TREATING PSYCHOLOGICAL TRAUMA AND PTSD

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A Holistic, Organismic Approach to Healing Trauma and PTSD

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> Healing from trauma requires a reverence for life. Reverence requires a state of meditative reflection on life's goodness. Meditative reverence is a consciousness of ultimate being and daily presence. Transformation of trauma is spiritual reverence. Spiritual reverence is the embodiment of soul and the sanctity of life.
>
> —JOHN. P. WILSON (2000)

The considerations concerning the psychological treatments for posttraumatic stress syndromes (PTSS) are complex and multidimensional in nature. The treatment of posttraumatic stress disorder (PTSD) involves contact with forces that inflict psychological injury and attack the human spirit and efforts to remain psychically whole. In the day-to-day reality of the clinical practitioner, the basic needs, anxieties, pain, anger, depression, and life conflicts of the trauma client are paramount. With few exceptions, their levels of psychological distress are undeniably evident and reflect internal struggles to come to grips with what happened to them in trauma. In the most basic sense, clinical intervention centers around the question of how to be most helpful to ameliorate distressing symptoms in posttraumatic psychological states.

What forms of support, counseling, psychotherapy, or human relatedness will be effective in assisting traumatized individuals in processing and integrating what has happened to them in the aftermath of a traumatic life event? How do they come to an emotional and spiritual understanding of what being a survivor means? How do they overcome the profound and often long-lasting effects of traumatization? What are the pathways to healing? What treatments exist for PTSD? How will clients become integrated in their

spirits? What treatments will empower their capacity to once again function optimally with a joy and reverence for life? How will patients discover their own pathways to healing?

It is clear and beyond doubt that there are many crucial issues which confront those who choose to engage in posttraumatic therapies (Friedman, 2000; Ochberg, 1993; Herman, 1992; Wilson & Lindy, 1994; Foa, Keane, & Friedman, 2000). There is nothing easy in the work, although through it therapists may deepen their insight into themselves as persons and their wisdom as healers. It must be recognized that therapeutic recovery from PTSD is a complex interactive process between the therapist and the client during which both struggle together to find pathways to healing. Traumatic events may fracture a person's sense of wholeness and his or her willingness to persevere and go on with life. In that regard, there are no well-defined "road maps" that reveal the direction the therapist and client must pursue together in order to find the place of peace, restoration of vitality, psychological integration, and mental health. The therapist and the client walk a jointly created path to find ways that will enable the transformation of trauma.

Now, at the dawn of the 21st century, as we discussed in Chapter 1, we can see more clearly the legacy of trauma in the past century: massive global conflicts, both "hot" and "cold," including catastrophic wars, threats of nuclear annihilation, genocidal massacres (now called "ethnic cleansings"), major technological disasters, escalating terrorist assaults and reprisals, and other horrors have challenged the human spirit worldwide in ways that defy comprehension. Nevertheless, a retrospective look is important so that we never forget the magnitude of devastation that has been wrought by humankind. Yet, as malevolent as humanity has sometimes been through acts of utter cruelty and extreme violence, we also can see that a *counterforce* exists among us to promote healing, self-actualization, states of well-being, and psychic integration.

The process of understanding the way that the core treatment approaches work to ameliorate PTSD is a scientific effort which is establishing workable parameters to assist victims of trauma. As an empirical process, it is moving us closer, step by step, to the integration of theory, the creation of practice standards, and the coordination of scientific studies (e.g., clinical outcome trials), which ultimately will enhance the data-base on forms of organismic modes of recovery and healing (Friedman, 2000). Our goal in this chapter is to present a holistic, organismic approach to healing trauma and PTSD.

TOWARD NEW CONCEPTUAL PARADIGMS OF PTSD: INTRAPSYCHIC DYNAMICS

The scientific understanding of PTSD has evolved steadily during the 20th century, with a notably rapid acceleration of progress in research in the

1980s and especially in the 1990s (Friedman, 2000; Foa et al., 2000; Wilson & Keane, 1997; Raphael & Wilson, 2000; Wilson & Raphael, 1993). Such progress was inevitable once mental health scientists and clinicians began to focus on ways to assess the impact of catastrophic wars, natural disasters, acts of domestic violence, and other types of trauma that resulted in needs for crisis interventions, health care programs, counseling innovations, psychotherapy, social policy programs, and research studies. *Traumatic events tax human coping abilities and produce acute, chronic, delayed, and complex forms of PTSD.* Traumatic stress syndromes encompass but are not limited to psychiatric definitions of PTSD and its most common sequelae, such as major depression and alcohol abuse and generalized anxiety (Breslau, 1999). Posttraumatic change in psychosocial functioning also occurs and includes altered ego states and a shift in life-course developmental trajectories.

PTSD is a multidimensional construct of stress response syndromes. In a dynamic psychobiological sense, PTSD consists of many subsystems that interact in complex ways which are manifest in affective reactions, altered ego states, and fluctuating psychological phenomena (Green, Wilson, & Lindy, 1985; van der Kolk & Sapporta, 1993). The symptoms reflect the level of pain. Trauma impacts the psychic core—the very soul—of the survivor and generates a search for meaning as to why the event had to happen. A state of "dispiritedness" may cause a profound questioning of existence and force belief systems to change (Wilson & Moran, 1997). The alteration of psychoformative processes may lead to a decentering of the self, a loss of groundedness and of a sense of sameness and continuity (Lifton, 1976, 1979, 1993; Erikson, 1968; Putnam, 1997). In extreme cases, a radical discontinuity may occur in ego identity, leaving scars to the inner agency of the psyche (Watkins & Watkins, 1997; Krystal, 1968, Spiegel, 1994; Steinberg, 1997). Fragmentation of ego identity has consequences for psychological stability, well-being, and psychic integration, resulting in a proneness to dissociation (van der Kolk, McFarlane, & Weisaeth, 1996). In many cases of PTSD, the fragmentation of ego identity is a fracturing of the soul and spirit of the person (Lifton, 1979; Wilson & Lindy, 1994). As noted by Krystal (1968) and Lifton (1979), such a "broken connection" in an individul's existential sense of meaning may be a precursor to major depression, psychological surrender, and, in extreme cases, suicidality and death.

We clinicians undertaking therapeutic approaches to PTSD need to recognize that it is not a static psychopathological entity or quantity (Green, Wilson, & Lindy, 1985; Wang, Wilson, & Mason, 1996). Rather, like the changing colors of a kaleidoscope, its form, structure, and "flow" vary according to the principles associated with stress response interactions within the brain. For this reason, the clinical presentations of traumatized clients may vary significantly. Levels of severity of the condition can range from mild to disabling. There may be marked differences in degrees of traumatic impact on adaptive functioning in areas of psychosocial behavior. Diverse

life-span and developmental effects may be produced by traumatic stressors (e.g., depending on the age, level of ego strength). The patterning of posttraumatic effects may range from relatively slight to profound consequences for psychological well-being and the degree of efficacy in coping at different epigenetic stages in the life cycle (Erikson, 1968; Wilson, 1980; Wilson, Harel, & Kahana, 1988; Harel, Kahana, & Wilson, 1993). Complex forms of PTSD have also been recognized in the literature, dating from Freud's various discussions of traumatic neuroses (e.g., 1895, 1917, 1920) to Lifton's (1967) description of radical traumatization in Hiroshima survivors and to more recent accounts of interpersonal violence and abuse (Herman, 1992).

Clearly, then, treatment approaches for traumatic stress syndromes must recognize the diversity, complexity, and transformability of posttraumatic conditions. While most practitioners would agree on some general treatment principles, such as the need to reduce physiological hyperarousal, depressive states, and debilitating traumatic memories, the techniques and methods which demonstrate scientific standards of effectiveness for the treatment of PTSD in its complexity are less well established or agreed upon at the present time (Foa & Meadows, 1997; Foa et al., 2000). For example, what set of techniques is most useful for treating a person who is experiencing emotionally overwhelming visual flashbacks to a trauma scene? What if the client can only report fragments of the distressing, intrusive recollections, which have a depth of allusions to many other elements of the stressors that created the memories in the first place? At the other end of the continuum, what of cases in which patients have so sealed over traumatic memories that they are psychically numb, angry, or depressed and may have classic forms of denial, repression, resistance, and counterphobic behaviors? These three examples illustrate that the configuration of posttraumatic states may vary among many subdimensions depending on such factors as the following: (1) the context of the traumatic event and the person's role in it; (2) cognitive coping and appraisal styles (e.g., Lazarus & Folkman, 1984; Wilson, 1989); and (3) cultural and prior history "risk" or "resiliency" factors (Antonovsky, 1979; Flannery, 1992). *Nevertheless, it is the structural configuration of dynamic ego states in PTSD and similar conditions that commands the attention and therapeutic efforts of the clinician* (Watkins & Watkins, 1997).

TRAUMATIC STRESS AND ORGANISMIC FUNCTIONING

Figure 2.1 illustrates traumatic impacts on organismic functioning. The figure depicts complex forms of PTSD processes within the organism. As shown, the triad (△) of core PTSD symptoms (i.e., DSM-IV B, C, and D criteria) interact synergistically, impacting the dynamics of ego states, self-structure, and identity configuration. The structural configurations of trauma-

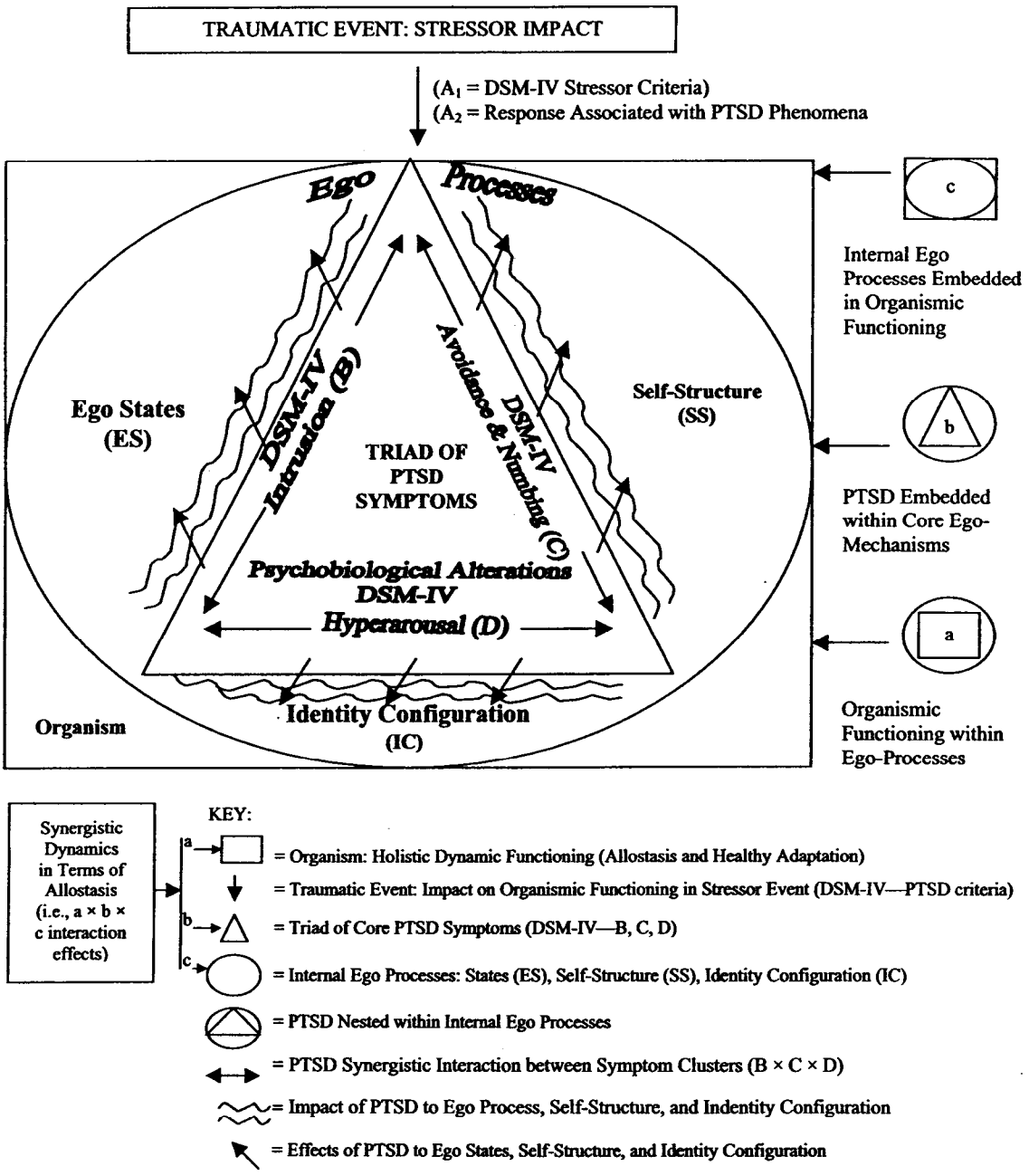

FIGURE 2.1. Traumatic impacts to organismic adaptations: PTSD, ego states, self-structure, and identity configuration.

tized ego states are epiphenomenal manifestations of the psychobiology of PTSD (i.e., allostasis). At the organismic level, posttraumatic adaptations include individual subjective responses and reaction patterns in terms of five interrelated psychological processes: (1) emotional regulation (i.e., affect modulation); (2) cognitive processes and information processing at different levels of conscious awareness (LCA); (3) motivational predispositions (i.e.,

need-based, goal-directed behaviors); (4) psychobiological processes; and (5) ego defenses, coping patterns, and the systems of belief, meaning, and spirituality.

We now consider the organismic model and conceptual nature of PTSD symptoms which constitute the structure of the disorder. Later in this volume, in Tables 3.2 to 3.6 of Chapter 3, Wilson identifies 80 specific objectives for the treatment of PTSD. In this chapter, we identify 65 separate PTSD symptoms within five clusters. Clearly, PTSD is a multidimensional phenomenon and the clinical symptoms which a client exhibits are products of psychobiological processes. While allostatic manifestations of PTSD take various forms and the configurations blend more than one type of behavioral adaptation, there *is* a core process in PTSD. Figure 2.1 represents the triadic relationship (△) of the core PTSD criteria and their relationship to ego states (ES), self-structure (SS), and identity configuration (IC). As illustrated in Figure 2.1 there is a dynamic interrelationship between the core PTSD processes and their impact on organismic functioning, especially on those internal processes which are intrapsychic in nature (i.e., ego states, memory, cognition, self-structure, and identity configuration). Figure 2.1 illustrates how a traumatic event impacts organismic functioning. The examination of the possible interrelations within the organism allow us to redefine and expand the core triad of symptoms presented in DSM-IV (American Psychiatric Association, 1994) to a more comprehensive set of symptoms (see Tables 2.1–2.5 and Figure 2.4).

TRAUMATIC IMPACTS ON ORGANISMIC ADAPTATIONS: PTSD AND EGO PROCESSES

Examination of Figure 2.1 reveals a model of how the core triad of PTSD symptoms impacts organismic functioning and ego processes. Inspection of the figure reveals three basic dimensions of psychological functioning: (1) the entire organism (□); (2) the triad of core PTSD symptoms per the DSM-IV criteria (△); (3) internal ego processes, including ego states (ES), self-structure (SS), and identity configuration (IC). The three dimensions depicted in the model interact synergistically in terms of allostatic processes. For convenience, each part has been identified with a lower case letter: *a*, organism; *b*, PTSD triad; and *c*, ego processes. Thus, synergistic dynamics involve all possible interaction effects among the dimensions (e.g., $a \times b \times c$, as depicted in Figure 2.1).

The model in Figure 2.1 also illustrates that the core triad of PTSD symptoms (△) impact ego processes in terms of ego states, self-structural dynamics, and the structure of identity configuration. In other words, PTSD symptom clusters can and do impact basic ego processes, cognition, information processing, memory, and ego-defensive operations within the organism. Moreover, Figure 2.1 illustrates that in terms of intrapsychic dynamics and

clinical presentation the following are possibilities: First, internal ego processes (*c*) embedded in organismic functions directly impact somatic and integrated biological–organismic system functioning (*a*). Second, the triad of PTSD symptoms is embedded within core ego processes (*b*). Therefore, the existence of PTSD symptoms deterministically influences ego processes, cognition, self-reference, ego identity, and the operation of ego-defensive mechanisms. Third, the organismic functioning (*a*) is intrinsically embedded in ego processes. Thus, the psychobiological processes of the organism are represented in ego states, ego processes, and elements of the self-structure, individual persona (i.e., mask of self-presentation), and the entire range of dynamics in personality processes (Aronoff & Wilson, 1985).

The model presented in Figure 2.1 is a rather oversimplified but useful way of thinking about "mind–body" phenomena, or (as we prefer to say) complex psychobiological interrelationships, in PTSD.

A HOLISTIC, ORGANISMIC MODEL OF PTSD PHENOMENOLOGY

Figure 2.2 presents a graphic illustration of the psychodynamic phenomenology of PTSD from a holistic perspective (Maslow, 1968, 1970; Wilson, 1989; Friedman, 2000). The model of PTSD is designed as a tetrahedral representation of the organism with five symmetries, the well-known mathematical representation of living systems (Hoagland, 1992; Mack, 1999). The tetrahedral model depicts organismic functioning in posttraumatic states. The model represents multiple levels of posttraumatic ego and psychobiological states and encompasses all aspects of organismic adaptations. An integrated theoretical approach to the facets of PTSD, social behavior, and personality processes, the model provides a theoretical basis for understanding natural, organismically based healing of traumatic injury.

First, as explained in Figure 2.2., the tetrahedral shape of the organismic model represents the human organism. Second, inscribed in the center of the model is an inverted tetrahedron formed by the five-pointed star created by the arc angles of the tetrahedral structure. The central inverted tetrahedron contains the core PTSD phenomenology, reflecting complex allostatic adaptations. Third, the core PTSD phenomenology is formed by the three triangles (marked B, C, and D) which represent the triad of PTSD symptoms (i.e., DSM-IV PTSD criteria B, C, D). Fourth, the bold arrows (emanating from the PTSD symptom clusters point (→) to the interior core tetrahedron, indicating *variability* in their contributions to specific configurations of posttraumatic processes in the core phenomenology of the syndrome. For example, person *A* experiences frequent traumatic memories, whereas person *B* has extreme denial and repression of the traumatic experience and person *C* manifests anxiety and hyperarousal. Thus, persons *A, B,* and *C* may have *dif-*

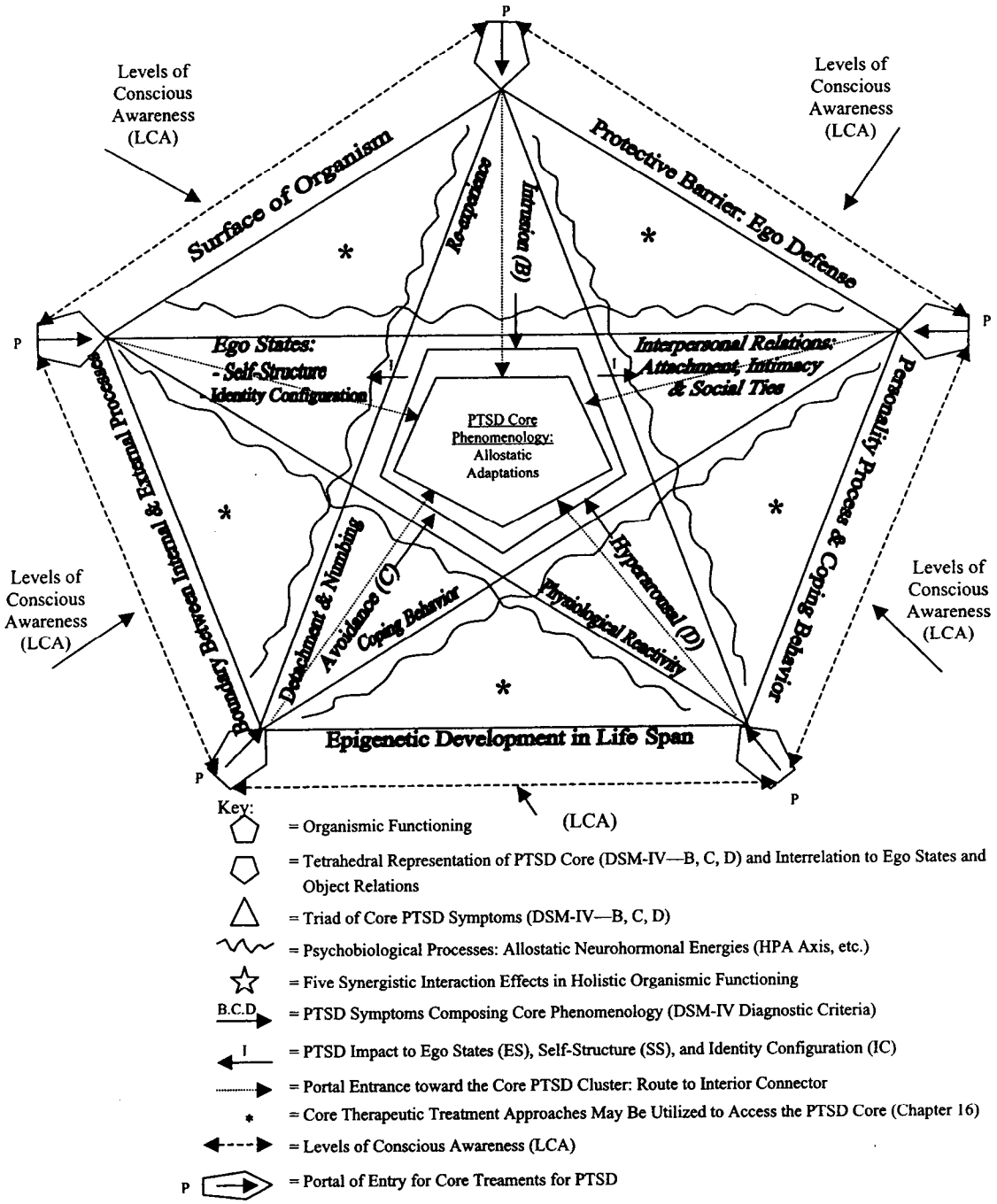

FIGURE 2.2. Organismic representation of PTSD phenomenology and its relations to ego states and interpersonal relations.

ferent degrees of PTSD symptoms manifest in coping adaptations; hence, different syndrome dynamics in PTSD and subtypes of the disorder would be discernible. Fifth, the arrows marked by an "I" that extend laterally from the interior core tetrahedron to the exterior triangles represent the impact (I) of PTSD on ego states (including self-structure and identity configuration) and

interpersonal relations (including attachment, intimacy, and social ties); or the triad (△) of core PTSD phenomenology thus respectively impacts *intra*personal or *inter*personal processes. Sixth, the five-pointed star (depicting the symmetrical systematic organismic interactions) is bordered by a single "wavy" or "vibrating" line, representing psychobiological processes (i.e., allostasis, neurohormonal HPA [hypothalamic–pituatary–adrenal axis energies] that operate within the entire organism afflicted with PTSD. These neurohormonal energies (wavy lines) reflect fluctuating allostatic states and influence PTSD symptom expression, ego states, and object-relational capacities (Friedman, 1994, 1998, 2000; Yehuda, 1998). Seventh, the exterior of the tetrahedron contains five portals (P) of entry into the core PTSD phenomenology. *The portals indicate areas of access to the treatment, understanding and analysis of PTSD phenomena.* These portals of entry include the core triad (△) of PTSD symptom clusters as well as ego states and interpersonal relations. If one considers them in terms of a three-dimensional organismic model (i.e., a pyramidal tetrahedron), the portals of entry are passageways to interior connectors in ego states which reflect the totality of organismic functioning at any given moment. Moreover, each of the five triangles surrounding the five-pointed star are areas in which a core treatment technique can be used as a guide in the treatment process (see Wilson, Chapter 3, this volume). Thus, the model provides a method by which it is possible to determine how treatment should be approached for each of the five PTSD symptom clusters. Stated simply, the model illustrates synergistic interconnection in posttraumatic states.

The exterior of the tetrahedron contains five domains of organismic functioning which are related to each other by structure and function. The domain levels of organismic functioning include the following: (1) the surface (i.e., the totality) of the organism, representing holistic–dynamic adaptation; (2) the protective barrier of the organism (i.e., ego defenses and coping strategies to deal with traumatization); (3) personality processes and coping behavior; (4) the boundary between internal and external organismic and ego-level processes; and (5) epigenetic development and the potential impact of trauma to the trajectory of life-course development. Finally, enclosing the exterior are long double-headed dashed arrows representing levels of conscious awareness (LCA) among and within the domains of organismic functioning.

To summarize, the organismic model of PTSD phenomenology encapsulates the complexity and interrelatedness of posttraumatic adaptation. The model illustrates the multidimensional ways in which trauma impacts human adaptation and functioning in terms of internal psychological states (e.g., ego states), and external behavioral manifestations, (e.g., hyperarousal, startle response, response readiness, and sleep disturbance). The utility of the tetrahedral organismic model is that it illustrates the psychobiological connection at cellular, hormonal, psychological, behavioral, and cultural levels (Friedman, 2000; Bremner, 1999). In regard to the cultural level, it must be recognized

that it influences many aspects of healing and recovery (Wilson, 1989; Kinzie, 1988). *In terms of the treatment approaches for PTSD (*), the portals of entry into the interior core phenomenology allow the therapist different pathways by which to assist the client in transforming traumatization through organismic healing.* In terms of treatment, the portals of entry have both trauma-specific and culture-specific implications for healing and recovery as well as transformation of the self. The ultimate meaning of the transformation of the self has no meaning without a cultural content. The utility of the organismic model presented in Figure 2.2 is that it allows the therapist/clinician to envision and access at least five separate portals of entry to the complex phenomenology of PTSD in its integrated or fragmented states as seen in either ego functions, symptom manifestations, or somatic (i.e., physical) states.

PTSD AND DISSOCIATION: AN EXPANDED ORGANISMIC TETRAHEDRAL REPRESENTATION

Figure 2.3 is an expansion of Figure 2.2 to include the relationship between PTSD and dissociation. The perimeter of the tetrahedral model contains the five common forms of dissociation: amnesia, depersonalization, identity confusion, derealization and identity alteration (i.e., dissociative identity disorder or DID) (Putnam, 1997; Steinberg, 1997; Spiegel, 1994). The central inverted pentagon represents the core PTSD triad and dissociative ego states. The arrows emanating from the core to the five perimeter triangles reflect alternative pathways of dissociation in PTSD. The exterior surface of the tetrahedron (i.e., the organismic whole) contains five sets of basic psychological processes associated with the forms of dissociation and include the following:

1. Memory and information processing
2. Self-detachment, altered awareness, and sensory changes
3. Discontinuity in ego processes
4. Sensory, perceptual, kinesthetic, and levels of awareness phenomena
5. Ego-fragmentation processes within the organization of the self

Furthermore, the dotted-line arrows emanating outward from the core PTSD triad and dissociated ego states to the five triangles inside the tetrahedron create a second inverted pentagon which overlaps and intersects the PTSD triad, the five forms of dissociation, and ego states and interpersonal relations. The third, larger tetrahedron represents the multiple possibilities of the relations between PTSD and dissociated ego states and their relation to the underlying psychobiological processes defined by the data on the exterior surface of the tetrahedron. There are five portals of entry (P) indicating pathways to the core PTSD processes and/or dissociated ego states.

The addition of the representation of dissociated ego states in PTSD

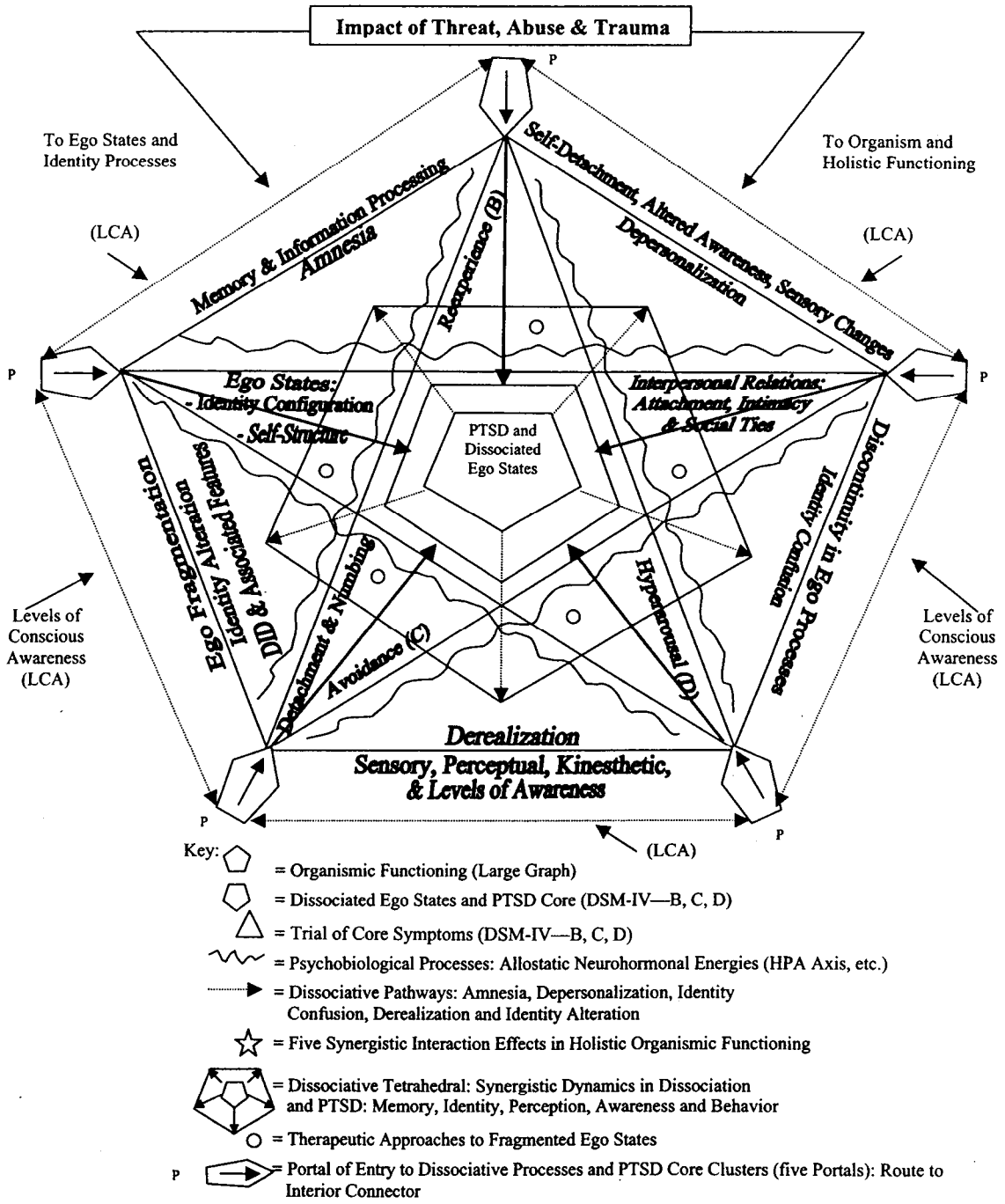

FIGURE 2.3. PTSD and dissociation.

permits a more complex analysis of psychic traumatization. As Figure 2.3 illustrates, it is the impact of threat, abuse, and trauma to organismic functioning, especially to ego states and identity processes, that creates combinations of PTSD symptoms and dissociative processes. For example, there are cases of amnesia for childhood sexual abuse with unconscious reenactment behav-

ior activities in adulthood which are derivatives of the earlier abuse and are split-off ego states (e.g., repetitive self-destructive relationships; Watkins & Watkins, 1997). In this example, the underlying psychological processes include memory and information processing which have, through learning and conditioning, impacts on social relations, especially in terms of attachment, intimacy attempts, and the patterning of interpersonal relationships. Alternatively, there are other cases, at the other end of the spectrum, in which individuals have clear, vivid, intrusive traumatic memories which are associated with extreme levels of hyperarousal and proneness to dissociation (e.g., depersonalization) upon exposure to trigger events containing trauma-specific stimuli. These two examples are just a few of the forms of allostatic adaptation in organismic adaptation. Through systematic analysis, it is possible to discern the subtypes of the PTSD-dissociative spectrums and their configuration in ego states in victims of trauma.

TRAUMA-SPECIFIC CONFIGURATIONS OF EGO STATES AND DISSOCIATION IN PTSD

Wilson and Lindy (1994) have noted that one clue to understanding the configuration of ego states associated with PTSD are trauma-specific transference (TST) manifestations. Stated differently, persons afflicted with traumatic stress syndromes will manifest specific sets of cues in their behavior which reveal the meaning of the trauma-related behavior and its origin in dysregulated subsystems of functioning (see Putnam, 1997; Bedosky, Wilson, & Iskra, 1996; Wilson & Lindy, 1994; and Friedman, 1998, for a review). In TST, the patient engages in transference behaviors with the therapist. *The nature of the transference reveals content representations of unmetabolized elements of the traumatic event* (Haley, 1974; Danieli, 1988; Lindy, 1987). Dalenberg (2000), Ochberg (1988), Wilson (1989), and Wilson and Lindy (1994) suggest that an important therapeutic consideration is the proper timing of interpreting the underlying meaning of PTSD-related behaviors which are components of TST.

The parsimony of Figure 2.3 allows the therapist to further understand and interpret PTSD/dissociative phenomena. The core triad of PTSD symptoms impacts ego states and organismic functioning. Also, dissociative symptoms and phenomena are related to five basic psychological processes: (1) memory and information processing; (2) altered awareness, detachment, and memory/changes; (3) sensory and other changes in kinesthetic awareness; (4) ego fragmentation; and (5) discontinuity in ego processes. Moreover, the domain of the five PTSD symptom clusters (criteria B, C, D, plus ego states and interpersonal dispositions) interact with dissociative mechanisms to create an extraordinarily rich combination of posttraumatic adaptations. These adaptational configurations span the range of clinically and anthropologically observed phenomena in dissociation, dissociative disorders, personality alter-

ation, PTSD in all its combinations with other Axis I or Axis II disorders, paranoid phenomena, and anomalous forms of adaptation (Laibow & Laue, 1993). In this sense, what looks like an impossibly difficult task of unraveling the organization of mental processes associated with posttraumatic states of adaptation can be placed within a meaningful conceptual framework as depicted in Figure 2.3. Although at first glance several geometric structures nested within each other might seem rather confusing, with closer examination they reveal pathways into the ego space of the PTSD client. If we saw Figure 2.3 as a three-dimensional object, that is, a pyramid, the directional arrows would indicate passageways and entry portals to different "floors" of the structure containing different processes and types of information regarding the unique ways in which the client's response to traumatic injury is organized. Visualized in that way, the model should seem much less complex.

DEFINITION OF CORE TREATMENT APPROACHES FOR POSTTRAUMATIC THERAPIES

As noted earlier, PTSD is a dynamic and complex form of stress-response syndrome (Horowitz, 1999). The core treatment approaches target symptom reduction and enable conditions of safety and equilibrium which permit trauma healing. Such a treatment approach aims at mastering specific reexperiencing phenomena, reducing physiological hyperarousal, and/or restoring capacity for attachment and integrity of self-structure. *A core treatment approach removes obstacles so that the organism can heal on its own.* Such a treatment proceeds from a body of clinical evidence demonstrating effectiveness, is consistent with a disciplined body of applicable theory, subjects its results to scientific criticism, and approaches PTSD through a valid entry portal (see Figure 2.2). A core treatment approach reduces allostatic load and produces positive changes in homeostatic regulation (McEwen, 1998). (See our Chapter 1, this volume, for a discussion of allostasis.)

THE TARGET SYMPTOMS OF POSTTRAUMATIC THERAPIES

Target I. The core triad of PTSD symptoms

1. Traumatic memory and stress-reexperiencing phenomena (Table 2.1).
2. Avoidance, numbing, depression, and coping adaptations (Table 2.2).
3. Psychobiological alterations in behavior (Table 2.3).

Target II. Ego states, identity, and interpersonal relations

4. Impact on attachment, intimacy and interpersonal relations (Table 2.4).
5. Impact on the self, identity, and life-course development (Table 2.5).

In this section we undertake a task that is twofold in nature. First, to revisit and review the triadic clusters of the B, C, and D criteria for PTSD in DSM-IV of the American Psychiatric Association (1994) and associated features. Second, to reconceptualize those primary triadic clusters in terms of recent advances in the scientific database (Friedman, 2000; Raphael & Wilson, 2000) and attempt to further define and integrate core symptom clusters which comprise the structural foundations of the "three legs" of the triad that define PTSD as presented in the DSM-IV. Furthermore, we attempt to move beyond the DSM-IV criteria to add other core psychological processes that are intrinsic to posttraumatic adaptations (see Tables 2.4 and 2.5). Some researchers (e.g., Horowitz, 1999; Yehuda, 1998; Herman, 1992; Wilson, 1995) refer to these dimensions as complex PTSD since by definition the symptom clusters and styles of behavioral adaptation transcend the diagnostic criteria set forth in the DSM-IV.

As with any diagnostic syndrome, new empirical information calls for an evaluation of the adequacy, complexity, and inclusivity of the diagnostic criteria. In that regard, we have expanded in Tables 2.1–2.5 the core criteria of PTSD symptoms into five distinct and separate categories. We consider PTSD not so much as a traditional psychiatric illness but as an adaptational pattern to traumatic stress. A holistic, dynamic perspective implicitly recognizes the synergistic nature of the phenomena. A synergistic perspective is consistent with approaches to understanding allostatic changes within the organism that have specific pathways of adaptation to trauma-related stress (McEwen, 1998). Consequently, the core treatment approaches must be tailored to the client's clinical presentation. Treatment protocols need to be designed around the adaptations of allostatic patterns of trauma syndromes (see Chapters 1, 3, 4, 5, and 16, this volume). *To be effective, treatment protocols should therefore recognize the need to individualize therapy to the patterned specificity of the patient's PTSD profile.*

BEYOND DSM-IV: REVISION, EXPANSION, AND RECONCEPTUALIZATION OF PTSD SYMPTOMS

To begin our reformulation, the set of criteria presented in Tables 2.1–2.5 each contain 13 symptoms for five interrelated dimensions of PTSD, or 65 separate but interrelated components of posttraumatic stress phenomena. The permutation of the five factors defines allostatic patterns of PTSD syndrome dynamics suggested by McEwen (1998). Like the amino acid peptide strands that define the DNA code in biological science, PTSD has its own "stress response psychobiological code" which defines the combinations of elements that can cohere in adaptational configurations. The understanding of these psychobiological processes eventually will lead to scientific advances in the understanding of PTSD in all of its complex behavioral and psychoso-

cial manifestations (Yehuda, 1998). Allostatic adaptations refer to the subtypes of PTSD which are different forms of psychic integration after trauma. Clinicians who treat PTSD confront dynamic clinical phenomena for which there are no universally standardized protocols for treatment. In that sense, they face professional uncertainty in attempting to assist their trauma clients—which has a high potential to trigger countertransference reactions in the process of therapy (Wilson & Lindy, 1994).

In Parts II and III of this volume, the current therapeutic treatment approaches for PTSD are presented; in Part IV, case history analyses are discussed as well as a set of practical considerations for the treatment of PTSD (see in particular Chapters 5 and 15).

Tables 2.1–2.3 present the triad of the core PTSD symptoms which are noted in DSM-IV (American Psychiatric Association, 1994) and its predecessors (DSM-I, 1952; -II, 1968; -III, 1980; and -III-R, 1987—all cited by us in Chapter 1, this volume). Similarly, Tables 2.4 and 2.5 present symptoms related to ego processes and interpersonal relations. Thus, there are five domains of PTSD symptom clusters which are the targets for treatment.

Target I(1). Traumatic Memory and Stress-Reexperiencing Phenomena

Table 2.1 presents 13 distinct but interrelated symptoms or modalities by which a traumatic event is reexperienced. In a general sense, the treatment approaches for PTSD share the objective of reducing the distressing aspects of reliving trauma. In a pragmatic and utilitarian way, the presence of symptoms associated with reexperiencing elements of the traumatic event provides both the client and the therapist trauma-related information to work with in treatment. Understanding the patterns and content of the material allows discovery of how homeostasis was breached and disrupted in the first episodes of trauma and led to allostatic load. As noted by Wilson (1989), intrusive traumatic memories are the *sine qua non* of PTSD; they are the hallmark features which distinguish PTSD from other disorders. Intrusive, traumatic memories and the other forms of reexperiencing trauma are the nodal focal points of treatment. As constructed in the DSM-IV (American Psychiatric Association, 1994), the PTSD C criteria (i.e., avoidance and numbing symptoms) are forms of coping and adaptation manifest after the traumatic event and attempts to remove traumatic memories. The C criteria symptoms are reactions to the various forms of reexperiencing trauma and thus constitute parallel psychological processes which attempt to govern the intensity and severity of distress associated with reliving phenomena.

As a clinical goal, most research and reviews of the literature (e.g., Friedman, 2000; Marmar, Weiss, & Metzler, 1997; Foa et al., 2000; Foa & Meadows, 1997) agree that integration of the traumatic experience within existing cognitive schema is an important objective in the treatment of PTSD. In a

TABLE 2.1. PTSD Triad: The Reexperiencing of Trauma (DSM-IV B Criteria Revised)

1. Involuntary, unbidden, unexpected intrusive thoughts of the trauma with or without distressing emotions
2. Traumatic memory consciously or unconsciously manifest in declarative (visual or verbal memory) or nondeclarative forms (somatic or sensory modalities)
3. Dreams and nightmares associated with the trauma and sleep cycle disruptions which may be fragmented, symbolic, allusory, or accurate visual and emotional recall
4. Emotional flooding states with or without visual imagery (emotional flooding may be disguised in somatic complaints)
5. Conscious or unconscious behavioral reenactments which repeat or parallel behaviors that occurred during the trauma (i.e., peritraumatic and traumatic reenactments)
6. Dissociative and peridissociative episodes which include derealization, depersonalization, amnesia, reduction of awareness, perceptual distortions and reenactment behaviors
7. Trauma-based hallucinatory experiences (i.e., rooted in the experience) as distinct from psychotic hallucinations
8. Anniversary reactions with or without somatic reactions
9. Increased psychological or physiological distress by exposure to "triggering cues" (i.e., trauma-specific cues which have a potential to evoke a cascade of symptoms)
10. Feeling that the traumatic event is, or could be, recurring, or behaving as if it is happening or about to happen
11. Reenactment play in children or expressive behavior in adults, with trauma-specific relevance and psychological meaning
12. Perceptual vigilance, illusions, and similar phenomena triggered by stimuli with trauma-specific information
13. Somatic memories which trigger intrusive or ego-defense processes

Source: Wilson (1989).

basic sense, integration means that the trauma and its emotional aftermath have become part of the life history of the person. Upon successful integration, the client can discuss and recall the trauma without undue distressing or disabling influence. While its effects may change personality, alter meaning and beliefs about life, the deleterious consequences of trauma have been overcome, if not transformed, in a positive direction that energize growth and self-individuation (Lifton, 1993; Wilson, 1989). Unfortunately, this is not always the case, as depressions, alcoholism/drug abuse, suicide, and other forms of self-destructive behavior are sometimes manifest in the absence of treatment.

Table 2.1 is an effort to delineate the diversity of symptoms which constitute the reexperiencing elements of PTSD, listing 13 such symptoms. Further, it notes that the symptoms can be experienced at all levels of awareness (i.e., unconscious, preconscious, conscious, and in nondeclarative memory systems). It recognizes that the symptoms may or may not have associated features of emotional responsiveness. As Table 2.1 indicates, the symptoms

involve different forms of cognitive activities: perception, memory, alteration in levels of awareness or behavior, problem-solving activities, dream content, thought processes, and more.

Furthermore, Table 2.1 contains information that reexperiencing phenomena in PTSD are not separable from psychobiological processes. There are distinct somatic components and complex psychophysiological reactions which are associated with the various forms of reliving aspects of the traumatic event. In a different way, there are levels of reenactments of trauma which get "played out" in dissociative processes, including unconscious behavioral acts which parallel the actions at the time of the trauma (i.e., rekindling, peritraumatic, and dissociative-like responses) and painful conscious memories (Marmar et al., 1997). There are also perceptual processes involving stimulus and sensory perceptions, cognitive encoding, and information processing—all of which affect behavioral dispositions. Thus, illusions, hallucinations, stimulus generalization, and sensory sensitivity to trauma-specific cues, reflect elements of the traumatic experience stored in "files" (cognitive domains of memory) consistent with the survivor's capacity to process the experience (Horowitz, 1986). The body stores the records of trauma in declarative and nondeclarative forms of memory (van der Kolk, 1999; Wilson, 1989). Depending on the emotional valence of the memory, the impact on the person may be devastating or lead to forms of avoidance and detachment. For some survivors, being alone in quietude is therapeutic and peaceful. For others, nothing short of extreme stimulation, "action addiction," and risk taking is acceptable as a "normal" part of life (Wilson et al., 1988; Wilson, 1989). Between these extremes are survivors of trauma who show varying degrees of fatigue, malaise, wariness, anger, anxiety states, fears, depressive symptoms, personal vulnerability and a changed sense of psychological well-being.

In regard to the core treatment approaches for PTSD, when we utilize the information from reexperiencing traumatic phenomena, we need to consider that these components of the disorder have their own underlying structure which is discernible through rational, empirical, and statistical factor analyses. The structural components are interrelated aspects of the organism's attempt to master the experience (Freud, 1917, 1920) and restore optimal functioning (Figley, 1985; Wilson, 1989; Horowitz, 1999).

The underlying structural components have several interrelated elements which influence symptom presentation. These core subcomponents are important for therapists because they yield information as to how to decode trauma-specific transference behaviors (i.e., TST projections) and requests for help which are typically shielded by avoidance symptoms. These 10 subcomponents are as follows: (1) intrusive, unbidden, unexpected, and distressing thoughts, feelings, and images associated with the trauma; (2) conscious reflections of traumatic memories which may or may not activate "cascades" of other intrusive processes; (3) dreams, nightmares, and cogni-

tions during the sleep cycle associated with the trauma; (4) emotional flooding associated with the trauma as a form of "somatic intrusive recollection"; (5) physiological symptoms which are linked to the phenomena of sensation (e.g., visual, olfactory, tactile, auditory, kinesthetic) and perception, especially involving perceptual distortions or hallucinations associated with the trauma; (6) dissociative processes; (7) reenactment behaviors with varying levels of personal awareness; (8) somatic memories of the trauma in nondeclarative states (van der Kolk, 1996; Layton & Zonna, 1995); (9) psychophysiological reactivity associated with traumatic information processing; and (10) reenactment of the trauma through play in children or expressive behavior in adults without conscious insight as to the origin or trauma-specific derivation of such behavior. For example, it is relatively easy to see a one-to-one reenactment of a child's or adolescent's reaction to trauma (Pynoos & Nader, 1993), but it is more difficult to discern patterns of reenactment in adults with a history of trauma that has been sealed over or blocked by ego-defensive mechanisms and is symbolic in its behavioral manifestation (Niederland, 1962).

Target I(2). Avoidance, Numbing, Depression, and Coping Adaptations in PTSD

The reexperiencing of trauma is inevitably accompanied by attempts to defend against the pain and distress produced by traumatic memories. In terms of targeting symptom clusters for treatment, assessment should be made of the ways the individual defends against the pervasiveness of distressing intrusive recollections of the traumatic event.

As part of the assessment process, the clinician involved in posttraumatic therapy should evaluate the functionality of symptoms in terms of how they promote positive coping or are associated with problems and conflicts in daily life and personal responsibilities. In extreme cases, the symptoms presented in Table 2.2 are manifestations of human dispiritedness which include helplessness, demoralization, withdrawal, alienation, a lack of ego mastery, detachment, a loss of essential vitality, and a generalized shutting down of organismic functioning. *In severe cases of PTSD, the psychic core, or soul, of the survivor is diminished and attachments to other persons and life itself are lost.* Further, the capacity to experience positive emotions is often enmeshed and lost in a web of depression, despair, and sense of futility. The individual appears to have given up the struggle to remain alive (Wilson et al., 1988; Lifton, 1979, 1993). Such psychological surrender is connected to states of hopelessness and helplessness which are precursors of suicidality or other forms of self-destruction. In the most severe cases of PTSD, clinical interventions target depression, levels of helplessness, despair, and the decompensated downward spiral toward self-destructive behaviors (Wang, Wilson, & Mason, 1996).

TABLE 2.2. PTSD Triad: Avoidance, Numbing, and Detachment—Changes in Coping and Adaptation Not Present before the Trauma (DSM-IV C Criteria Revised)

1. Active or passive avoidance of thoughts, feelings, or conversations associated with the traumatic event
2. Active or passive avoidance of activities, places, or people that are associated with recall of the traumatic event
3. Emotional constriction and psychic numbing (i.e., reductions in emotionality and capacity to express affect)
4. Detachment, estrangement, withdrawal, or alienation
5. Desexualization: loss of sex drive or interest in sexual behavior and physical sensuality in general
6. Amnesia for trauma-related information
7. An inability to recall aspects of the trauma, which may include a loss of chronology or only fragmented and partial memories
8. A sense of a foreshortened future and a negative outlook on life and one's role in it
9. An altered or diminished interest or participation in significant activities
10. Compulsive overactivity as an attempt to avoid thoughts or feelings associated with the trauma (includes action-oriented, high-risk, sensation-seeking behaviors and impulsiveness)
11. Excessive use of alcohol or other substance abuse/dependence as self-medication for allostatic load, hyperarousal states, or depressive moods
12. Social and geographic isolation from others
13. A preference for solitary activities in work, shopping, recreation, and other pursuits

Source: Wilson (1989, 2001).

While it is clear that there are degrees of avoidance and numbing symptoms which range from mild to extremely severe, the 13 symptoms presented in Table 2.2 have an underlying structure which includes the following: (1) active and passive efforts to avoid cues or stimuli that could activate intrusive, distressing, and potentially cascading recollections of the trauma; (2) reduction in emotionality in terms of the capacity to feel or express internal affect; (3) social disengagement and efforts to minimize contact with others in an attempt to control emotional states and levels of arousal; (4) cognitive mechanisms to avoid recall of traumatic memories and feelings by repression, amnesia, dissociation, or frenetic overactivity to "jam" attention (Horowitz, 1986); (5) self-medication with alcohol or drugs to reduce hyperarousal or obliterate reexperiencing phenomena (physical and emotional numbing).

Target I(3). Psychobiological Alterations in Behavior

The three groups of symptom criteria that make up the PTSD algorithm in DSM-IV include psychobiological mechanisms which are part of the disorder (see Friedman, Chapter 4, this volume). The treatment approaches for PTSD recognize the third leg of the core triad as equally important as the other two in terms of target objectives in psychotherapy.

PTSD is a complex pattern of stress response. The psychobiological connection is transparent during treatment of clients with PTSD, as is manifest in their hyperarousal states, sleep disturbance, and problems of concentration. The amelioration or attenuation of the more biologically based symptoms of the disorder is an important part of the treatment plan (van der Kolk & Sapporta, 1993; van der Kolk, 1997). Table 2.3 presents 13 symptoms of psychobiological alterations associated with PTSD. We have made an attempt to expand the five symptoms of the PTSD D criteria in DSM-IV. These symptoms are manifestations of allostatic adaptations which reflect dysregulated neurohormonal processes. As allostatic adaptations, these symptoms can disrupt psychological functioning at varying levels of cognitive, emotional, and interpersonal behavior. The core treatment approaches for PTSD recognize the necessity to reduce physiological hyperarousal through cognitive behavioral therapy, medication, desensitization techniques, meditation, relaxation, exercise, diet, and other forms of deconditioning. *Further, since the triad of PTSD symptoms function synergistically, reduction of physiological alterations will generate changes in the other symptom clusters of PTSD as well* (Yehuda, 1998; DeBellis et al., 1999).

As with the other two core diagnostic legs of the PTSD triad presented in DSM-IV, the persistent symptoms of increased autonomic nervous system arousal have an underlying structure. The four subcomponents are as follows:

TABLE 2.3. PTSD Triad: Psychobiological Alterations Not Present before the Trauma (DSM-IV D Criteria Revised)

1. Sleep disturbances (i.e., early-, middle-, or late-cycle phenomena)
2. Irritability, outbursts of anger or rage, and problems of modulating affect
3. Cognitive processing deficits (e.g., problems of concentration, attention shifts, cognitive "drift" and difficulty encoding and retrieving information)
4. Hypervigilance: excessive perceptual scanning for cues to threat or harm; behavioral readiness to respond and increased emotional arousal
5. Exaggerated startle response
6. Sensory sensitivity to trauma-specific cues, i.e., olfactory, auditory, visual, tactile, and/or kinesthetic—with stimulus generalization to the traumatic event
7. Hyperarousal states: emotional, cognitive, and dispositional
8. Homeostatic dysregulation: emotional lability with variable cycling times and interepisode recovery
9. Chronic fatigue, exhaustion, weariness, and loss of essential vitality as part of PTSD
10. Somatic symptoms which have generalized, symbolic, or trauma-specific significance
11. Endocrine system physiological markers of allostatic load (e.g., thyroid dysfunction)
12. Sensation-seeking, high-risk behaviors, action addiction, impulsive behavior, gambling, sexual acting-out, etc.
13. Generalized existential malaise, ennui, despair, fatigue, loss of vitality, spirit, etc., which may or may not be associated with depressive episodes

Source: Wilson (2001).

1. *Sleep cycle disturbances* (i.e., problems going to sleep, staying asleep, nightmares, dreams of the trauma, early awakening, night sweats, difficulty returning to sleep, etc.)
2. *Hyperarousal phenomena* (i.e., homeostatic dysregulation, hypertension, depression, high risk taking, sensation seeking, action addiction, chronic fatigue, malaise, hypervigilance, startle response, thyroid dysfunction, etc.)
3. *Perceptual and sensory sensitivity* to trauma-specific cues (i.e., olfactory, tactile, visual, auditory, kinesthetic) with stimulus-specific generalization (SSG) to a traumatic event through cognitive associative processes
4. *Cognitive processing deficits* including problems of concentration, attention shifts, cognitive drift, difficulty encoding information, and impaired executive functions

BEYOND THE PTSD TRIAD

Target II(4). PTSD Impact on Attachment, Intimacy, and Interpersonal Relations

The presence of PTSD symptoms impacts a person's psychobiological capacity for attachment, intimacy, and the quality of interpersonal relationships. Table 2.4 presents 13 symptoms associated with traumatic impact on attachment, intimacy, and interpersonal relations. These symptom clusters point to adverse impact to interpersonal and intrapersonal functioning. The impact of PTSD symptoms to interpersonal functioning includes such difficulties as problems with relationship boundaries, sexual intimacy, trust of others, fears of abandonment, repetitive self-defeating relationships, impulsive behavior, and various forms of personal and social alienation. At the individual level, the impact of trauma may be associated with tendencies toward secretive and non-self-disclosing behaviors, object-relation deficits (i.e., interpersonal relations), poor or inadequate self-care, and chronic states of tension and anxiety which make it difficult for the person to accept nurturing from others. A tendency toward guardedness and suspiciousness may underlie difficulties in interacting with others at normal social occasions (e.g., reticence, withdrawal, social isolation, or shyness). Further, if the trauma occurs in the formative years of childhood and adolescence, personality development may be affected and result in features of PTSD in character structure. These features include narcissistic, borderline, dissociative, antisocial, oppositional, schizoid, or other patterns of adaptation (Wilson, 1987). Clearly, trauma can alter the normal trajectory of personality development in the life-course epigenesis (Hyler, 1994; Pynoos & Nader, 1993; Wilson, 1980; Erikson, 1968). Thus, depending on the nature of the traumatic event the

TABLE 2.4. PTSD and Associated Symptoms: Problems in Attachment, Intimacy, and Interpersonal Relations (Not Present before the Trauma)

1. Alienation: social, emotional, personal, cultural, spiritual
2. Mistrust, guardedness, secretive behaviors, non-self-disclosure, reticence towards social encounters
3. Detachment, isolation, withdrawal, estrangement, and feelings of emptiness
4. Anhedonia: loss of pleasure in living; loss of sensuality, sexuality, feeling, capacity for joy, etc.
5. Object relations deficits; loss of capacity for healthy connectedness to others
6. Self-destructive or self-defeating interpersonal relationships which are repetitive in nature
7. Impulsiveness, sudden changes in residence, occupation, or intimate relationships
8. Impaired sensuality, sexual drive, capacity for sexuality or loss of libidinal energy in general
9. Inability to relax; discontent with self-comfort activities and an inability to receive nurturing, affection, or physical touching from others
10. Unstable and intense interpersonal relationships whose origin is in trauma experiences
11. Problems with establishing or maintaining boundaries in relationships based on trauma experiences
12. Anxiety over abandonment or loss of loved ones, which is either conscious or unconscious in nature and based in traumatic experiences
13. Repetitive self-defeating interpersonal relationships which reflect unmetabolized patterns of attachment behavior from abusive developmental experiences

Source: Wilson (2001).

traits of personality transformation which develop (e.g., oppositional features in childhood, narcissistic tendencies in adolescents and adults) reflect damage to the self-structure and ego states. The person protects his or her vulnerability by developing defenses against basic anxiety, vulnerability, and fears of rejection and abuse. The resultant character defenses against inner vulnerability protect traumatized states by developing traits which attempt to optimize functioning while controlling the anxiety, anger, rage, and self-destructive symptoms of PTSD. This process may lead to the development of complex PTSD (Herman, 1992; Wilson, 1994) and alterations in personality functioning and character formation. However, such posttraumatic changes in personality processes are not necessarily the same as "traditional personality disorders" (Wilson et al., 1988; Wilson, 1989).

Traumatic events can cause damage to the fabric of the self at any stage of life-course development (i.e., epigenetic and ontogenetic development; see Wilson, 1980, 1989; Erikson, 1968; Pynoos & Nader, 1993). However, when trauma strikes during formative periods of personality development, it may produce damage to ego states, the sense of personal identity, and the self-concept of the survivor (discussed next). Table 2.5 presents 13 characteristics which reflect forms of damage or changes to the core self-structural dimensions of the traumatized self.

TABLE 2.5. PTSD and the Self-Structure: Problems Associated with Structural Dynamics, Ego States, Personal Identity, and Self (Not Present before the Trauma)

1. Narcissistic and other personality characteristics which reflect damage to the self-structure associated with trauma
2. Demoralization, dispiritedness, dysphoria, and existential doubt as to life's meaning
3. Loss of ego coherence and integration of the self-structure
4. Loss of a sense of sameness and continuity to ego identity or capacity for ego stability
5. Fragmentation of ego identity and identity disturbance (e.g., identity diffusion)
6. Shame, self-doubt, loss of self-esteem, guilt, and self-recrimination
7. Fluctuating ego states; proneness to dissociation and lack of ego mastery
8. Hopelessness, helplessness, and self-recrimination; masochistic, and self-destructive tendencies
9. Suicidality; patterns of self-destructiveness or self-mutilation
10. Chronic feelings of uncertainty and vulnerability; levels of depression, helplessness, and hopelessness
11. Existential personal or spiritual angst; dread, despair, and a sense of futility in living
12. Loss of spirituality, essential vitality, willingness to thrive, loss of religious/cosmic belief systems, etc.
13. Misanthropic beliefs, cynicism, and a view of the world as unsafe, dangerous, untrustworthy, and unpredictable

Source: Wilson (2001).

Target II(5). PTSD Impact on the Self, Identity, and Life-Course Development

To explain adequately the nature of the injury to the self-structure is a difficult task. The self-structure refers to the organization of the ego and inner processes of identity functioning. Thus, there may be several areas of psychic injury. First, there may be a narcissistic injury to the self in which a normal, healthy sense of vitality, integrity, and wholeness is partially lost (Simpson, 1993). Second, repetitive abuse in childhood or adolescence may lead to demoralization and a loss of ego coherence and integration. Third, ego identity may be fragmented and associated with identity diffusion and loss of self-sameness and continuity (Erikson, 1968). The destabilization of core ego processes is frequently associated with feelings of shame, anxiety, panic, doubt, helplessness, hopelessness, guilt, and chronic feelings of uncertainty and vulnerability, as well as obsessive-ruminative thoughts and feelings (Agger & Jensen, 1993). Fourth, assaults on the self-structure are also associated with misanthropic beliefs, existential despair, and a loss of spirituality and faith (Wilson & Moran, 1997). Fifth, single or repetitive abuse may increase the use of dissociation as a defense against pain, humiliation and degradation. Moreover, the internalization of a poor self-image (i.e., PTSD fragmented ego identity) may be expressed as depression and suicidal symptoms. When individuals feel trapped in the trauma *with no foreseeable exit from their distressing symptoms*, they may be at high risk for suicide or repetitive pat-

terns of self-destructive behaviors and personal relationships (Wilson, 1989). The damage to the core ego processes, personality development, and self-structure is one of the least understood aspects of PTSD (Wilson, 1995; Herman, 1992). We believe that this is particularly unfortunate since such damage is injury to the soul—the innermost core of each human being. When a traumatic event breaks a person's spirit, it damages the basis of personhood and the capacity for self-actualization. To restore humanness is to create conditions of acceptance of the spirit. To restore the spirit may require rituals which are organized for collectively shared experiences of pain, stress, and recovery (Manson, 1997; Wilson, 1989). To facilitate the reintegration of psychically traumatized persons may require a collective sense of responsibility and judiciously used rituals for healing that enable transformation of allostatic states of PTSD to new, healthier levels of functioning.

Figure 2.4 presents a summary illustration of PTSD and its organismic impacts. The figure is a simplification of various pathways by which PTSD impacts psychological functioning.

Traumatic events produce organismic impacts which include allostatic load, psychobiological disequilibrium, and effects on life-course development (i.e., epigenesis). Among the direct consequences of a traumatic life event is the development of PTSD in all of its facets.

Traumatic life events have a direct impact on personality processes, ego functions, and the self-structure. Clearly, this encompasses a broad range of psychosocial phenomena including ego identity, ego defenses, cognitive schema, intellectual functions, and psychoformative processes (Lifton, 1993).

Traumatic life events also have an impact on attachment behaviors, capacity for intimacy, and the quality of interpersonal relationships. As Figure 2.4 indicates, this is an important area of psychosocial behavior and encompasses such issues as trust, safety, personal boundaries, sexuality, capacity for self-care, generativity (Erikson, 1968), and alienation from significant others.

In terms of the treatment approaches for PTSD, the 13 specific symptoms for each component of our tetrahedral model are targets for clinical intervention. In this perspective the target symptoms provide clear information to clinicians as to their alternatives for therapeutic interventions.

The core treatment approaches for PTSD recognize that the most profound injuries produced by trauma are located deep within the human psyche. PTSD symptoms are largely surface manifestations of these inner processes which cause allostatic transformations that attempt to restore organismic integrity. The healing transformations are themselves processes which dynamically alter a system dysregulated by overwhelming and painful traumatic experiences. Therapists who treat PTSD in all of its forms need to discover the portals of entry (see Figures 2.2 and 2.3) into traumatized ego states. *The client will, in one way or another, provide the clues to passageways leading to the inner sanctum of traumatization and vulnerability. The portals to traumatized ego states will show the therapist entryways to the path by which to assist in the healing trans-*

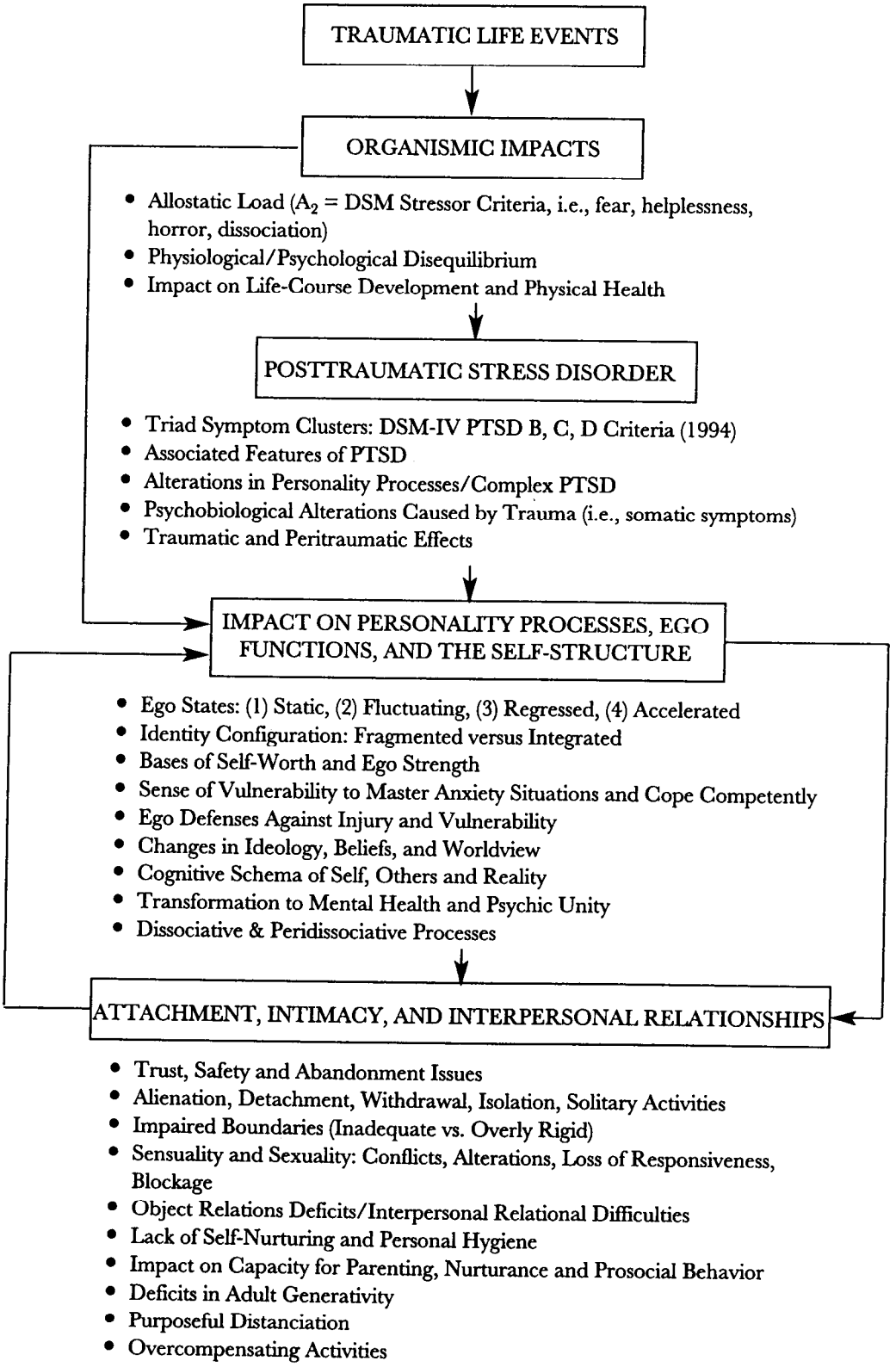

FIGURE 2.4. PTSD and traumatic impact on the self and interpersonal relations (Wilson, 2001).

formations of PTSD. Once discovered, the interactive process becomes a journey of mutually shared transformations: both the healer and patient change in the process. Both persons grow and become wiser and healthier because of their joint journey to overcome the disruption of ego and spiritual continuity in the life of the client.

Toward the end of therapy, healing transformations begin to manifest themselves in reintegration of the survivor's sense of human integrity. For the therapist there may be a sense of enrichment that the efforts to help have been rewarded with more knowledge about trauma, transference, and the client's psychic processes. Healing from PTSD is the transformation of trauma within the self-structure and ego states of the individual. Healing from trauma is self-integration, growth, and the continuance of organismic self-actualization.

In Chapter 3 we identify 60 specific treatment objectives for the five domains of PTSD symptoms. In the present chapter, we have indicated that these five domains of PTSD symptoms have 65 total symptoms, 13 for each cluster: (1) traumatic memory, (2) avoidance/numbing, (3) psychobiological alterations, (4) impacts on ego states, and (5) interpersonal relations. Thus, there is an approximate match between the treatment objectives and the total number of PTSD symptoms identified. The chapters in Parts II and III of this volume illustrate how the treatment approaches are used to ameliorate allostasis and other disruptive and distressing elements of PTSD. The models presented in Chapter 1 and this chapter (i.e., PTSD allostasis; tetrahedral models of PTSD and dissociation; traumatic impact on organismic functioning) can serve as conceptual road maps for therapists and clinicians in their work with traumatized clients.

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