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From *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror*

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PTSD: A New Diagnosis

Most people have no knowledge or understanding of the psychological changes of captivity. Social judgment of chronically traumatized people therefore tends to be extremely harsh. The chronically abused person's apparent helplessness and passivity, her entrapment in the past, her intractable depression and somatic complaints, and her smoldering anger often frustrate the people closest to her. Moreover, if she has been coerced into betrayal of relationships, community loyalties, or moral values, she is frequently subjected to furious condemnation.

Observers who have never experienced prolonged terror and who have no understanding of coercive methods of control presume that they would show greater courage and resistance than the victim in similar circumstances. Hence the common tendency to account for the victim's behavior by seeking flaws in her personality or moral character. Prisoners of war who succumb to "brainwashing" are often treated as traitors.[1] Hostages who submit to their captors are often publicly excoriated. Sometimes survivors are treated more harshly than those who abused them. In the notorious case of Patricia Hearst, for instance, the hostage was tried for crimes committed under duress and received a longer prison sentence than her captors.[2] Similarly, women who fail to escape from abusive relationships and those who prostitute themselves or betray their children under duress are subjected to extraordinary censure.

The propensity to fault the character of the victim can be seen even in the case of politically organized mass murder. The aftermath of the Holocaust witnessed a protracted debate regarding the "passivity" of the Jews and their "complicity" in their fate. But the historian Lucy Dawidowicz points out that "complicity" and "cooperation" are terms that apply to situations of free choice. They do not have the same meaning in situations of captivity.[3]

Diagnostic mislabeling

This tendency to blame the victim has strongly influenced the direction of psychological inquiry. It has led researchers and clinicians to seek an explanation for the perpetrator's crimes in the character of the victim. In the case of hostages and prisoners of war, numerous attempts to find supposed personality defects that predisposed captives to "brainwashing" have yielded few consistent results. The conclusion is inescapable that ordinary, psychologically healthy men can indeed be coerced in unmanly ways.[4] In domestic battering situations, where victims are entrapped by persuasion rather than by capture, research has also focused on the personality traits that might predispose a woman to get involved in an abusive

relationship. Here again no consistent profile of the susceptible woman has emerged. While some battered women clearly have major psychological difficulties that render them vulnerable, the majority show no evidence of serious psychopathology before entering into the exploitative relationship. Most become involved with their abusers at a time of temporary life crisis or recent loss, when they are feeling unhappy, alienated, or lonely.[5] A survey of the studies on wife-beating concludes: "The search for characteristics of women that contribute to their own victimization is futile.... It is sometimes forgotten that men's violence is men's behavior. As such, it is not surprising that the more fruitful efforts to explain this behavior have focused on male characteristics. What is surprising is the enormous effort to explain male behavior by examining characteristics of women."[6]

While it is clear that ordinary, healthy people may become entrapped in prolonged abusive situations, it is equally clear that after their escape they are no longer ordinary or healthy. Chronic abuse causes serious psychological harm. The tendency to blame the victim, however, has interfered with the psychological understanding and diagnosis of a post-traumatic syndrome. Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the abusive situation to the victim's presumed underlying psychopathology. [...]

The tendency to misdiagnose victims was at the heart of a controversy that arose in the mid-1980s when the diagnostic manual of the American Psychiatric Association came up for revision. A group of male psychoanalysts proposed that "masochistic personality disorder" be added to the canon. This hypothetical diagnosis applied to any person who "remains in relationships in which others exploit, abuse, or take advantage of him or her, despite opportunities to alter the situation." A number of women's groups were outraged, and a heated public debate ensued. Women insisted on opening up the process of writing the diagnostic canon, which had been the preserve of a small group of men, and for the first time took part in the naming of psychological reality. [...]

Need for a new concept

Misapplication of the concept of masochistic personality disorder may be one of the most stigmatizing diagnostic mistakes, but it is by no means the only one. In general, the diagnostic categories of the existing psychiatric canon are simply not designed for survivors of extreme situations and do not fit them well. The persistent anxiety, phobias, and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder.

The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient's present symptoms and the traumatic experience is frequently lost. Attempts to fit the patient into the mold of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment. All too commonly, chronically traumatized people suffer in silence; but if they complain at all, their complaints are not well understood. They may collect a virtual pharmacopeia of remedies: one for headaches, another for insomnia, another for anxiety, another for depression. None of these tends to work very well, since the underlying issues of trauma are not addressed. As caregivers tire of these chronically unhappy people who do not seem to improve, the temptation to apply pejorative diagnostic labels becomes overwhelming.

Even the diagnosis of "post-traumatic stress disorder," as it is presently defined, does not fit accurately enough. The existing diagnostic criteria for this disorder are derived mainly from survivors of circumscribed traumatic events. They are based on the prototypes of combat, disaster, and rape. In survivors of prolonged, repeated trauma, the symptom picture is often far more complex. Survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity. Survivors of abuse in childhood develop similar problems with relationships and identity; in addition, they are particularly vulnerable to repeated harm, both self-inflicted and at the hands of others. The current formulation of post-traumatic stress disorder fails to capture either the protean symptomatic manifestations of prolonged, repeated trauma or the profound deformations of personality that occur in captivity.

The syndrome that follows upon prolonged, repeated trauma needs its own name. I propose to

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 hypermnesia for traumatic events
   - transient dissociative episodes
   - 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

call it "complex post-traumatic stress disorder." The responses to trauma are best understood as a spectrum of conditions rather than as a single disorder. They range from a brief stress reaction that gets better by itself and never qualifies for a diagnosis, to classic or simple post-traumatic stress disorder, to the complex syndrome of prolonged, repeated trauma. [...]

Lawrence Kolb remarks on the "heterogeneity" of post-traumatic stress disorder, which "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 severe personality disorganization."[7] Others have also called attention to the personality changes that follow prolonged, repeated trauma. The psychiatrist Emmanuel Tanay, who works with survivors of the Nazi Holocaust, observes: "The psychopathology may be hidden in characterological changes that are manifest only in disturbed object relationships and attitudes towards work, the world, man and God."[8]

Many experienced clinicians have invoked the need for a diagnostic formulation that goes beyond simple post-traumatic stress disorder. William Niederland finds that "the concept of traumatic neurosis does not appear sufficient to cover the multitude and severity of clinical manifestations" of the syndrome observed in survivors of the Nazi Holocaust.[9] Psychiatrists who have treated Southeast Asian refugees also recognize the need for an "expanded concept" of post-traumatic stress disorder that takes into account severe, prolonged, and massive psychological trauma.[10] One authority suggests the concept of a "post-traumatic character disorder."[11] Others speak of "complicated" post-traumatic stress disorder.[12] [...]

As the concept of a complex traumatic syndrome has gained wider recognition, it has been given several additional names. The working group for the diagnostic manual of the American Psychiatric Association has chosen the designation "disorder of extreme stress not otherwise specified." The International Classification of Diseases is considering a similar entity under the name "personality change from catastrophic experience." These names may be awkward and unwieldy, but practically any name that gives recognition to the syndrome is better than no name at all.

Naming the syndrome of complex post-traumatic stress disorder represents an essential step toward granting those who have endured prolonged exploitation a measure of the recognition they deserve. It is an attempt to find a language that is at once faithful to the traditions of accurate psychological observation and to the moral demands of traumatized people. It is an attempt to learn from survivors, who understand, more profoundly than any investigator, the effects of captivity.

NOTES

1 A. D. Biderman and H. Zimmer, eds., *The Manipulation of Human Behavior* (New York: John Wiley, 1961), 1–18.

2 P. Hearst and A. Moscow, *Every Secret Thing* (New York: Doubleday, 1982).

3 L. Dawidowicz, *The War Against the Jews* (London: Weidenfeld and Nicolson, 1975).

4 Biderman and Zimmer, *Manipulation of Human Behavior;* F. Ochberg and D. A. Soskis, *Victims of Terrorism* (Boulder, CO: Westview, 1982).

5 G. T. Hotaling and D. G. Sugarman, "An Analysis of Risk Markers in Husband-to-Wife Violence: The Current State of Knowledge," *Violence and Victims* 1 (1986): 101–24.

6 Ibid., 120.

7 L. C. Kolb, letter to the editor, *American Journal of Psychiatry* 146 (1989): 811–12.

8 H. Krystal, ed., *Massive Psychic Trauma* (New York: International Universities Press, 1968), 221.

9 Ibid., 314.

10 J. Kroll, M. Habenicht, T. Mackenzie et al., "Depression and Posttraumatic Stress Disorder in Southeast Asian Refugees," *American Journal of Psychiatry* 146 (1989): 1592–7.

11 M. Horowitz, *Stress Response Syndromes* (Northvale, NJ: Jason Aronson 1986), 49.

12 D. Brown and E. Fromm, *Hypnotherapy and Hypnoanalysis* (Hillsdale, NJ: Lawrence Erlbaum, 1986).