Chapter Four

C-PTSD

Complex Post Traumatic Stress Disorder

(and unstable attachment)

Complex post-traumatic stress disorder (**C-PTSD**; also known as **complex** trauma disorder) is a psychological disorder that can develop in response to prolonged, repeated experience of interpersonal trauma in a context in which the individual has little or no chance of escape.

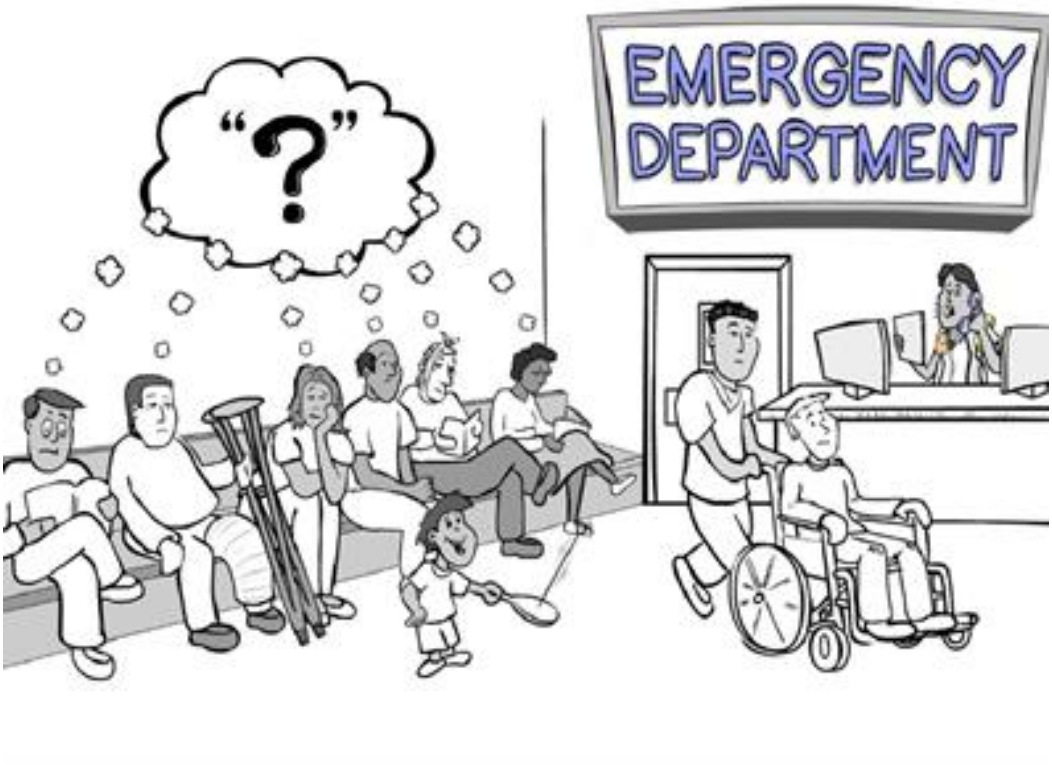
Many traumatic events (e.g., car accidents, natural disasters, etc.) are of time-limited duration. However, in some cases people experience chronic trauma that continues or repeats for months or years at a time. Some have suggested that the current PTSD diagnosis does not fully capture the severe psychological harm that occurs with prolonged, repeated trauma. Treatment considerations for those with such complex trauma histories are reviewed.

History of Complex PTSD Diagnosis

In 1988, Dr. Judith Herman of Harvard University suggested that a new diagnosis, Complex PTSD, was needed to describe and understand the indicators of long-term trauma. Differences from single event trauma include:

- Behavioural difficulties (e.g. impulsivity, aggressiveness, sexual acting out, alcohol/drug misuse and self-destructive behaviour)
- Emotional difficulties (e.g. affect lability, rage, depression and panic)
- Cognitive difficulties (e.g. dissociation and pathological changes in personal identity)
- Interpersonal difficulties (e.g. chaotic personal relationships)
- Somatization (resulting in many visits to medical practitioners)

Longer term or repeated trauma, including negligence and abandonment (as seen on the right) are probably, by now, more common than single incident trauma. Any prolonged restriction or pressure (like COVID-19) can be causative. One form we too frequently see in our practice are (especially) women who have taken emotional symptoms to their doctor, who quickly (but prolongingly) puts them on antidepressants, which temporarily cover up underlying C-PTSD, only to be discovered years later when the antidepressant no longer works. Criminal!



C-PTSD patients often present at *Emergency Departments,* as they often have somatic symptoms they can't cope with - symptoms which other people would take in stride.

Migraine can be one. Its not so much that the patient goes to the ER, rather that they go very often and with varying symptoms. There are, in Ottawa, 452 known ER "abusers." We may think of them as sad cases, but some hospitals have special classes for frequent users, to provide them with skills so that they can handle their own "somatization." There is a questionnaire called the ACES study, which identifies childhood traumatizing situations, While it isn't absolutely indicative of PTSD, it can give insight into what is going on underneath their need for excessive attention. This need for attention can happen in therapy groups as well.

About 60-70% of patients who come or are sent to our programs will have **TAS-20 scores** higher than 100. While there are other reasons than PTST it's a good bet that someone who scores that high has alexithymia and won't progress until the are over it. We have **emWave2**.

Our program is not set up to solve problems, like say, *Interpersonal Therapy* might. We deal with more serious, intransigent and refractory-to-treatment cases, But if you have C-PTSD the tendency is to want relief at every step along the way. You aren't prone to learning to cope. I have a cartoon video here that explains this . You may want to **show ii to some people.**

Here are the **ACES study** questions…

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
2. No___If Yes, enter 1__
3. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
4. No___If Yes, enter 1__
5. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
6. No___If Yes, enter 1__
7. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

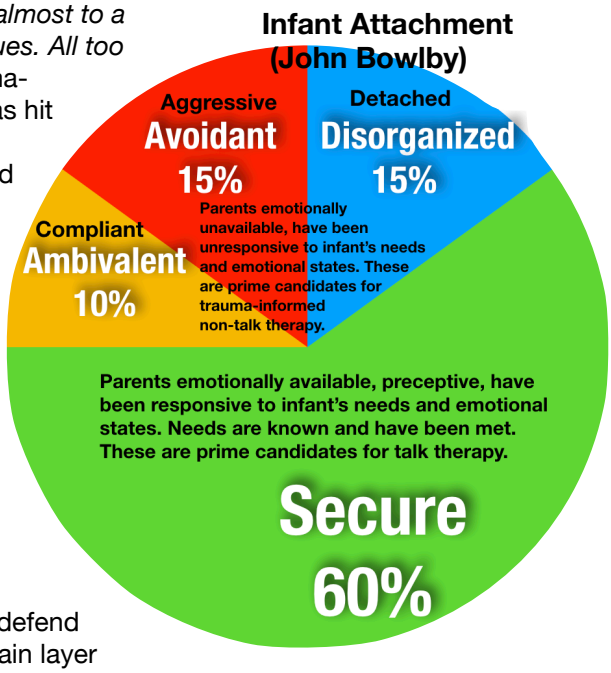
8. No___If Yes, enter 1__
9. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
10. No___If Yes, enter 1__
11. Were your parents ever separated or divorced?
12. No___If Yes, enter 1__
13. Was your mother or stepmother:
14. Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
15. No___If Yes, enter 1__
16. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
17. No___If Yes, enter 1__
18. Was a household member depressed or mentally ill, or did a household member attempt suicide? No___If Yes, enter 1__
19. Did a household member go to prison?
20. No___If Yes, enter 1__

Now add up your "Yes" answers: _ This is your ACE Score

And here's **some perspective** on applying the questionnaire. Remember scores do not have a direct correlation with C-PTSD. The score, however, just may create "an index of suspicion."

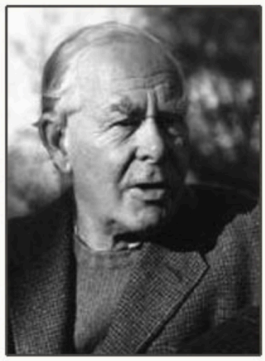
Unstable Attachment (the background of much C-PTSD

Acquired Defencelessness *Those who don't benefit from talk therapy often test as alexithymic (oblivious to their own and others' feelings), overlapping almost to a person with those who have had Bowlby's childhood attachment issues. All too many develop Complex-PTSD, necessitating treatment with a "*trauma-informed approach*."* Early life (or, less frequently, later life) trauma has hit them "below the belt" where talking things through either had not developed yet, or, if later, overwhelmed them beyond what they could handle. Some of them were traumatized verbally, physically or sexually before coming upon any way at their childhood level of development, of talking themselves out of it at the time or through it afterwards. More about this below.



Add to this that all children had, to a person, by age 6 months, learned to cope with *helplessness* by developing primitive *object relation triads*- a reactive use of knee jerk emotional reactions as a default response to stress. This helped during infancy, but without unravelling the underlying problem - just coping with it. We hadn't learned to speak by this time, so our defences sprung from the more primitive brain layers where speech is absent.

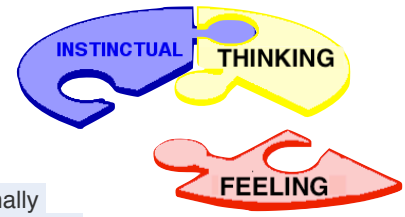
Traumatized subjects, left with only reflex fear or anger, ineffectively defend themselves, using their limbic brain (the mammalian development brain layer which adds discerning the feelings of others) and the brainstem (the primitive brain which in all animal including humans, adds "fight or flight.") Traumatized people reflexly feel fear or anger, or a combination of both, via a chemical pathway which produces them over and over when triggered. In other words, we can say that they become addicted to their responses, even to the extent of altering their brain's response to μ-opioid receptors as occurs in Borderline Personality Disorder.



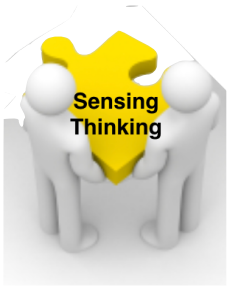
One of Bowlby's most famous statements, "The infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment" - Bowlby, 1951. *(As far as I know, photo is public domain)*

Bowlby's attachment theory *(see pie chart last page)*

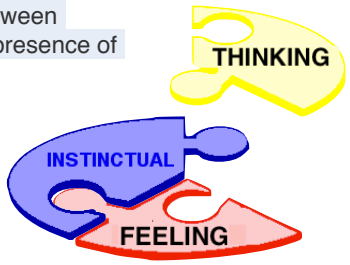
Secure attachment (55-65% in non-clinical populations)[1] In the Strange Situation (SS[2]), the infants used the mom as a secure base from which to explore. The infants noticed when mom left the room and protested. When mother returned, the infant went straight to the mother to be held, was easily reassured, and quickly returned to play. In the home, these parents were emotionally available, perceptive, and responsive to infant's needs and mental states. The internal working model of these infants is likely to be one that expects that their needs will be known and met, that they will be attuned to and emotionally regulated, and that they can freely explore their environment in safety. *(the placement of personality models below is mine)*



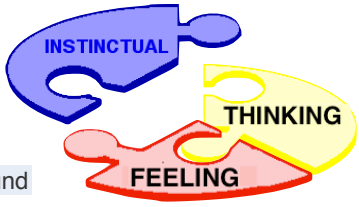
Avoidant attachment (20-30% in low risk samples) In the SS, the infants did not use the mom much as a secure base from which to explore. When the mother began to leave the room, the infant might move toward her, but often did not. When the mother returned, the infant acted like she was not even there and just continued playing. In the home, these parents were seen to be emotionally unavailable, imperceptive, unresponsive, and rejecting. Some were responsive in many non-emotional interactions, but were very dismissive and non-responsive when the infant was emotionally needy, frustrated, or angry. These infants often expressed random aggression, and were more clingy and demanding in the home then securely attached infants. The internal working model is likely, "mom does not respond to my emotions, especially when I am needy or angry, so I will shut down my needs and try to become independent." The infants then protect themselves from this difficult situation by dissociating from contact with their normal need for connection, and repress their emotions more generally. This is a "deactivating" strategy with respect to attachment.



Ambivalent attachment (5-15% of low risk samples) In the SS, these infants were more alert of the whereabouts of mother while playing. They were very upset when she left the room, immediately went to her upon return and got very clingy. Their behaviour upon reunion alternated between outbursts of anger and going limp, and in either case the infant was not soothed by the presence of the caregiver even if the mother was seen to be caring and emotionally available. In these homes, the mother was inconsistently available for the infant, and when she was available she was often pre-occupied and un-attuned to the infant in her responses. These infants were the most anxious, clingy, and demanding at home. The likely internal working model here is "even if mom is available physically, she will likely not be able to soothe me." These infants respond by "over-activating" their attachment system.



Disorganized attachment (20-40% in non-clinical populations?? And up to 80% in situations of abuse. This is not used as a primary classification, but rather an additional descriptor.) This was not an original classification in the SS, but later studies showed some infants who got disorganized when their mothers left the room, and also expressed disorganized patterns of behaviour on return (move towards mother, then away; freeze; go into a corner). They were not soothed if they made contact with the mother. The homes of these infants often had physical or sexual abuse histories, psychologically disturbed parents, and/or parents with substance abuse. Their inner working model of this relationship is not functional, and is one where the "supposed" source of soothing is also the source of danger — a situation of "fright without solution" — leaving their mind to exist in disorganized way. If the begins to sound a bit like *Borderline Personality Disorder* - it can be. Even then, **it can be corrected.**



[1] Forms of Attachment http://www.essentialparenting.com/2010/05/22/the-forms-of-attachment/

[2] testing attachment in infants and their mothers is done by watching how the infant responds to what us called the Strange Situation. The mother leaves the room, with a surrogate in her place. The baby is observe during her absence and when she returns. The way the baby relates to her allows a "diagnosis" of attachment typing.