

# Introduction

## WHY THIS GUIDEBOOK?

Many women seeking treatment for depression, suicidal feelings, substance use problems, difficult or abusive relationships and self-inflicted harm may actually be experiencing complex post-traumatic stress responses. These responses most often result from a history of chronic abuse or neglect in childhood. While post-traumatic stress disorder (PTSD) has been recognized for some time, complex PTSD is a recently recognized diagnostic category. It is a category that better captures the range of adaptations and effects of trauma resulting from early and/or chronic child abuse — abuse that is most often perpetrated in a larger context of neglect and deprivation.

Many mental health professionals are aware that their clients have histories of abuse and neglect that have resulted in post-traumatic stress. However, they can underestimate the degree to which the trauma has been pathogenic, or the origin of their responses (or symptoms). Mental health professionals sometimes focus in a fragmented way on different symptoms (e.g., depression, inability to maintain close, intimate relationships and panic attacks), not realizing that the client's apparently chaotic presentation reflects underlying complex post-traumatic stress.

An increased understanding of the pervasive role of psychological trauma in the lives of clients with histories of abuse and neglect will lead to more effective and appropriate treatment approaches.

## SIMPLE AND COMPLEX POST-TRAUMATIC STRESS — WHAT IS THE DIFFERENCE?

Because simple and complex post-traumatic stress disorders are two distinct diagnostic and descriptive categories, it is important to understand the differences between them. (These differences are elaborated more fully in subsequent sections of the guidebook.)

### **Simple post-traumatic stress**

In brief, **simple post-traumatic stress disorder** (simple PTSD) typically results from a one-time terrible event, such as a rape or a serious car accident.

To be given a clinical diagnosis of PTSD, certain criteria must be met. These include:

- A. experiencing an event in which the life, physical safety or physical integrity of the client was threatened or actually harmed, resulting in feelings of intense fear, helplessness or horror
- B. continuing to re-experience the **traumatic event** after it is over
- C. seeking to avoid reminders of the event
- D. exhibiting signs of persistent arousal

(American Psychiatric Association, 1994)

### **Complex post-traumatic stress**

By contrast, women with **complex post-traumatic stress disorder** (complex PTSD) have often experienced chronic and repeated abuse in intimate relationships throughout their lives. Women with these experiences often mistrust others and, understandably, tend not to believe in the existence of safety. Complex PTSD includes the impairment or destruction of the capacity to trust and the loss of faith that safety is possible. Usually, the client's feelings of trust, which existed before the abuse, are replaced by an active and pervasive expectation of harm, exploitation and further betrayal. As a result, the body and mind are continuously mobilized, anticipating the need for self-protection.

Complex PTSD is multi-dimensional and pervasive because it is often the result of ongoing damaging and neglectful experiences, and is frequently compounded by a childhood that lacked consistent, predictable and attuned parenting. Because of this, the effects of complex PTSD are typically more far-reaching than simple PTSD and affect six dimensions of psychological functioning (detailed in the following sections of the guidebook). Simple PTSD affects only three dimensions of psychological functioning.

Note: Individuals who have had severe and frightening experiences as children or as adults can have complex PTSD and not have simple PTSD, but usually they have both (Luxenberg, Spinazzola & van der Kolk, 2001).

## GOALS OF THIS GUIDEBOOK

The major goals of this guidebook are to:

- expand and deepen mental health professionals' knowledge of complex post-traumatic stress responses (which include depression, suicidal feelings, substance use problems, difficult or abusive relationships and self-inflicted harm).
- address the common clinical error of uncovering and exploring clients' traumatic experiences before they are equipped to do so. Establishing the foundation to do this later work is an arduous and complex process. Highly skilled clinicians need to help clients develop initial stabilization and containment strategies, using a variety of clinical techniques and approaches.
- present the biological, psychological and social contexts of trauma and its treatment. This includes a gender-sensitive analysis that grasps the significance of women's unequal gender status in society and also takes into account other social inequalities such as those of class, race, ability and sexuality.
- give a greater appreciation and understanding of the multi-dimensional nature of complex post-traumatic stress responses and the complexity of treatment.

Greater awareness of what causes the various mental health difficulties associated with complex post-traumatic stress has resulted in a profound shift in the services and treatment offered to women who have experienced abuse-related trauma.

One consequence of this shift is that phase-oriented trauma treatment is now the standard approach.

Clinicians agree that treatment for clients who have histories of abuse and neglect should be conducted in a series of distinct therapeutic stages (Courtois, 1999; Chu, 1998).

The concept of stage-oriented treatment is based on extensive clinical experience demonstrating that many survivors of severe childhood abuse require an initial and often lengthy period to develop fundamental skills before they can explore or process their childhood traumatic events.

## WHO SHOULD READ THIS GUIDEBOOK?

Most mental health professionals recognize the challenges and difficulties in offering help when a client's problems seem complex and overwhelming — both for the client and for the caregiver. Professionals may feel unsure about how best to intervene. In developing this guidebook, mental health service providers — including emergency nurses, alcohol and drug counsellors, psychologists, psychiatrists and social workers — working in varied settings were surveyed about what kind of information on treatment approaches to trauma would be helpful. Those surveyed expressed a strong interest in learning more about ways to increase their clients' safety and reduce and stabilize responses to trauma in the lives of the women abuse survivors with whom they work.

This guidebook has therefore been written specifically for professionally trained mental health workers who are actively engaged in treating women abuse survivors and for related caregivers who wish to understand more about the lives of the clients they serve. Because this guidebook is written with a multidisciplinary audience in mind, the terms therapist and mental health professional are used interchangeably throughout.

Women experiencing complex post-traumatic stress responses may seek help through any number of services. While the focus of this guidebook is on trained mental health professionals providing first stage trauma treatment, some of the information in this guidebook is relevant for a somewhat broader and more diverse audience. For example, some front-line workers who may deliver supportive services that are not actually psychotherapy may wish to better understand the complex set of trauma responses often manifested in abuse survivors, and they may want to know more about the components of first stage trauma treatment for women. Such knowledge can be useful when making referrals or finding suitable additional resources for women abuse survivors. Selected specialized terminology, appearing in bold type, is defined in the glossary at the end of this book.

## OVERVIEW OF THIS GUIDEBOOK

This guidebook provides a conceptual map for understanding women's experiences of trauma, outlines the basic components of first stage trauma treatment, and offers specific tools and concrete strategies to use in beginning this work.

It is conceptualized as a resource for therapists who work with clients who experience simple or complex post-traumatic stress responses.

### **Part I**

Part I begins with a review of the nature of both simple and complex post-traumatic stress. Next, there is a discussion of biological and psychological responses to traumatic experience(s) and the role of the social contexts in which neglect and abuse — particularly violence against women and children — are perpetrated. The combination of biology, psychology and social context gives rise to responses in six areas of psychological functioning for people with complex PTSD. These dimensions are discussed in depth in the sections that follow.

### **Part II**

The sections in Part II clarify and explain a first-phase treatment approach. They also address clinical challenges in trauma therapy and how to diagnose the need for specialized trauma treatment.

### **Part III**

Techniques and strategies needed to effectively conduct this work with trauma clients can be found in Part III. The information about complex trauma responses and the specific skills and interventions offered in this guidebook should help mental health professionals face the clinical challenges inherent in this work with greater ease and, ultimately, greater effectiveness.

### **A NOTE ABOUT LANGUAGE**

It is extremely important that the language used by mental health professionals to describe and identify the issues women are struggling with is accurate, sensitive, respectful and appropriate. It is also crucial to use language that avoids stigmatizing clients with abuse histories or pathologizes their ways of coping. The language should also more accurately and respectfully capture the essence of their experiences.

Using more appropriate language is part of a broader commitment to develop respectful mental health approaches to describe and work with the effects of violence and abuse in women's lives.

Too often, the traditional language and terminology used in the mental health field has been problematic — it has pathologized those who seek and use mental health services. Some key examples are explained below with suggestions for terms that avoid, or at least minimize, this problem.

### **“Responses” instead of “disorders”**

The term post-traumatic stress “disorder” identifies the person experiencing stress from a traumatic event as having an internal psychological “illness.” This label implies that there is something wrong with the person, rather than acknowledging that the person is dealing with typical and normal repercussions from having experienced a traumatic life event or events. It is crucial to find language that identifies the psychological effects while avoiding constructing a label or identity that stigmatizes the person experiencing these effects.

Meichenbaum (1994) suggests that to avoid pathologizing the client’s condition, the therapist can use the term post-traumatic reactions or “responses” instead of the term post-traumatic stress disorder. This terminology will relieve some clients, particularly if they have previously received multiple psychiatric diagnoses. Other clients may feel that the term “responses” minimizes the extreme nature of their experience. Skilled clinicians will choose language that takes into account their clients’ specific preferences and needs.

Wherever possible, instead of using the term “syndrome” or “disorder,” this guidebook uses the term “post-traumatic stress responses” (PTSR) to capture the ways in which the effects of trauma are typically experienced. However, the literature in the field and the emerging diagnostic category continues to refer to complex PTSD. This results in some unavoidable inconsistency throughout the text.

### **“Adaptations” instead of “symptoms”**

The term “symptoms” suggests a traditional medical model (or framework) for understanding abuse and the related traumatic effects on women’s lives, which does not take into account the context of abuse or adequately grasp its long-term effects. The term “symptoms” is less effective in this regard, and is more appropriate in discussions of diseases. The terms “adaptations,” “effects” and/or “responses” better capture the ways in which people cope

with abuse and other traumatic events in their lives. These terms will be used whenever possible throughout the text.

### **Clients/patients**

The same concerns surround the best terminology for referring to the women (and men) with whom therapists work in their clinical practices. While the term “patient” is restricted to those seen in professional medical practices, the term “client” (despite its unfortunate commercial connotations) more accurately describes people seen in a range of professional mental health contexts. There has been a move toward describing those making use of mental health services as “consumers.” However, the commercial connotations of this term are even starker, making it a less appropriate descriptor.

### **Survivors/victims**

There is also a move to describe those who have experienced childhood sexual abuse as “survivors,” instead of victims. While the term “victim” tends to label the person in terms of what has been done to her, the term “survivor” highlights the strengths and resilience she uses in coping with abuse experiences. For this reason, this guidebook uses “survivor” wherever possible, but also refers to “women who have experienced abuse” to reduce the use of labels.