# Changing Diagnostic Landscapes in Trauma and PTSD: Recognition and Re-Association in the Recalibration of the Traumatized Mind.

**Presented by**

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As the end of the Second World War approached, Franklin D. Roosevelt declared,

“If civilization is to survive, we must cultivate the science of human relationships – the ability of all peoples, of all kinds, to live together, in the same world at peace”

(Deacon, 1945)

# Communicative Exchange, Psychotherapy and the Resonant Self

## Roads to Realization

Anthony Korner

# Trauma and Science: uncomfortable bedfellows?

- The objective perspective is the hallmark of the scientific perspective
- The psyche involves meaning / value / the sense of significance / ongoing integration of experience
- The DSM classification self-consciously moved towards value-free definition in terms of symptoms and behaviours in defining syndromes
- Value-free definition of diseases and disorders has had great value in modifying ideas of illness as due to moral failings or malign external factors
- If something not included in a system of classification, inevitably something that is represented will be found by the clinician
- Trauma is an inherently meaningful term in relation to individual-environment interaction
- It implies a story

# Trauma blindness: “keeping it clean”

Whilst, “we can… identify the metaphorical strategies the clinics use to understand and relate to these (unassimilable) experiences (medicalize, technologize or scientize them)”, this doesn’t necessarily constitute psychological understanding.” (Cammell, 2016; in, Korner, 2021, p.179)

- It’s natural to avoid trauma as far as possible
- This often involves looking the other way
- The ‘3 monkeys’ syndrome
- Interpersonally, failures of recognition and resonance
- Clinically, powerlessness to ‘fix’ may lead to bias towards ‘not seeing’
- The problem of ‘vehement’ emotions
- The scale of the problem

# Historical Perspective

- 1890s: Freud's seduction theory (a trauma theory)
- Recanted in favour of model of unconscious fantasy and drive as primary motivators (*intrapsychic* model)
- Janet: contemporaneous theory of trauma-related dissociation
- "Shell shock"; "combat fatigue"
- Kaplan & Sadock c. 1970 – incest seen as extremely rare *(Van der Kolk, BKTS)*
- DSM III (1980): PTSD
- Herman c.1990 – *Trauma and Recovery*
- Intersubjective and Interpersonal / relational perspectives gain prominence in psychoanalytic community (feeling as a marker of relational experience)
- Increased public awareness – e.g. *Royal Commission into Institutional Abuse*
- Prominence of consumer voices / organizations w.r.t. health policy – *Blue Knot Foundation*

# Resistance to PTSD

- Within Military Services, endemic culture of mental disorder as weakness
- Priority towards getting soldiers back to the front
- Recognition that many with PTSD also had traumatic backgrounds and comorbidities
- Preference in identifying problems within the individual – inherent in classification systems
- Concerns about cost and liability

# Trauma- and Stressor-Related Disorders DSM 5

- DSM-5 – first edition to have a chapter devoted to “Trauma- and Stressor-Related Disorders (located between ‘Anxiety Disorders’ and ‘Dissociative Disorders’)
- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Posttraumatic Stress Disorder – Criterion A broader – includes not only direct experience but witnessing and events that occur to significant others as well as occupational related exposure (still highlights exposure to actual or threatened death, serious injury or sexual violence). Other criteria cover re-experiencing, avoidance, hyperarousal, with or without dissociation, duration > 1 month (doesn’t cover ongoing relational / early developmental trauma)
- Acute Stress Disorder
- Adjustment Disorders
- Other Specified Trauma- and Stressor-Related Disorders (includes AD with delayed onset; Persistent complex bereavement disorder)
- Unspecified Trauma- and Stressor-Related Disorders

# Trauma-linked Disorders DSM 5

- Dissociative Disorders
- Dissociative Identity Disorder
- Anxiety Disorders
- Borderline Personality Disorder (despite weight of evidence, little emphasis on developmental trauma in DSM 5 for BPD or other PD diagnoses)
- Other Personality Disorders
- Substance Abuse Disorders
- Eating Disorders
- Depressive Disorders ?

(link not emphasized in DSM 5 although *'adverse childhood experiences, particularly when there are multiple experiences of diverse types, constitute a set of potent risk factors for major depression'*)

- Psychotic Disorders ? ….,etc

# PTSD with Dissociative Symptoms (Dissociative Subtype)

Specify whether:
With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g. complex partial seizures).

# Complex Post-Traumatic Stress Disorder

**(NOW A HARD-WON DIAGNOSIS;** into effect 1st January 2022):

*`Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that is experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse)'.*

WHO releases new International Classification of Diseases (ICD 11) 18 June 2018 News Release Geneva

http://www.who.int/news-room/detail/18-06-2018-who-releases-new-international-classificationof-diseases-(icd-11)

**slide adapted from Dr Pam Stavropoulos, Blue Knot Foundation*

# Dissociation: Definition

*"a disruption of and/or discontinuity in the normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior. Dissociative symptoms can potentially disrupt every area of psychological functioning."* (DSM 5 2013)

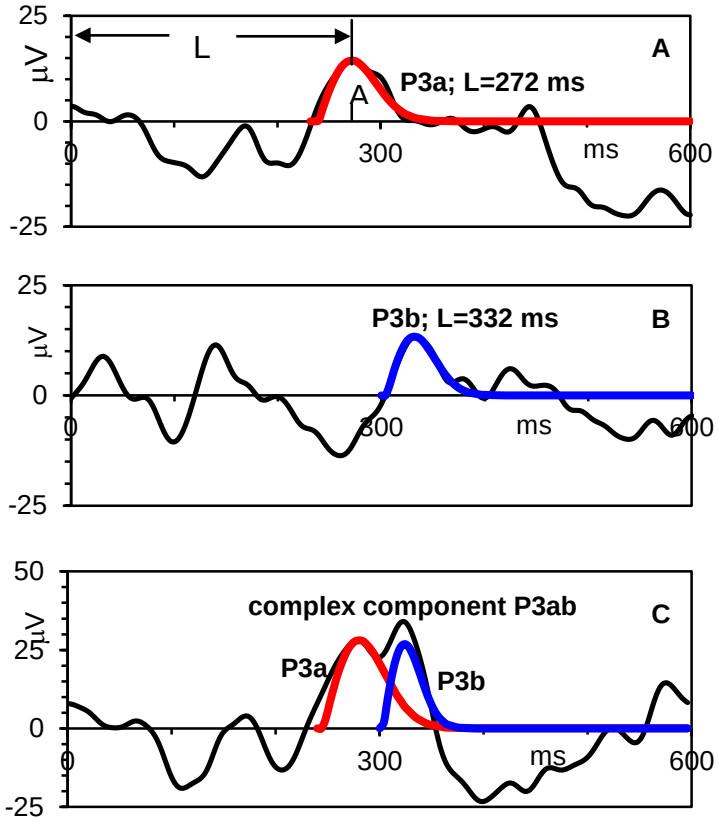
*"involuntary disruption or discontinuity in the normal integration of one or more of the following: identity, sensations, perceptions, affects, thoughts, memories, control over bodily movements, or behaviour."* (ICD 11, 2018)

- Loss of integration – loss of sense of meaning, coherence, continuity….story!

# The Problem of Dissociation: dealing with what isn't there

- Humans have evolved towards social engagement (Porges, 2011); "Being present" to others / environment reflects a high level of consciousness (Janet)
- Language also required for highest levels of consciousness (Edelman & Tononi, 2000)
- First 'language' – feeling and emotional expression….needs to be integrated with acquired mother tongue – the work of a lifetime
- Primary Dissociation – "fragmentation or a disintegration of the sense of personal existing" (Meares, 2012, p. 153) – resolved by hypo- or hyper- arousal
- Secondary Dissociation – "arises out of primary dissociation… A sequestration of a complex of psychic life now occurs. This compartmentalization is achieved by neuroinhibitory mechanisms …to reduce the high arousal characteristic of primary dissociation" (ibid) – an overall state change (derealization / depersonalization) – detachment / "negative" dissociative symptoms or sequestration, relating to "positive" dissociative symptoms
- Tertiary Dissociation – "…might be understood as more or less chronic state of secondary dissociation" (ibid, p. 155)

# Dissociation & BPD (Meares, Melkonyan, Schore, 2012)




- Increased in BPD
- P3b related to capacity to sustain attention
- Decreased in BPD
- Separation of P3a and P3b in BPD
- P3a related to ‘orienting response’ (disposition of attention)
- Associated with failure of habituation
- ? A marker of ‘disintegration’ / disintegrative tendency

# Lived Experience

- Consumers don’t just want symptoms to be defined but also want an understanding of how they arose – don’t just ask ‘what’s wrong’ – rather ‘what happened to get me to this point’
- Strengths focus
- Spirituality
- Cultural context
- The seeking system (part of our biology)
- Sense of purpose
- ‘Coming out’ phenomenon
- Need for recognition

# Early Trauma

*“Rape and being eaten by cannibals, these are mere bagatelles as compared with violation of the self’s core, the alteration of the self’s central elements by communication seeping through the defences….this is a sin against the self.”* *D.W. Winnicott, 1965; in Abram, 2021*

A child is born, the product of an abusive relationship between a stepfather and his adolescent stepdaughter. This adult male wants to kill the child at birth. The mother/stepdaughter pleas for the child to be spared, shielding the infant. The child lives but the abuse continues. The infant’s mother escapes the home, leaving the child in the care of her mother and her abusive partner. Sadistic punishments for the child’s ongoing bedwetting persist over years…

In early trauma, the mind is born into darkness and pain, the infant struggles to adapt.

# The Traumatic-Dissociative Dimension (Farina, et al, 2019)

- "…traumatic attachments during the early years of life are associated to specific psychopathological vulnerabilities based on dissociative pathogenic processes… … may contribute to the genesis of well-defined mental disorders or may variably occur in many other diagnostic categories, complicating their clinical pictures and worsening their prognosis."
- This is best thought of as the "Traumatic-Dissociative Dimension" in clinical presentations
- "Even if emotional, physical and sexual abuse constitute typical forms of developmental traumatization, **neglect** constitutes the major form of developmental trauma"
- When involving ongoing relational trauma, there is a cumulative burden of trauma – Cumulative Developmental Trauma underpins a large range of clinical presentations and disorders
- Disorganized attachment (DA) associated with "disaggregation of the infant's developing mental functions"
- Paradoxical position of parent being "at the same time the source of, and the solution to, the child's fear …represents …inescapable threat….in the face of which the child is powerless"

# The Traumatic-Dissociative Dimension 2 (Farina, et al, 2019)

- DA not a validated individual-level clinical diagnosis (not a stable feature of the child) but rather "relationship specific". Therefore "**attachment trauma**" preferred.
- Chronic stress response interferes with brain development (sympathetically mediated)
- Inescapable threat created by "simultaneous and conflicting activation of attachment and survival defence systems triggers an autonomic parasympathetic response"
- Simultaneous tendencies to get close and to flee **can't be assimilated into the same framework of meaning** – no possibility of single synthesis.
- Leads to the construction of incompatible and incoherent Internal Working Models (IWM) – loss of overall coordination of mental and relational function
- "…affect dysregulation, relationship disturbances, and disturbances in a system of meaning… are core symptoms of complex PTSD that are always present".
- Early trauma makes establishment of safety / trust in the therapeutic relationship more difficult

# The Inevitability of Comorbidity

*"Persons who experienced four or more categories of childhood exposure, compared to those who experienced none, had a 4- to 12-fold increases for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4- fold increase in smoking, poor self-rated health, > 50 sexual intercourse partners, and sexually transmitted disease…"*

*"The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease."* *Felitti et al, 1998*

- 'Hidden epidemic'
- Failure of integration implies global dysfunction
- Loss of higher function
- Decreased participation
- Disruption of 'worldview'

# Traumatic Stories

No Story: *I was working as a young doctor, in a country with limited medical facilities, on a paediatric ward. A young girl was there perched on her bed, unmoving with wide eyes. She was nearly five, although only had the weight and size of an infant of 15 months. She had arrived without a name. The nurses gave her one. She sat upright with a vacant stare. There were nurses trying to engage her, to talk to her, to cajole her but there was no response. She wouldn't take food. It was too late they said. They had seen it before. There wasn't any specific illness that could be found. She was malnourished of course but nothing else. She sat hour after hour. Not sleeping much. Not really awake. Some sort of limbo. Staring, no word, no language, no response, no self at all, or so it seemed. After about 16 weeks she disappeared in the night. The next day it was said that she died at night, alone. It was a life that never happened. No family, no traces left. Her stare looks through me still. I don't remember her name.*

The Script: In adapting to a situation of traumatic relatedness the most effective response is to restrict activity and consciousness to a very limited scope, a set of invariant organizing principles based upon acceptance of the impinging script. There is little story other than adaptation to others. Transformations won't be possible on the basis of instruction as this involves repetition of the old pattern.

The Chronicle: Under chronic stress, psychological isolation a common outcome. In these circumstances the child is left feeling everything is up to them, that existence is only possible if effort and activity are maintained. The patient's language is likely to be reflected in chronicles involving recitations of events and facts without the colour of personal experience.

# Re-Association (Trauma-informed psychotherapy)

- Awareness of the many forms of dissociation and their relation to trauma
- Recognition of suffering in the service of an embryonic self (core of value)
- Working with dissociation – grounding, relaxation, ‘safe place’ imagery, working on connection
- Responding to ‘that which is most alive’ – gradual growth in associations within the therapeutic relationship (first) and within the patient.
- Working on the patient’s agenda
- Developmental deficit – complex trauma – need for experience in the ‘zone of proximal development’
- Respect for adaptations
- Activation of the “Seeking system” (Panksepp)
- “Post-Traumatic Growth”: ‘positive psychological change resulting from struggle with highly challenging / stressful / traumatic life circumstances; experience of improvement deeply meaningful / not simply a return to how things were before period of suffering’

# Allostasis

*"…self, which is private, grows in the public domain"* (Meares, 2005, p.3)

*"I can only find myself in and between me and my fellows in a human conversation"* (Hobson, 1985)

We are an inherently social species. Mutual regulation through communication occurs throughout life.

A social species is one "where animals regulate one another's fundamental physiological processes", also know as **allostasis** (Atzil et al., 2018). Allostasis accounts for change in response to the environment in the service of balance and stability. For humans, with prolonged dependency and continuing reliance on social networks throughout life, it is an important property over the lifespan.

(from Korner, 2021)

# An integrated response to comorbidity

- From the patient's perspective "one condition" rather than many
- Identification of symptom clusters that may benefit from specific interventions: mood, sleep, intrusive / re-experiencing phenomena, affect dysregulation, nightmares, etc
- Ideally multidisciplinary team, with psychotherapist in a central role
- Pharmacological interventions to target specific symptom clusters as per general psychiatric practice
- Validation of experience
- Co-creating a sense of purpose and future
- Language as an instrument of connection, association and growth, facilitation / creation of the self-story

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