Contents

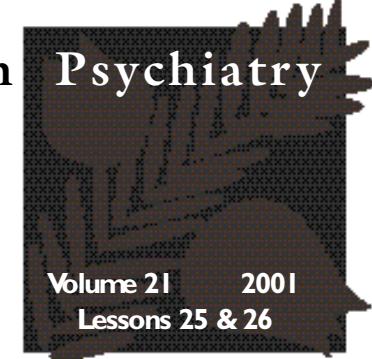**Volume 21   Lesson 25**

Complex Trauma and Disorders of Extreme Stress (DESNOS) Diagnosis, Part One: Assessment

Toni Luxenberg, PsyD, Joseph Spinazzola, PhD, and Bessel A. van der Kolk, MD

Dr. Luxenberg is a Supervisor and Staff Psychologist, Dr. Spinazzola is the Associate Director of Research and a Staff Psychologist, and Dr. Van der Kolk is the Medical Director of The Trauma Center, Arbour Health System, Allston, MA, and Boston University School of Medicine.

Learning Objective

Clinicians will learn to understand the progressive developmental impact of traumatic experiences that compromise ongoing psychological, biological, and social maturation and lead to a diagnosis of Complex PTSD or Disorders of Extreme Stress, Not Otherwise Specified (DESNOS). They will also learn to recognize the clinical symptomatology of this condition and how to assess patients for it.

Editor's Note

The diagnostic concept of Post Traumatic Stress Disorder was first introduced into DSM-III in the mid-l970s, representing a major step forward in our definition and understanding of psychiatric conditions. Since then, various modifications have been introduced, such as Acute Stress Disorder (ASD) and Complex PTSD or Disorders of Extreme Stress, Not Otherwise Specified (DESNOS), in order to more precisely identify etiological issues and target early, effective interventions.

Characteristic of DESNOS is trauma which involves interpersonal victimization, multiple traumatic events, or events of prolonged duration. Disturbances in six areas of functioning are required for the diagnosis: (1) regulation of affect and impulses; (2) attention or consciousness; (3) self-perception; (4) relations with others; (5) somatization; and (6) systems of meaning. The authors offer clinical examples of each of these and go on to describe psychometric tests that can be used as valuable diagnostic aides.

Introduction

In the middle of the 1970s, when Post Traumatic Stress Disorder (PTSD) was first proposed for inclusion in the *Diagnostic and Statistical Manual of Mental Disorders*, Third edition, (DSM-III), only a sparse literature on "traumatic neuroses" was available to guide the creation of a diagnostic construct for PTSD.[1] The DSM-III PTSD committee depended mainly on the existing literature on traumatized male adults—combat veterans[2,3] and holocaust survivors.[4] Beginning even before the publication of the DSM-III, in 1980, rapidly growing research literature confirmed the relevance of PTSD as a diagnostic construct, applicable to a large variety of traumatized populations, such as rape survivors, abused children, refugees, and survivors of accidents, disasters, and domestic violence.[5] The modification of the PTSD definition in the DSM-III-R reflected the incorporation of evolving research findings and theoretical formulations into psychiatric nomenclature.[6–8] Indeed, research in the past two decades has firmly established the high prevalence of PTSD and its potentially debilitating impact on the lives of individuals. **Epidemiological research has shown that the majority of individuals experience at least one traumatic event during their life, and up to a quarter of those individuals will ultimately develop PTSD.[9,10]**

The relevance of trauma has begun to permeate our culture's popular awareness, but a large body of research investigating the effects of trauma on psychological functioning has shown that **PTSD captures only a limited aspect of post-traumatic psychopathology.[11–13] One critical element in determining psychopathology outcomes is the developmental level at which the trauma occurs and whether it occurs in the context of a relationship with a caregiver or intimate partner. For example, victims of car accidents and natural disasters often have quite different clinical presentations than those who experienced abuse, deprivation, and/or neglect at the hands of their caregivers. In addition, the age at which the trauma occurred also shapes subsequent adaptation patterns.** While the symptomatology of victims of single-incident traumas are fairly well captured in the DSM-IV diagnosis of PTSD, victims of interpersonal trauma present with a more complex picture.[12–19]

This lesson will explore the concept of *Disorders of Extreme Stress Not Otherwise Specified* (DESNOS), which has a symptom constellation delineated in the DSM-IV under "associated features of PTSD." Though DESNOS is not currently a distinct diagnosis identified in the DSM-IV, its symptom constellation has been identified in numerous research studies and is currently being researched and considered for inclusion, as a free-standing diagnosis, in the DSM-IV. **We will begin by examining the differences between PTSD** (as defined in the DSM-IV) **and the associated features of PTSD—DESNOS.** The components of DESNOS will be explored in depth. Next, we will discuss various means of assessing DESNOS that can be integrated into practice. Finally, a phase-oriented model of treatment will be presented, and a number of therapeutic techniques to use in the stabilization of these challenging patients will be discussed.

PTSD Diagnostic Criteria

For an individual to be diagnosed with PTSD, he or she must: have experienced an event in which the life, physical safety, or physical integrity of the patient or another person was threatened or actually damaged; and the patient must have experienced intense fear, helplessness, or horror in response; continue to reexperience the traumatic event after it is over (e.g., flashbacks, nightmares, intrusive thoughts, and emotional and physiological distress in the face of reminders of the event); **seek to avoid reminders of the event** (e.g., avoidance of

---

Table 1
DIAGNOSTIC CRITERIA FOR DISORDERS OF EXTREME STRESS (DESNOS) [A]

I. Alteration in Regulation of Affect and Impulses
(A and 1 of B–F required):

   A. Affect Regulation (2)
   B. Modulation of Anger (2)
   C. Self-Destructive
   D. Suicidal Preoccupation
   E. Difficulty Modulating 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
(Two of A–F required):

   A. Ineffectiveness
   B. Permanent Damage
   C. Guilt and Responsibility
   D. Shame
   E. Nobody Can Understand
   F. Minimizing

IV. Alterations in Relations With Others
(One of A–C required):

   A. Inability to Trust
   B. Revictimization
   C. Victimizing Others

V. Somatization
(Two of A–E required):

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

VI. Alterations in Systems of Meaning
(A or B required):

   A. Despair and Hopelessness
   B. Loss of Previously Sustaining Beliefs

[A] Numbers in parentheses indicate number of subscale items required for endorsement of subscale. Only one item required for endorsement of all other subscales.

---

thoughts, feelings, and conversations about the event; avoidance of people, places, and activities that are associated with the event; difficulty recalling aspects of, or the totality of the event; diminished interest in formerly pleasurable activities; feelings of detachment; and a sense of a foreshortened future); **exhibit signs of persistent arousal** (e.g., difficulty with sleep, increased irritability, concentration problems, scanning of environment for danger, and heightened startle responses).

DESNOS Criteria

In exploring the disparate adaptations to complex trauma, the DSM-IV PTSD taskforce[21] highlighted alterations in six areas of functioning for the diagnosis of DESNOS: (1) regulation of affect and impulses; (2) attention or consciousness; (3) self-perception; (4) relations with others; (5) somatization; and (6) systems of meaning (Table 1). The PTSD taskforce also discussed alteration in one's view of the perpetrator, but this was not considered a mandatory aspect of the diagnosis of DESNOS. We will examine each of these six areas in turn in the section "Aspects of DESNOS."

While DESNOS is not officially predicated on specific traumatic experiences, both **clinical consensus and research in the field have linked the DESNOS diagnosis with histories of interpersonal victimization, multiple traumatic events, and/or traumatic exposure of extended duration.** Awareness of the characteristic backgrounds of individuals who meet criteria for DESNOS will aid in effective case conceptualization and treatment planning. Often these individuals have histories of a large variety of traumatic events, spanning years and even decades. Such individuals may not have had discrete traumatic experiences so much as ongoing, chronic exposure to untenable environments. An example of a typical DESNOS history would be a woman who reports that she was never held as a child and was sexually abused throughout her childhood by her alcoholic father, who also physically assaulted her mother in her presence. Even when sober, her father frequently called her names and insulted her intelligence, attractiveness, and capabilities. As an adolescent, she may have witnessed the seri-

ous injury of several friends during a drunk-driving accident. As an adult, this woman may have been raped and had a series of emotionally and physically abusive partners. *A history of chronic traumatization, however, will not always lead to the development of DESNOS symptomatology. We will now turn to an exploration of the conceptual evolution from PTSD to DESNOS.*

The Co-Occurrence of PTSD and Other Disorders: The Concept of DESNOS

It has been noted in numerous studies that there is a high rate of "comorbidity" between PTSD and other disorders.[22–24] **In the National Comorbidity Study, Kessler and his colleagues[25] found that approximately 84% of their sample had another disorder at some point in life. Individuals with PTSD were found to be eight times more likely to have had three or more additional disorders than individuals who were not diagnosed with PTSD. The disorders most consistently found to co-occur with PTSD are: major depression, other anxiety disorders, substance abuse, somatization disorder, and a variety of Axis II disorders.[25–28]** In fact, in a consensus statement, leaders in the field noted that the "pure form" of PTSD is actually unrepresentative of the typical clinical presentation of PTSD.[29] They described PTSD as being associated with an "increased risk for secondary . . . disorders."[(p. 63)] While many have conceptualized this as "comorbidity," a number of clinicians and researcheers have begun to reconsider what such co-occurrence of disorders indicates about the diagnosis of PTSD. In response to such issues, Herman and van der Kolk[30] and, independently, Pelcovitz and colleagues,[21] delineated a syndrome, based on symptoms associated with PTSD, for further study in the DSM-IV. This syndrome was called "Disorders of Extreme Stress" in the field trial for PTSD,[24] and later also called "Complex PTSD" by Herman.[13] In 1992, the World Health Organization[31] described the "lasting personality changes following catastrophic stress," which went well beyond the classic PTSD criteria and research has supported these theoretical conceptualiza-

tions. **In the DSM-IV Field Trial, van der Kolk and his colleagues[32] reported that PTSD, dissociation, somatization, and affect dysregulation were all highly interrelated.** They further found that many individuals with PTSD also consistently displayed a number of other symptoms not captured in the PTSD diagnostic criteria. Subsequent research has provided strong empirical support for these initial observations.[33–35]

The findings of the DSM-IV Field Trial for PTSD suggest that trauma has its most profound impact when its onset occurs during early childhood or adolescence and becomes less pervasively damaging with later onset.[32,36] In fact, almost half of the traumatized sample in this research had experienced Criterion A traumatic stressors before age 11; individuals in this subgroup were most likely to meet diagnostic criteria for DESNOS. The high rates of current DESNOS in these individuals provided compelling evidence for the enduring impact of exposure to trauma during childhood. The DSM-IV Field Trial for PTSD[32,33] also lent support to the notion that trauma, especially interpersonal trauma, can have pervasive effects on the totality of personality and social development, resulting in chronic affect dysregulation, aggression against self and others, dissociative symptoms, somatization, and character pathology. These symptoms occur together in many traumatized individuals, and rarely occur as a syndrome in subjects not exposed to high-magnitude or chronic stressors, which supports the notion that DESNOS constitutes a complex post traumatic syndrome associated with chronic/severe interpersonal traumatization.[13] In the National Comorbidity Study carried out by Kessler and colleagues, it was found that while approximately one fifth of all individuals diagnosed with PTSD did not meet the criteria for another diagnosis, the remaining 79% met criteria for at least one additional disorder, and a full 44% met the criteria for at least three other diagnoses.[25] For a substantial proportion of traumatized patients the diagnosis of PTSD captures only limited aspects of their psychological problems. The combination of posttraumatic symptoms represented by DESNOS and PTSD criteria, rather than by PTSD alone, causes people to seek psychiatric treatment.

Aspects of DESNOS

Estimates of the prevalence of histories of childhood trauma in psychiatric populations range from 40% to 70%.[13–19] **Yet trauma-related disorders, including dissociative disorders, continue to be grossly underdiagnosed.[19] This underrecognition can be best understood in light of the multiplicity of symptoms with which these patients present that may not be readily recognized as being related to their traumatic experiences.**

AFFECT DYSREGULATION:

Individuals who meet criteria for DESNOS have difficulty managing their emotional experiences. In fact, it has been suggested that affect dysregulation may be the core dysfunction that results from psychological trauma.[37,38] **Such individuals tend to overreact to minor stresses, become easily overwhelmed, appear to have "extreme" reactions to neutral or mild stimuli, have trouble calming themselves, and may use extreme, self-destructive measures, such as self-injury, drug use, eating disorders, or compulsive sexual activity, in attempts to manage their emotions.[39–41] They also typically have a great deal of trouble either expressing or modulating their anger,** and numerous studies have found that these individuals' anger can significantly impact and interfere with the course of treatment.[37,41–43] Further, **such individuals frequently exhibit suicidal preoccupation, either sexual preoccupation, or difficulty modulating sexual impulses, and heightened risk-taking behavior.** Affect dysregulation is one of the most problematic aspects of working with chronically traumatized patients and should be a central focus of treatment, as it can interfere with the therapy process itself if not explicitly addressed.

DISTURBANCES IN ATTENTION OR CONSCIOUSNESS:

Individuals frequently learn to cope with traumatic experiences by dissociating, or separating these experiences from their "everyday" level of consciousness.[44] In the normal course of events, information about an experience is a more or less coherent whole, with most parts connected and readily accessible. In dissociation, however, this integration of information does not occur, to a greater or lesser degree. Individuals often find that they cannot reconcile traumatic experiences with their sense of who they are and how they perceive the world. **Such experiences become relegated to separate aspects of consciousness[45] that do not impinge on the individual's day-to-day level of consciousness.** For example, when the totality of an experience is too overwhelming, various elements (e.g., visual, emotional, somatic) of the experience may be split off from one another, and from the individual's own personal narrative. As van der Kolk and colleagues[46] have discussed, **these "split off" aspects of the traumatic experience(s) are typically perceptual or sensory** (rather than linguistic) **in nature, and are often initially experienced as inexplicable physical sensations that cannot be verbally explained or deconstructed, as is often expected in therapy.** In addition, chronically traumatized patients often learn to dissociate their bodily sensations and experiences, as the body frequently becomes linked with danger and distress in trauma. **Such individuals may actually not have a sense of what it feels like to be in their bodies.**

Chronically traumatized individuals may have only intermittent ability to access certain information, they may be very "forgetful," they may appear to "space out" regularly, and they may retreat within themselves when confronted with painful emotions or reminders of their traumatic experiences. *It is common, for example, for such individuals to have difficulty remembering what was discussed between sessions, or to forget safety plans or coping skills.* This will be discussed in greater depth shortly. In addition, chronically traumatized individuals often have amnesia for significant portions of their lives. This can involve single experiences (e.g., graduating from college), or whole months or even years (e.g., not remembering anything from the time period that one lived in a certain city). In treatment, this clearly complicates history gathering and the cohesiveness of interventions, and can be a source of distress in and of itself.

In one study, **the highest levels of dissociation occurred in individuals who had experienced multiple traumas.**[47] Dissociation in its extreme form can lead to Dissociative Identity Disorder (DID), but it is important to note that while a substantial number of individuals carry that diagnosis (1% of the general population),[48] a larger number of individuals with chronic trauma histories experience significant amounts of some form of dissociative symptomatology. Saxe and colleagues,[19] for example, found that 15% of 110 psychiatric inpatients exhibited significant dissociation, while Waller and Ross[49] found that a full 3.3% of the general population sampled displayed what they called "pathological dissociation." This led Ross[48] to state that dissociative disorders "as a group are as common as anxiety and affective disorders." (p. 515)

DISTURBANCES IN SELF-PERCEPTION:

Individuals with DESNOS often develop negative views of themselves as being helpless, ineffectual, damaged, and undesirable to others.[50] *These perceptions spring directly from the way young children interpret the world; their preoperational thinking places them in the center of the universe, leading them to believe that they have "caused" their own mistreatment.* At the same time, they often have problems taking appropriate responsibility for their actions, just as young children do. In addition, chronically traumatized individuals often feel that no one can understand their experience, or they may drastically minimize their own experiences as not having had a major impact on them or being unrelated to their current difficulties. Such individuals may emphatically insist that they were at fault for childhood molestation due to some inherent character flaw or "badness" that their abuser detected in them, and on which they acted.

DISTURBANCES IN RELATIONSHIPS:

Chronically traumatized patients typically have histories marked by numerous and varied dysfunctional relationships. **Childhood maltreatment has consistently been linked with difficulty trusting others, revictimization, and the victimization of others.**[51-53] Such individuals often **"shut down" and do not pick up danger signs, such as their own feelings of unease, hurt, or anger, or inappropriate behavior on another's part. For example, overly friendly behavior in a virtual stranger or new acquaintance typically will lead to a sense of confusion and wariness in most non-traumatized individuals, but it may not in those who have been chronically traumatized and have no healthy template for interpersonal interactions.** In addition, a non-traumatized individual who finds him- or herself being treated in manner which makes them uncomfortable (e.g., being called names by his or her partner) will typically insist that such behavior stop and will cease to interact with the person involved if it continues. This, however, is frequently not the case with chronically traumatized individuals, who often continue to pursue interaction with those who embarrass, confuse and upset them. Further, traumatized individuals often are not able to see initial, "minor," incidents as harbingers of what is to come, as happens in the case of a woman who is severely beaten by her boyfriend after experiencing multiple incidents of being slapped and pushed. In addition, chronically traumatized individuals are often unable to use bodily signals (such as accelerated heart rate, discomfort, changes in breathing, physical urges to flee, or gastrointentional distress) as guides for action, only feel alive when agitated or in conflict, and often accept revictimization as a matter of course in relationships. In the latter case, they may actually be aware of danger signals, but feel powerless to act on them, or be too frightened of the consequences to do so. They may anticipate that their partners will leave or hurt them, and they may have difficulty developing supportive social relationships, given their mistrust of others. In addition, their limited sense of self, and the problems they have experiencing their separateness from others, reduce their ability to truly engage in mature mutuality and sharing. The propensity of chronically traumatized individuals to dissociate from their own bodies also severely constricts their capacity to enter into relationships, as they struggle to know even themselves. Trauma's profound impact on the body is a very important topic, please see Beyond the Talking Cure by Dr. van der Kolk for more information.[54]

Relationship building in therapy with such individuals can be a slow and arduous process, and therapists typically must wrestle with and adjust for their patients' feelings of being traumatized and victimized **by the therapy relationship. Further, it is typical for such patients to reenact their interpersonal traumas in therapy and elsewhere.**[33,55] For example, a woman who has a history of childhood sexual assault may frequently pick intimate partners who are domineering and who do not take her needs or desires into account. These relationships will cause the individual to feel out of control and trespassed against, as she did when she was being molested as a child. This may or may not be explicitly reenacted in the realm of sexuality. Alternatively, individuals may victimize others in ways that replicate their own traumas, either literally or emotionally.

SOMATIZATION:

Many chronically traumatized patients suffer from persistent physical complaints that often defy medical explanation or intervention. Before examining this, however, it is necessary to further explore the effects of trauma on the body. **There is ample evidence that repeated traumatic experiences have an impact on a biological level.** Research[38,56–58] has demonstrated that the stress response entails the release of endogenous, stress-responsive hormones. These hormones prepare the body to mobilize resources to respond to threatening situations quickly and effectively. Chronic exposure to stress results in the effectiveness of this system being significantly compromised.[59] **In addition to neurohormonal dysregulation, exposure to trauma has also been found to significantly impact the limbic system and its crucial role in evaluating the emotional significance of incoming stimuli and facilitating the encoding of semantic memory.** Trauma has neuroanatomical impacts as well, with hippocampal volume having been found to be smaller in traumatized versus nontraumatized individuals;[60] **and the negative impact on information processing is well-known.**[61]

Chronically traumatized individuals have difficulties adjusting their level of physiological arousal,[59] suggesting that the nervous system has become overresponsive to previously innocuous stimuli. Traumatized individuals have overactive sympathetic and parasympathetic nervous systems.[62] One obvious example of this is the **exaggerated startle response that is characteristic of PTSD.** Traumatized individuals respond to various stimuli at a lower threshold than do nontraumatized individuals.[58] The overproduction of catecholamines, such as norepinephrine, is just one of the many neurohormonal reactions involved in this unmodulated response to minor stresses.[62] This overproduction results in general feelings of anxiety, and signs of hyperarousal, such as oversensitivity to stimuli, and difficulty sleeping. The underproduction of serotonin, another neurohormone that mediates[63–66] the behavioral inhibition system, leads to increased reactivity and "emergency" responses. Overall, loss of neuromodulation often translates into heightened irritability, impulsivity, and aggressiveness for traumatized individuals.[64,67] Further, it has been well documented that **traumatized individuals underproduce cortisol,**[68] which, according to Yehuda and colleagues[69] serves as an "anti-stress" hormone by signaling that other stress-related responses should be suppressed. In addition to reduced glucocorticoid production (of which cortisol is an example), chronic stress or traumatization also leads to **elevated rates of endogenous opioid production,**[70,71] **resulting in analgesia in response to reminders of traumatic events. Wilson and colleagues**[72] **have found immune system dysfunction in women with histories of chronic sexual abuse in childhood.** Out of ten subjects, all had increased lymphocyte immune activation, as compared to matched controls. Although this phenomenon is not yet fully understood, it is believed that chronic trauma may "reset" the body's physiologic functioning, in the service of being prepared for the next dangerous event, which may come to be anticipated on a physiological level. Over time, this may have negative consequences for basic functioning.

Many chronically traumatized patients exhibit multiple somatic difficulties. Felitti and colleagues[39] found that as the number of traumas increased, physical health decreased precipitously. Traumatized individuals have documented increases in difficulties in their digestive, cardiopulmonary, and urogenital

systems.[73] **Typical complaints include Irritable Bowel Syndrome, chronic pelvic pain,[74] headaches, and "acid" stomach. Chronically traumatized individuals often respond poorly to conventional medical treatment,** and experience more severe or persistent symptoms than would be expected in conjunction with an existing disorder or disease. They also frequently report unusual symptoms for which there can be found no obvious physical cause, such as temporary blindness, tingling in extremities, or seizure-like activity. In a large-scale survey of almost 10,000 adults,[39] exposure to adverse childhood experiences (including numerous traumatic events) was found to dramatically increase health risk factors for several of the leading causes of death in adults, including heart disease, stroke, diabetes, skeletal fractures, and cancer. For those individuals who had three or more adverse childhood events, they were typically twice as likely as their peers without any adverse events to develop the above-mentioned diseases and medical problems. In the case of chronic bronchitis or emphysema, those individuals with three or more adverse events were a stunning four times as likely the disease when compared to their peers who had not suffered any adverse events. **As van der Kolk[38] has pointed out, having lost the ability to put words to their traumatic experiences, physical symptoms may provide some chronically traumatized individuals with a symbolic way of communicating their emotional pain.** In fact, such individuals may experience no psychological distress at all, but simply report troubling physical symptoms.[74]

DISTURBANCES IN MEANING SYSTEMS:

Many chronically traumatized individuals often view the world through a dark lens. They frequently report that they no longer believe that life makes sense or has a purpose.[50] They may question the religious or ethical belief structures with which they were raised, and see any spiritual being or force as being actively malevolent or insensitive to human suffering. They may adopt an "every person is out for themselves" attitude or a fatalistic approach to life,

anticipating that, ultimately, they will not be able to make positive changes in their life. This is a profound, persistent, and physical sense of learned helplessness that dramatically affects the capacity to formulate options, make choices, act on one's own behalf, or implement changes in one's life. Clearly, such conditions can undermine the effectiveness of therapy and must be addressed.

Psychometric Assessment of DESNOS

To date, two clinical instruments have been developed and validated for the purpose of comprehensive assessment of DESNOS in clinical practice and research. These are the *Structured Interview of Disorders of Extreme Stress* (SIDES)[21] and the *Self-Report Inventory for Disorders of Extreme Stress* (SIDES-SR).[75] In addition to these instruments, a handful of other psychometric measures, while not specifically developed for this purpose, have been found in our clinical work and research to be useful in assessing particular components of the DESNOS construct. These include the *Traumatic Antecedents Questionnaire* (TAQ),[82] the Dissociative Experiences Scale (DES),[83] the *Inventory of Altered Self-Capacities* (IASC),[84] and a careful review of health service utilization.

STRUCTURED INTERVIEW OF DISORDERS OF EXTREME STRESS (SIDES):

The SIDES was developed during the DSM-IV Field Trial for PTSD as a companion to existing clinical interview-based rating scales for PTSD and other Axis I disorders such as the *Clinician Administered PTSD Scale* (CAPS)[76] and the *Structured Clinical Interview for DSM-IV Disorders* (SCID-IV).[77] The SIDES is a 45-item structured clinical interview that consists of six subscales corresponding to the six DESNOS symptom clusters. The SIDES was designed to measure current and lifetime presence of DESNOS, as well as current symptom severity (past month). Item descriptors contain concrete behavioral anchors to better facilitate clinician ratings of symptom presence and severity.

The SIDES is the only instrument that has been validated for the purpose of diagnostic assessment of DESNOS. Research on the psychometric properties of the SIDES has supported its reliability as a diagnostic tool[21] and as a continuous measure of symptom severity for the overall diagnosis (J. Spinazzola, Ph.D., M.E. Blaustein, Ph.D., B.A. van der Kolk, unpublished data, 2001). While to date this research has focused on the utility of the SIDES as a baseline measure of DESNOS diagnosis and symptom severity, additional research is currently underway to evaluate its utility as a measure of treatment outcome.

Additional research using this instrument has provided sound preliminary empirical evidence for the validity of the DESNOS construct.[78–80] For example, in a study examining the affect dysregulation, dissociation, self-perception and somatization subscales of the SIDES, Zlotnick and Pearlstein found strong support for the convergent and discriminant validity of these subscales by comparing them to other established measures of similar and divergent constructs.[78] Furthermore, **in a recent study comparing a clinical research sample of patients diagnosed with PTSD alone versus patients with diagnoses of PTSD and DESNOS as measured by the SIDES, the latter group were not only found to meet criteria for a greater number of comorbid Axis I and Axis II DSM-IV diagnoses, but were also found to exhibit a pattern of comorbid diagnoses reflective of four of the same underlying deficit areas purported to characterize the DESNOS construct: regulation of affect, self-perception, somatic function, and relationships.[80]**

A comprehensive training manual for clinicians and researchers containing detailed information pertaining to the administration, scoring, interpretation, and norms of the SIDES, as well as the SIDES-SR is currently in preparation. A preliminary version of this manual and information regarding SIDES training workshops is available through the Trauma Center website (www.traumacenter.org) or by contacting the second author of this lesson (spinazzola@traumacenter.org).[81]

SELF-REPORT INVENTORY FOR DISORDERS OF EXTREME STRESS (SIDES-SR):

The SIDES-SR is a 45-item self-report measure that has recently been developed by van der Kolk[75] for measurement of: (a) baseline severity of DESNOS; (b) baseline symptom severity of each of the six individual symptom clusters; and (c) symptom change over time. As such, the SIDES-SR is the only instrument to date that has been developed to provide a continuous measure of current severity scores for each of the six DESNOS symptom clusters. A printout of a SIDES-SR scoring sheet, illustrating life symptom endorsement and current symptom severity for a typical patient with DESNOS is provided in the Appendix A. A recent psychometric study on the SIDES-SR has generally supported its use for this purpose (J. Spinazzola, Ph.D., M.E. Blaustein, Ph.D., B.A. van der Kolk, unpublished data, 2001). In this study, the authors found acceptable to high rates of internal consistency for the full scale (Cronbach (a = .93) and five subscales (a = .74 to .82) of the SIDES-SR, indicating that these scales may be reliably interpreted in a continuous fashion. Lower observed levels of internal consistency on the Somatization subscale (a = .68) suggest that scores on this scale should be interpreted with caution. Additional empirical research evaluating the utility of the SIDES-SR in measuring state-dependent variability in DESNOS severity over time, in particular at multiple time points during the treatment course, is currently underway.

Like the SIDES, the SIDES-SR consists of 45 items that correspond to symptoms delineated in the DESNOS diagnosis. Patients are asked to endorse the lifetime and current presence or absence of each symptom, as well as to rank the current severity of endorsed symptoms. Each item's descriptors contain concrete behavioral anchors to better facilitate patient ratings. SIDES-SR scale items and behavioral anchors were developed by content area experts to convey DESNOS symptoms in a manner readily understandable to patients. Item and anchor revision and modification were based on scale reliability estimates (e.g.,

subscale alphas, item-scale correlations), as well as patient feedback (J. Spinazzola, Ph.D., M.E. Blaustein, Ph.D., B.A. van der Kolk, unpublished data, 2001).

TRAUMATIC ANTECEDENTS QUESTIONNAIRE (TAQ):

Numerous self-report measures and clinician-interview–based inventories have been developed to assess lifetime exposure to a range of traumatic events (for a review, see Wilson and Keane).[85] Of these, we have found the TAQ.[82] particularly useful because of its focus on the occurrence of traumatic exposure within a developmental framework. The current version of the TAQ is a 42-item self-report measure developed by van der Kolk (B.A. van der Kolk, M.D., unpublished instrument, 1997) to be used in conjunction with the SIDES to gather information about the frequency and severity of exposure to traumatic as well as adaptive experiences within and across four developmental periods: early childhood (birth to age 6); middle childhood/latency (age 7 to 12); adolescence (age 13 to 18); and adulthood. The following eleven domains of experience are assessed using the TAQ: (1) competence, (2) safety, (3) neglect, (4) separation, (5) family secrets, (6) emotional abuse, (7) physical abuse, (8) sexual abuse, (9) witnessing trauma, (10) other traumas (e.g., natural disaster, serious accident, traumatic loss of intimates), and (11) exposure to drugs and alcohol. The first two domains represent experiences associated with adaptive functioning and protection against the development of psychopathology, with higher scores on these scales reflecting superior adjustment. The latter eight domains assess exposure to traumatic or adverse experiences, with higher scores reflective of more frequent and or severe traumatic exposure. A printout of a TAQ scoring sheet, illustrating extent of trauma exposure by type and developmental period for a typical patient with DESNOS, is provided in Appendix B.

Routine use of the TAQ as a component of the intake evaluation for patients at our center has suggested the **following key indicators of poor prognosis: (a) low scores on early childhood measures of**

competence and/or safety; and (b) presence of multiple forms of trauma during early childhood. Analysis of the psychometric properties of the TAQ is currently underway, and preliminary research utilizing this instrument has been promising. In a recent study examining data from 70 consecutive adult admissions to our center[75] scores on the TAQ were consistently found to be significantly related to symptoms of DESNOS, and to a lesser extent with an adapted version of the **Modified PTSD Symptom Scale.**[86] Specifically, preliminary correlational analyses indicated **a significant association between trauma type and outcome, with Sexual Abuse, Physical Abuse, Emotional Abuse, and Other Traumas as the domains most associated with symptoms of DESNOS, and Other Traumas as most strongly associated with PTSD.** Subsequent regression analyses, however, revealed that **the developmental period during which traumatic exposure occurred played a more critical role in adult outcomes related to DESNOS than did the specific type(s) of trauma experienced.**[75] In particular, consistent with our clinical observations, cumulative trauma during early childhood and adolescence, respectively, emerged as the two most powerful predictors of current DESNOS severity in our adult sample.

DISSOCIATIVE EXPERIENCES SCALE:

The DES is a 28-item self-report instrument that instructs patients to rate the percentage of time they engage in a range of normative and pathological dissociative experiences.[83] **The DES is the most widely used and well-validated measure of dissociation,** and research employing this instrument has provided normative data for various clinical and community samples, including patients with PTSD, Dissociative Disorder-Not Otherwise Specified, and Dissociative Identity Disorder.[87] *Mean DES scores for DESNOS patients have yet to be established. Preliminary findings from use of the DES with DESNOS patients in our clinic and research center, however, suggest that the mean DES score for DESNOS patients is significantly higher than for patients with PTSD in the absence of DESNOS. In turn, DES levels for this sample*

of DESNOS patients were observed to be lower than those that have been typically reported in the literature for patients with Dissociative Disorders.[88] Inclusion of this measure in a comprehensive assessment battery for DESNOS is recommended to facilitate treatment planning by identifying the extent and specific types of dissociative phenomena experienced by these patients. This is particularly relevant given consistent clinical indications of lower tolerance for trauma-processing interventions in trauma patients with more severe dissociative problems.

INVENTORY OF ALTERED SELF-CAPACITIES:

The IASC is a 63-item self-report measure that yields seven scale scores reflective of difficulties in the areas of affect control, relatedness, and identity.[84] Initial validity and reliability estimates of the IASC are impressive (e.g., Cronbach alphas range from .79 to .83).[84] Although the specific utility of the IASC in assessing baseline severity of DESNOS symptoms or in monitoring symptom change during the course of treatment has yet to be determined, three of the IASC scales appear to be particularly applicable to this purpose, including two indices of affect control (Affect Dysregulation and Tension Reduction Activities) and one index of relatedness (Interpersonal Conflicts). Additional IASC scales assessing dimensions of identity and interpersonal disturbance, while more akin to dimensions of disturbance tapped by the Borderline Personality Disorder (BPD) diagnosis (e.g., Idealization-Disillusionment, Abandonment Concerns, Identity Impairments), may also prove to be relevant to the evaluation of functioning deficits in patients with DESNOS.

HEALTH SERVICE UTILIZATION REVIEW:

Optimal evaluation and tracking of medically identifiable as well as psychogenic somatic complaints in DESNOS patients require careful attention to general and mental health service utilization over time. This can be accomplished through a variety of means, including review of patient medical records, thorough baseline and subsequent clinical interviews, and utilization of standardized instruments specifically designed for these purposes. Advantages of incorporating the latter method include facility and uniformity of systematic data collection across patients. **Toward this purpose we recommend that such forms gather data about the following types of medical and psychiatric health services the patient has used during specified time periods: (1) frequency of telephone and in-person crisis support; (2) frequency of medical and psychiatric outpatient care; (3) frequency of medical and psychiatric inpatient care; (4) frequency of emergency room use; and (5) frequency and nature of changes in prescription of psychotropic medication.**

Differential Diagnosis

A word about diagnosis is in order at this point. The current diagnostic system is embodied in the _Diagnostic and Statistical Manual of Mental Disorders_, Fourth Edition (DSM-IV).[20] This nosological system endeavors to guide both treatment and research on mental illness, most recently through a reliance on incremental advances in empirical research intended to clarify, confirm, or revise clinically and theoretically derived constructs of psychopathology that were initiated in the first edition of this manual. Like other non-etiologically based classification systems, however, the DSM-IV ultimately must succumb to the compromise position of drawing somewhat arbitrary distinctions between clinical phenomena in the service of constructing a widely used, if not universal, nosological system. The benefits of this system are efficiency and the development of a common language for mental health practitioners, clinical researchers, policymakers, and the patients themselves. One cost of such a system is that practitioners can become overly reliant on artificial distinctions between disorders, and thereby fail to account for symptomatology that is not readily subsumed under existing diagnostic formulations. The challenge thus becomes to work within the existing system to characterize as precisely as possible what we know about the statement of psychopathology in various clinical populations.

This issue becomes particularly salient when evaluating the presence of DESNOS in patients with histories of chronic traumatization. In such situations, the issue of differential diagnosis frequently emerges. This is not surprising, given both the high incidence of comorbid disorders in trauma patients as well as the substantial overlap that has been observed between symptom clusters of DESNOS and those of other Axis I and II disorders common to this population, such as PTSD and BPD. Presenting symptoms of DESNOS are often overlooked or misdiagnosed as atypical symptom formations of established DSM-IV diagnoses because of the nascent awareness of the DESNOS construct. Alternately, patients are assigned multiple DSM-IV diagnoses (e.g., PTSD + BPD + Bipolar II Disorder) in an attempt to account for symptom presentations that in fact can best be understood by incorporation of the associated features of PTSD or DESNOS. The presence of DESNOS is often overlooked entirely in the evaluation and treatment of patients presenting with severe mental illness, particularly when these patients are encountered in inpatient settings, and despite the accumulation of a significant body of research in the past decade that substantiates the high prevalence of histories of chronic traumatization in these populations (e.g., Darves-Bornoz and colleagues,[88] Mueser and colleagues).[89] Not uncommonly, patients have arrived at our center with histories of treatment-refractory conditions that have been defined by some ill-fitting, conventional diagnosis (e.g., Bipolar II Disorder) made in an effort to account for chronic and severe affect dysregulation in the absence of full-blown manic states.

In recognition of these challenges to the differential diagnosis of DESNOS, we will briefly address distinctions between DESNOS and simple PTSD and BPD, two of the disorders for which it is most frequently confused. At the same time, it should be noted that this potential for misdiagnosis is by no means mutually exclusive from the potential for the presence of comorbid conditions of DESNOS and PTSD and/or BPD. Along these lines, empirical data from the DSM-IV Field Trial as well as from our center[24,32,80] have firmly established the common co-occurrence of DESNOS, PTSD, and BPD in patients with histories of chronic traumatization.

DESNOS VERSUS PTSD:

As described above, data from the DSM-IV Field Trial revealed the diagnosis of DESNOS to be more common in individuals exposed to interpersonal trauma of early onset and of lasting duration.[32] Although initially conceptualized as a constellation of symptoms frequently associated with the PTSD diagnosis, subsequent research[90] has confirmed that the presence of PTSD is not in fact a necessary precondition for DESNOS. A complete understanding of the absence of current PTSD diagnoses in some DESNOS patients with histories of chronic traumatization will require further empirical research. Thus far, **our extensive clinical work with this population suggests that this diagnostic profile may be a byproduct of two factors common in this subpopulation of trauma patients: (a) severe avoidance and suppression of trauma-related memories** (often facilitated through self-medication through chronic substance dependence and abuse) **with associated affective numbing and constriction** (PTSD Criterion C); **and (b) over-reliance on dissociation as a coping mechanism and defense against intolerable affect. In these patients, avoidance, numbing, and dissociative symptoms may function over time to mask the overt intrusive symptomatology** (PTSD Criterion B) **required to meet full criteria for the PTSD diagnosis. Likewise, for trauma patients with severe mental illness, traumatic intrusions may become overshadowed by, or less discernibly embedded within, more severe manifestations of psychopathology, including paranoid ideation, persecutory delusions, and reports of perceptual disturbance** (i.e., traumatic flashbacks that are overlooked because they are experienced within the context of otherwise bizarre auditory or visual hallucinations). In the course of successfully treatment with this subset of DESNOS patients (see next lesson on DESNOS treatment), increased capacity to access and express formerly intolerable affect states associated with the trauma may actually lead to the reemergence of intrusive PTSD symptomatology. Assuming adequate affective stabilization has been achieved and internal and environmental coping resources established during the first phase of trauma treatment, desensitization of the traumatic memories associated

with these emerging intrusive symptoms can then be addressed as a formal component of treatment (see next lesson on DESNOS treatment).

DESNOS VERSUS BPD:

The distinction between DESNOS and BPD provides perhaps the most challenging differential diagnosis to the clinician unversed in psychological adaptations to chronic trauma, especially in view of the potential for diagnostic overlap or dual-diagnosis. Nevertheless, in our clinical work we have frequently observed that many patients who have been historically conceptualized as "borderline" are, upon more thorough evaluation, better characterized by the DESNOS framework. In numerous instances, we have observed that such patients are not only understood through different diagnostic and conceptual frameworks depending on the clinical orientation of their treatment site, but actually present with varying symptom profiles based on the extent to which their trauma histories have been (a) identified by their treating clinicians and incorporated into clinical case formulations, (b) acknowledged as relevant factors in the etiology of psychopathology and current symptom presentations, and (c) addressed as significant targets in treatment. Notably, **we have found that the thoughtful inclusion of trauma history in the case conceptualization and treatment planning with these patients often contributes to significant changes in their symptom presentations. Specifically, trademark personality features of the BPD patient such as hostility, emotional manipulation, and deception come to be replaced with more genuine feelings of sadness, loss, and traumatic grief.** Accordingly, shifts in the clinician's formulation of presenting problems as well as in the patient's developmental adaptation to his or her experience of childhood trauma can, at times, influence the subsequent symptom expression and diagnostic classification of a particular patient as DESNOS versus BPD.

   Empirical research has established that the BPD and DESNOS diagnoses in general represent overlapping but distinct symptom profiles.[32,80] On the surface, these disorders may appear to be quite similar, as both relate to aspects of four of the six domains of

self-regulatory deficit captured by the DESNOS construct (i.e., affect, attention/consciousness, self-perception, and relationships). Several important distinctions exist, however, between DESNOS and the classic BPD construct, including notable differences in the relative importance and nature of disruptions in these four domains of self-regulation. For instance, **whereas chronic affect dysregulation is the hallmark feature of DESNOS, this symptom is secondary to disturbances in identity and relationships with others in BPD.**[20] **In essence, BPD represents a disorder of attachment, while DESNOS is considered by most leading clinicians and researchers in the field to be better understood as a disorder of self-regulation.**

Affect Regulation

Affect in DESNOS patients is more chronically and persistently emphasized in the direction of a downward dysregulation than is the case in BPD patients, who in contrast exhibit greater range in their capacity for transient upward emotional spikes. The continuum of mood in patients with DESNOS typically ranges from a dysthymic/anxious baseline to profound states of rage, terror, or hopelessness. The brief periods of excitement, positive anticipation, and euphoria observed in BPD patient—often associated with transient idealizations of new intimate others or treatment providers—are less commonly observed to be components of a true DESNOS symptom presentation. In fact, **a cardinal but under-recognized feature of DESNOS patients is their profound deficit in the capacity to sustain positive emotional states, experience pleasure, and become absorbed in positive and present-focused states of awareness.**

Relationships

The nature of interpersonal dysfunction characterized by the DESNOS construct varies from that of the BPD diagnosis as articulated in the DSM-IV. The BPD patient's fundamental interpersonal orientation is an active one: an approach-based stance characterized by the duality of desire and disillusionment. **BPD is often characterized by the oscillation between intense longing and search for idealized** (and therefore unrealistic and ultimately untenable) **relation-**

ships, and the equally intense devaluation and ultimate sabotage of these relationships. Conversely, when an intimate other threatens to pull out of what had been perceived by the patient to be an unsatisfying relationship, the BDP patient can become overcome with a resurgence of desire to maintain this relationship occasioned by desperate fear of abandonment and rejection by the other. In other instances, the BPD patient will concoct, and become temporarily consumed by vaguely articulated fantasies of a "perfect" future with a new caregiver or potential lover, only later to feel the sting of disappointment at the other's inability to fill the profound emptiness at the core of his or her own being. As has been well established and the subject of much of the clinical literature on BPD, these patterns typically manifest themselves early in these patients' transference responses to new treatment providers.

In contrast, **the basic interpersonal orientation of the DESNOS patient is passive in nature, characterized by a duality of avoidance and revictimization.** For example, these patients often engage in prolonged periods of self-inflicted social isolation and avoidance of intimate contact. At other times, however, they report abruptly discovering themselves to be in the midst of an intense emotional relationship that feels unsafe or out of control. In fact, when DESNOS patients do enter intimate relationships, it is often as a result of being the target of victimizing others who have been drawn to these patients' emotional vulnerability, underdeveloped capacity to identify danger cues, and tolerance for violence and boundary violations as an inherent component of intimate relationships. DESNOS patients are often observed, to the chagrin of their therapists, to reenact their interpersonal traumas, repeatedly finding themselves helplessly playing out the role of victim, or, alternately, compelled to victimize others in ways similar to those experienced in their own history of childhood traumatization.

DESNOS patients not only tend to fear and believe themselves to be unworthy of meaningful relationships with others; they are generally incapable of imagining a future for themselves in which they can love and be loved in a relationship that is free of abuse.

Given this pessimism about the potential for positive interpersonal connection and general distrust of others, DESNOS patients are not surprisingly somewhat less likely than patients with BPD to engage in boundary violations and intrusiveness with their therapists at the outset of treatment. In contrast, they often present as apprehensive, guarded, and at times hostile toward new treatment providers. The establishment of safety and trust is perhaps the most important component of the initial phase of treatment with these patients.

Dissociation

Dissociative symptom presentations differ notably in patients with these two disorders. Dissociative symptoms associated with BPD are characterized by transient responses to stress, the occurrence of which is not required to meet diagnostic criteria. Clinical research on dissociative symptomatology as measured by the DES has consistently found that patients with BPD report lower levels of dissociative symptoms than patients with PTSD.[88] In contrast, **the presence of significant dissociative symptomatology is an essential and required component of the DESNOS diagnosis. These symptoms may take a variety of forms ranging from episodic experiences of derealization to lasting psychogenic amnesia for portions of one's traumatic experiences, to the presence of *Dissociative Identity Disorder.***

Self-Perception

The following distinctions can be made regarding the type and extent of disturbances in self-perception observed in these two disorders. **Whereas the primary feature of disturbance in self-perception for patients with BPD involves a fundamental confusion about self, the DESNOS patient experiences a self that has been permanently damaged and alienated from others.** At the core of identity disturbance for patients with classic BPD lays the absence of a sense of self or ego identity, and the persistent affective experience of emptiness associated with the void left by the unformed self. Perhaps the key component of the severe psychopathology of these patients is the intolerable black hole of this void that always beckons, making the risk for suicide a constant consideration in

treatment. DESNOS patients, in contrast, although plagued by negative affect states of guilt, shame, and ineffectiveness associated with their experience of a damaged self, nevertheless possess, on some fundamental level, a basic core sense of identity, albeit often the problematic dual identity of victim and patient. In fact, their desperate clinging to trauma-based identities as victim/patient is often quite pronounced, as it becomes a source of personal meaning-making and provides a compelling explanatory model for and source of "proof" of their chronic experience of interpersonal suffering and emotional pain. For such patients, this identity formation is perhaps the greatest obstacle to genuine treatment progress.

Obviously, symptom presentation and treatment course becomes more complicated for individuals dually diagnosed with DESNOS and BPD. A full consideration of this issue is beyond the scope of the present paper. In brief, however, it is strongly recommended that treatment for such patients prioritizes and begins with the targeting and stabilization of more severe deficits in self- and affect-regulation including treatment interfering, suicidal and self-harming behaviors. **Treatment approaches with these patients should involve the incorporation of modalities specifically developed and validated for patients with BPD** within a framework of trauma-focused clin-ical formulation, psychoeducation, and patient validation of emotional pain. Of the existing interventions for BDP, we have found Dialectical Behavior Therapy (DBT)[91] to be particularly applicable to the treatment of patients dually diagnosed with DESNOS and BPD.

Summary

DESNOS is a diagnosis that encompasses a pervasive pattern of adjustment that may occur in response to persistent traumatization that occurs across settings, and frequently involves numerous types of trauma, or trauma of long duration. Such experiences disrupt and alter maturing biological and emotional systems, particularly when they occur during early childhood. DESNOS has persistent biological, emotional, interpersonal, and social components that all must be assessed and addressed in treatment. The primary deficits relate to: (1) the regulation of affect and impulses; (2) attention or consciousness; (3) self-perception; (4) relations with others; (5) systems of meaning; and (6) somatization. DESNOS can be directly assessed through the use of the SIDES and SIDES-SR. Further, aspects of the DESNOS constellation can be evaluated through the use of instruments such as the DES and the IASC, as well as through health services utilization review.

Appendix   A
SCORING SHEET ILLUSTRATING LIFE SYMPTOM ENDORSEMENT AND CURRENT SYMPTOM SEVERITY FOR THE TYPICAL PATIENT WITH DESNOS

Scores of 2 or above are clinically significant, and "Current" threshold scores for items and subscales.

	LIFETIME	CURRENT
I. Alterations in regulation of affect and impulses (A and one of B–F required)		**YES 1.3**
A. Affect Regulation	Yes	2.0
B. Modulation of Anger	No	0.0
C. Self-Destructive	Yes	0.0
D. Suicidal Preoccupation	Yes	3.0
E. Difficulty Modulating Sexual	Yes	3.0
F. Excessive Risk Taking	No	0.0
II. Alterations in attention or consciousness (A or B required)		**YES 1.0**
A. Amnesia	Yes	2.0
B. Transient Dissociative Episodes and Depersonalization	No	0.0
III. Alterations in self-perception (Two of A–F required)		**YES 1.3**
A. Ineffectiveness	Yes	2.0
B. Permanent Damage	Yes	3.0
C. Guilt and Responsibility	No	0.0
D. Shame	Yes	0.0
E. Nobody Can Understand	Yes	3.0
F. Minimizing	No	0.0
IV. Alterations in relationships with others		**YES 1.8**
A. Inability to Trust	Yes	2.3
B. Revictimization	Yes	3.0
C. Victimizing Others	No	0.0
V. Somatization (Two of A–E required)		**YES 0.8**
A. Digestive System	Yes	2.0
B. Chronic Pain	Yes	2.0
C. Cardiopulmonary Symptoms	No	0.0
D. Conversion Symptoms	No	0.0
E. Sexual Symptoms	Yes	0.0
VI. Alterations in systems of meaning (A or B required)		**YES 1.3**
A. Despair and Hopelessness	Yes	2.5
B. Loss of Previously Sustaining Beliefs	Yes	0.0

Appendix B
INTAKE SUMMARY SCORES: TRAUMATIC
ANTECEDENTS QUESTIONNAIRE (TAQ)

SCALE	CHILDHOOD			ADULTHOOD	TOTAL
	Young Child (0–6)	School Age (7–12)	Adolescent (13–18)		
Higher Scores are Better:					
COMPETENCE	2.0	3.0	2.5	2.0	9.5
SAFETY	0.0	0.0	0.0	2.0	2.0
Higher Scores Indicate Greater Exposure:					
NEGLECT	2.7	2.7	2.0	2.0	9.3
SEPARATION	3.0	3.0	3.0	3.0	12.0
SECRETS	3.0	3.0	0.0	0.0	6.0
EMOTIONAL ABUSE	3.0	2.5	2.3	0.0	7.8
PHYSICAL ABUSE	0.0	0.0	0.0	2.5	2.5
SEXUAL ABUSE	2.0	2.3	2.0	0.0	6.3
WITNESSING	0.0	2.0	2.0	0.0	4.0
OTHER TRAUMAS	0.0	2.0	2.3	2.0	6.3
ALCOHOL & DRUGS	2.0	2.0	2.0	3.0	9.0

Explanation of Scores:

Scores are calculated with a threshold-based system.

No raw scores of 0 or 1 for individual TAQ items, i.e., endorsements of (1) "Not at all" or "Never" and (2) "Rarely" or "A little bit" are included in the calculatin of scores for age periods.

Only raw scores of 2 or 3, endorsements of (2) "Occassionally" or "Moderately" and (3) "Often" or "Very Much," are averaged to generate age-period scores.

TOTAL scores are sums of age-period scores for that scale.

References

1. Scott WJ. PTSD in DSM III: A case in the politics of diagnosis and disease. *Social Problems*. 1990;37:294–310.

2. Kardiner A. *The traumatic neuroses of war*. New York: Hoeber, 1941.

3. Shatan CF, Smith J, Haley S. *Johnny comes marching home: DSM-III and combat stress.* Paper presented at: 130th Annual Meeting of the American Psychiatric Association; May 6, 1977; Toronto.

4. Krystal H, ed. *Massive Psychic Trauma*. New York: International Universities Press; 1968.

5. van der Kolk BA. *Psychological Trauma.* Washington DC: American Psychiatric Press; 1987.

6. Horowitz M, Wilner N, Kaltreider N. Signs and symptoms of posttraumatic stress disorder. *Arch Gen Psychiatry*. 1980;37:85–92.

7. Brett E, Spitzer R, Williams J. DSM-III-R criteria for posttraumatic stress disorder. *Am J Psychiatry.* 1988;144: 1232–1236.

8. Terr LC. Children of Chowchilla: A study of psychic trauma. *Psychoanal Study Child*. 1979;34:552–623.

9. Hidalgo RB, Davidson JR. Posttraumatic stress disorder: Epidemiology and health-related concerns. *J Clin Psychol.* 2000;61:5–13.

10. Davidson JR, Hughes D, Blazer DG, George LK. Posttraumatic stress disorder in the community: An epidemiological study. *Psychol Med.* 1991;21:713–721.

11. Breslau N, Davis GC, Andreski P. Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Arch Gen Psychiatry*. 1991;48:216–222.

12. Cole P, Putnam FW. Effect of incest on self and social functioning: A developmental psychopathology perspective. *J Consult Clin Psychol*. 1992;60:174–184.

13. Herman JL. Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *J Trauma Stress.* 1992;5: 377–391.

14. Kroll J, Habenicht M, Mackenzie T, Yang, M. Depression and posttraumatic stress disorder among Southeast Asian refugees. *Am J Psychiatry.* 1989;146:1592–1597.

15. Bryer JB, Nelson BA, Miller JB, Krol PA. Childhood sexual and physical abuse as factors in adult psychiatric illness. *Am J Psychiatry.* 1987;144:1426–1430.

16. Herman JL, Perry JC, van der Kolk BA. Childhood trauma in borderline personality disorder. *Am J Psychiatry.* 1989;22: 231–237.

17. Carmen EH, Reiker PP, Mills T. Victims of violence and psychiatric illness. *Am J Psychiatry*. 1984;141:378–379.

18. Chu JA, Dill D. Dissociative symptoms in relation to childhood physical and sexual abuse. *Am J Psychiatry.* 1989;148: 50–54.

19. Saxe G, Berkowitz R, Chinman G, Hall K, Leiberg G, Schwartz J, van der Kolk BA: Dissociative disorders in psychiatric inpatients. *Am J Psychiatry.* 1993; 150(7):1037–42.

20. American Psychiatric Association, Committee on Nomenclature and Statistics. *Diagnostic and Statistical Manual for Mental Disorders, 4th ed.* Washington, DC: American Psychiatric Association Press; 1994.

21. Pelcovitz D, van der Kolk BA, Roth S, et al. Development of a criteria set and a structured interview for disorder of extreme stress (SIDES). *J Trauma Stress.* 1997;10:3–16.

22. Mueser KT, Goodman LA, Trumbetta SL, et al. Trauma and posttraumatic stress disorder in severe mental illness. *J Consult Clin Psychol.* 1998;66:493–499.

23. Saxe G, van der Kolk BA, Berkowitz R, et al. Dissociative disorders in psychiatric inpatients. *Am J Psychiatry.* 1993; 150:1037–1042.

24. van der Kolk BA, Roth S, Pelcovitz D, Mandel F. *Complex PTSD: Results of the PTSD Field Trial for DSM-IV.* Washington, DC: American Psychiatric Association; 1993.

25. Kessler R, Sonnega A, Bromet E, Hughes M, Nelson C. Posttraumatic stress disorder in the national comorbidity survey. *Arch Gen Psychiatry.* 1995;52:1048–1060.

26. Deering C, Glover S, Ready D, Eddleman H, Alarcon R. Unique patterns of comorbidty in posttraumatic stress disorder from different sources of trauma. *Comp Psychiatry.* 1996;37:336–346.

27. McFarlane A. Posttraumatic stress disorder: A model of the longitudinal course and the role of risk factors. *J Clin Psychology.* 2000;61:15–20.

28. Shalev A. Measuring outcome in posttraumatic stress disorder. *J Clin Psychiatry*. 2000;61:33–39.

29. Ballenger J, Davidson J, Lecrubier Y, et al. Consensus statement on posttraumatic stress disorder from the international consensus group on depression and anxeity. *J Clin Psychology.* 2000;61:60–66.

30. Herman JL, van der Kolk BA. Traumatic antecedents of borderline personality disorder. In: van der Kolk BA, ed. *Psychological Trauma.* Washington, DC: American Psychiatric Press; 1987; 111–126.

31. World Health Organization. *The ICD-10 Classification of Mental and Behavioral Disorders: Clinical Descriptions and Guidelines.* Geneva: Author; 1992.

32. van der Kolk BA, Pelcovitz D, Roth SH, et al. Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *Am J Psychiatry.* 1996;153: 83–93.

33. Roth S, Newman E, Pelcovitz D, van der Kolk, BA, Mandel F. Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trial for posttraumatic stress disorder. *J Trauma Stress.* 1997;10:539–555.

34. Ackerman PT, Newton JE, McPherson WB, Jones JG, Dykman RA. Prevalence of posttraumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse Negl.* 1998;22:759–774.

35. Zlotnick C, Zakriski AL, Shea MT, et al. The long-term sequelae of sexual abuse: Support for a complex posttraumatic stress disorder. *J Trauma Stress.* 1996;9:195–205.

36. van der Kolk BA. Adolescent vulnerability to posttraumatic stress. Psychiatry. 1985;48:365–370.

References

37. Ford J. Disorders of extreme stress following war-zone military trauma: associated features of posttraumatic stress disorder or comorbid but distinct syndromes. *J Consult Clin Psychol.* 1999;67:3–12.

38. van der Kolk BA. The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In: van der Kolk BA, McFarlane A, Weisaeth L, eds. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press; 1996; 182–213.

39. Felitti V, Anda R, Nordernbeg D, et al. Relationship of childhood abuse to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *Am J Prev Med.* 1998;14:245–258.

40. Poulsny M, Follette V. Long-term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied & Preventive Psychology.* 1995;4:143–166.

41. Linehan MN, Tutek DA, Heard HL, Armstrong HE. Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *Am J Psychiatry.* 1994;151:1771–1776.

42. Chemtob CM, Novaco RW, Hamada RS, Gross DM, Smith G. Anger regulation deficits in combat-related PTSD. *J Trauma Stress.* 1997;10:17–36.

43. Foa EB, Riggs DS, Massie ED, Yarczower M. The impact of fear activation and anger on the efficacy of exposure treatment for posttraumatic stress disorder. *Behavior Therapy.* 1995;26:487–499.

44. Braun BG. The BASK (behavior, affect, sensation, knowledge) model of dissociation. *Dissociation.* 1988;1:4–23.

45. Draijer N, Langeland W. Childhood trauma and perceived parental dysfunction in the etiology of dissociative symptoms in psychiatric inpatients. *Am J Psychiatry.* 1999;156:379–385.

46. van der Kolk, BA, van der Hart O, Marmar CR. Dissociation and information processing in posttraumatic stress disorder. In: van der Kolk BA, MacFarlane A, Weisaeth L, eds. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press; 1996;303–327.

47. Harter S, Alexander PC, Neimeyer RA. Long-term effects of incestuous child abuse in college women: Social adjustment, social cognition, and family characteristics. *J Consult Clin Psychol.* 1988;56:5–8.

48. Ross CA. Epidemiology of multiple personality disorder and dissociation. *Psychiatry Clinics of North America.* 1991;3:503–517.

49. Waller NG, Ross CA. The prevalence and biometric structure of pathological dissociation in the general population: Taxometric and behavior genetic findings. *J Abnorm Psychol.* 1997;106:499–510.

50. Herman JL. *Trauma and Recovery.* New York: Basic Books; 1992.

51. Fleming J, Mullen PE, Sibthrope B, Bammer G. The long-term impact of childhood sexual abuse in Australian women. *Child Abuse Negl.* 1999;23:145–159.

52. Bryer J, Nelson B, Miller JB, Krol P. Childhood sexual and physical factors in adult psychiatric illness. *Am J Psychiatry.* 1987;144:1426–1430.

53. Lisak D, Hopper J, Song P. Factors in the cycle of violence: Gender rigidity and emotional constriction. *J Trauma Stress.* 1996;9:721–743.

54. van der Kolk BA. Beyond the talking cure. In: Shapiro F, ed. *The Paradigm Shift.* Washington, DC: American Psychiatric Press; 2001, in press.

55. Chu JA. *Rebuilding Shattered Lives: The Responsible Treatment of Complex Post-traumatic and Dissociative Disorders.* New York: Wiley; 1998.

56. Yehuda R. Linking the neuroendocrinology of post-traumatic stress disorder with recent neuroanatomic findings. *Seminars in Clinical Neuropsychiatry.* 1999;4:256–265.

57. Shalev AY, Rogel-Fuchs Y. Psychophysiology of PTSD: From sulfur fumes to behavioral genetics. *J Nerv Ment Dis.* 1993;55:413–423.

58. Pitman RK, Orr SP, Forgue DF, de Jong J, Claiborn JM. Psychophysiologic assessment of posttraumatic stress disorder imagery in Vietnam combat veterans. *Arch Gen Psychiatry.* 1987;44:970–975.

59. Yehuda R. Biology of posttraumatic stress disorder. *J Clin Psychiatry.* 2000;61:14–21.

60. Bremner J, Randall P, Scott TM, et al. MRI-based measurement of hippocampal volume in patients with combat-related posttraumatic stress disorder. *Am J Psychiatry.* 1995;152:973–981.

61. van der Kolk BA, Saporta J. Biological response to psychic trauma. In: Wilson JP, Raphael B, eds. International Handbook of Traumatic Stress Syndromes. New York: Plenum Press; 1993;25–33.

62. Kosten TR, Mason JW, Giller EL, Ostroff RB, Harkness L. Sustained urinary norepinephrine and epinephrine elevation in PTSD. *Psychoneuroendocrinology.* 1987;12:13–20.

63. Depue RA, Spoont MR. Conceptualizing a serotonin trait: A behavioral dimension of constraint. *Ann NY Acad Sci.* 1986;487:47–62.

64. Coccaro EF, Siever LJ, Klar HM, Maurer G. Serotonergic studies in patients with affective and personality disorders. *Arch Gen Psychiatry.* 1989;46:587–598.

65. Raleigh MJ, McGuire MT, Brammer GL. Social and environmental influences on blood serotonin concentrations in monkeys. Arch Gen Psychiatry. 1984;41:505–510.

66. Valzelli L. Serotonergic inhibitory control of experimental aggression. *Psychopharmacolical Research Communications.* 1982;12:1–13.

67. Mann JD. Psychobiologic predictors of suicide. *J Clin Psychiatry.* 1987;48:39–43.

68. Yehuda R, Kahana B, Binder-Byrnes K, et al. Low urinary cortisol excretion in Holocaust survivors with posttraumatic stress disorder. *Am J Psychiatry.* 1995;152:982–986.

69. Yehuda R, Southwick SM, Mason JW, Giller EL. Interactions of the hypothalamic- pituitary-adrenal axis and the

References

catecholaminergic system of the stress disorder. In: Giller ED, ed. *Biological Assessment and Treatment of PTSD.* Washington, DC: American Psychiatric Press; 1990.

70. van der Kolk, BA, Greenberg MS, Orr SP, Pitman RK. Endogenous opiods and stress- induced analgesia in posttraumatic stress disorder. *Psychopharmacol Bull.* 1989;25: 108–112.

71. Pitman RK, van der Kolk, BA, Orr SP, Greenberg MS. Naloxone reversible stress-induced analgesia in posttraumatic stress disorder. *Arch Gen Psychiatry.* 1990;47: 541–547.

72. Wilson S, van der Kolk BA, Burbridge J, Fisler R, Kradin R. Phenotype of blood lymphocytes in PTSD suggests chronic immune activation. *Psychosomatics.* 1999;40: 222–225.

73. Berkowitz CD. Medical consequences of child sexual abuse. *Child Abuse Negl.* 1998;22:541–550.

74. Saxe GN, Chinman G, Berkowitz R, et el. Somatization in patients with dissociative disorders. *Am J Psychiatry.* 1994; 151:1329–1335.

75. Spinazzola, J, Blaustein, M, Kisiel, C, van der Kolk, B. *Beyond PTSD: Further evidence for a complex adaptational response to traumatic life events.* Paper presented at the American Psychiatric Association Annual Meeting, May, 2001, New Orleans.

76. Blake DD, Weathers FW, Nagy LM, et al. *Clinician-Administered PTSD Scale for DSM-IV.* Boston, MA and West Haven, CT: National Center for Posttraumatic Stress Disorder; 1995.

77. Spitzer RL, Williams JB, Gibbon M, First MB. *Structured Clinical Interview for DSM-IV-Patient Edition.* New York: New York State Psychiatric Institute, Biometrics Research Department; 1994.

78. Zlotnick C, Pearlstein T. Validation of the structured interview for Disorders of Extreme Stress. *Comprehensive Psychiatry.* 1997;38:243–247.

79. Spinazzola J, Roth S, Derosa R, et al. *The Specificity of the Disorders of Extreme Stress Construct.* Poster presented at: 10th Annual Meeting of the International Society for Traumatic Stress Studies; November, 1994; Chicago.

80. Blaustein ME, Spinazzola J, Simpson W, van der Kolk BA. *Psychological sequelae of early trauma: Comorbid diagnoses or diagnostic entity?* Paper presented at: 16th Annual Meeting of the International Society for Traumatic Stress Studies; November, 2000; San Antonio, TX.

81. Trauma Center website. Available at: http://www.trauma-center.org. Accessed: October 15, 2001.

82. Herman JL, van der Kolk, BA. Childhood trauma in borderline personality disorder. *Am J Psychiatry.* 1989;146: 490–495.

83. Bernstein EM, Putnam FW. Development, reliability, and validity of a dissociation scale. *J Nerv Ment Dis.* 1986;174: 727–735.

84. Briere J. *Inventory of Altered Self-capacities (IASC): Professional Manual.* Odessa, FL: Psychological Assessment Resources; 1998.

85. Wilson J, Keane TM. Assessing Psychological Trauma and PTSD. New York: Guilford Press; 1997.

86. Falsetti S, Resnick H, Resick P, Kilpatrick D. The Modified PTSD Symptom Scale:A brief self-report measure of posttraumatic stress disorder. *Behavior Therapist.* 1993;16: 161–162.

87. Carlson EB, Putnam FW. An update on the dissociative experiences scale. *Dissociation.* 1993;6:16–27.

88. Darves-Bornoz JM, Lemperiere T, Degiovanni A, Gaillard P. Sexual victimization in women with schizophrenia and bipolar disorder. *Soc Psychiatry Psychiatr Epidemiol.* 1995; 30:78–84.

89. Mueser KT, Goodman LB, Trumbetta SL, et al. Trauma and posttraumatic stress disorder in severe mental illness. *J Consult Clin Psychol.* 1998;66:493–499.

90. Ford J, Kidd T. Early childhood trauma and disorders of extreme stress as predictors of treatment outcome with chronic posttraumatic stress disorder. *J Trauma Stress.* 1998;11:743–761.

91. Linehan M. *Cognitive Behavioral Treatment of Borderline Personality Disorder.* New York: Guilford Press; 1993.

73. Which one of the following statements is *not* correct?

A. The majority of people experience at least one traumatic event during their lifetimes, and up to 25% of them will ultimately develop PTSD.

B. The clinical presentations of patients with PTSD who have survived car accidents or natural disasters do not differ materially from those who have experienced abuse at the hands of caregivers.

C. Individuals with PTSD have been found to be eight times more likely to have three or more additional disorders than those without PTSD, most commonly major depression, anxiety disorder, substance abuse, and somatization disorder.

D. The DSM-IV diagnosis, Disorders of Extreme Stress, Not Otherwise Specified (DESNOS), or Complex PTSD, is linked with histories of interpersonal victimization, multiple traumatic events, and traumatic exposure of extended duration.

74. The diagnosis of DESNOS involves disturbances in all of the following areas of functioning, *except*:

A. Regulation of affect (e.g., troubling expressing or modulating anger and overreacting to minor stresses).

B. Attention or consciousness (e.g., perceptual or sensory "split-off" aspects of the traumatic experiences, often experienced as inexplicable physical sensations or a feelings of not sensing what it is to be "in their bodies").

C. Appreciation of reality (e.g., tightly constructed system of delusional thought processes surrounding imagined traumatic events).

D. Relationships (e.g., difficulty trusting others, revictimization and victimization of others).

75. Which of the following psychometric assessment instruments is the only one that has been validated for the purpose of diagnostic assessment of DESNOS?

A. Structured Interview of Disorders of Extreme Stress (SIDES)

B. Traumatic Antecedents Questionnaire (TAQ)

C. Dissociative Experiences Scales (DES)

D. Inventory of Altered Self-Capacities (IASC)

For more information about Hatherleigh, look up our website at www.hatherleigh.com, or give us a call at 800-367-2550.

Volume 21   Lesson 26

Complex Trauma and Disorders of Extreme Stress (DESNOS) Part Two: Treatment

Toni Luxenberg, PsyD, Joseph Spinazzola, PhD, Jose Hidalgo, MD,
Cheryl Hunt, PsyD, and Bessel A. van der Kolk, MD

*Dr. Luxenberg is a Clinical Supervisor and Staff Psychologist,
Dr. Spinazzola is the Associate Director of Research & a Staff Psychologist, Dr. Hidalgo is a Staff Psychiatrist;*

*Dr. Hunt is a Clinical Supervisor, and Dr. Van der Kolk is the Medical Director
of The Trauma Center, Arbour Health System, Allston, MA and Boston University School of Medicine.*

Learning Objective
Clinicians will understand the three basic phases of treatment for DESNOS, as well as psychotherapeutic and psychopharmacologic techniques that may be helpful in each phase.

Editor's Note

The authors conceptualize recovery in DESNOS as entailing three phases. The first is stabilization, where areas of affect dysregulation, alteration in consciousness, and disturbances in self-perception are addressed. Much of the work here is psychoeducational—focusing on issues of physical needs, trust, safety, self-soothing, and building support networks, and not the trauma.

Phase Two consists of processing and grieving of traumatic memories. Here exposure-based treatments, such as Prolonged Exposure, Stress Inoculation Training, and Cognitive Processing Therapy are useful. Traumatic experiences should be explored in depth and integrated into a coherent life narrative that primarily impacts the patient's self-perception and his/her ability to be in relationships with others. The third phase involves focusing on present-day issues, reconnecting with peers, exploring meaningful work, pleasurable activities, and constructive relationships.

The authors advocate the judicious use of psychopharmacological agents, especially in the early phase of treatment when disturbing affect is evident. We know that sertraline has been shown to be effective in PTSD; thus this drug and perhaps SSRIs in general would prove the most useful class of agents. There is a place for benzodiazpines, used with care, as well as mood stabilizers, and perhaps even stimulants such as methylphenidate. None of these agents have been adequately studied in treating DESNOS. The clinician can be guided by target symptoms and experience with PTSD in choosing among them.

The Treatment of Disorders of Extreme Stress

The treatment of simple PTSD and DESNOS require different approaches. The treatment of DESNOS is conducted in stages or phases that are generally agreed upon by clinicians and experts in the field. Some of the earliest writing delineated three phases, and these three phases continue to guide treatment today.[50] Several extensive reviews of phase-oriented treatment are currently available.[92,93] We will discuss the main therapeutic tasks and foci of each of the three phases, as well as the different therapeutic strategies and interventions that are associated with each stage of treatment.

The recovery process is most often conceptualized in terms of the following three phases: (1) stabilization, (2) processing and grieving of traumatic memories, and (3) reconnection/reintegration with the world.[2] The first stage involves the establishment of safety, stabilization, containment, and symptom reduction. Although treatment should not be construed as a strictly linear process, and there is considerable overlap between the phases, **this *first phase* of treatment primarily addresses the areas of affect dysregulation, alteration in consciousness** (e.g., dissociation), **and disturbances in self-perception. The *second phase* involves the work of exploring traumatic experiences in depth, and the integration of those experiences into a coherent life narrative, which primarily impacts the patients' self-perception and ability to be in relationships with others. The third phase involves focusing on present-day** issues—**reconnection with peers, and moving on with life through the exploration of pleasurable activities, meaningful work, bodily comfort, and constructive relationships.**[50] This phase of treatment is primarily concerned with relationships with others and altering systems of meaning. **The stages of recovery are fluid,** and patients typically move back and forth between the stages throughout the healing process, and even within individual sessions.

Phase One: Stabilization

In this first phase of recovery, much of the initial work of therapy is psychoeducational. It is necessary to assist patients in making sense of their experience by providing them with basic information about the effects of trauma on individuals, both in the short- and long-term. Psychoeducation should include a rationale and explanation for specific symptoms, such as affect dysregulation, dissociation, flashbacks, and hyperarousal.[94] Psychoeducation also includes helping patients, over time, to identify aspects of their environment that remind them (consciously or otherwise) of their trauma, thus causing subsequent distress. "Mood logs" often help in assisting patients with identifying where they were and what were they thinking, feeling, experiencing in their bodies, and doing right before they became distressed. ***Such identification allows patients to begin to evaluate realistically the amount of danger actually present in their current environments, rather than continually being at the mercy of their own hyperarousal.***[95] An example of this occurred in the treatment of a patient who felt increasingly anxious

and frightened after moving into a new apartment. Through therapy, she was able to identify that this feeling intensified whenever she walked into her bathroom, which was decorated with floral wallpaper. She was then able to make the connection between this wallpaper and the similarly styled wallpaper in the bathroom in which she was molested as a child. Armed with this information, she was able to ask her landlord for permission to re-wallpaper her bathroom, which was granted, resulting in a resolution of her anxiety and fearfulness.

Physical Well-Being

In addition to basic psychoeducation about trauma, attention needs to be given to the person's physical well-being and bodily experiences. This includes addressing relevant health issues (e.g., medication compliance), and the regulation of body functions such as sleeping, eating, and exercise.[2] In seeking to regulate patients' physical functioning, the groundwork is laid for both regulating affect, and addressing issues of somatization and disruption of bodily experience. Starting to take care of their bodies is frequently an important first step in helping patients feel agentic and in control, and in changing their perception of themselves as being helpless. Chronically traumatized individuals cannot begin to tolerate the next phase of treatment until they have at least a rudimentary familiarity and comfort with their own body and physical experiences.

Environment

Also at issue in this stage is the patient's external environment,[50,94] with focus on practical issues such as having a safe living situation, terminating current abusive relationships, and having adequate access to health care, money, and employment opportunities. Many patients need to be assisted in obtaining safe housing, reliable transportation, or other practicalities before further work in therapy is possible. Finally, **to combat the dysregulation in the lives of DESNOS patients, it is necessary to incorporate structure into their lives through the implementation of routines and schedules that allow for a sense of predictability.** Many of these issues, of course, will be ongoing throughout treatment.

ISSUES OF TRUST:

Another ongoing issue that is particularly figural at the beginning of therapy with chronically traumatized individuals is that of trust. Given their histories of chronic traumatization in the context of interpersonal relationships, chronically traumatized individuals tend to expect similar experiences in both the present and the future; such individuals may have significant difficulty feeling safe in relationships and being calmed through interpersonal means. Such individuals conduct themselves in ways designed to minimize the potential for further harm. The consequence of such behavior is often an interpersonal wariness and distance that can make relationship building in therapy an extended process. **This can be understood as a consequence of the interaction between two domains of difficulty related to the DESNOS construct: problems with relationships, and disturbances in self-perception. These areas interact synergistically causing chronically traumatized individuals to fear that they cannot be understood or valued, see others as potential sources of further mistreatment, and use interpersonal caution as their primary means of protecting themselves from anticipated cruelty in the face of their own perceived inadequacies and shameful sense of self.** Trust is likely to be an issue, to varying degrees, throughout the course of therapy, and may well need to be addressed continually. Trust will be particularly important in the initial stage of therapy, as patients are being asked to enter into an intense interpersonal relationship (i.e., therapy) at the same time that they are acknowledging (at least implicitly, through their mere presence in therapy) how harmed they have been in the past.

ISSUES OF SAFETY:

In the first phase of recovery, safety is often a focal issue; no other work can proceed until the patient is safe.[50] Depression and anxiety can be intense during this phase of treatment, and often present are issues of suicidality and self-harm in the form of self-injury, substance abuse, or eating disorders.[96] **Another focus in this phase of treatment is affect regulation and the management of PTSD symptoms such as flash-**

backs, nightmares, and sleep difficulties. Because of these factors, this phase is often filled with crisis.[50,97] During this period, it is important not only to address these problems behaviorally, but also to gain an understanding of their psychological meaning for the patient. Importantly, it is not helpful or advisable for the clinician to communicate this understanding to the patient during this phase of treatment. While, at a later date, it may be very useful for a patient to recognize the psychological "goal" of his or her behavior, in the service of finding more adaptive means of meeting that goal (e.g., a woman may realize that she has frequent, intense crying spells because she feels this is the only way to communicate to her partner that she needs support and comforting), *it may actually be destabilizing in the first phase of treatment to explicitly comment on the historical origins of behavior to the patient.* **Specifically, patients who are very unstable, highly defensive, actively self-harming, or using other destructive means of coping** (e.g., drug use) **are unlikely to profit from the connection of the past with the present, as they are clearly indicating with their behavior that such connections are currently intolerable to them.** The linking of past experiences with current behavior almost always involves the evocation of traumatic material, which is to be avoided during this stage. Once stabilization and constructive coping skills have been achieved, the clinician can use the knowledge gained in the previous phase of treatment to help patients break destructive patterns of behavior, thought, and affect. Many self-destructive behaviors can be best understood as reenactments of earlier abuse,[55] an internalization of the abuser and his or her negative messages, or attempts to pierce dissociative barriers and "feel" something (this will be explored in more depth later in this lesson). Those who self-injure commonly state that they do so to help themselves reduce their level of negative affect. This is likely due to the release of powerful endogenous opioids that can become a highly addictive means of managing intense emotions.[98] **Pharmacotherapy is often an important adjunct to ongoing psychotherapy to help reduce patients' reactivity and hyperarousal, address sleep difficulties, minimize nightmares and other intrusive experiences, and provide relief from anxiety and depression.**[99]

CREATING BOUNDARIES AND ESTABLISHING PATIENT RESPONSIBILITIES:

Due to the volatility of patients during this phase of treatment and their intermittent ability to access coping skills, **it is necessary that the therapist take an active and direct role in therapy.**[97] This may include developing concrete "safety plans" with the steps patients will take when feeling overwhelmed and unable to cope. It may be necessary during this phase of treatment for the therapist to develop rules and boundaries for out-of-session contact with the patient.[97] Due to the crisis-oriented nature of this phase of treatment, some patients will call their therapist frequently, demand extra sessions, and continually threaten to hurt themselves. Therapists must be clear in their own minds about the limits of what they are willing to do, and communicate these limits explicitly to the patient. Important considerations are: amount and length of out-of-session contact; availability of therapist during evenings and on weekends; and use of hospitalization. Such limits will vary across cases, and they may also change throughout the course of treatment; these should be explained to the patient as they change. **It is important for patients to be expected to take responsibility in the management of their affect.**[97] A therapist who continually "saves" the patient only serves to reinforce the patient's own sense of helplessness and powerlessness. It is important to understand that suicidal, self-harming, or "out-of-control" behavior serves the crucial function, for patients diagnosed with DESNOS, of regulating intolerable feeling states in the absence of more adaptive self-soothing strategies.

BUILDING SELF-SOOTHING CAPACITIES IN PATIENTS:

It will be important during this first phase of treatment to help patients develop the capacities for self-care and self-soothing that they were not able to develop previously.[55] Having distanced themselves from their bodily experiences, patients will often have limited awareness of what would be helpful to them when they are distressed. It is often helpful for the clinician to present the patient with a range of self-soothing options; the patient should be instructed to

consider self-soothing an experiment, and try different options to see what works and what does not. This trial-and-error attitude allows the patient permission to reject methods that are not helpful, and to not view an unsuccessful application of a technique as a "failure." It may also be helpful for some patients to do their own related reading.[100,101] **Initially, lists of self-soothing strategies written down on paper are often necessary because patients may not be able to remember what self-soothing options they have available when they are very distressed.** It is important to consider, however, the danger that both patients and clinicians may ultimately use self-soothing skills as a means of avoiding the patients' distressing emotions. **Patients need assistance in strengthening their emotional tolerance; self-soothing strategies are best thought of as a means of helping patients bear and move through their uncomfortable emotions,** rather than as a means of warding off such emotions.

It is helpful for patients to be encouraged to explore coping skills that encompass as many senses as possible. This addresses the patient's separation from his or her own body and physical needs. Patients often need assistance in accessing and most effectively using their own capacities for tolerating and managing affect. Exploration of options can build a sense of empowerment. *Patients can be encouraged, for example, to buy a warm, soft article of clothing to wear when upset, develop a list of comforting foods, identify music that is calming, etc. Care should be taken, however, to avoid potential traumatic reminders while exploring soothing activities. For example, bubble baths and massages may be very upsetting and anxiety-provoking for individuals who have been sexually abused or assaulted.* **A number of relaxation techniques can be quite beneficial for patients, such as progressive muscle** *relaxation, deep breathing,* **and** *guided imagery.*[100] The goal should be for patients to learn to perform these exercises themselves, without the assistance of the therapist, so that they can become active in managing their own emotions. *Care should be taken, however, because states of relaxation can sometimes precipitate panic or anxiety in traumatized individuals.* One technique that can be particularly helpful, both in and

out of session, is having the patient imagine a container of some kind (patients have imagined everything from shoe boxes to bank vaults),[100] and to visualize putting distressing feelings, sensations, memories, or images into the container and then securing it in some manner; sometimes a simple lock is sufficient, and other times, the container has to be sunk to the bottom of the ocean or shot into space). As van der Kolk and Fisler have pointed out,[102] traumatic memory may well be stored in somatosensory formats rather than verbal formats. This may, therefore, necessitate the use of nonverbal techniques for working with memory and containing affect. Such techniques may involve movement, touch, artwork, dance, etc.[103]

Dialectical Behavior Therapy

Dialectical Behavioral Therapy (DBT), developed by Marsha Linehan,[91] is an example of a treatment that assists patients in developing the skills to deal with affect regulation, and DBT can be extremely helpful during the stabilization phase of treatment. DBT also has components such as building and reinforcing relational skills. Although DBT is an entire treatment program, including coordinated group and individual work, there are groups offered by agencies based on the concepts of DBT, and these can be helpful as adjunctive treatment, or sometimes as preparatory treatment for individual work.

SUPPORT SYSTEMS:

It is also important in this phase of treatment to **assist patients in mobilizing and utilizing as many support systems as possible.**[50] This helps begin to address their difficulties in relationships with others. Group treatment, as mentioned above, can be helpful, as can 12-step programs. Day treatment programs and connections with other agencies can often add additional support, particularly during times of crises. Patients should be encouraged to identify supportive individuals in their environment who can be relied upon in times of distress. It is often helpful to assist patients in developing a hierarchy of resources in their environment by asking them to identify individuals with whom they can: (1) have fun and distract themselves from their difficulties; (2) share that they are

upset and receive some comfort, without going into details; and (3) share their distress on a more intimate level and be understood and supported. Individual psychotherapy—and individual therapists—alone are typically not adequate for addressing all of the issues that will arise in the course of treatment during this initial stage.

Focus on Stabilization

During this phase of treatment, the above issues (physical needs, trust, safety, self-soothing, and the building of support networks), **and not the trauma, should be the focus of the treatment. Therapy during this stage of treatment should be reparative, not explorative.** In a very real sense, patients do not have the tools they need at this stage to tolerate trauma-focused work; forcing patients to do such work before they are ready risks symptom exacerbation, escalated self-injury and suicide attempts, premature termination of treatment, and retraumatization.[50,55] In fact, it is frequently necessary to stop patients from delving into their trauma, and explain to them the necessity of making sure that they have consistent access to all the necessary skills and supports before doing so.[97] **This stage may be quite brief for acutely traumatized individuals, but it can be quite lengthy, sometimes spanning years in treatment, for patients who meet the criteria for DESNOS.**[97]

Vignette

> "Jeannette," a 34-year-old woman, was referred to a therapist after being hospitalized for several weeks subsequent to attempting to kill herself by taking several medications she had on hand and consuming a bottle of wine. This was Jeannette's fourth hospitalization in the last two years. The previous hospitalizations had all been precipitated by similar suicide attempts, or self-injury in the form of burning herself with a cigarette lighter. Jeannette explained to hospital staff that she had to burn herself sometimes, because otherwise she would "go

> crazy," or start crying and never stop. Indeed, she was observed to scream and cry for extended periods of time over what appeared to be minor stressors in the hospital (e.g., having to wait to use the telephone). After one conflict with another patient, she banged her head against the wall and had to be restrained. During the restraint, Jeannette appeared to be experiencing a flashback, crying out that she wouldn't take her panties off and asking repeatedly for her grandmother, who had raised her for several years during her childhood.

> Jeannette reported that her childhood had been a "nightmare," with her bouncing between relatives and foster homes as her mother went in and out of drug treatment programs and lived with a series of abusive men. Jeannette refused to talk about any of her mother's boyfriends or her experiences with them, simply stating that "I hope they all rot in hell." Jeannette was removed from her mother's care for the first time when she was six months old. Jeannette insists that her mother did the best she could, but she acknowledges that she was often without food or heat as a young girl, and she was frequently left to care for her two younger siblings when her mother would disappear for several days at a time. Jeannette has memories, over which she experiences intense shame, of going through the neighbors' trashcans, looking for food for herself and her siblings. As an adult, Jeannette became involved with a violent man, and she used drugs heavily during this time period. Jeannette was able to leave this man when she became pregnant and entered a detox program, which she successfully completed. She reports that the birth of her son turned her life around, but that she finds the stresses of single motherhood to be overwhelming at times.

In addition, Jeannette reports significant sleep problems, often not falling asleep until two or three in the morning, because she "can't turn her mind off and stop remembering stuff." Jeannette has frequent nightmares whose content she cannot remember upon waking. Jeannette also reports that "everything" scares her, and that she screams at any sudden noise or movement. She particularly is frightened by men and reports that she once broke a man's nose after being startled when he approached her from behind to return an item she had dropped from her purse. Jeannette reports that she no longer abuses drugs or alcohol, but finds she sometimes drinks and uses marijuana to temporarily escape from domestic pressures and master her fear. Despite this, she often has panic attacks when away from home. Due to these attacks, she no longer can ride in crowded subway cars.

Jeannette is significantly overweight and reports feeling depressed about this. She experiences chronic heartburn which she reports was not helped by her medication, so she discontinued taking it and has not sought other solutions, stating that "nothing will help." Jeannette reports that the only things that help her feel better are "stuffing" herself with food and spending time with her son. She has no friends, stating that the only person she needs is her son. She has intermittent contact with her mother, but she does not see either of her siblings, although they live in the neighboring town. Jeannette works part-time, but she finds that she often has difficulty focusing on her work, because she is thinking about "all the bad things that happened to me." This has caused her to be fired on several occasions. More typically, however, she quits when she becomes involved in a dis-

pute with a fellow employee or boss. Jeannette also works as a free-lance artist, occasionally selling illustrations to magazines. Although she loves this work, she finds it hard to make a living.

Jeannette has been in therapy prior to this incident, and she reports that none of the therapists truly understood her, and that she ultimately left therapy each time, feeling disappointed and betrayed again. When asked what she does to help herself cope with the difficulties in her life, Jeannette replied, "Just not think about things, I guess. Or I just cry and cry until I'm just too tired to care." Jeannette also reported stock piling broken glass. Although she has never actually cut herself, she states that just knowing it is there comforts her.

Conceptualization

It is important to note that this vignette is not meant to provide a comprehensive treatment plan that addresses all possible aspects of treatment. It is meant, rather, to provide an illustration of typical considerations during the first phase of treatment. Not all of the treatment aspects mentioned previously will be relevant for any one individual patient, and some will take precedence over others.

Jeannette was clearly in the first phase of trauma treatment—she required significant stabilization before other work could commence. This was clear from the following information: (1) Jeannette currently had very active PTSD symptomatology which was interfering to a great extent with her daily functioning; (2) she was self-medicating through alcohol and drug use; (3) she had very destructive and/or ineffective means of coping; (4) she was not currently making significant use of constructive coping strategies; (5) she had a minimal support system; (6) and she was experiencing significant affect dysregulation.

It is important to remember that not everything can be accomplished at once. Priorities had to be set, and the initial work focused on helping Jeannette to build

up a repertoire of specific, concrete means of coping with distress. Jeannette's therapist referred her to an adjunctive DBT group, feeling that this would provide both a skills-focused atmosphere, as well the beginnings of the support network that Jeannette so clearly needed. The therapist also referred Jeannette for a psychiatric evaluation, and she was ultimately placed on several medications to address her sleep difficulties, intrusive symptomatology, and anxiety, as these were seen as being the largest, most immediate, impediments to her daily functioning. In addition, the therapist recommended that Jeannette consult with her doctor about trying additional medications for her heartburn, which she ultimately did, and found a medication that managed her discomfort quite well. This accomplished several goals beyond the obvious one of symptom relief: (1) it taught Jeannette that her body was an important and worthy focus of attention; (2) it encouraged Jeannette to begin to care for herself on a basic level; and (3) it allowed Jeannette to experience success in taking charge of an aspect of her life. After additional evaluation, the therapist determined that Jeannette was not currently using drugs and alcohol at a level that necessitated a higher level of care (i.e., inpatient), but he recommended that Jeannette join an Alcoholics Anonymous group, both to prevent further and heavier use from occurring, and again, to begin to build up a supportive social network.

The therapeutic work initially focused on helping Jeannette identify when she was becoming distraught or overwhelmed. This was accomplished primarily through helping Jeannette learn to focus on her body signals that let her know that she was in distress. This was difficult for Jeannette to do, not being very aware of her body, and finding sensation in it to be upsetting. The therapist, therefore, taught Jeannette how to do progressive muscle relaxation as a gentle way of having her become more familiar with her body and its signals. Once this was accomplished, Jeannette was able to notice when she was becoming hyperaroused and distressed. In an attempt to help Jeannette learn to recognize "shades" of affect, the therapist taught her to visualize different feelings as different colors (e.g., anger was red), and equate different hues with differ-

ent levels of that particular emotion. Over time, they identified the shades that signified that Jeannette was experiencing a problematic level of an emotion. This technique strengthened one of Jeannette's existing resources, her artistic skill.

The next step in treatment was to help Jeannette begin to identify means of calming herself when she noticed that she was experiencing distress. Initially, Jeannette handled distress by calling the therapist and demanding that he help her because she felt like "she was going to die." The therapist explained that it was ultimately counter-productive for him to "sweep in" and save Jeannette from her feelings, because this would prevent her from both learning how to handle such situations herself and reinforce that feelings themselves were dangerous and to be avoided, rather than dealt with. Over time, an agreement was reached that Jeannette could call her therapist if she had tried at least three different coping techniques and experienced no lessening in distress. Such calls were understood to be time-limited, and for the purpose, not of solving whatever the specific problem might be, but for further strategizing about what Jeannette could do to manage her affect. The therapist encouraged Jeannette to practice muscle relaxation and visualization of a peaceful scene several times a day, so that she became facile at their use and could easily employ them when in distress. The therapist helped Jeannette deepen her experience of being relaxed and calm by employing her artistic talents and having her draw a peaceful scene for her to imagine when distressed, and a picture of what it felt like to be relaxed and calm. Jeannette hung both of these in her bedroom and found looking at them was more effective than imagining the scenes in her head.

Finally, the last focus of stabilization in work with Jeannette was on helping Jeannette to address her fear of public transportation and her interpersonal difficulties with co-workers. Both of these problems were compromising Jeannette's ability to earn a living, and she identified them as the areas in which she needed the most help, so that her life could become more routine and manageable. This work was primarily cognitive-behavioral in nature, helping Jeannette to learn to

identify the thoughts that were triggering both the fear and anger that she found to be so problematic, and then replacing those thoughts with constructive ones that stopped the fear and anger "cycles." Jeannette was able to use her already-learned relaxation skills to undergo progressive imaginal exposure to riding public transportation, until she became able to effectively manage her fear and was able to ride on public transportation without having panic attacks. She also learned how to notice when she was becoming angry enough to compromise her position at work, and calm herself down and take "timeouts" so that she could resolve the conflict in an appropriate fashion.

After a year of treatment, Jeannette had not been hospitalized, and had only one instance of self-injury early on in treatment. She was attending therapy regularly, and had been able to maintain her job over the last six months. She had made a few friends through the various groups that she attended, and several times when in distress, she had called these individuals, rather than using drugs or alcohol, or self-injuring. She still refused most invitations from others, however, preferring to remain at home. She was sleeping regularly, and had only infrequent nightmares and intrusive thoughts. She still struggled with anxiety, but found she was able to manage it so that she no longer experienced full-blown panic attacks. Jeannette also still struggled with significant feelings of depression, and had recently begun to feel despair that she would never have an intimate relationship. She stated that now that her life was not so chaotic and her symptoms were not so crippling, she was becoming aware of an intense loneliness that she had not expected. She stated, however, that, on balance, her life was much improved from a year before, and she felt much more confidence in herself to manage whatever came her way. She and her therapist began to discuss the possibility of exploring the impact of some of her traumatic childhood experiences on her current interpersonal functioning, and how she felt about herself. Jeannette realized that this was the next step for her, and she felt both apprehensive and excited about breaking away from old, trauma-based ways of understanding herself, others, and the world around her.

Phase Two: Processing and Grieving of Traumatic Memories

The second stage of treatment involves the work of exploring the traumatic memories in some depth. The purpose of this stage in recovery is the integration of traumatic memories into a coherent narrative about one's life,[50,95,104] along with desensitization of the intense negative affect associated with these memories. Ultimately, the memories evolve from being the focal point of an individual's life to being a set of experiences that occurred within a larger context.[105] This work helps address the alterations in these individuals' meaning systems by instilling a sense of hope for the future that it is no longer merged with a traumatic past. In addition, in processing their traumatic memories, many individuals find that they change their perceptions of others and their expectations in relationships, allowing them to build more healthy relationships than previously possible.

At the same time, whereas ample empirical evidence supports the necessity of exposure/trauma processing in the treatment of patients with simple PTSD,[106–108,110–116] the necessity of phase two intervention for clinical improvement in chronic trauma patients with PTSD and DESNOS is less clear and awaits empirical substantiation. In some instances, the specifics of a patient's circumstances may argue against trauma processing. An example would be an elderly patient who is dying of cancer and who also has DESNOS related to numerous traumatic childhood experiences. In this case, a focus on stabilization and the management of anxiety may well be indicated. The decision to embark on the work of trauma processing should be made according to the exigencies of the life of each patient, and the patient's own wishes must be taken into account.[55] Moreover, in our clinical work we have frequently come across the treatment-induced decompensation of DESNOS patients, secondary to premature introduction of trauma processing techniques before the attainment and maintenance of safety and stabilization described in phase one. In these instances, DESNOS patients are flooded with, and affectively overwhelmed by, a resurgence of long-contained traumatic memories that have been acti-

vated by exposure-based interventions without adequate development of the requisite internal coping resources to tolerate these memories and their associated cognitive, affective, and somatic correlates. Accordingly, the importance of timing, sequencing, and titration of phase two intervention with DESNOS cannot be underestimated.

This work should not be attempted by individuals who are not qualified to handle traumatic memories and the intense affects and behaviors that may ensue. Specific training in the therapeutic handling of traumatic content should be sought before such work is undertaken. **The primary goal of this phase of treatment is to have the patient acknowledge, experience, and normalize the emotions and cognitions associated with the trauma at a pace that is safe and manageable.** The primary rationale for the work with traumatic memories is to provide the patient with symptom relief, integrate split-off aspects of the self and the traumatic experience, and to allow the patient to shift focus to nontraumatic aspects of his or her life. **As van der Kolk[36] has noted, trauma is often registered in the body as unspeakable terror, and the processing of traumatic experiences can allow individuals to put their experiences into words, thus robbing these experiences of their disruptive, often somatically based or kinesthetically based power.** Processing may also be achieved through nonverbal means as well, such as body-oriented therapies, self-defense training, and other physically based means of moving through emotions, discovering resources, and seeking empowerment.

EXPOSURE-BASED TREATMENTS:

It is important that graduated exposure be incorporated into the second phase of treatment with the support of the therapeutic relationship. In controlled exposure situations, traumatic memory is activated along with any associated affect, with the therapeutic aim of modifying that memory and reducing or discharging anxiety and negative affect associated with the memory. This allows the memory to become less rigid and distressing and more like memories of nontraumatic events.[95] **There are a number of highly**

effective exposure-based PTSD treatments. Many of these treatments, such as Prolonged Exposure,[106] Stress Inoculation Training,[107] and Cognitive Processing Therapy (CPT),[108] **are cognitive-behavioral in nature and focus on patients' cognitions and attributions about both the traumatic event(s) and themselves.** The common theme is that patients are purposefully exposed to their own traumatic memories until they learn to tolerate the attendant emotions, and a diminution of anxiety occurs. In CPT, a further step is taken in which patients' faulty beliefs (e.g., "It was my fault. I'm bad") are then challenged and more adaptive beliefs sought. **Eye Movement Desensitization and Reprocessing** (EMDR) **is another exposure-based intervention that has been shown to be very effective in dealing with traumatic experiences.**[109,110] In fact 60,000 clinicians around the world have been trained in EMDR—far more than all other techniques combined. This technique involves calling up traumatic memories, attendant emotions, and associated faulty beliefs while undergoing bilateral stimulation (e.g., through following rhythmically moving objects with the eyes; hand taps; or alternating auditory tones). This allows the processing of memories in a manner that is often faster than that achieved by verbally based treatments.[111,112] EMDR has been found to be at least as effective as other exposure-based treatments for trauma.[113–115]

While cognitive-behavioral treatment (CBT) has been proven to be a very effective form of therapy for PTSD,[106,111,116] there are indications that it is not sufficient for DESNOS populations. Fairly high dropout rates are frequently reported, and some studies have even found significant morbidity.[106,107,117] For example, Jacycox and colleagues[118] found that 67.5% of their sample was still symptomatic and exhibiting poor levels of functioning after treatment. According to Ford and Kidd,[90] only one in three participants enrolled in the CBT treatment studies they examined were able to complete the study and show clear treatment gains. Some studies have even needed to be prematurely terminated, due to significant increases in symptomatology.[119] The literature indicates a myriad of factors that may contribute to adverse outcomes in exposure-based

treatments, such as high and persistent levels of anger,[120–122] attitudes of mental defeat,[123] feelings of alienation and being permanently damaged,[124] and the experience of guilt and shame.[125] While most individuals may experience at least some of these feelings at some point in their lifetime, what characterizes the chronically traumatized is the persistence and pervasiveness of these feelings. Individuals, for example, may feel chronically ashamed, and therefore tolerate abusiveness in relationships, not take good care of themselves physically, and not seek help when in distress. The parallel between these sources of treatment failures and the categories of DESNOS is striking. The predictors of treatment failure appear to be various expressions of precisely the symptoms (e.g., affect dysregulation) that are central features of the DESNOS diagnosis.

Combination Treatments

Effective treatment for individuals who meet the criteria for DESNOS requires both affect regulation (phase one) and exposure (phase two) to be addressed. Cloitre and colleagues[123] have combined skills-based training in affect and interpersonal regulation (STAIR) with CBT-based exposure and emotional processing.[106,107] Cloitre's model is the first such model to formally incorporate both aspects of treatment, and it has been found to be effective in treating chronically traumatized individuals in a relatively short period of time (16 weeks). It is important to note, however, that many of Cloitre's participants still experienced significant dysfunction at the end of the study; according to a letter from M. Cloitre they frequently expressed fear, anger, and resentment that therapy was being terminated (personal communication, January 2001).

STABILIZATION ISSUES
DURING THE PROCESSING PHASE:

What has not been formally articulated anywhere in the literature is the need to move back and forth between stabilization and processing, and how and when to make those transitions. To that end, the research group at The Trauma Center, led by Bessel van der Kolk, is currently working on developing a treatment manual that makes explicit how one determines when to shift back and forth between stabilization and processing, both within and between sessions. (A grant is currently under review to develop this manual).

It is not unusual in this second phase of treatment for safety and stabilization concerns to resurface, particularly when key memories are addressed that involve themes of violation, betrayal of trust, loss of the capacity to protect oneself, and impotence of others to protect one from danger. When this occurs, the safety issue should be addressed, strategies to deal with it reviewed, and stabilization again achieved before the work of processing continues. Sometimes this may entail a considerable amount of time and involve a number of sessions. Other times, it may be addressed relatively quickly within session.

During processing work it is crucial for the clinician to pay very careful attention to signs that the patient is becoming overwhelmed. This can be a subtle procedure, and questions of intensity and duration must be addressed—is the patient somewhat anxious during session, or does she or he have a series of panic attacks after leaving the session? The former is potentially a sign that processing is occurring, while the latter may be a sign that basic stabilization has been breached and needs to be repaired. When assessing level of distress, the clinician should attend to breathing, posture, and gaze, as well as the patient's ability to formulate thoughts and sentences, to respond to the clinician, and to interact in an adult manner.

DISSOCIATION:

Although it is not possible to give a thorough treatment to the subject here, one very important consideration in balancing stabilization and processing is a patient's level of dissociation. (The interested reader should refer to the reference list for articles that explore this area in greater detail. No.126–133) As mentioned previously, dissociation is a way for patients to "split off" aspects of their experience and insulate the larger system from the emotions, beliefs, assumptions, and sensory and somatic experiences

associated with certain events. This can happen along any of four dimensions of "knowing"—behavior, affect, sensation, and knowledge (BASK model of dissociation).[44] Dissociative experiences vary in intensity, ranging from persistent forgetfulness to engaging in behavior of which one later has absolutely no memory. Many chronically traumatized individuals experience significant levels of dissociation,[126] and this can have a critical impact on treatment as patients who are dissociated are not emotionally available for the integrative work of therapy.

Clinicians must pay close attention for signs of dissociation so that they can assist patients in "grounding" themselves. Occasionally, dissociation is dramatic, involving eye rolling or eye fluttering; more frequently, it is relatively subtle, consisting of blank stares, inattention, or fixed looks that seem to "go through" the clinician. A gentle way to explore possible dissociation is to ask a patient "What's happening right now for you?" or "Where are you right now?" In extreme cases, the patient may be unresponsive, but, typically, patients can report feeling "fuzzy," "out of it," or otherwise not engaged in therapy. The therapist can then assist the patient in becoming focused again. This might entail having the patient look around the room and describe objects, identify colors, or feel textures. Strategies for combating dissociation should involve all of the senses and a gentle focus on the patient's physical body and immediate surroundings. Movement or change of posture or position may also be helpful. Patients should be encouraged to keep their eyes open to maintain contact with their surroundings and the clinician.

Patients can be taught to use these same grounding techniques themselves, outside of session. Often, patients will develop their preferred methods for coping with dissociation, and carry around "grounding objects" with them, such as smooth stones to rub, sour candy to suck, or vials of scented oil to smell. In addition, patients can also be taught to purposefully dissociate and then "reassociate." This puts the dissociation under their control; the most important aspect of this technique is that patients learn how to break their own dissociative states. This can be done by pairing a simple physical stimulus (e.g., making a fist) with emer-gence from a dissociative state, so that the stimulus can be used at the first signs of unplanned dissociation and deter it.

Vignette

"Jonah" is a large, muscular, and slightly overweight 35-year-old single Caucasian male employed full-time as a carpenter. He lives in a rural community in a house that he rents with four other men, most of whom work for the same construction firm as Jonah. Jonah was referred for evaluation and trauma-focused treatment by a pastoral counselor secondary to increased difficulty controlling anger, concentration problems, and intermittent violent outbursts with male coworkers and housemates. These problems had recently become exacerbated to the extent that his employment and living arrangements were in jeopardy.

A history of Jonah's present illness revealed that he suffered chronic back pain from a work-related injury three years ago. Jonah's medical providers, however, believed that the continued severity of this back pain was in excess of what could be attributable to his specific form of injury. The suspicion that psychological problems exacerbated Jonah's level of chronic pain resulted in a consulting physician asking Jonah (approximately 1 year ago) whether he had any history of child maltreatment or abuse: As such, a childhood history had anecdotally been observed by this physician to be associated with chronic pain presentations. These questions reactivated Jonah's long-suppressed, albeit never forgotten, memories of repeated beatings followed by sexual molestation for a period of approximately 2 years as a prepubertal early adolescent at the hands of a trusted adult male recreational counselor, "Jake."

When Jonah's memories of childhood molestation were reactivated, they were accompanied by a resurgence of intense emotional distress including feelings of anger, shame, aggressive ideation, and desire for retaliation. This reactivation precipitated increased volatility and fighting with his coworkers and housemates to near-intolerable levels, such that both his employer and housemates warned Jonah that if he did not get help he would have to leave. Having maintained close ties to the church throughout his life, Jonah initially sought support through a pastoral counselor in his local parish, with some limited relief of symptoms. Consultation with a local psychiatrist led to prescription of anti-depressant and anxiolytic medication, again with limited results. Having attended a training workshop offered through our Trauma Center, the psychiatrist recommended that Jonah undergo an evaluation to assist with treatment planning and assess the appropriateness of treatment involving the processing of traumatic memories.

A comprehensive psychological and psychiatric evaluation at our clinic was conducted. This evaluation revealed Jonah's history of childhood maltreatment to have been complicated by his experience of preferential treatment and affection by the perpetrator before and after instances of abuse. Further, the abuse occurred against the backdrop of parental emotional neglect and disapproval, scholastic problems, and social rejection by peers. Jonah's father was a minister whom Jonah perceived as stern and unavailable. While Jonah identified his mother as a comparatively greater source of affection and nurturance, he explained that due to his family's financial hardship he rarely saw his mother as she was typically required to work two jobs and suffered from exhaustion

and frequent physical illness. In contrast, Jonah's recreational counselor through the church took special notice of and interest in Jonah and gave him unique privileges and responsibilities, including serving as his assistant in maintaining the rectory grounds. These activities became a source of pride and competence for Jonah.

When his special "friendship" with Jake escalated into secret beatings and molestation in the gardening shed, accompanied by alternating expressions of endearment and debasement, Jonah experienced deep ambivalence and confusion. Unable to report these violations, both out of fear of being labeled "crazy" or "perverted," as well as fear of losing his important attachment to Jake, Jonah quietly endured this abuse and suppressed his growing confusion about normal sexual behavior and feelings. His approaching puberty added to Jonah's inner sense of turmoil, shame, and self-debasement.

Jonah ultimately dropped out of school at age 16 and began working as a carpenter's apprentice. Soon thereafter he moved out of his family home. Jonah's twenties were characterized by hard physical labor, periodic heavy drinking, and occasional violent brawls with men at bars. Jonah reported having a number of acquaintances and casual friends, and explained that he rarely had difficulty finding other men with whom to room or socialize. However, while perceived by his peers to be at core a kind-hearted and well-intentioned person, Jonah's unpredictable temper and intermittent violent streak, in addition to his guarded distrust of others, prevented him from forming more meaningful friendships. Similarly, his experience with dating was extremely limited and short-term.

Conceptualization

Findings from the evaluation indicated that Jonah was currently suffering from DESNOS, in addition to PTSD. Further, while Jonah had considerable access to various environmental resources, including supportive peers, family members (by this point in his life, Jonah had reconciled his relationship with both his parents, who lived nearby and were available to Jonah for ongoing support), and church involvements, he was not very adept or consistent in making use of these resources. Jonah also lacked adequate internal coping resources to reduce and prevent the buildup of anxiety and aggressive feelings. In fact, Jonah perceived himself as unable to tolerate the overwhelming feelings of shame and anger that he associated with his history of molestation and the subsequent confusion and ambivalence he experienced regarding the emergence of developmentally normative sexual desires.

Jonah believed himself to be defective in the area of relationships, and felt that he was doomed never to achieve a normal intimate relationship with a woman. Consequently, he alternated between fearful avoidance of contact with women and finding himself compelled to test appropriate boundaries with typically younger female peers involved in church activities. Although these interactions never lead to inappropriate physical contact, on several occasions Jonah needed to be redirected by church elders and instructed to discontinue interactions with young women in the church who had become intimidated by his excessive attention, unannounced visits, and jealousy in response to their friendships with other young men in the community.

Treatment began with psychoeducation about the long-term effects of childhood trauma on the mind and body, including introduction of the PTSD and DESNOS diagnoses and the phase-oriented model of trauma treatment. Explanation of the causes and effects of these diagnoses, and of DESNOS in particular, provided a sense of comfort and increased self-understanding for Jonah, serving as an explanatory model for the confusing array of emotional, interpersonal, somatic, and self-image difficulties he had been experiencing since adolescence.

Treatment began with a "*Phase One*" focus on establishing an internal sense of safety and self-con-trol and the increased stabilization and containment of angry affect. The goal was to eliminate outbursts of physical aggression by identifying and blocking precipitants of this behavior through the implementation of a regimen of coping techniques. These coping techniques heavily relied on elements of *Dialectical Behavior Therapy* (DBT) and included incorporation of EMDR-based guided imagery techniques to help Jonah develop an internal sense of safety, self-acceptance, and capacity to self-soothe in the presence of situational stress. In addition, on the basis of the psychiatric medication evaluation at our clinic, a mood stabilizer was added to Jonah's medication regimen.

Concurrent behavioral interventions employed with Jonah included daily stress logs in which he recorded morning, afternoon, and evening stress levels in conjunction with medication compliance, use of DBT and EMDR skills, and adherence to a physical therapy regimen. Jonah demonstrated good compliance with these treatment efforts, and over a period of 8 weeks demonstrated a noticeable increase in his capacity to tolerate and appropriately express his emotions, including feelings of anger and shame associated with his trauma. Incidents of physical altercations were dramatically reduced. On the basis of these treatment gains, plans to move toward the processing of traumatic memories were discussed and mutually agreed upon.

Preparations to begin this phase of intervention, however, lead to marked anticipatory anxiety in Jonah that ultimately precipitated an emotional decompensation and resurgence of overwhelming affect, culminating in the first physical altercation with peers in over 2 months. Consequently, trauma-processing initiatives were put on hold and Phase One safety stabilization efforts were resumed. Successive attempts to begin trauma processing resulted in similar, albeit somewhat reduced, periods of emotional decompensation. Over time this pattern revealed itself to be a nondeliberate and yet not entirely unconscious attempt by Jonah to sabotage the treatment to avoid having to face the emotional pain and fear anticipated to emerge once he began the process of intentionally exposing himself to memories of his traumatic experience.

At this point treatment efforts focused on empathic and direct confrontation of this pattern, with acknowledgement of his treatment progress thus far and validation of his fears about proceeding with the next step of treatment. Psychoeducation regarding the normalcy of this reaction and at the same time the impact of avoidance on anxiety maintenance and treatment impasse led to increased insight and awareness for Jonah. A titrated model of trauma processing was discussed with the patient, and the metaphor of a dam with controlled release and filtration of small amounts of water was employed.

Phase Two intervention for Jonah involved use of EMDR to facilitate the imaginal exposure to and desensitization of targeted traumatic memories. To begin this work, a hierarchy of specific memories of Jonah's experience of beatings and sexual molestation was identified. Given Jonah's marked apprehension about this phase of treatment and limited capacity to tolerate overwhelming affect, it was decided to begin processing with the least distressing memory of these experiences. While processing feelings and beliefs associated with this memory, it was also necessary to process associated feelings of ambivalence about the abuse because Jonah was made to feel special by Jake while feeling overlooked and undervalued by his parents.

As treatment progressed Jonah experienced increased self-control and reduction of aggressive behavior with peers. Jonah was taught to anticipate warning signs of potential behavior problems between sessions and to recognize these as attempts to disrupt the hard work of trauma processing and thus prolong and undermine the treatment. When these impulses occurred, Jonah over time learned to bring them to treatment before engaging in acting-out behaviors and explore then as potential indications that the work was progressing too quickly or with incomplete resolution between sessions. Thus Jonah began to take a more active role in the titration process of treatment, and this proactive behavior was identified and labeled as such.

While Jonah's feelings of anger at the perpetrator persisted throughout this work, over time a notable shift from desire for physical retaliation to a more sophisticated consideration of options for justice emerged. In addition, more vulnerable feelings of loss around the betrayal by a trusted adult caretaker began to surface and become incorporated into the treatment. At this juncture, with the majority of trauma targets processed, intervention with Jonah moved toward the beginning of Phase Three of intervention: namely, the desensitization of and preparation for anticipated challenges to current relationships with peers and intimate others.

Phase Three: Reconnection

The third phase of treatment resembles that of more general psychotherapy. Unencumbered by many of the initial after-effects of chronic trauma, attention is now shifted out into the world of relationships. Educational and occupational endeavors, friendships and intimate relationships, and spiritual and recreational activities and hobbies may all develop in ways that were previously impossible.[104] Intimacy and sexuality often become a focus of treatment for individuals who have experienced sexual trauma. This is frequently a time in which patients explore connections with others through joining clubs, reconnecting with old friends, taking lessons, and becoming involved in other group activities at work, church, and other settings. This does not mean that traumatic material will not be presented, but it is not the primary focus of this phase of treatment, nor does it consume the patient's life or sense of self anymore.

Herman[50] notes that the "best recoveries" are seen in patients who develop a "survivor mission." She states that these individuals are able to understand the social as well as the personal dimension of their traumatic experience(s), and transform the meaning of the trauma by making it the basis for social action in connection with others. This may take various forms, such as volunteering in a battered women's shelter, becoming a mental health worker, or simply discussing one's experience with others. At this stage patients frequently access their creativity in ways that were previously impossible for them, and use that creativity to address any remaining issues in relation to the trauma. Patients have written books, produced plays, given lectures, and created art about their traumatic experiences, and, more importantly, their recov-

ery from those experiences. One can see the profound way such activities could assist patients in altering their previously negative or fatalistic systems of meaning, as well as their sense of themselves and their feelings of being powerless and helpless.

The clinician's most vital role during this phase of treatment is helping patients to develop their sense of themselves as something other than a victim or even a trauma survivor. We can think of no better way to encapsulate this than to use the words of one of our patients, who said to us during this stage: "Well, yes, I was abused, but that's not who I am! I'm a mother and a wife and student and a runner and an artist and someone with a great sense of humor and adventure, and an appreciation of nature and beauty! That's who I am!"

Pharmacotherapy

Patients with DESNOS often present with a bewildering set of symptoms: psychobiological dysregulation involving sleep, anxiety, abnormal arousal states, rage, and mood disorders; biobehavioral adaptations to the trauma; attachment problems; and dissociation. The multiplicity of symptoms and lack of consistent diagnosis make it difficult to study it scientifically. *There is no published literature on the pharmacological treatment of DESNOS.* Hopefully, in the next few years increased attention will be directed toward the need for clinical trials in this area. In the meantime, the burgeoning knowledge of the biology of trauma1[33] and growing research on biological treatments for PTSD can help to guide the pharmacological treatment of DESNOS patients. Ultimately, however, the pharmacological treatment for DESNOS is for now nonspecific and **symptom-driven.**

Before discussing target symptoms for medication management, the following principles need to be kept in mind when treating patients with DESNOS:

> 1   *Pharmacotherapy is a component of a more comprehensive treatment; one can view pharmacotherapy as a means of helping the patient calm down enough to be able to make good use of therapy.* **Patients need to be brought into a dis-**

cussion about the role of medications in their treatment and recovery, and learn to use medications in conjunction with strategies learned in their psychosocial therapies. Given the multifaceted nature of DESNOS, it is not uncommon to see patients on a complicated regimen of medications. A collaborative relationship with the psychopharmacologist will help ensure proper use and limit the risk of polypharmacy. Rapidly shifting symptoms are often not occasions for medication adjustments, but opportunities for mastery and learning how to manage and tolerate painful emotional states using CBT, relaxation exercises, insight, imagery, etc. Without a good therapeutic alliance, and close collaboration between providers, it will be difficult to assess such developments effectively.

2   **Physicians need to pay meticulous attention to safety. As authority figures, doctors are likely to elicit powerful feelings and behaviors of mistrust and fear, and noncompliance in patients with histories of abuse and neglect. This power differential needs to be addressed early in treatment by sharing with patients knowledge about symptoms and available treatment strategies. Effectively reducing the information gap between doctor and patient, offering options, and valuing the patient as an expert in his or her own experience will increase the sense of safety and encourage the patient to take an active role in recovery. This, however, does not take doctors off the hook; they must be present for their patients and offer specific recommendations. The strategy chosen will depend on the specifics of the situations, the patient's**

preference, and the doctor's confidence that the strategy will not be harmful to the patient. For example, sometimes a patient may refuse to follow a recommendation for a full trial of an SSRI. The patient may only accept a low dose of a medication for sleep. This should be honored, provided that the patient's safety is not in jeopardy. Honoring the patient's ability to make a choice could lead to a strengthening of the therapeutic alliance, and the possibility that the patient may accept the recommendation in the future. Managing the subtleties of the doctor–patient relationship is as important as knowledge of psychopharmacology.[134]

3 Core symptoms need to be assessed along a *state-or-trait continuum*. Patients often present with acute PTSD-like symptoms triggered by a recent event. *State-dependent reactions often respond to a combination of temporary use of medications and psychosocial interventions.* Long-term pharmacologic strategies do *not* need to be changed as a consequence of state-dependent events or patients will end up with an unnecessarily complicated medication regimen.

4 *Comorbid problems need to be actively treated* (e.g., depression, thought disorders, substance abuse, etc.).

TARGET AREAS FOR MEDICATION MANAGEMENT:

Affect Dysregulation

Patients with DESNOS often have disproportionate reactions to minor stresses (affect dysregulation) **and can react to objectively neutral events as threats or reminders of the past, which can unleash strong emotional and behavioral responses.** For example, a slight insult may lead to rage, a minor disappointment to profound sadness, or a reminder of a threat to panic. These all-or-none emotional reactions aggravate interpersonal and social problems. **When not overreacting, patients often shut down emotionally and employ self-destructive or isolative strategies to contain painful affects. They often present with an inability to get along with people, an inability to manage a job, or a feeling of being disconnected.** *Obtaining a detailed history will help to establish a specific pattern of reactions for each individual, which can be tracked to see whether medications are effective.*

SSRIs

SSRIs are good first-line agents because of their broad-spectrum effectiveness over a wide range of symptoms: mood, anxiety, and impulsivity. SSRIs have also been shown to be effective for core symptoms of PTSD: reexperiencing, avoidance, and hyperarousal.[133,135,136] Our research[133] has shown that SSRIs improve people's capacity to observe their own emotional reactions without necessarily acting on them. We have postulated that this is due to increasing the availability of serotonin in the amygdala. SSRIs are generally well-tolerated, and have a low risk of lethal overdose. A gradual titration is preferable. Starting at high doses could trigger states of panic and jeopardize compliance. For example, increasing Prozac 10 mg per week until reaching 20 mg–40 mg, (Paxil 20 mg–40 mg, Zoloft 50 mg–150 mg.) **Newer antidepressants such as *nefazodone* (Serzone), *venlafaxine* (Effexor), and *mirtazapine* (Remeron) are probably effective, but their track record for treatment of trauma-related symptoms is not yet established.** TCAs and MAOIs are also effective, but their side-effect profile makes them less than desirable as first-line agents. Ameliorating intensity of painful affects often leads to significant changes in other areas; patients report being able to develop better perspective, separate past from present, and, paradoxically, develop a wider range of affect as there is less of a need to shut down emotions.

However, SSRIs alone will often not be enough to contain severe symptoms. Severe states of hyper-

arousal, irritability, aggression, anxiety, insomnia, psychotic-like symptoms, and dissociation may remain and will require adjunctive treatment with other classes of medications. These symptoms need to be separated as chronic or episodic.

Treating Severe Symptoms with Other Agents

BENZODIAZPINES:

Anxiety, irritability, and insomnia will respond to benzodiazepines.[135] **The risk of substance abuse and the possibility of withdrawal symptoms that may trigger more hyperarousal need to be taken into account.** A longer-acting agent such as _clonazepam_ (Klonopin) (0.5 mg–3.0 mg/day) should be used if it is going to be prescribed on an ongoing basis. _Trazodone_ (Desyrel) or low-dose TCAs may also be used adjunctively to treat insomnia. _Antiadrenergic agents_ such as _propranolol_ (Inderal) (60 mg–240 mg/day) and _clonidine_ (Catapres, Clorpres) (0.1 mg–0.6 mg/day) are an alternative to benzodiazepines. These agents may improve sleep, flashbacks, nightmares, and hyperarousal, and can often be used temporarily as patients work through difficult material.[135,137]

MOOD STABILIZERS:

Chronic levels of irritability, aggression, and hyperarousal often appear to be hypomanic or manic episodes. Mood stabilizers, such as _divalproex_ (Depakote)**,** _lithium_**, and** _carbamazepine_ (Tegretol) **have been effective with this spectrum of symptoms.**[136–138] It is too early to tell whether the newer mood stabilizers, such as _gabapentin_ (Neurontin) and _topiramate_ (Topamax), will be as effective. Once a mood stabilizer has been prescribed, there is often less of a need for benzodiazepines, except for prn use (in patients with low risk of substance abuse, benzodiazepines can be used as one of multiple options to deal with acute fear and anxiety when other strategies such as self-soothing have not worked.) Patients with DESNOS will often require lower doses of mood stabilizers than patients with bipolar disorder; for example 250 mg–500 mg/day of Depakote.[139]

ANTIPSYCHOTICS:

In our treatment of chronic trauma patients in our outpatient clinic, **we have found that the use of antipsychotics such as risperidone** (Risperdal) **or olanzapine** (Zyprexa) **is often helpful if the patient presents with paranoia, a generalized thought disorder, or dissociative hallucinations. Antipsychotics can also help reduce agitation, insomnia, and aggressive behavior. Most DESNOS patients receiving pharmacotherapy in our practice have been observed to tolerate low doses of these medications** (Risperidone 0.5–2 mg/day, Zyprexa 1.25 mg–5 mg/day). **Ideally, these patients should be actively involved in the determination of what dosage works best for them.**

STIMULANTS:

Chronic trauma patients who suffer from attention problems and unfocused agitation _may_ benefit from _methylphenidate_ (Ritalin) or other agents that have been proven to be helpful in the treatment of ADHD. However, the evidence supporting this hypothesis has been inconclusive to date in our clinical practice and thus awaits further substantiation.

Dissociation and self-injurious behavior are difficult to treat with pharmacological means alone, though they often are a function of the patient's experiencing an uncontrollable state of hyper- or hypoarousal. Most patients dissociate less if they learn to manage arousal states, sometimes with the use of pharmacological agents. Medications that decrease anxiety, such as Clonazepam have been found to help patients gain control over dissociative states.[61] Similarly, decreasing temporal lobe activity with the use of anti-convulsant medication is likely to decrease the pressure to act on impulses to fight, flee, or freeze.

Summary

The treatment of DESNOS should be phase-oriented and involve movement back and forth between three basic stages: (1) stabilization; (2) trauma processing; and (3) reintegration into the world. These phases of treatment are useful as guidelines. It is important to remember, however, that each patient, and each treat-

ment, is unique. The ultimate goal in the treatment of DESNOS is to help individuals place their traumatic experiences in the past, to access their inherent abilities to experience their emotional and physical worlds in tolerable ways, and to develop a sense of themselves as individuals who are defined by what they think, what they feel, who they love, the activities they enjoy, and the values they hold, rather than by their past traumatic experiences.

References

The following references are continued from the previous lesson.

92. Brown D, Scheflin AW, Hammond DC. *Memory, Trauma Treatment, and the Law: An Essential Reference on Memory for Clinicians, Researchers, Attorneys and Judges*. New York: W.W. Norton; 1998.

93. van der Kolk BA, McFarlane A, Weisaeth L, eds. *Traumatic Stress: The Effects of Overwhelming Experience on Mind,* Body, and Society. New York: Guilford Press; 1996.

94. Turnbull GJ, McFarlane AC. Acute treatments. In: van der Kolk BA, McFarlane AC, Weisaeth L, eds. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press; 1996;480–490.

95. van der Kolk BA, McFarlane AC, van der Hart O. A general approach to the treatment of post-traumatic stress disorder. In: van der Kolk BA, McFarlane AC, Weisaeth L, eds. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press; 1996;417–440.

96. van der Kolk BA, Perry JC, Herman JL. Childhood origins of self-destructive behavior. *Am J Psychiatry.* 1991;148: 1665–1671.

97. Fisher J. *Recognizing and Treating Patients with Dissociative Disorders.* Paper presented at: Psychological Trauma Conference; March, 1999; Boston, MA.

98. Segal J, Hunter EJ, Segal Z. Universal consequences of captivity: Stress reactions among divergent populations of prisoners of war and their families. *Int J Soc Sci.* 1976;28: 593–609.

99. Davidson JR, van der Kolk BA. The psychopharmacological treatment of posttraumatic stress disorder. In: van der Kolk BA, McFarlane AC, Weisaeth L, eds. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press; 1996;510–524.

100. Napier NJ. *Getting Through the Day: Strategies for Adults Hurt as Children.* New York: W.W.Norton: 1993.

101. Black C. *Changing course.* New York: MAC Publishers: 1999.

102. van der Kolk BA, Fisler R. Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study. *J Trauma Stress*. 1995;8:607–627.

103. Simonds SL. *Bridging the Silence: Nonverbal Modalities in the Treatment of Adult Survivors of Childhood Sexual Abuse.* New York: W.W. Norton; 1994.

104. Courtois CA. *Recollections of Sexual Abuse: Treatment Principles and Guidelines.* New York: W.W.Norton; 1999.

105. van der Kolk BA. Trauma and memory. In: van der Kolk BA, McFarlane AC, Weisaeth L, eds. Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society. New York: Guilford Press; 1996;279–302.

106. Foa EB, Rothbaum B, Riggs DS, Murdock T. Treatment of postttraumatic stress disorder in rape victims: A comparison between cognitive behavioral procedures and counseling. *J Consult Clin Psychol.* 1991;59:715–723.

107. Foa EB, Dancu CV, Hembree EA, et al. A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *J Consult Clin Psychol.* 1999;67: 194–200.

108. Resick PA, Schnicke MK. Cognitive processing therapy for sexual assault victims. *J Consult Clin Psychol.* 1992;60: 748–756.

109. Shapiro F. *Eye Movement Desensitization and Reprocessing.* New York: Guilford; 1995.

110. Chemtob CM, Tolin DF, van der Kolk BA, Pitman RK. Eye movement desensitization and reprocessing. In: Foa EB, Keane TM, Friedman MJ, eds. *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford Press, 2000;139–155,333–335.

111. Renfrey G, Spates CR. Eye movement desensitization: A partial dismantling study. *J Behav Ther Exp Psychiatry.* 1994;25:231–239.

112. Vaughn K, Armstron MS, Gold RS, et al. A trial of eye movement desensitization compared to image habituation training and applied muscle relaxation in posttraumatic stress disorder. *J Behav Ther Exp Psychiatry.* 1994;25: 283–291.

113. Carlson JG, Chemtob CM, Rusnak K, Hedlund, NL, Muraoka MY. Eye movement desensitization and reprocessing (EMDR) treatment for combat-related posttraumatic stress disorder. *J Trauma Stress.* 1998;11:3–24.

114. Van Etten ML, Taylor S. Comparative efficacy of treatments for posttraumatic stress disorder: a meta-analysis. *Journal of Clinical Psychology and Psychotherapy.* 1998;5: 126–144.

115. Wilson S, Becker L, Tinker R. Fifteen-month follow-up of eye movement desensitization and reprocessing (EMDR) treatment for posttraumatic stress disorder and psychological trauma. *J Consult Clin Psychol.* 1997;65:1047–1056.

116. Foa EB, Keane TM, Friedman MJ, eds. *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford. 2000.

References

117. McDonagh-Coyle A, McHugo GJ, Friedman MJ, et al. *Cognitive Restructuring and Exposure Treatment for CSA Survivors with PTSD.* Paper presented at: 16th Annual Meeting of the International Society for Traumatic Stress Studies; November, 2000; San Antonio, TX.

118. Jaycox LH, Foa EB, Morral AR. Influence of emotional engagement and habituation on exposure therapy for PTSD. *J Consult Clin Psychol.* 1998;66:185–192.

119. Pitman RK, Altman B, Greenwald E, et al. Psychiatric complications during flooding therapy for posttraumatic stress disorder. *J Clin Psychiatry.* 1991;52:17–20.

120. Chemtob CM, Novaco RW, Hamada RS, Gross DM. Cognitive-behavioral treatment for severe anger in posttraumatic stress disorder. *J Consult Clin Psychol.* 1997;65:184–189.

121. Chemtob CM, Novaco RW, Hamada RS, Gross DM, Smith G. Anger regulation deficits in combat-related PTSD. *J Trauma Stress.* 1997;10:17–36.

122. Foa Eb, Hearst-Ikeda D, Perry KJ. Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault vicitms. *J Consult Clin Psychol.* 1995;63:948–955.

123. Cloitre M, Koenan K, Cohen L, Han H. *Skills Training in Affective and Interpersonal Regulation Followed by Exposure: A Phase-Based Treatment for PTSD Related to Childhood Abuse.* Paper presented at: 16th Annual Meeting of the International Society for Traumatic Stress Studies; November, 2000; San Antonio, TX.

124. Ehlers A, Clark D, Dunmore E, Jaycox L, Meadows E, Foa EB. Predicting response to exposure treatment in PTSD: The role of mental defeat and alienation. *J Trauma Stress.* 1998;11:457–471.

125. Kubany ES, Abueg FR, Brennan JM, Owens JA, Kaplan A, Watson. Initial examination of a multidimensional model of trauma-related guilt: Applications to combat veterans and battered women. *J Psychopathol Behav Assessments.* 1995;17:253–258.

126. Albini TK, Pease TE. Normal and pathological dissociations of early childhood. *Dissociation.* 1989;2:144–150.

127. Putnam FP. Dissociation as a response to extreme trauma. In: Kluft RP, ed. *Childhood Antecedents of Multiple Personality Disorder.* Washington, DC: American Psychiatric Association Press; 1985; (pp. 66–97).

128. Coe MT, Dalenberg CJ, Aransky KM, Reto CS. Adult attachment style, reported childhood violence history and types of dissociative experiences. *Dissociation.* 1995;8:142–154.

129. Putnam FW. Pierre Janet and modern views of dissociation. *J Traumatic Stress.* 1989;2:413–429.

130. Kluft RP. The initial stages of psychotherapy in the treatment of multiple personality disorder patients. *Dissociation.* 1993;6:145–161.

131. Silberg JL. Fifteen years of dissociation in maltreated children: Where do we go from here? *Child Maltreatment.* 2000;5:119–136.

132. Kluft RP. The treatment of dissociative disorder patients: An overview of discoveries, successes, and failures. *Dissociation.* 1995;6:87–101.

133. van der Kolk BA. The body keeps the score. In: van der Kolk BA, McFarlane A, Weisaeth L, eds. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press; 1996;214–241.

134. Tasman A, Riba M, Silk K. *The doctor-patient relationship in pharmacotherapy: Improving treatment effectiveness.* New York: Guilford Press: 2000.

135. Friedman MJ. Current and future drug treatment for posttraumatic stress disorder patients. *Psychiatric Annals.* 1998;28:461–468.

136. Marshall RD, Stein DJ, Leibowitz MR, Yehuda R. A pharmacotherapy algorithm in the treatment of posttraumatic stress disorder. *Psychiatric Annals.* 1996;26:217–226.

137. Sutherland SM, Davidson JRT. Pharmacotherapy for posttraumatic stress disorder. *Psychiatric Clin N Am.* 1994;17:449–480.

138. Kavoussi RJ, Coccaro EM. Divalproex sodium for impulsive aggressive behavior in patients with personality disorder. *J Clin Psychiatry.* 1998;59:676–680.

139. Jacobsen FM. Low-dose valproate: A new treatment for cyclothymia, mild rapid cycling disorders, and premenstrual syndrome. *J Clin Psychiatry.* 1993;54(6):229–234.

76. **The recovery process in DESNOS is conceptualized as entailing all of the following phases, *except*:**

    A. Stabilization.

    B. Processing and grieving of traumatic memories.

    C. Constructing a plan of revenge against victimizers.

    D. Reconnection/reintegration with the world.

77. **Which one of the following statements is correct?**

    A. In the first phase of psychological treatment, stabilization, the trauma(s) should be the main focus of therapy, not such issues as trust, safety, self-soothing or building support networks.

    B. Van der Kolk noted that trauma is often registered in the body as unspeakable terror, and the processing of traumatic experiences can allow individuals to put their experiences into words, thus robbing them of their disruptive, often somatically-based power.

    C. Exposure-based treatments, such as *Prolonged Exposure*, *Stress Inoculation Training*, and *Cognitive Processing Therapy* are highly effective for PTSD, but too simplistic for the treatment of DESNOS.

    D. Those patients who come to see a social as well as personal dimension of their traumatic experiences and make them the basis for social concern and action with others are the least likely to ever resolve their own problems and tend to remain symptomatic for years.

78. **Which one of the following statements is correct?**

    A. DESNOS patients treated with antidepressants alone are much more likely to improve and stay well than those who receive any kind of psychological therapy, with or without medication.

    B. If at all possible, it is best never to give any psychopharmacologic agents to DESNOS patients because this is so often misinterpreted by them as another form of victimization.

    C. The medications which have been most extensively studied and found highly effective in DESNOS are stimulants like methylphenidate.

    D. Extrapolating from medication studies in patients with PTSD, the SSRIs appear to be the most desirable agents to use to manage affect dysregulation, reexperiencing, avoidance, hyperarousal, and depression in DESNOS patients.