

**PERSONALITY CHANGES AFTER COMPLEX TRAUMA:  
A LITERATURE SURVEY AND CASE STUDY**

LYDIA MARY VAN NIEKERK

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Supervisor: Dr JW Wait

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## **DECLARATION**

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.



## SUMMARY

A century of clinical observations and literature has repeatedly noted that trauma responses occur in across a spectrum and on a continuum of severity. The existing, DSM-IV trauma response classifications include Acute Stress Disorder and PTSD as anxiety disorders. Complex PTSD or DESNOS was considered as a proposed, alternative classification during the DSM-IV PTSD Field Trials. It was not included as a separate diagnosis, but briefly mentioned as an associated feature of PTSD. Subsequent research and replica studies have not proved conclusively whether Complex PTSD should be a separate or associated feature of PTSD, and the controversy continues to date.

Childhood traumatization is strongly associated with adult psychopathology, and various Axis I and Axis II disorders, especially Borderline Personality Disorder, and to a lesser extent, Antisocial Personality Disorder. Prolonged, repeated traumatization during adulthood is also associated with subsequent Axis II pathology, including Borderline, Obsessive-Compulsive and Avoidant Personality Disorders. Chronically traumatized people with Axis II pathology often present with comorbid Axis I disorders including Major Depression, PTSD, Substance Abuse, Somatization Disorder, and Dissociative Disorders.

There are divergent views regarding the etiology of personality disorders in chronically traumatized individuals. On the one hand, repeated, prolonged trauma could cause enduring personality dysfunction in individuals despite normal premorbid functioning. On the other hand, genetics, temperament, environmental factors and even a pre-existing stress diathesis in the pre-trauma personality could contribute to the development of post-trauma personality disorders. These two views do not necessary contradict each other, but illustrate the complexity the human stress reaction.

Despite the controversy the inclusion of DESNOS into the diagnostic canon, it is a valuable measure of predicting prognosis to existing treatment options. The present main psychological treatment for post-traumatic stress disorders has been a cognitive-

behavioral based, exposure intervention. Alternative therapies include psychodynamic approaches, pastoral interventions and more recently, ecological and recovery based models.

The Complex PTSD conceptualization contributes to a better understanding of the personality structure of chronically traumatized people. There are three main areas of disturbance. Firstly, a complex symptomatic presentation including somatization, dissociation, and affect dysregulation. Secondly, deep characterological shifts including deformations in concepts of relatedness and identity. Thirdly, and increased vulnerability to harm, either self-inflicted or at the hands of others. The usefulness of integrating these three concepts into the personality conceptualization of chronically traumatized individuals is illustrated a case study.



## OPSOMMING

Die literatuur en kliniese waarneming vand die afgelope eeu dui herhaaldelik op trauma reaksies oor 'n spektrum. In die bestaande DSM-IV stelsel, val trauma reaksies net Akute Stress Steuring and Post-Traumatische Stress Steuring. Hoewel Komplekse PTSD in 1992 voorgestel was as 'n alternatief in die DSM-IV, is dit nie as aparte diagnose ingesluit is nie, maar wel wel gelys as geassosieerde simptoem van PTSD. Latere navorsing en duplikaat studies het nog nie konklusief bewys of Komplekse PTSD 'n geassosieerde or aparte simptoem van PTSD is nie, en debat duur nog voort.

Trauma gedurende kinderjare word sterk geassosieer met volwasse psigopatologie en verskeie As I en As II steurings, veral Grenslyn Persoonlikheids Steuring, en tot 'n mindere mate, Antisosiale Persoonlikheids Steuring. Langstaande, herhaalde traumatisering gedurende volwassenheid word ook geassosieer met latere As II patologie, insluitende, Grenslyn, Obsessief-Kompulsief en Vermydende Persoonlikheids Steurings, Kronies getraumatiseerde individue met As II patologie presenteer ook dikwels met komorbiede As II steurings insluitende Major Depressie, Post-Traumatische Stres Steuring, Somatiserings Steuring, and Dissosiatiewe Steurings.

Daar is uiteenlopende sienings oor die etiologie van persoonlikheids steurings in kronies getraumatiseerde individue. Aan die een kant, kan langstaande, herhaalde trauma persoonlikheids veranderinge veroorsaak ongeag normale premorbide funksionering. Aan die ander kant, kan genetika, temperament, omgewing en 'n pre-morbide stress-vatbaarheid almal bydra tot die ontwikkeling van post-trauma persoonlikheids steurings. Hierdie twee sienings weerspreek mekaar nie noodwendig nie, maar dui op die kompleksiteit van die menslike stres reaksie.

Ongeag die akademiese debakel oor die insluiting van die Kompleks PTSD konseptualisasie in DSM-IV diagnostiese stelsel, is dit 'n waardevolle praktiese meetinstrument van prognose onder bestaande behandelings opsies. Tot dusver word die primere sielkundige intervensies gebaseer op 'n kognitiewe-gedragsterapie model.

Alternatiewe terapieë sluit in psigodinamiese, pastorale en meer onlangse ekologiese en herstel-gebaseerde intervensies.

Die Kompleks PTSD konseptualisasie dra by tot beter kennis oor die persoonlikheids struktuur van kronies, getraumatiseerde mense. Daar is drie hoof areas of versteuring. Eerstens, a komplekse simptomatiese presentasie insluitende somatisering, dissosiasie en affek disregulasie. Tweedens, diep veranderings in karakter insluitende verstourings in identiteit en interpersoonlike verhoudings. Derdens, in groter vatbaarheid vir seerkry, of aan hulle eie hande, of aan die hande van ander. Die waarde van die integrasie van hierdie drie konsepte in die persoonlikheids konseptualisasie van kronies getraumatiseerde individue word geillustreer deur 'n gevallestudie.



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## 1. INTRODUCTION AND BACKGROUND

What is the effect of psychological trauma on personality structure? Does the existing Post-Traumatic Stress Disorder (PTSD) classification of the American Psychiatric Association (DSM-IV, 1994) fully address the distress that follows in the wake of prolonged, repeated traumatization? Does trauma amplify the dysfunctionality of pre-existing personality traits, or does trauma lead to personality adaptations? And finally, how could increased knowledge about the interplay between trauma and personality improve treatment and prognosis? This literature survey addresses the above questions, investigates the concept of a complicated trauma syndrome, and presents an observational case study that illustrates some of the concepts.

The effects of prolonged, repeated trauma include complex symptomatic presentations of dissociation and somatization, affect dysregulation, characterological deformations in identity and relatedness, and an increased vulnerability to harm (Herman, 1998; Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman, 1996). However it is uncertain whether such a complicated trauma syndrome should be conceptualized as an associated feature of PTSD, or a separate diagnostic entity.

Trauma has been periodically investigated during the major events of the 20<sup>th</sup> century, including the two World Wars, various nationalistic and colonial wars, widespread civil violence and mass genocide, catastrophic disasters of human and natural origin, increased awareness of domestic violence and childhood sexual abuse, famine and more recently widespread diseases such as HIV AIDS (Wilson, 1994). Freud, Charcot and Janet were the first to study hysteria in women and their writings on hysteria formed the conceptual basis of the medical-psychiatric professions from 1895 until the end of the Vietnam War in 1975 (Wilson, 1994). The horrors of trench warfare in World War I produced "shell shock" or combat neurosis, a psychological trauma reaction caused by prolonged exposure to violent death resembling hysteria in men (Herman, 1998). Following World War II and the Holocaust, there were various investigations into the



long-term effects of prolonged captivity and terror, and subsequent adaptations in personality (Krystal, 1968; Horowitz, 1986).

Trauma studies continued during and after the Vietnam War with the start of “rap groups” that served the double purpose of providing individual support for war veterans and raising public awareness about the effects of war. The feminist women’s liberation movement of the 1970’s raised consciousness about domestic and sexual violence, which led directly to increased research of the sexual abuse of children. After PTSD was accepted into the DSM III in 1980, knowledge and research accumulation took on “light year” speed on a global level (Wilson, 1994, p.682). According to Van der Kolk et al. (1996) hysteria simultaneously “disappeared from psychiatric nomenclature and was deliberately ‘split asunder’ into different diagnoses: somatoform disorders, factitious disorders, dissociative disorders, and histrionic and borderline personality disorders” (p.85). Nemiah (quoted in Van der Kolk et al., 1996) summarizes the crux of the dilemma as follows “Indeed, what we have now put asunder, perhaps Mother Nature meant to go together” (p. 83).

South Africa faces the very real challenge of both past and present trauma. The Truth and Reconciliation Commission publicly encouraged people to tell their stories, for perpetrators and victims to speak of political terror, violence and betrayal. Family murders, rape, gang shootings, muti killings and child abuse are symptoms of a highly traumatized society that has lost its sense of safety. Depression, PTSD and suicide within the Police Force draws attention to the effects of secondary traumatization. HIV Aids is forcing parents and children to helplessly witness one another die slowly, leaving broken families and orphans in its shadow. Sadly, there seems to be ample opportunities for future research on complex adaptations to trauma.

This literature survey aims to synthesize the accumulating body of literature since the early 1990’s on the interwoven complexities of trauma reactions and personality pathology. It reviews the complex trauma syndrome and its official conceptualization in the 1991-1992, DSM-IV PTSD Field Trials as “Disorder of Extreme Stress Not



Otherwise Specified” (DESNOS), (Davidson & Foa, 1991). This paper summarizes the presentation, associated clinical features, comorbid disorders and etiology of complex trauma and investigates existing treatment options. It further reviews the symptoms and personality changes that occur after complex trauma, and the controversy around its diagnostic status.

A case study to illustrate the complex trauma concept is included. It describes personal history, clinical course and progress, and a discussion of the psychodynamics of the psychotherapy. Finally, the literature surveyed is summarized and used to offer possible answers to questions raised. Simultaneously, the need for future research on complex trauma from a South African perspective is emphasized.

## 2. THE DIAGNOSTIC FRAMEWORK OF TRAUMA DISORDERS

### 2.1 Definitions and Terminology

The concept “traumatology” generally refers to the study of “wounds” and therefore bound to the study of physical medicine. To differentiate and specify its use in a psychological context, Everly and Lating (1995) used the term “psychotraumatology” which is defined as “the study of the processes and factors that lie (a) antecedent to, (b) concomitant with, and (c) subsequent to psychological traumatization” (p. 4.). Although never systematically outlined as such, many experienced clinicians have commented on the concept of a spectrum of post-traumatic disorders. Lawrence Kolb (1989) remarked on the “heterogeneity” of PTSD that “is to psychiatry as syphilis was to medicine. At one time or another (this disorder) may appear to mimic every personality disorder... It is those threatened over long periods of time who suffer the long-standing effects of severe personality disorganization” (p.811).

Terr (1991) differentiated between “Type I” and “Type II” traumas during childhood. Type I trauma occurs after a single, unanticipated, traumatic blow and results in re-experiencing, avoidance and hyper-alertness. Type II trauma occurs after prolonged, repeated traumatization and results in “denial, psychic numbing, self-hypnosis, dissociation and alterations between extreme passivity and outbursts of rage” (Terr, 1991, p.10).

Herman (1992) extended this differentiation to chronically traumatized adults by describing the features of “Complex Post-Traumatic Stress Disorder” (Complex PTSD). Simple or classic PTSD, similarly to Type I trauma, is based on observations of survivors of relatively circumscribed traumatic events such as combat, disaster and rape, and refers to the re-experiencing, avoidance and increased arousal symptoms often experienced after exposure to such a single, horrifying event. Complex PTSD, similarly to Type II trauma, aims to capture the psychological effects of prolonged, repeated trauma. Herman (1992) described these effects as firstly, complex symptomatic disturbances including



somatization, dissociation and affect dysregulation, secondly, characterological changes including deformations in relatedness and identity, and thirdly, an increased vulnerability to harm, both self-inflicted and at the hands of others. Such conditions where the victim is in a state of captivity, unable to flee, and under the control of the perpetrator, could exist in prisons, concentration or slave labor camps, some religious cults, brothels or other places of sexual exploitation, and in some dysfunctional families.

Horowitz differentiated between normal and pathological phases of the post-stress response (Figure 1). He wrote of chronic trauma reactions as “an even more complex compounding of personality characteristics... and the response to the particular serious life event may lead to further character changes beyond those that occur during adolescence and early adulthood” (Horowitz, 1986, p.39).

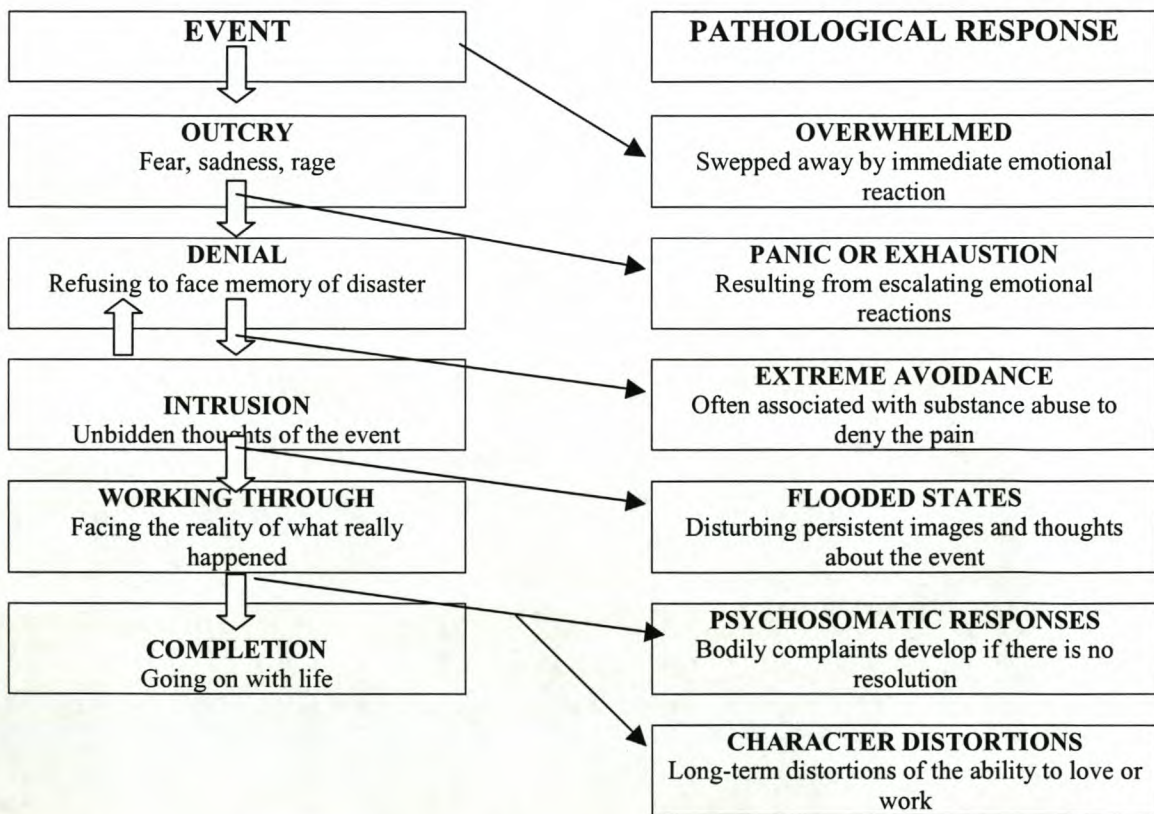


Figure 1. Normal and Pathological Phases of Post-stress Response (Horowitz, 1986, p. 41).



As time passes after trauma, survivors of repeated traumatic experiences such as found in concentration camps and combat, may develop syndromes “so complex that multiple diagnoses need to be made and carefully formulated in order to understand the individual” (Horowitz, 1986, p.39).

The damage to personality structure is also noted in classical literature describing life after severe trauma. War poet and World War I veteran Siegfried Sassoon (quoted in Herman, 1998, p. 23) described the after-effects of war trauma with almost clinical clarity:

Shell shock. How many a brief bombardment had its long-delayed after-effect in the minds of these survivors, many of whom had looked at their companions and laughed while the inferno did its best to destroy them. Not then was their evil hour; but now; now, in the sweating suffocation of nightmare, in paralysis of limbs, in the stammering of dislocated speech. Worst of all, in the disintegration of those qualities through which they had been so gallant and selfless and uncomplaining – this, in the finer types of men, was the unspeakable tragedy of shell-shock.... In the name of civilization to prove that their martyrdom wasn't a dirty swindle.

## **2.2 Existing and Alternative Classifications**

According to Van der Kolk et al. (1996), a century of clinical observations and systematic research has shown there is a variety of other symptoms associated with exposure to extreme stress that cannot be easily understood within the existing PTSD framework of alternating intrusion and numbing. The diagnostic categories of the existing psychiatric canon were not designed for survivors of extreme situations, and there is a need for a diagnostic conceptualization that grasps the complex symptomatic and characterological changes that accompany prolonged, repeated trauma. According to Herman (1998) the quality of the anxiety, phobias, panic, mood, and somatic symptoms



was not the same as the ordinary Axis I disorders, and the degradation of identity and relational life was not the same as ordinary personality disorders.

Continued research into psychotraumatology followed in the wake of the inclusion of PTSD into the DSM III in 1980. The DSM IV classified Acute Stress Disorder and PTSD among the anxiety disorders as the main diagnostic responses to trauma (APA, 1994). The complex effects of more chronic traumatization are only described among the associated features of PTSD:

The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g. childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired affect modulation; self-destructive and impulsive behavior; or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change in the individual's previous personality characteristics. (APA, 1994, p. 425)

Trauma responses could be classified as "a spectrum of conditions as opposed to a single diagnosis...that range from a brief stress reaction that gets better by itself and never qualifies for a diagnosis, to classic or simple PTSD, to the complex syndrome of prolonged, repeated trauma" (Herman, 1998, p.119). Similar to the Mood and Anxiety categorical divisions of the DSM IV (APA, 1994), trauma disorders could perhaps be conceptualized as a diagnostic cluster.

A myriad of names has been used to describe the complex trauma syndrome including "post-traumatic character disorder" and "complicated stress disorder". During the early 1990's, the complex traumatic syndrome came under consideration for inclusion into the American Psychiatric Association's (APA) fourth edition of the Diagnostic and Statistical Manual IV (DSM-IV) under the name of "Disorder of Extreme Stress Not



Otherwise Specified” (Addendum 1). Herman (1998) described the diagnostic criteria (Addendum 2) as subjection to totalitarian control over a prolonged period (months to years), with subsequent alterations in affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others and systems of meaning. Although not included in 1994 into the DSM IV, it led to a collection of field data that encouraged further empirical research.

A similar entity under “Personality Change from Catastrophic Experience” (Addendum 3) was entered into the International Classification of Mental and Behavioral Diseases 10 (World Health Organization, 1992). Turner (2002) described this diagnosis as “a long term condition, which can be made two or more years after an especially severe trauma in adulthood such as in prolonged hostage situations, or after severe torture” (¶6). He listed the symptoms as permanent hostility and distrust, social withdrawal, emptiness and hopelessness, dependency and problems modulating aggression, hypervigilance, irritability and alienation. According to Turner (2002) this diagnosis was significantly influenced by a European tradition of work with refugees and other victims of political violence, and “attempted to describe the consequences of prolonged interpersonal violence” (¶6).

### **2.3 DSM-IV PTSD Field Trial And Replica Studies**

According to Roth, Newman, Pelcovitz, van der Kolk and Mandel (1997), between 1991 and 1992 several researchers specializing in the treatment of trauma-related disorders collaborated on the DSM IV PTSD Field Trial. The Structured Interview for Disorders of Extreme Stress (SIDES) was successfully developed and administered to 520 subjects. The SIDES assessed the presence of impaired affect modulation, self-destructive and impulsive behavior, dissociation, somatic complaints, feelings of ineffectiveness, shame, despair or hopelessness, impaired relationships with others, and loss of previously sustaining beliefs (Roth et al., 1997). The study also investigated the relationship between age of onset, duration, abuse type and the complex PTSD lifetime diagnosis for men and women.



Most of the participants (92%) who classified for DESNOS also met the criteria for PTSD, and DESNOS was associated with a history of childhood traumatic abuse (Pelcovitz et al., 1997). Van der Kolk et al. (1996) concluded DESNOS was “an associated feature of PTSD, not likely to constitute separate ‘double diagnoses’ but representing the complex somatic, affective, and behavioral effects of psychological trauma” (p.90).

According to Roth et al. (1997) sexually abused women, especially those who had also experienced physical abuse, had a higher risk of developing complex PTSD, although complex PTSD symptoms occurred at a high base rate among physically abused women. Both physical and sexual abuse shared several characteristics including terror and captivity at the hands of another, which increases the likelihood of sequential problems with self-regulation, self-definition, interpersonal functioning and adaptational style consistent with complex PTSD nomenclature (Herman, 1992). Roth et al. (1997) stated “there is a complex pattern to understanding onset, chronicity and type of abuse in predicting complex PTSD symptoms” (p.551).

There were various limitations to the field trial that prevented generalizability including uneven gender distribution (over representation of women in sexual abuse groups), the data was based on interviews with treatment-seeking volunteers only, and the lack of non-trauma exposed control group (Roth et al., 1997). Despite these limitations the results had clinically meaningful implications for assessment, conceptualization and treatment. Unlike the similarly conceptualized ICD-10 Personality Change from a Catastrophic Experience addition, the complex PTSD/DESNOS name and criteria were not officially included into the DSM IV diagnostic canon, but were listed instead as associated features of PTSD.

In a similar exploratory study on complex PTSD, Jongedijk, Carlier, Schreuder and Gersons (1996) used the SIDES to investigate PTSD and DESNOS among Dutch War Veterans. Jongedijk et al. (1996) presumed that as DESNOS hardly ever appeared without PTSD, DESNOS was associated with PTSD and not a separate diagnostic entity.



In their study, 67% of the veterans interviewed met the criteria for PTSD, 38 % also qualified for DESNOS, and all subjects with DESNOS qualified for PTSD, supporting the proposition that DESNOS is associated with PTSD (Jongedijk et al., 1996).

However, more recent literature holds an alternative view. According to van der Kolk et al. (quoted in Ford, 1998) the Field Trial results did not show dissociation, somatization, and affect dysregulation to be isomorphic with PTSD, but that each shared between 26-28% common variance with PTSD. Ford (1998) found DESNOS and PTSD to be comorbid but distinct post-traumatic syndromes, stating:

Despite their strong correlation with PTSD, the DESNOS features thus may occur independently of PTSD. The large degree of non-overlap between PTSD diagnosis and the features of DESNOS appears largely due to the fact that a substantial proportion of trauma survivors who did not meet the criteria for lifetime PTSD were classified as exhibiting pathological dissociation (61%), somatization (47%), affect dysregulation (34-37%). Thus, trauma survivors not meeting PTSD diagnosis often display substantial DESNOS symptoms (¶32).

Additionally DESNOS (but not PTSD) was associated with “(a) early childhood trauma and/or participation in warzone activities, (b) extreme levels of intrusive trauma re-experiencing symptoms, (c) impaired characterological functioning (object relations), and (d) elevated risk of utilization of intensive psychiatric services” (Ford, 1998¶1).

At present there remains uncertainty on whether DESNOS is best classified as an associated feature of PTSD, or as a distinct but comorbid post-traumatic syndrome. Future clinical research is needed to focus on the assessment and treatment of complex PTSD, and to investigate the relationship between complex PTSD and Axis II symptoms.



### 3. TRAUMA AND PERSONALITY

#### 3.1 Presentation, Comorbidity and Associated Features

In both clinical practice and literature there is an increasing awareness of the dynamic interplay between complex trauma and personality. According to Herman (1998, p.117) “the clinical picture of a person who has been reduced to the elemental concerns of survival is frequently mistaken for a portrait of a person’s underlying character”. She contended that diagnostic mislabeling occurred when concepts of personality organization developed under ordinary circumstances were applied to victims without full understanding of the personality corrosion that occurs under conditions of prolonged terror. According to Herman (1998) patients who have been subjected to chronic trauma risk being misdiagnosed as having personality disorders, or being labeled as dependent, masochistic or self-defeating.

A study of effects of repeated, prolonged traumatization on personality should differentiate between three groups, namely (1) children who are traumatized, (2) adults with histories of childhood trauma, and (3) adults who are traumatized during adulthood.

How do traumatic events interact with normal child development? Terr (1991) defined childhood psychic trauma as “the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations” (p.11). She further broadened the concept to include not only conditions of intense surprise, but also those of prolonged and sickening anticipation. According to Terr (1991) all childhood traumas begin outside the child, although once the events occur, a number of internal changes occur in the child that stay active for years and often cause detriment to the young victim. These internal changes include memories and visualizations of traumatic incidents, stereotypical movements, trauma specific fears and changed attitudes about people, life, and the future.



A history of childhood trauma is consistently associated with various Axis I and Axis II disorder in adulthood (Terr, 1991; Boudewyn & Liem, 1995; Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman, 1996). Similar to childhood rheumatic fever that leads to a variety of medical problems in adulthood, childhood psychic trauma is associated with a number of mental changes, such as adult character problems, certain kinds of psychotic thinking, episodes of violence and dissociation, extremes of passivity, self-mutilation, and various anxiety disorders (Terr, 1991). Herman (1992) noted that a history of abuse, particularly in childhood, appeared to be one of the major factors predisposing a person to become a psychiatric patient, yet most people who had been abused in childhood never approached the mental health system. However, Jacobson and Richardson (quoted in Herman, 1998) found that 50-60% of psychiatric inpatients and 40-60% of outpatients reported histories of physical or sexual abuse or both.

According to Gelinas (quoted in Herman, 1992), when survivors of childhood abuse seek treatment, they came as a disguised presentation of chronic depression complicated by dissociative symptoms, substance abuse, impulsivity, self-mutilation and suicidality. A history of childhood trauma is associated with various Axis I disorders including depression, PTSD, dissociative disorders, somatization disorders and substance abuse, often with comorbid Axis II disorders during adulthood (Herman, 1992; Southwick, Yehuda & Giller, 1993; Boudewyn & Liem, 1995). Survivors of childhood trauma are also more prone to suicidality and chronic self-destructiveness (Boudewyn & Liem, 1995). There are relatively more women with borderline personality disorder, and men with antisocial personality disorder among survivors of childhood abuse, although basic developmental problems shared by men and women may have been finding different manifestations (Van der Kolk, 1991; Boudewyn & Liem, 1995).

Southwick et al. (1993) stressed the importance of the precise characterization of Axis II psychopathology in chronic stress disorders as it could effect the course, severity, prognosis and response to pharmacological interventions. The same writers studied the rates of personality disorders found among treatment seeking Vietnam war veterans with chronic PTSD. The results are shown in Table 1. High rates of comorbid personality



disorders were found among both in and outpatients. The most frequently diagnosed disorders included borderline (26%), obsessive-compulsive (15%), avoidant (14%), and paranoid (13%) personality disorders, with more than one-third of all patients meeting the criteria for at least two of these dysfunctions (Southwick et al., 1993).

Table 1

DSM-III-R Personality Disorder Diagnoses in Vietnam Combat Veterans with PTSD

DSM-III-R Personality Disorder (Axis II)	All Patients (n=34)		Inpatients (n=18)		Outpatients (n=16)	
	n	%	n	%	n	%
Cluster A						
Paranoid	13	38	9	50	4	25
Schizoid	2	6	2	11	0	0
Schizotypal	9	26	8	44	1	6
Cluster B						
Antisocial	5	15	4	22	1	6
Borderline	26	76	15	83	11	69
Histrionic	3	9	1	6	2	13
Narcissistic	7	21	4	22	3	19
Cluster C						
Avoidant	14	41	10	56	4	25
Dependent	7	21	5	28	2	13
Obsessive-compulsive	15	44	8	44	7	44
Passive-aggressive	12	35	8	44	4	25
Self-defeating	11	32	9	50	2	13

According Southwick et al. (1993) combat soldiers in their late adolescence or early adulthood may be particularly susceptible to such fragmentation as they have not necessarily fully consolidated their identity. They further hypothesized that the high rates

of obsessive-compulsive, avoidant and paranoid personality disorders could reflect adaptations to combat related trauma. According to Southwick et al. (1993), chronically traumatized soldiers are left with a sense of vulnerability and experience the world as perpetually dangerous. In an attempt to control the danger and constantly be prepared for the worst, they may acquire a paranoid personality style of constant vigilance, defensiveness and suspiciousness.

According to Southwick et al. (1993) avoidant behaviors are also characterological adaptations to minimize potential dangers and conflicts, and “chronic war-related PTSD was often accompanied by diffuse, debilitating and enduring impairments in character” (p.1022). Clinically it made sense to the authors to view diffuse Axis II pathology as symptom clusters rather than personality disorders per se, alternatively “these changes can be viewed as part of an expanded symptom complex resulting from trauma” (Southwick et al., 1993, p.1022). This view appeared similar to the complex trauma syndrome conceptualized by Herman (1992) and further investigated as DESNOS in various trauma studies over the past decade.

### **3.2 Etiology and Risk Factors**

There are two views regarding the etiology of character pathology in chronic stress disorders. According to Southwick et al. (1993), one view held that pathological personality traits existed before the trauma occurred. Further, the pre-trauma personality was linked to the actual development of PTSD, and more specifically pre-existing emotional problems or disorders rendered the individual especially susceptible to the development of a post-traumatic syndrome (Southwick et al., 1993). The alternative view of Hendin and Brende (quoted in Southwick, 1993) suggested that severe trauma may cause enduring changes in character even in individuals with normal premorbid functioning.

According to van der Kolk, Perry and Herman (1991), childhood sexual abuse played a significant role in the development of borderline personality disorder. However,



childhood sexual abuse did not happen in a vacuum, it often co-existed with various forms of neglect, family disruption and other stressful life events (Briere, 1992). Joel Paris (1998) placed a valid reality check on drawing correlations between childhood trauma and personality pathology. He suggested that relationships between risk factors and outcomes can often be explained by “latent variables” (¶2), and in the case of personality disorders such factors could range from coexisting environmental risks to genetic vulnerabilities. The mediating effect of resilience also effected long-term outcome after trauma.

Paris (1998) considered some of the environmental risks when he questioned the long accepted *primacy effect*, namely the assumption that “psychopathology is shaped by events during childhood” (¶10) due to little empirical evidence. In his review of the clinical literature he found “negative childhood events were one of many risk factors for psychopathology in adulthood, whether such events went on to produce long-term consequences depended on interactions with other risks and protective factors in development” (Paris, 1998, ¶11). Negative events were contributory factors to pathology, but not unique causes. Paris (1998) stated that resilience, defined as “the capacity to emerge intact from life experiences” (¶13), was the rule rather than the exception, with only about 25% of children exposed to severe trauma developing demonstrable psychopathology as adults. However the long-term consequences of childhood sexual abuse were also dependent on the severity of the childhood sexual abuse, and the presence or absence of protective factors (Paris, 1998). Paris (1998) concluded:

The role of childhood trauma in personality disorders can be best understood in the context of gene-environment interactions, which corresponds with the stress-diathesis theory of psychopathology. Biological factors, as reflected in trait profiles determine vulnerability. Psychological and social factors function as precipitants for psychopathology. Thus the psychological risk factors for personality disorders do not depend only on traumatic experiences, but on temperament and on the cumulative effects of multiple stressful events (¶38).



Paris (1998) conceptualized personality disorders as dysfunctional exaggerations of personality traits that were reasonably heritable (genetic component considered 40% of trait variance). If personality was considered stable and rooted in temperament, it helps to explain the early onset and long-term chronicity of personality disorders. Although personality disorders are much less heritable than traits, recent twin studies by Torgeson (quoted in Paris, 1998) found genetic factors accounted for half the variance in borderline and avoidant personality disorders, suggesting more research is needed into the genetic component involved in personality disorders.

According to Millon and Everly (quoted in Everly, 1989) there existed consistent, personality-based predispositions, that is, "vulnerabilities" in all personality compositions. These "vulnerabilities" served collectively as a form of Achilles' heel, or "personologic diathesis", that created a predisposition to a specific stress response and many other subsequent stress-related disorders.

Millon (quoted in Everly, 1989) suggested there were eight basic personality styles which were fundamentally adaptive under normal circumstances, but each had its own intrinsic personologic diathesis which predisposed it to excessive states of stress arousal under specific circumstances. He identified eight basic "normal" personality formulations (aggressive, narcissistic, histrionic, dependent, passive-aggressive, compulsive, avoidant and schizoid) and the personality factors inherent to each that contributed to chronic stress arousal. Everly (1989) concluded these factors should play a major role in treatment planning, responsiveness and a "better understanding of chronic stress arousal and its subsequent disorders" (p.117).



## 2.2 Treatment Options

Ford and Kid (1998) questioned why the majority of adults with chronic PTSD did not complete or benefit from intensive psychotherapy. A history of early childhood abuse and DESNOS were identified as the two characteristics that firstly, could differentiate responders from non-responders, and secondly, could guide the development of alternative treatment interventions for non-responders. Although a history of childhood trauma was prevalent and highly correlated with DESNOS, it was not predictive of treatment outcome. By contrast, DESNOS emerged as a consistent and robust predictor of poor inpatient PTSD outcome. More specifically, “the presence of DESNOS was associated with an absence of therapeutic change, while the absence of DESNOS was associated with evidence of therapeutic change” (Ford and Kid, 1998, ¶20).

Additionally the researchers found DESNOS predicted poorer self-reported PTSD, quality of life outcome, ethnicity, prior level of trauma exposure, Axis I (PTSD and major depression) and Axis II diagnostic status. Reich and Vasile (1993) stressed the predictive importance of personality disorders on the treatment outcome of a wide range of Axis I disorders. DESNOS appeared to play an important role in assessment and treatment planning for psychotherapeutic rehabilitation of complex PTSD (Ford and Kid, 1998).

The treatment options for the survivors of chronic trauma vary from outcome-based cognitive behavioral methods, to psychodynamic approaches, to pastoral interventions and more recent ecological, context-based therapies.

At present cognitive behavioral therapies are the main PTSD interventions. These include imaginal or in vivo exposure, either by intense (implosive) or graded (systematic) desensitization. Ford and Kidd (1998) reviewed various outcome-relevant treatment formulations for chronic PTSD using DESNOS as an empirical basis, and drew attention to the potentially overwhelming character of intrusive trauma re-



experiencing. Trauma focused treatments intended to therapeutically re-experience memories, may inadvertently expose survivors with DESNOS to overwhelming affects that elicit dissociative avoidance, thus being re-traumatized instead of “fostering a therapeutic course of cognitive behavioral habituation or dynamic-interpersonal working through” (Ford and Kid, 1998, ¶23).

Furthermore, van der Kolk (quoted in Ford and Kidd, 1998) contended avoidance and emotional numbing may be complicated by pathological dissociation and the fragmentation of normal memory. Treatments based on therapeutic re-experiencing of trauma memories and emotions in a narrative-building and control-enhancing manner such as therapeutic exposure, may need to be preceded and/or accompanied by interventions bolstering the survivor’s capacities to ego-syntonicly manage pathological dissociation and cognitive schemas, primitive affect states and impulses (Ford and Kidd, 1998). They contended that the treatment of chronic PTSD must not only focus on the fear, avoidance and hype-arousal symptoms, but also on the complex alterations in affect regulation, consciousness, interpersonal engagement, and meaning/spirituality.

Van der Kolk (1997) reviewed the psychobiology of PTSD and concluded the conceptualization and appropriate therapeutic interventions may have to be re-evaluated. Neuro-imaging has provided new ways of understanding the neuronal filters concerned with the sensory information in PTSD. Intense, persistent emotional arousal may develop conditioned emotional and biological responses that have long-term effects on subsequent information processing. If derealization and depersonalization occur at the moment of traumatization, it can effect the functioning of the Broca’s area in the brain, which is necessary to label emotions and feelings. When individuals are re-exposed to traumatic experiences, their bodies are aroused and fragments of memory may be activated, but they may not be able to communicate their feelings, as if being “dissociated from semantic knowledge” (van der Kolk, 1997, p.22). This could explain the alexithemia often found in survivors of prolonged, repeated psychic trauma. Treatment involves helping people integrate their trauma into



the totality of their lives by “processing the traumatic information on a symbolic level, through the use of words and symbols, proper categorization, and integration, in hope that this will abolish conditioned physiologic and neuro-hormonal responses.” (Van der Kolk, 1997, p.22).

According to Kaplan and Saddock (1998), the psycho-analytical model hypothesizes that trauma reactivates previously quiescent, yet unresolved psychological conflicts. The revival of childhood trauma causes regression, and the use of repression, denial and undoing as defense mechanisms. Recovery from psychological trauma could involve long-term psychotherapy to attain mastery and final resolution of psychological conflicts that may or may not have their origins in traumatic exposure. Psychodynamic therapy that reconstructs the traumatic events with associated abreaction and catharsis may be useful, although psychotherapy must be individualized, as some patients may be overwhelmed by re-experiencing traumas.

Lifton (quoted in Ford and Kidd, 1998) suggested the incorporation of moral and spiritual issues that could address the sense of shame and emptiness experienced in DESNOS. Although people differ in their needs for spiritual guidance, many do find relative peace for their existential crises in their religion of choice. Everly (2000) maintained the pastoral community could contribute unique healing qualities and powerful restorative attributes during the turmoil of psychological crisis. If the pastoral crisis intervention approach of “functional integration of any and all religious, spiritual and pastoral resources” (Everly, 2000) could be included as a therapeutic intervention option for complex PTSD, it could help address the deep alternations in systems of meaning that can follow repeated, prolonged psychic trauma.

According to Harvey’s (1996) ecological model there was an under emphasis on environmental contributions to individual variations in post-traumatic responses and recovery. This model proposed a multi-dimensional definition of trauma recovery, and suggested the efficacy of trauma-focused interventions depended on the degree to



which they enhanced the person-community relationship, and achieved “ecological fit” within individually varied recovery contexts. Harvey (1996) understood recovery from psychological trauma as a multidimensional phenomena that included the following outcome criteria: (1) authority over the remembering process, (2) integration of memory and affect, (3) affect tolerance, (4) symptom mastery, (5) self-esteem and cohesion, (6) safe attachment, and (7) meaning making. Simultaneously, the ecological model “acknowledges the possibility of recovery in the absence of clinical intervention, highlights the construct of resilience, the role of the larger environment, the contributions of natural support, and the relevance of community interventions” (Harvey, 1995, p.21).

Herman’s (1998) recovery based therapy model favored a process of re-integration and reconnection over one of catharsis. A healing relationship, based on trust and empathy, that addresses traumatic transference and countertransference, within a secure therapy contract and boundaries, needed to be established between survivor and therapist. The process of recovery then unfolded in three stages, firstly, the establishment of safety, secondly, the process of remembrance and mourning, and thirdly, the task of reconnection with ordinary life (Herman, 1998). Both the ecologically based and recovery-based psychotherapies explicitly dealt with DESNOS by “establishing a context of safety in which to re-examine one’s own body, thoughts and feelings, re-establishing safety and intimacy with trusted others”(Ford and Kidd, 1998, ¶28).

Finally, as alternatives requiring further research, Ford and Kid (1998) described more specialized therapeutic approaches. Firstly, self-psychology, that addresses disturbances in sense of self, affects and dissociation. Secondly, dialectic behavior therapy, that targets Axis II features such as impulsivity, dependency, parasuicidality or psychopathy from a supportive and educative stance. Thirdly, providing a “holding environment” in which trauma focused and cognitive-behavioral treatment methods could be used.



In summary, DESNOS has important predictive value for clinicians to select appropriate treatment options by taking into consideration the type, severity and duration of the trauma. Additionally, it serves as a clinical and conceptual framework that opens the option of “differential treatment planning and patient-treatment matching, although any prescription of such approaches to individualizing treatment must await further empirical evidence” (Ford and Kid, 1998,¶28). The literature reviewed shows that there is no single, preferred therapy of choice, instead the treatment option needs to be individualized according to the trauma type and individual context. The recent increased knowledge of the psychobiology of trauma, stress-diathesis, resilience and ecological models suggests further research is needed in this field.

## **4. COMPLEX TRAUMA**

In the next section Complex PTSD (Addendum 2) as conceptualized mainly by Judith Herman is discussed. Her formulation of the complex traumatic syndrome formed the basis of the seven DESNOS diagnostic criteria (Addendum 1) chosen for the DSM IV PTSD Field Trials. Herman divided the seven criteria into “three broad areas of disturbance which transcend simple PTSD” (p.379) including (1) more complex symptomatic presentations, (2) characterological changes including deformations in relatedness and identity, and (3) a high vulnerability to repeated harm, both self-inflicted and at the hands of others.

### **4.1 Symptom Presentation**

According to Herman (1992) the pathological environment of prolonged, repeated trauma fosters the development of various psychiatric symptoms, revealing pathology in somatic, cognitive, affective, behavioral and relational domains. She noted that the general levels of distress seem higher than those of patients who do not have abuse histories and described somatization, dissociation and affect dysregulation as the three main sequelae of prolonged, repeated trauma that do not fall into the classic diagnostic criteria of PTSD. Van der Kolk et al. (1996) confirmed dissociation, somatization and affect dysregulation to be closely associated features of PTSD that do not occur in isolation but are often, but not invariably, found in the same individual (Table 2).



Table 2

Endorsement of Lifetime Incidence of Features Associated With PTSD

Symptom Category	Subjects with Current PTSD (n=182)		Subjects with Lifetime (Not Current) PTSD (n=71)		Subjects who never had PTSD (n=139)	
	n	%	n	%	n	%
<b>Affect Dysregulation</b>						
Difficulty with affect modulation	164	90	52	73	47	34
Unmodulated anger	158	87	49	69	51	37
Self-destructiveness	115	63	30	42	28	20
Suicidal behavior	127	70	36	51	35	25
Unmodulated sexual involvement	153	84	45	63	51	37
Dissociation	173	95	59	83	61	44
Somatization	158	87	53	75	47	34

**4.1.1 Somatization**

Herman (1992) maintained that repetitive trauma seems to amplify and generalize the physiological symptoms of PTSD, leaving chronically traumatized people permanently hyper-vigilant, anxious and agitated, without a baseline state of physical calm or comfort. Over time, they perceive their bodies having turned against them, complaining not only of insomnia and agitation, but also expressing numerous other somatic complaints including tension headaches, tremors, choking sensations, heart palpitations, gastro-intestinal disturbances, and abdominal, back or pelvic pain (Herman, 1992). "Some survivors conceptualize the damage of prolonged captivity primarily in somatic terms or may have become so accustomed to their condition that they no longer recognize the connection between their bodily distress symptoms and the climate of terror these symptoms were formed in" (Herman, 1992, p.86).

Van der Kolk et al. (1996) noted that somatization is marked by alexithemia, or the inability to identify the emotional valence of physiological states. Nijenhuis, Spinhoven, van Dyck, van der Hart and Vanderlinden (1998) investigated a phenomena they called “somatoform dissociation” that is not a somatic disturbance, but a mental condition defined as “dissociation which is manifested in a loss of the normal integration of somatoform components of experience, bodily reactions and functions (such as anaesthesia and motor inhibitions)” (p. 713). They found physical and sexual trauma, especially before the age of 7 predicted both somatoform and psychological dissociation (Nijenhuis et al., 1998).

According to Morgan, Hazlett, Wang, Richardson, Schurr and Southwick (2001), dissociation was found to be significantly related to somatic complaints reported by victims of trauma and may play a significant role in the reported relationship between PTSD and physical health. Van der Kolk et al. (1996) noted that PTSD sufferers with somatization are less likely to seek help in mental health settings, and more likely to be treated with medical interventions which can be both costly and ineffective in alleviating their distress (p. 89).

#### ***4.1.2 Dissociation***

According to Herman (1992) people in captivity become adept practitioners in the arts of altered consciousness and learn to survive the horror of reality by altering it through dissociation, voluntary thought suppression, minimalization, denial, trance-like states, positive and negative hallucinations, and alterations in sense of time, memory and concentration.

According to van der Kolk et al. (1996), there is a strong relationship between trauma and dissociative symptoms, and they confirmed previous studies that found a childhood history of abuse as the main predictor of dissociation. Similarly, Nijenhuis et



al. (1998) reported that pathological dissociation was best predicted by early onset of reported, chronic and multiple traumatization.

Disturbances in memory are often seen in survivors of prolonged childhood abuse which Shengold (quoted in Herman, 1992) described as the “mind-fragmenting operations” used by abused children to preserve “the delusion of good parents.” He found that by creating isolated divisions of memory, contradictory images of the self and parents are never allowed to coalesce, thereby allowing the victim to dissociate from the full truth of the memory. In its extreme form such fragmentation manifests as dissociative identity disorder but in a less obvious way it is seen in “doublethink”. Orwell (quoted in Herman, 1998) defined this as “the power of holding two contradictory beliefs in one’s mind simultaneously, and accepting both of them” (p.87).

#### **4.1.3 *Affective Dysregulation***

There are a few individuals with extremely strong and secure belief systems, who could endure prolonged abuse and emerge with their faith in themselves, humanity and God still intact, but the majority of chronically traumatized people sink into deep states of depression (Krystal, 1969). The PTSD symptoms of hyper-arousal and intrusive thoughts merge with the depressive neuro-vegetative symptoms in what Niederland called the “survivor triad” of insomnia, nightmares and psychosomatic complaints (quoted in Krystal, 1969). Van der Kolk et al. (1996) confirmed that PTSD sufferers are prone to problems of affect dysregulation including difficulty modulating anger, chronic self-destructive and suicidal behaviors, difficulty modulating sexual involvement, and impulsive and risk-taking behavior (p.86).

Herman (1992) noted that “the dissociative symptoms of PTSD merge with the concentration difficulties of depression....and the paralysis of initiative of chronic trauma combines with the apathy and hopelessness of depression”(p.382). She further contended that the chronically traumatized individual’s experience of relationship disruptions, feelings of a debased self-image and loss of faith, merges with the isolation, withdrawal,



guilt and hopelessness of depression. Unexpressed anger at the perpetrator, often out of fear of retribution, and at those who remained indifferent and failed to help, can contribute to the depressive burden (Herman, 1992). Occasional outbursts of suppressed rage could further contribute to the alienation of the survivor and put at risk rebuilding relationships while “the internalization of rage may result in a malignant self-hatred and chronic suicidality” (Herman, 1992, p.382).

## **4.2 Character Adaptations**

### **4.2.1 *Deformations in Relatedness***

According to Herman (1992) the perpetrator becomes the most powerful person in the victim’s life as he has the ability to shape the actions and beliefs over time. To gain control the perpetrator inflicts systematic, repetitive psychological trauma which aims at instilling terror and helplessness, destroying the victim’s sense of self in relation to others, and fostering a pathological attachment to the perpetrator (Herman, 1992). Although physical violence is universally used to induce terror, the threat of death or harm to loved ones is used more often, and increased by unpredictable outbursts of violence with the inconsistent enforcement of trivial demands and petty rules.

In some extreme cases the victim’s sense of autonomy is systematically destroyed by taking control of the victim’s body and bodily functions by deprivation of sleep, food, shelter, exercise, personal hygiene or privacy (Herman, 1992). By capricious granting of allowances, the perpetrator becomes the potential source of solace as well as humiliation, a method to undermine the psychological resistance far effectively than unremitting deprivation and fear.

Sometimes the perpetrator increases isolation and dependence by breaking down all strong relationships with others by prohibiting communication, material support and emotional ties (Herman, 1992). The final step in “breaking” the victim is the forced betrayal of basic attachments, by witnessing or participating in crimes against others



(Herman, 1992, p.384). During prolonged confinement and isolation, the victim becomes increasingly dependent on the perpetrator not only for survival, but also basic bodily needs, information and emotional sustenance. A bond of identification can develop between perpetrator and victim resulting in a “traumatic bonding” as seen in hostages who come to see the captors as their saviors and hate their rescuers. Symonds (quoted in Herman, 1992) described this process as “enforced regression to “psychological infantilism” which “compels victims to cling to the very person who is endangering their life” (p. 384). This may be similar to the “Stockholm syndrome” which Janof-Bulman (Everly and Lating, 1995) described as the alignment of positive affections by hostages towards their captors.

According to Herman (1992) the survivor seems to have no range of moderate engagement, “approaching all relationships as though questions of life and death are at stake, oscillating between intense attachments and terrified withdrawal” (p.385). Such relationship disturbances are frequently seen in patients with borderline personality disorder, who are often survivors of childhood abuse. According to Melges and Swartz (1989) they are terrified of abandonment on the one hand and domination on the other, and oscillate between extremes of abject submissiveness and furious rebellion, tending to form “special” dependent relationships with idealized caretakers where ordinary boundaries are not observed (Zanari, Gunderson, Frankenburg, Chauncey, 1990).

#### **4.2.2 *Deformations In Identity***

According to Herman (1998) chronically traumatized people undergo profound alterations in identity, whereby all structures of the self are invaded and systematically broken down. Subjection to a relationship of coercive control causes deep changes to self and body image, the internalized images of others, and the held values and ideals necessary to maintain a sense of coherence and purpose (Herman, 1992). “While the victim of a single trauma may say she is 'not herself' since the event, the victim of chronic trauma may lose the sense that she has a self” (Herman, 1992, p.385). In his clinical observations of concentration camp survivors, Niederland (quoted in Herman, 1998, p.64) noted that alterations in personal identity were a constant feature of the survivor



syndrome. Most of his patients reported: "I am now a different person", but the chronically traumatized simply said: "I am not a person".

According to Herman (1992), even more complex deformations of identity are found in survivors of childhood abuse, with the sense of self often experienced as contaminated, guilty and evil. Fragmentation of identity is also common, reaching an extreme in dissociative identity disorder where the self fragments into dissociated alters (Herman, 1992). While borderline personality disorder patients lack such dramatic dissociative capacity, they have similar difficulties forming an integrated identity, and the "splitting" of inner representations of self and others can be seen as part of the unstable sense of identity (Herman, 1992).

Parallel to deformations in identity, lies alterations in systems of meaning that include loss of sustaining faith and a deep sense of hopelessness and despair (Herman, 1998). According to Everly (1999) a traumatic event can violate some deeply held belief or "Weltanschauung" (worldview) causing a psychologic hypersensitivity. He described four themes that seem universally traumatogenic including (1) violation of the belief that the world is 'just' or 'fair', (2) a defiled sense of who you are, by having not done something you should, or by having done something you should not have done, (3) broken trust, feelings of abandonment and betrayal, (4) and the loss of a sense of safety.

### **4.3 Increased Vulnerability To Harm**

In simple PTSD, victims experience repetitive intrusive thoughts and somato-sensory reliving of the original trauma. By contrast, according to Herman (1992), after prolonged, repetitive trauma, survivors may be at risk for repeated harm, either self-inflicted or at the hands of others. This repetitive harm does not necessarily bear direct relation to the original trauma as in flashbacks, rather it takes a disguised symptomatic or characterological form (Herman, 1992). Follette, Polusny, Bechtle and Naugle (1996) studied the cumulative impact of multiple victimization and confirmed that a history of sexual or physical abuse increased the likelihood of revictimization later in life (Follette



et al., 1996). However individuals who had been traumatized earlier in life showed increasingly higher levels of post-trauma symptomology (anxiety, depression and dissociation) when revictimized, suggesting that they do not habituate to repeated violent life experiences (Follette et al., 1996). Further exposure to multiple traumatization was found to effect recovery rates and treatment efficacy (Follette et al., 1996).

According to Favazza and Conterio (quoted in Herman, 1992) between 7 and 10 percent of psychiatric patients intentionally injure themselves. Compulsive self-mutilization is quite different to attempted suicide and appears strongly associated with a history of prolonged, repeated trauma, especially protracted child abuse (Herman, 1992).

Herman (1992) described a phenomena of repeated victimization that seems specifically associated with histories of prolonged child abuse. She reviewed wide scale epidemiological studies which provide evidence that survivors of child abuse are at increased risk for repeated harm in adult life, such as a doubled risk for rape, sexual harassment and battering, which Kluft (quoted in Herman, 1992) called the "sitting duck syndrome".

In a few rare cases, victims of prolonged, repeated abuse have become passive bystanders, collaborators and occasionally perpetrators of abuse of others (Herman, 1992). Hotaling and Sugarman (quoted in Herman, 1992) found that especially in men, childhood abuse is a risk factor for becoming an abuser, and that in women, a history of witnessing domestic violence or sexual victimization in childhood raises the risk of subsequent relationships with abusive partners. However, contrary to the popular notion of a generational cycle of abuse, the majority of abuse survivors do not abuse others, instead as parents they frequently mobilize caring and protective capacities that they did not experience themselves (Herman, 1992).



## 5. SUMMARY OF LITERATURE SURVEY

A century of clinical observations and literature has repeatedly noted that trauma responses occur in across a spectrum and on a continuum of severity. The existing, DSM-IV trauma response classifications include Acute Stress Disorder and PTSD as anxiety disorders. Complex PTSD or DESNOS was considered as a proposed, alternative classification during the DSM-IV PTSD Field Trials. It was not included as a separate diagnosis, but briefly mentioned as an associated feature of PTSD. Subsequent research and replica studies have not proved conclusively whether Complex PTSD should be a separate or associated feature of PTSD, and the controversy continues to date.

Childhood traumatization is strongly associated with adult psychopathology, and various Axis I and Axis II disorders, especially Borderline Personality Disorder, and to a lesser extent, Antisocial Personality Disorder. Prolonged, repeated traumatization during adulthood is also associated with subsequent Axis II pathology, including Borderline, Obsessive-Compulsive and Avoidant Personality Disorders. Chronically traumatized people with Axis II pathology often present with comorbid Axis I disorders including Major Depression, PTSD, Substance Abuse, Somatization Disorder, and Dissociative Disorders.

There are divergent views regarding the etiology of personality disorders in chronically traumatized individuals. On the one hand, repeated, prolonged trauma could cause enduring personality dysfunction in individuals despite normal premorbid functioning. On the other hand, genetics, temperament, environmental factors and even a pre-existing stress diathesis in the pre-trauma personality could contribute to the development of post-trauma personality disorders. These two views do not necessary contradict each other, but illustrate the complexity the human stress reaction.

Despite the controversy the inclusion of DESNOS into the diagnostic canon, it is a valuable measure of predicting prognosis to existing treatment options. The present main psychological treatment for post-traumatic stress disorders has been a cognitive-



behavioral based, exposure intervention. Alternative therapies include psychodynamic approaches, pastoral interventions and more recently, ecological and recovery based models.

The Complex PTSD conceptualization contributes to a better understanding of the personality structure of chronically traumatized people. There are three main areas of disturbance. Firstly, a complex symptomatic presentation including somatization, dissociation, and affect dysregulation. Secondly, deep characterological shifts including deformations in concepts of relatedness and identity. Thirdly, and increased vulnerability to harm, either self-inflicted or at the hands of others. The usefulness of integrating these three concepts into the personality conceptualization of chronically traumatized individuals is illustrated a case study.



## 6. CASE STUDY

This assignment aims at reviewing the personality changes that can follow in the wake of complex trauma. A case study, discussing personal history, clinical presentation and course is presented to illustrate some of the concepts.

### 6.1 The Patient

#### 6.1.1 Identifying details and family structure

Cathy Jones (fictitious name) was a 22-year old, single woman. She was in her first year of BA Health Studies at university, living in a student residence. She was the oldest of three children, with two half-sisters (ages 16 and 2) who still lived with her mother and stepfather. Her mother never married her biological father, but had been married to the stepfather since the patient was 5 years old. Cathy had sporadic contact with her biological father, although he occasionally gave her some financial support. The family was of a lower socio-economic status and “there was not always food to eat”. See Figure 2 for a genogram of the family structure.

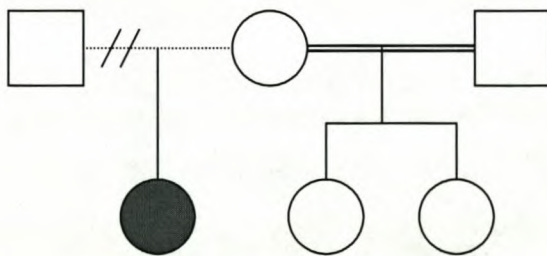


Figure 2. Genogram of the patient's family structure



### **6.1.2 Personal history**

Cathy's personal history started with being conceived by rape. Her mother planned to give her up for adoption, but decided to keep the baby at the last minute. After an easy pregnancy, and Cathy was born by a normal vaginal delivery. At birth she officially registered as Michelle Peters (fictitious name) to carry her biological father's surname. However, from an early age she was unofficially called "Cathy Jones" by her mother's family, to take her stepfather's surname. She attained normal developmental milestones and was a quiet, withdrawn child whose very protective mother did not allow her to play with other children. For the first few years of Cathy's life she experienced repeated uprootment as her family moved between relatives due to financial problems.

Her stepfather started sexually abusing her from the age of 5. He abused her twice a day, for ten years, mostly at their home at 10 Lakeview Drive (fictitious address). When she was 7 years old he insisted that she legally change her surname to his own, namely Jones. He "performed movements on her body" and ejaculated on her, but allegedly there was no penetration. When her mother found out about the sexual abuse she involved social work and laid criminal charges against her husband, who was found guilty and subsequently served a three-year prison sentence. At the time there was a social work intervention with family sessions and the patient received counseling from Safeline, a crisis intervention service for abused children. According to the mother, Cathy's stepfather converted to Christianity and was rehabilitated during his prison sentence, and he returned to live with the family after three years. Although the mother subsequently always avoided leaving her other daughters alone with her husband, she suspected he had "touched the children", but could not separate because she was financially dependent on him.

When Cathy was in Grade 9 her family converted to a charismatic Christian church and she recalled being much admired at school for her good values. After completing matric she worked for three years as an assistant supervisor at a small



business. She described herself as “ an introverted, serious and pessimistic person who had always found it difficult socializing with people”. During this period she was befriended by Nandi (fictitious name), a young woman who encouraged her to leave her church to join a breakaway denomination her family did not approve of.

Cathy, then 21, went to live in Pretoria with Nandi’s family who she felt very close to. She considered Nandi’s mother to be “like her own” and stuck many photographs of her on her walls. Cathy was also prepared to marry Nandi’s brother. At this time the patient had a fleeting lesbian encounter with Nandi. However, when Cathy became romantically involved with another man this caused conflict and jealousy with Nandi. The patient was ostracized from the communal group of friends and she returned to Cape Town with Nandi’s mother promising to pay for her studies. Prior to her admission, she attempted unsuccessfully to reconcile with Nandi.

### ***6.1.3 Psychiatric and medical history***

Apart from the family counseling after the childhood sexual abuse, Cathy’s psychiatric history includes twelve sessions with a counseling psychologist soon after she started her studies in Cape Town. She requested therapy for stress management, academic coping skills and to work on her relationships (especially with men) because she “sabotaged relationships”. She reported taking an overdose a year before admission, gathering pills, contemplating ingesting toxic substances, and scratching her wrists. Contrary to her presenting complaint, the central issue addressed in therapy was around over-dependency on her friends and how to be more independent. The therapist experienced the patient as “avoiding therapeutic issues, talking in circles and being manipulative at times”. The therapist also became concerned about possible ongoing sexual abuse of the youngest half-sister, after the patient reported her stepfather became sexually aroused when his two-year daughter sat on his lap. Although no diagnosis was made, the therapist felt that Cathy showed avoidant, dependent and sometimes schizoid personality traits.



Cathy reported no family psychiatric history and denied any personal substance abuse. Her medical background included being diagnosed with tuberculosis two years ago and subsequent treatment for six months.

#### ***6.1.4 Presenting problem***

In February 2002 the patient was referred from the student health service department with a history of depressive psychosis with auditory hallucinations, and disorientation for place but not time and person. She was subsequently hospitalized. As presenting problem, Cathy reported fleeting panic symptoms, feelings of derealization, and two episodes of transient amnesia where she "suddenly lost my memory of where I was, and was unable to find my way around". As she walked out of a classroom, she could not remember where she was or how to get anywhere. Some friends showed her to a phone booth where she called her psychologist. She had similar half-hour episode of "going blank" the previous day while at class. This disorientation had resolved completely by the time of admission.

#### ***6.1.5 Mental status evaluation***

On day one, Cathy's mental status was evaluated upon admission on by a psychiatric registrar, who noted a two month period of depressed mood, increased fatigue, poor concentration, feelings of worthlessness and guilt, and occasional suicidal ideation. She had also experienced recent increases in weight and appetite, and terminal insomnia. The patient reported intermittent fleeting auditory hallucinations since age 12 of "a voice inside her head saying negative things to her." She related general feelings of non-specific anxiety and derealization, but no recent panic attacks.

Cathy appeared well groomed and cooperative. She was cognitively intact and orientated to time, place and person. Her immediate and delayed memory was intact, and speech was normal. Her affect was somewhat constricted and there was slight psychomotor retardation. The patient's attitude was one of being perplexed as to what



was happening to her, and she rejected the offer of outpatient treatment as she felt “too scared to go back to campus as she was afraid she may not find her way around”. No physical or neurological abnormalities were detected. All special medical investigations including CT brain imaging and EEG were normal.

#### **6.1.6 Summary and diagnosis upon admission**

To summarize, Cathy was a 22-year old, single, female student who was hospitalized after becoming disorientated to place, and having auditory hallucinations. She had a one-month history of depressed mood, guilt feelings, disturbed neuro-vegetative signs and occasional suicidal ideation. The acute psychosocial stressors were interpersonal problems with friends, religious differences with her family and financial problems. Chronic stressors included a history of prolonged sexual abuse. She was admitted for further clinical observation and her initial multi-axial DSM IV diagnosis was as follows:

<b>Axis I:</b>	Major Depressive Disorder (with psychotic features)
<b>Differentials</b>	<ul style="list-style-type: none"> <li>• Factitious Disorder (with predominantly psychological signs and symptoms)</li> <li>• Dissociative Amnesia</li> <li>• Amnestic Disorder due to a General Medical Condition</li> <li>• First onset of a Psychotic Disorder (Brief Psychotic Disorder, Schizophreniform Disorder or Schizo-affective Disorder)</li> <li>• Malingering</li> </ul>
<b>Axis II</b>	<ul style="list-style-type: none"> <li>• Deferred</li> </ul>
<b>Axis III</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>
<b>Axis IV</b>	<ul style="list-style-type: none"> <li>• Family conflict surrounding religious issues, peer group pressure and rejection, childhood sexual abuse</li> </ul>
<b>Axis V</b>	<ul style="list-style-type: none"> <li>• &lt; 50</li> </ul>



## 6.2 Clinical Course and Progress

On day two after admission, the patient's mental state changed dramatically. She denied that her name was Cathy Jones, any knowledge of her previous life as a student and failed to recognize her family when they visited. The only information she recalled was her name Michelle Peters, believed she was in Grade 11, that it was 1997 and that she lived alone at 10 Lakeview Drive (the same address where most of the reported sexual abuse occurred). She persistently failed to recognize her family, remained disorientated for time, place and person but could recall the ward staff and recent conversations with them.

By day three, Cathy's mood was predominantly depressed, but she described unstable fluctuations from happy to sad while in the ward, as well as nihilism and occasional suicidal ideation. She also reported constant feelings of emptiness and guilt about not recognizing her family. Her affect was somewhat constricted and she had an attitude of "la belle indifférence". Cathy initially still reported auditory hallucinations but these disappeared and amnesia became the main clinical problem. Her previous therapist and mother were contacted for collateral and her diagnosis was adjusted as follows by day five:

- |                 |   |
|-----------------|---|
| <b>Axis I</b>   | <ul style="list-style-type: none"> <li>• Dissociative Amnesia</li> <li>• Major Depressive Disorder</li> </ul>   |
| Differentials   | <ul style="list-style-type: none"> <li>• Dissociative Identity Disorder</li> <li>• Factitious Disorder with predominantly psychological signs and symptoms</li> <li>• Amnestic Disorder due to a General Medical Condition</li> <li>• Psychotic Disorder (prodrome to Schizophreniform Disorder)</li> </ul> |
| <b>Axis II</b>  | <ul style="list-style-type: none"> <li>• Borderline Personality Disorder Traits</li> <li>• Schizoid Personality Disorder Traits</li> </ul>  |
| <b>Axis III</b> | <ul style="list-style-type: none"> <li>• Anemia</li> </ul>  |



**Axis IV**                      • Family conflict, possible ongoing sexual abuse of siblings,  
financial stress

**Axis V**                      • <50

Cathy was started on 20mg of Fluoxetine daily and a vitamin supplement with iron. The patient was becoming increasingly distressed and anxious about her condition as she continued recalling only the previous two or three days. During this period she related a dream to the psychiatrist with themes of sexual abuse. In light of collateral from the mother and previous therapist, the patient's case was referred to social work to investigate possible ongoing sexual abuse in the family. Cathy was also referred for ongoing inpatient psychotherapy. Cathy's mother expressed dissatisfaction that her daughter was hospitalized and tried to convince her not to take her medication. Her biological father wrote a letter to the hospital requesting she not be allowed visits by anyone except her mother.

Cathy displayed the borderline personality traits of affective instability, chronic feelings of emptiness, past suicidal and self-mutilization gestures, identity disturbance, severe dissociation, and there was some evidence of unstable interpersonal relationships. However she had shown no impulsivity or intense displays of anger, and it was agreed she probably had more of the dissociative than impulsive borderline features. Ten days after admission her working diagnosis was as follows:

**Axis I**                      • Dissociative Amnesia  
• Major Depressive Disorder

**Axis II**                      • Borderline Personality Disorder

**Axis III**                     • Anemia

**Axis IV**                     • Family conflict, possible ongoing sexual abuse of siblings,  
financial stress

**Axis V**                     • <50



Further treatment suggestions included ongoing inpatient psychotherapy, a referral for a MRI and SPECT scan.

Cathy showed a changing clinical picture over the next three and a half months as an inpatient. Initially her mood symptoms lifted, the hallucinations disappeared but she still could only recall the previous two to three. Her attitude was childlike and detached, although she described feelings of anger and frustration during therapy. Cathy was positive about the possibility of a drug-assisted interview, but when it had to be rescheduled due to logistics she wrote an angry letter expressing feelings of “deep hurt” at her psychiatrist.

At the end of the first month after admission Cathy’s feelings of depression became more prominent again accompanied by decreased appetite, insomnia, blunted affect and psychomotor retardation. She appeared increasingly suspicious and fearful. She started refusing to leave the ward, showing symptoms of agoraphobia, and started having panic attacks. In therapy she was tearful, expressed feelings of “emptiness” and drew a picture of herself with a black empty cloud above her head.

Just after the first month the patient started reporting auditory hallucinations of voices saying “I hate you” and “Help me”. She continued showing symptoms of agoraphobia and had some panic attacks in the ward. During this period it was her birthday and she was visited by various family members and friends whom she did not recognize or feel comfortable seeing. At this stage she was responding to the name “Cathy” again although she was “not sure if this was her real name.”

Cathy’s mood lifted briefly during week six, before the first drug assisted interview, while fears and realistic expectations were addressed in therapy. The interview was done by the psychiatrist using Valium. Initially she became emotional and tearful but could not recall anything, subsequently becoming increasingly drowsy and less responsive. After the interview she felt depressed again, although neuro-vegetative symptoms were normal.



Although still hesitant, her agoraphobia was becoming less, there were no further panic attacks, her mood was improving and her socialization in the ward was better. With the assistance of a nurse she managed to go for a SPECT scan. Despite the fact that the therapist had to reintroduce herself during their twice a week sessions, somehow a therapeutic relationship of trust had started developing. Two months after admission Cathy had a second drug-assisted interview using Midasolan during which she again had no recall and became sleepy.

By this time the social worker had completed her investigation regarding the family. No evidence of ongoing sexual abuse at home was found, although this possibility could not be ruled out. Cathy also showed an abnormal SPECT scan, but no deductions could be made. At two and a half months after admission, a ward round decision was taken to send Cathy home for a weekend under the care of her mother. This was addressed in therapy and the patient admitted to being afraid of "leaving the ward with strangers". Two days before her first weekend out she had a micro-psychotic episode hearing voices commenting on her actions. She expressed delusions of guilt and persecution "to take cold showers, not eat jam on her bread and not speak to anyone or she would be punished". This was tentatively interpreted as possibly "acting-up" against having to leave for the weekend.

Her family reported the weekend as "unsuccessful" as Cathy did not recognize anyone, isolated herself and did not speak one word. The next week in therapy she expressed her anger at the ward staff for "pushing her out". Despite being amnesic, her mood seemed to have improved and she was again a psychotic. The psychiatric team was considering the possibility of discharge after another weekend out, and for her to return to her previous therapist to ensure continuity of care.

Three months after admission, Cathy was sent home for the second time, but returned in a highly distressed and anxious condition. She had regressed back to being the 17-year old Michelle Peters, in 1997 with no further recollection of her history. Although



her mood gradually improved to euthymic, she remained disorientated to person and she consistently had no recall of more than the previous day. During this period she suddenly recognized a melody a fellow patient had sung to her seven weeks ago "Somewhere, over the rainbow". She started responding to the name Cathy again, participated well in occupational therapy groups, had better self-grooming and appeared euthymic. In therapy she showed increasingly open emotional expression and had many questions about how other people "got their memories back".

During her third weekend home at the beginning of the fourth month after admission, Cathy was brought back early after she started having auditory hallucinations of a crying 7-year old child who was "her responsibility" and wanted to search for it. She isolated herself in the ward, rocking in a foetal position on the bed or on the floor, repeatedly asking to be let out of the ward to find and comfort the child. A few days later the hallucinations disappeared, she forgot about having them and continued functioning in the ward as Cathy. At this stage it was considered to transfer her to the therapeutic ward of the neighboring psychiatric hospital, as the psychiatric team agreed it was not advisable to send her home but neither could she stay in the ward indefinitely.

The following weekend during one of her mother's visits, she told of a "picture in her mind" of a 2-year old girl being severely beaten by a mother in front of a laughing group of people. The child was scared and confused. The patient's mother admitted that she recalled this incident from Cathy's childhood and apologized to her daughter for "things she had done wrong." That same weekend, Cathy was visited by some friends from university who told her "something had happened before she was admitted, but it was not their right to tell her." These incidents were addressed in therapy with the therapist not asking leading questions or making speculations about possible stressors.

The pace of progress was left to the patient and most of the therapy was in the here-and-now modality, addressing the immediate emotions she felt safe enough to explore. Cathy's immediate recall started improving after the above mentioned incidents.



Two weeks later she could still recall the incidents of the child being beaten and all events since, but nothing of her previous history.

Towards the end of Cathy's fourth month of hospitalization, termination of therapy and transfer to another psychiatric hospital were addressed. Cathy felt angry and abandoned, and was terrified of losing the few friends in the ward she could now remember. She admitted to hiding a pair of scissors in her drawer and wanting to harm herself. She expressed feelings of rage and resentment towards the therapist, the ward staff and patients she had become close to. Subsequently she wrote idealizing letters of apology and remarked "maybe if I push everyone away and make them hate me, it will hurt less when I have to go." Four months after admission, the last of the 33 sessions with Cathy as an inpatient was contained and appropriate. She was euthymic, apsychotic and could recall all the events of the past two weeks. She showed improved insight into her condition and was reasonably realistic about her transfer.

### **6.3 Discussion**

Despite fulfilling the DSM-IV criteria for dissociative amnesia and borderline personality disorder, the Axis II diagnosis remained ambiguous because it did, and it did not, fully capture the patient's mental state. The classical borderline picture of extreme oscillations from idealization to furious rejection, fleeting micro-psychotic episodes, threats of self-harm and terror of abandonment, became increasingly prominent over the four months in the ward. Although her lack of impulsivity, blunted affect, alterations between extreme passivity and occasional expressions of rage within therapy, and severe regression after psychosocial stress were still consistent with borderline personality disorder, it created a more complex conceptualization. The development of fleeting panic attacks, transient agoraphobia and fluctuating mood symptoms still further complicated the changing clinical picture.

The patient's self-reports on admission of prolonged, repeated sexual traumatization supports the literature findings that childhood sexual abuse is a risk factor



for developing subsequent borderline personality disorder. Although the precise acute stressor that caused her to become amnesic is not known, it can be hypothesized that in light of her severe, childhood sexual abuse history, she would be more susceptible to more serious reactions to any subsequent trauma. What is notable is that a diagnosis of PTSD was never considered, not even as a differential, which lends support to the view that a complex trauma diagnosis could be distinct category as opposed to an associated feature of PTSD.

Most prominent of the possible complex PTSD symptoms was dissociation. As one of the most powerful of psychological defenses, it also is a double-edged sword. Cathy could punish the perpetrator and any bystanders who failed to protect her by denying their existence, simultaneously protecting herself from any further harm by refusing the influence of abuse to enter into her consciousness. Combined with anterograde amnesia it spills over into a source of ongoing self-harm as it excludes the healing of any old relationships or the formation of any new ones by forgetting that they exist soon after they start. Alterations in sense of time, identity and memory could make it possible to exist in a reality that did not allow traumatic recollections of childhood or any ongoing conflicting images of caregivers to cause further harm, so remaining secure in a specific time, place and person of her own unconscious choice. By fixing herself in a specific time suggests a wish to change the script of her narrative, and/or a need to remind others of her ongoing pain

The patient displayed few actual somatic complaints but frequently communicated her distress in somatic terms as sensations of chronic emptiness she could not explain in words, and deep feelings of almost physical anger she could not direct at a cause. The labile mood swings, suicidal ideation, self-mutilization, delusions of guilt during the micro-psychotic episodes, and expressions of rage could be conceptualized as a difficulties with affect dysregulation. A similar pattern of instability was reported by the collateral reports of her turbulent interpersonal functioning including sabotaging relationships with men, fleeting lesbian experimentation and intense family conflict. This is all against a paradoxical background of what her previous therapist described as “a



childlike attitude to sexuality". She seemed to oscillate between intense relationships with the same dysregulation as her reactive mood state.

Both self-reports and collateral describe difficulties in relatedness, ranging from a conflictual love-hate relationship with her mother where she moved between the roles of parent and child, to enmeshment into another family with a subsequent intense attachment to a replacement "mother" and "special" bonding to other family members. Her relationships appear to be characterized by cycles of idealization, conflict, boundary violations, abandonment and rejection that again follows a borderline pattern of engagement.

Whether the patient felt she was Cathy, Michelle or was unsure either way, her deformations in identity went deeper than her name. Her sense of chronic emptiness, of not being a person or even a "being" of any value, seemed to lie beneath the daily inability to recall who she was. During the micro-psychotic episodes her delusions of guilt, the voices of persecution and her fear of being punished for being "bad" could suggest a contaminated, maybe even evil sense of self. Someone not worthy of having an identity. The fleeting, vague and inconsistent quality of her reported auditory hallucinations and delusions suggested her brief psychotic episodes were reactive to her environment, and not the prodromal signs of schizophrenia, although it was considered as a differential occasionally.

Although difficult to assess objectively due to her condition, the patient's history of religiousness, subsequent rejection of one denomination for another and family conflict about her beliefs, possibly points to a search for meaning and maybe protection or forgiveness. After years of uprootment and poverty, the family found some type of stability and nurturance in religion. The stepfather who abused Cathy claimed repentance after being caught, unnaturally forcing the family to forgive him and take him back, possibly suppressing anger and pain. The rebellion against her family's denomination could be seen as a subconscious, punitive rejection of the mother and her church, who both failed to protect her from the abuse. Themes of spirituality, both positive and



negative, repeatedly arose during therapy, although the question of alterations in systems of meaning is probably best left unanswered at this stage.

According to the literature and the complex PTSD conceptualization, a history of prolonged, repeated traumatization, especially childhood sexual abuse increases the vulnerability to future harm, either self-inflicted or at the hands of others. The patient's suicidal behaviors, self-mutilation and even her dissociative amnesia can all be seen as various expressions of borderline self-injury and defenses. It is uncertain if she had experienced additional abuse at the hands of others, but some of her existing coping mechanisms for daily life and relationships could have made her vulnerable to future harm and exploitation.

A long-term psychotherapeutic intervention is one of a few recommendations that can be made to assist the patient in using her own resilience to overcome the effects of chronic traumatization. In Herman's (1998) experience of recovery from severe, prolonged trauma, the first therapeutic step is to establish safety within a healing relationship. In the patient's case this would include a gradual shift from dissociated trauma to acknowledged memory.

Although Cathy remained amnesic about her past when the therapy was terminated, she had started remembering some haphazard fragments and could recall two weeks in immediate retrospect. Perhaps the initial foundations of a relationship of trust had been laid between Cathy and her in-patient therapist, and she felt safe enough to allow the initial glimpses of reality to start surfacing through the amnesic dissociation. However the strong borderline features and her ongoing psychosocial stressors still remained the core issues to be addressed in the future. Whether or not Cathy's symptoms fulfilled the DESNOS criteria, using the complex adaptation to severe trauma conceptualization provided valuable insight into the formulation of her psychological dynamics.



## 7. CONCLUSION

As a whole, the clinical literature of the past decade supports the hypothesis that severe traumatization significantly influences personality pathology and contributes to a range of Axis I conditions such as dissociation, somatization, some psychotic symptoms, depressive and anxiety features, and substance abuse. Researchers agree that pre-existing dysfunctional personality traits or disorders raise the likelihood of developing more serious post-trauma psychological reactions. However they disagree on if trauma is a cause or contribution to subsequent character dysfunctionality. History and clinical observation does seem to suggest that exposure to severe, prolonged terror and/or captivity could potentially produce long-term character changes in most people, irrespective of their pre-trauma personality structure. The issues are further complicated by the more recent focus on the genetic component in personality disorders, returning to the nature vs. nurture debate.

After various clinical studies researchers remain in disagreement whether complex trauma is an associated feature of PTSD or should be a separate diagnostic entity. However differences of opinion and academic debate generates increased research, knowledge and better treatment. Although the precise conceptualization remains a gray area, the understanding of the suffering of the survivors of trauma is improving. As the study of psychotraumatology progresses it remains integral to keep a balance between theory and reality, while always retaining respect for the human spirit's capacity to self heal.

More philosophically, could there be such a thing as a South African personality disorder caused by severe traumatization of a society? In many ways sections of our people dissociate from the horrors of daily reality by remaining sheltered in their own worlds. Perhaps the HIV Aids pandemic could be viewed as a somatoform symptom of a society in distress. And maybe the impulsivity of violent crime, the sadness of poverty, and the suicidal quality of hopelessness could be seen as a national version of affect dysregulation. Possibly Judith Herman's recovery strategy of first establishing safety,



then allowing space for remembrance and mourning, followed by reconnection and rediscovery of commonality among people could be recommended to overcome South Africa's trauma.



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## ADDENDUM 1

### *Diagnostic criteria for Disorder of extreme stress not otherwise specified (DESNOS)*

*(Roth et al., 1997) used in the 1991-1992 DSM-IV PTSD Field Trials*

- I. Alterations in Regulation of Affect & Impulses (A or one of B-F required)
  - A. Affect Regulation
  - B. Modulation of Anger
  - C. Self-Destructive
  - D. Suidical Preoccupation
  - E. Modulation of Sexual Involvement
  - F. Excessive Risk Taking
  
- II. Alterations in Attention or Consciousness (A or B required)
  - A. Amnesia
  - B. Transient Dissociative Episodes and Depersonalization
  
- III. Alterations in Self-perception
  - A. Ineffectiveness
  - B. Permanent Damage
  - C. Guilt and Responsibility
  - D. Shame
  - E. Nobody can understand
  - F. Minimizing
  
- IV. Alterations in Perception of the Perpetrator (Not required)
  - A. Adopting Distorted Beliefs
  - B. Idealization of the Perpetrator
  - C. Preoccupation with Hurting the Perpetrator
  
- V. Alterations in Relationships with Others (One of A-C required)
  - A. Inability to Trust
  - B. Revictimization
  - C. Victimizing Others



VII. Somatization (Two of A-E required)

- A. Digestive System
- B. Chronic Pain
- C. Cardiopulmonary Symptoms
- D. Conversion Symptoms
- E. Sexual Symptoms

VII. Alterations in Systems of Meaning (One of A-B required)

- A. Despair and Helplessness
- B. Loss of Previously Sustaining Beliefs



## ADDENDUM 2

### ***Diagnostic Criteria for Complex Post-Traumatic Stress Disorder (Herman, 1998)***

1. *A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.*
  
2. *Alterations in affect regulation, including*
  - *Persistent dysphoria*
  - *Chronic suicidal preoccupation*
  - *Self injury*
  - *Explosive or extremely inhibited anger (may alternate)*
  - *Compulsive or extremely inhibited sexuality (may alternate)*
  
3. *Alterations in consciousness, including*
  - *Amnesia or hyperamnesia for traumatic events*
  - *Transient dissociative states*
  - *Depersonalization/derealization*
  - *Reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation.*
  
4. *Alterations in self-perception, including*
  - *Sense of helplessness or paralysis of initiative*
  - *Shame, guilt, and self-blame*
  - *Sense of defilement or stigma*
  - *Sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)*



5. *Alterations in perception of perpetrator, including*

- *Preoccupation with relationship with perpetrator (includes preoccupation with revenge)*
- *unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)*
- *idealization or paradoxical gratitude*
- *sense of special or supernatural relationship*
- *acceptance of belief system or rationalizations of perpetrator*

6. *Alterations in relations with others, including*

- *Isolation and withdrawal*
- *Disruption in intimate relationships*
- *Repeated search for rescuer (may alternate with isolation and withdrawal)*
- *Persistent distrust*
- *Repeated failures of self-protection*

7. *Alterations in systems of meaning*

- *Loss of sustaining faith*
- *Sense of hopelessness and despair*

### ADDENDUM 3

#### *Diagnostic Criteria for Enduring Personality Change after Catastrophic Experience (ICD-10, 1992)*

- A. There must be evidence (from the personal history or from key informants) of a definite and persistent change in the individual's pattern of perceiving, relating to, and thinking about the environment and self, following exposure to catastrophic stress (e.g. concentration camp experience, torture, disaster, prolonged exposure to life-threatening situations).
- B. The personality change should be significant and represent inflexible and maladaptive features as indicated by the presence of at least two of the following:
- 1) a permanent hostile or distrustful attitude towards the world in a person who previously showed no such traits;
  - 2) social withdrawal (avoidance of contacts with people other than a few close relatives with whom the individual lives) which is not due to another current mental disorder (such as a mood disorder);
  - 3) a constant feeling of emptiness or hopelessness, not limited to a discrete episode of mood disorder, which was not present before the catastrophic stress experience; this may be associated with increased dependency on others, inability to express negative or aggressive feelings, and prolonged depressive mood without any evidence of depressive disorder before exposure to the catastrophic stress;
  - 4) an enduring feeling of being "on edge" or of being threatened without any external cause, as evidenced by an increased vigilance and irritability in a person who previously showed no such traits or hyper-alertness; this



chronic state of inner tension and feeling threatened may be associated with a tendency to excessive drinking or use of drugs;

- 5) a permanent feeling of being changed or being different from others (estrangement); this feeling may be associated with an experience of emotional numbness.
- C. The change should cause significant interference with personal functioning in daily living, personal distress, or adverse impact on the social environment.
  - D. The personality change should have developed after the catastrophic experience, and there should be no history of pre-existing adult personality disorder or trait accentuation, or of personality or developmental disorders during childhood or adolescence, that could explain the current personality traits.
  - E. The personality change must have been present for at least 2 years. It is not related to episodes of any other mental disorder (except post-traumatic stress disorder) and cannot be explained by brain damage or disease.
  - F. The personality change meeting the above criteria is often preceded by a post-traumatic stress disorder. The symptoms of the two conditions can overlap and the personality change may be a chronic outcome of a post-traumatic stress disorder. However, an enduring personality change should not be assumed in such cases unless, in addition to at least 2 years of post-traumatic stress disorder, there has been a further period of no less than 2 years during which the above criteria have been met.

## **ADDENDUM 4**

### **RESEARCH PROJECT GENERAL INFORMATION**

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This document is prepared by Lydia van Niekerk, clinical psychology intern at Tygerberg Hospital and registered final year clinical psychology masters student at University of Stellenbosch.

The research project is supervised by Dr Johnny Wait, clinical psychologist and senior lecturer at the Department of Psychology at the University of Stellenbosch.

Psychotherapy with patients is supervised by Helena Thornton, senior clinical psychologist and lecturer at Tygerberg Hospital and the University of Stellenbosch.

This document is prepared at the recommendation of Professor Willie Pienaar from the Tygerberg Hospital Medical Ethics Committee.

The purpose is to provide the necessary information and ask informed consent from voluntary participants in a research project that is part of a dissertation for a Masters Degree in Clinical Psychology at the University of Stellenbosch.

The thesis is an observational, descriptive study that includes a literature review of the psychological effects of trauma. An appropriate clinical case history without identifying details will be included to describe some of the concepts researched.

Participation and permission is voluntary.

The paper aims to contribute to the knowledge within the professional field of clinical psychology and encourage research into more effective future treatment.



**INFORMED CONSENT DOCUMENT FOR RESEARCH PROJECT**

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TITEL OF RESEARCH PROJECT: PSYCHOLOGICAL EFFECTS OF  
COMPLEX TRAUMA  
PRINCIPAL INVESTIGATOR LYDIA VAN NIEKERK  
ADDRESS PRIVATE BAG X3  
TYGERBERG HOSPITAL  
7503

**DECLARATION BY OR ON BEHALF OF PATIENT:**

**I, THE UNDERSIGNED,** .....(name) (ID  
Number:.....) of the patient of  
.....  
.....(address).

**A: HEREBY CONFIRM AS FOLLOWS:**

1. I was invited to participate in the abovementioned research project, which is being undertaken by the Department of Psychology, University of Stellenbosch.
2. The following aspects have been explained to me:
  - 2.1 **Aim:** Case study to be used as part of Masters Dissertation in Clinical Psychology that reviews that literature on psychological effects of complex trauma.
  - 2.2 **Procedures:** An anonymous case history without identifying details describing personal history, clinical presentation and treatment plan.
  - 2.3 **Risks:** No risks, invasive procedures or additional medication will be involved.

- 2.4 **Possible Advantages:** Although this study may not benefit the patient now, he/she and other patients may benefit in the future. This study may help clinicians to understand the condition better and develop new treatments for future patients.
- 2.5 **Confidentiality:** Participation is regarded as strictly confidential. The case history will be anonymous and all identifying details will be changed. The results of the study will be published in the professional literature and made available to Subcommittee C of the Research Committee, but the identity of participants will remain protected.
- 2.6 **Voluntary participation/refusal/discontinuation:** Participation in this study is voluntary and the patient may refuse to participate or discontinue participation at any time. Such refusal or discontinuation will not prejudice the patient's future treatment at this institution. The investigator may withdraw the patient from the study should she feel it would be in the patient's best interest.
- 2.7 **Compensation for Study Participation:** This study will use clinical notes already available in hospital files. Should any future interviews be necessary no costs to the patient are anticipated. While the patient will not be paid to take part in this study, travelling expenses will be reimbursed if necessary for future interviews.
3. The information above was explained to me by .....  
(name of the relevant person) in English/Afrikaans and I am in command of this language. I was given the opportunity to ask questions and all these questions were answered satisfactorily.
4. No pressure was exerted on me to the consent to participation and I understand that I can withdraw at any stage without any penalization.
5. Participation in this study will not result in any additional costs to myself.

**B: HEREBY CONSENT VOLUNTARILY GIVEN TO PARTICIPATE IN  
THE ABOVEMENTIONED PROJECT.**



Signed:.....(name)  
at .....(place), on.....(date).

Signature of Witness:.....

**STATEMENT ON BEHALF OF INVESTIGATORS:**

I, ....., declare that

- I explained the information in this document to  
.....(name of participant).
- He/she was encouraged and given ample time to ask me questions;
- This conversation was conducted in Afrikaans/English

Signed:.....	Signed:.....
Lydia van Niekerk	Helena Thornton
Clinical Psychology Intern	Supervisor
Tygerberg Hospital	Senior Clinical Psychologist and Lecturer
University of Stellenbosch	Tygerberg Hospital, University of Stellenbosch

Witness:.....