma-informed - The Trauma Toolkit Second Edition, 2013

‘Traumatic events often cause feelings of shame due to the powerlessness they create, which can lead to secrecy and further embed the experience of shame. It then becomes something to be greatly feared and avoided. It is at this point that negative coping behaviours may start and may continue until a person decides to face the difficult emotions that surround the traumatic experience.’


‘Factors that influence the creation as well as maintenance of the underreporting of sexual violence need to be better understood. The reasons for women not reporting sexual violence remain complex and may be different for individual women and for women in different communities and in different circumstances. As argued by Parpar (2010, p. 24), “[s]ilence and secrecy can take many forms and serve many purposes. They can reflect disempowerment as well as innovative strategies for survival in dangerous circumstances”.

‘The World Health Organization (2012a) proposes the following reasons for the underreporting of sexual violence: inadequate support systems; fear or risk of not being believed; fear or risk of being blamed; fear or risk of being mistreated and/or socially ostracised, fear of retaliation and shame. Shame has consistently been shown to play a role in impeding the disclosure of sexual violence (Bögner, Herlihy, & Brewin, 2007; Gilbert, 1998). It therefore seems imperative to understand the link between sexual violence, shame and disclosure.’

‘Shame can be defined in many ways (Seu, 2012), but generally refers to unbearable psychological pain (Pattison, 2003) related to perceptions of the self as being flawed, inadequate and bad (Gilbert & Procter, 2006). Our understanding of shame in this paper is broadly informed by self-psychology and intersubjective psychoanalysis, relying particularly on Orange’s more recent conceptualisation of shame as an intersubjective affective and cognitive experience (Morrison, 2008; Orange, 2008). Orange (2008, p. 7) describes an intersubjective shame system as follows: “We feel we are deficient by comparison with others, we feel we are failures in our own and others’ eyes, we feel so held up to critical scrutiny in our desperate misery that we want to sink into the ground and become invisible.” In this conceptualisation of shame, shame is always deemed to be a context-specific experience, shaped by the dominant discourses (Pattison, 2003).’


‘As clinical psychologists doing research and clinical work in low-income South African communities we, as the authors of this paper, have become aware of the presence of shame in our consulting rooms and in our research interviews (Kruger, 2012; Swartz, 2012). We have become aware of the shame of our patients and research participants (Jacobs, 1996, as cited in Orange, 2008), but we have also become aware of our own shame as therapists and researchers (Morrison, 2008; Orange, 2008). One of us (first author) is a novice in this world; the other (second author) has been in the field for more than 20 years. Both of us, in very similar but perhaps also different ways, have become aware of how our powerlessness in our interactions with our most impoverished and
disempowered participants/clients has left us feeling ashamed. We have wondered whether this feeling of powerlessness may be linked to the shame we have felt, but also whether this may be a factor that impacts on the shame of the women that we work with.’

Professor Warwick Middleton, MBBS, FRANZCP, MD Practice Guidelines for Treatment Of Complex Trauma and Trauma Informed Care And Service Delivery. Adults Surviving Child Abuse (ASCA) Authors: Dr Cathy Kezelman and Dr Pam Stavropoulos Funded by the Australian Government Department of Health and Ageing

‘Characteristically, abusers use a combination of fear, shaming and conditioning to ensure their victims remain silent. Abusers have a strong interest in denial of abuse and in attempts to discredit the accounts of victims. As evidenced by the fact that it has taken almost a century to even begin to really engage with the issues of widespread incest, abuses in state institutions, boundary violations in therapy, paedophile groups (some of which are now internet based), child prostitution/sex trafficking and the yet unfolding saga of clergy abuse, society has demonstrated an extreme reluctance to probe into how trauma and abuse fill our mental health units, our drug and alcohol detox services, our prisons and our medical wards.’

Van der Kolk, M.D. The Body Keeps the Score – Brain mind and body in the healing of trauma, Viking 2014

‘Addicted to trauma: The Pain of Pleasure and the Pleasure of Pain

Many traumatised people seem to seek out experiences that would repel most of us, and the patients often complain about the vague sense of emptiness and boredom when they are not angry, under duress, or involve in some dangerous activity.

Normally attractors are meant to make us feel better. So, why are so many people attracted to dangerous or painful situations? We eventually found a study that explained how activities that cause fear or pain can later become thrilling experiences. In the 1970’s Richard Solomon of the University of Pennsylvania had shown that the body leans to adjust to all sorts of stimuli. We may get hooked on the recreational drugs because they right away make us feel so good, but activities like sauna bathing, marathon running, or parachute jumping, which initially cause discomfort and even terror, can ultimately become very enjoyable. This gradual adjustment signals a new chemical balance has been established within the body, so that marathon runners, say, get a sense of well-being within the body and exhilaration from pushing their bodies to the limit.

At this point, just as with drug addiction, we start to carve the activity and experience withdrawal when it’s not available. In the long run people become more preoccupied with the pain of withdrawal than the activity itself. This theory could explain why some people hire someone to beat them, or burn themselves with cigarettes. Or why they are only attracted to people who hurt them. Far and aversion, in some perverse way, can be transformed into pleasure.’

‘Numbing is the other side of the coin in PTSD. Many untreated trauma survivors start out (), with explosive flashbacks, then numb out later on life. While reliving trauma is dramatic, frightening, and potentially self-destruct, over time a lack of presence can be more damaging. This is a particular problem with traumatise children. The acting-out kids tend to get attention; the blanked out ones don’t bother anybody and are left to lose their future bit by bit.’

‘Agency’ is the technical term for the feeling of being in charge of your life; knowing where you stand, knowing that you have a say in what happens to you, knowing that you have some ability to shape your circumstances. The veterans who put their fists through drywall at the VA were trying to assert their agency – to make something happen. But they ended up feeling even more out of control, and many of these once-confident men were trapped in a cycle between frantic activity and immobility.

Agency starts with what scientists call introception, our awareness of our subtle sensory, body-based feelings: the greater the awareness, the greater our potential to control our lives. Knowing what we feel is the first step to knowing why we feel that way. If we are of the constant changes in our inner and our environment, we can mobilise to manage them.’