# The Social Dynamics of Complex PTSD
# A Perversion of Intimacy

## A CRISIS INTERVENTION TO REMEDY IT

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# A disorder-specific, developmental impairment

- It is ***fundamental*** for disorder in persons
with Complex PTSD (including BPD and DID)

- It consists of **fixation on a futile method for ascertainment of others' trustworthiness.**

- It is the ***legacy of entrapment in mistrusted caretaking relationships***
with caretakers who made he child powerless to test their own trustworthiness.

- It is ***a perversion of intimacy***, of the process whereby
people in long-term relationships ordinarily restore trust
when one partner fears that the other is betraying
promises they made and expectations they fostered.

# The impairment is fundamental

- Mental disorder is always episodic.

- It may occur when the fundamental impairment pertains to a particular performance (a goal).
A goal which is also a ***singular and urgent*** priority.
The sufferer treats it as an irreplaceable priority
that must be fulfilled within an opportune timeframe.

- In persons with Complex PTSD, the troubled goal is ascertainment of someone's trustworthiness in a current relationship.

# The hallmark of disorder

- The disorder-specific impairment impedes the fulfillment

of the singular and urgent goal.

- The person fails  learn from each failure

enough to complete the goal while time is running out.

- With each failure, the person feels more compelled to persist,

despite growing awareness of futility.

Irrational repetition is the hallmark of disorder.

# Fundamental and secondary symptoms (Bleuler)

- Often, the troubled goal lingers subliminally,
as a compelling "implementation intention".

- Often, conscious and deliberate implementation of one step
is triggered without the person being aware
of its relation with the subliminal singular goal.
Example: reminders of old trauma and flashbacks.

- All irrationally repeated behavior, seemingly for no reason,
irrational emotions, beliefs and acts, hallucinations, etc.,
are the secondary or derivative symptoms of Complex PTSD.

# Clinical implications of Bleuler's concept

- Remediation of the fundamental impairment will end all symptoms.

  From Role Reconstrucion Therapy (RRT, The Cape Cod Model)

- Stepwise intervention:

1. Make the frustrated singular and urgent goal conscious.
2. Coach the patient to carry it out by the rules of intimacy, for effective ascertainment f the greatly needed and greatly feared partner's trustworthiness.

- A study of such an intervention's efficacy.

# The typical life course of complex PTSD
## (including its variants, BPD and DID)

Phases of engagement in ***experiments with long-term commitment***s alternating with phases of abstinence from such experiments.

### *Disengagement*

Enduring personality changes

- Fear of closeness
- Cynicism about others' benevolence or their own worth
- Certainty about others' love is an illusion

→ ***Engagement*** →

↓↑

***Crisis of trust***

Disorder

### *Disengagement*

Enduring personality changes become consolidated

# Familial and exchange relationships

1. ***Familial relationships***
   Long-term commitments.
   (e.g., between parents and children, best friends, lovers and lifemates)

   Partners commit to ***jointly pursue each partner's long-term goals***.
   They make their commitment ***before they could know*** each partner's future needs and each partner's future ability to contribute.

2. ***Exchange relationships***
   Partners trade goods and services for each other's immediate needs and wants in a specified time, without concern for how the tradeoff serves the other's future goals.

# The rules of intimacy

- Intimacy serves restoration of trust in familial relationships when one partner fears that the other is failing promises they made and expectations they fostered
- ***The failing partner*** discloses the reasons for failing, e.g., obstacles beyond their control, unpreparedness, selfishness, etc. and promises to prove correction in reasonable time.
- ***The aggrieved partner***, in turn, helps the failing partner make the correction, without punishment or tradeoffs.
- Proof of the failing partner's true intentions is possible only in that partner's future actions, as the aggrieved partner understands reasonable proof of it.
- Restoration of trust requires the failing partner's collaboration, first for self-disclosure and for evidence of his actions in the future.

# Perversion of intimacy

- Caretakers who act contrary to promises they made and expectations they fostered may deceive the child with false explanations (e.g., the child deserves it or it is ultimately for the child's own good.)
- Then, ***instead of collaboratively*** disclosing their true shortcomings and proving their intentions to remedy them, ***they put the burden on the child*** to prove their spoken reasons and intentions false. Furthermore, they obstruct the child's undertaking. They may inflict pains and privations on a child who resists obstruction.
- ***They pervert the rules of intimacy*** in order to make the trustworthiness of their words untestable.

# The legacy of entrapment in mistrusted caretaking relationships

- ***Assuming the burden*** of ascertaining another's true reasons and intentions without the other's collaboration, let alone despite the other's obstruction, ***is a futile endeavor.*** It is a flawed working model for restoration of trust. It never comes to closure and peace of mind for the aggrieved partner.
- The disorder-specific impairment for patients with Complex PTSD is their fixation on this perversion of the respective roles and responsibilities for restoration of trust.
- It is the cause of the two kinds of disorder that patients suffer. I will describe a crisis intervention that remedies that fixation.

# Two kinds of disorder

## *Crisis of trust*

***Anxious and depressive intrusive rumination*** about others' intentions and expectations

***Repetition compulsion***

Relentlessly ***testing*** others' intentions.

- During crises of trust in later relationships, patients ascertain the particular partner's trustworthiness in the only way they know that they can control (no collaboration needed).
- They do so relentlessly, ***irrationally***, i.e., despite awareness of its futility, ***the hallmark of disorder.***

# Anxious and depressive rumination

- The two kinds of disorder alternate, as the appraisal of the feared betrayal's consequences may shift between sufferable and catastrophic.
- The intrusive rumination is about ways to cope with the partner's recurrent failure to heed the patient's expectations. Each episode of perceived betrayal is sufferable, but cumulatively they become difficult to endure. The typical scenario is "I am the last thing on his mind…he makes promises to stay mindful, but never does…what are my options?" Patients judge the partner to be uncaring, oblivious and dismissive. Partners often find the patients' expectations ill-defined and shifting.

# Anxious and depressive rumination (continued)

- Occasionally, patients ask the partner to disclose their true reasons. But they often do that with little inclination to take the partner's perspective. Eventually, the discussion becomes adversarial on both sides, when partners assert their own expectation to be heard in good will. Then, patients take the partner's stern stance as one more cue of being oblivious and dismissive.
- Moody preoccupation has anxious and depressive phases. Both phases are punctuated with themes and moods of blame, rage, regret, self-loathing and more.
  - Patients' anxiety surges from a persistent intention to find a coping option ending up fearing worse with each one in turn.
  - In the depressive phases, the overarching theme is having no eagerness and joy for what was meaningful before. "If I can't be what matters most in someone's life, nothing else matters."

# Anxious and depressive rumination (continued)

- Phases of moody preoccupation are very costly because they recurrently displace their and the partner's daily priorities, as the patients themselves would ordinarily want them fulfilled. Bouts of moody preoccupation last for hours to days. Even when fear and guilt forces them to take care of their daily contributions, intrusions make them act unpleasantly and with errors.

# Repetition compulsion

- When patients fear the potential consequences to be catastrophic (traumatic) they become ***driven to disprove*** the feared partner's spoken reasons for failing ***with singularity of purpose and urgency***.
- ***They stage extreme situations of need or sacrifice, without revealing the testing purpose of it.*** They act out scenarios of rage, regret and expiation. Malevolent partners respond with exploitation, punishment or abandonment. Benevolent ones respond with stern limit setting. Patients take all these responses as new semblances of uncaring and selfishness, possibly to make new phobic cues of betrayal in the future. They take the partners' explanations as added reasons whose trustworthiness remains to be tested.

# Repetition compulsion (continued)

- Each round of testing leaves them more uncertain than before, ever more compelled to urgently repeat their futile testing.
- Concurrently, they test the trustworthiness of partners in other relationships with similar singlemindedness and urgency and they mentally relive the course of getting trapped in old, proven betrayal.
- "Repetition compulsion" was used to mean that patients act in this manner driven by an unconscious desire, unknowable to themselves, to replicate an old role of inadequacy, neediness and compliance in current relationships.

# A disorder-specific crisis intervention

- Both kinds of disorder consist of repetitive contemplation or action despite the sufferer's growing awareness of futility. In both endeavors, the patient's crucial shortcoming is about ascertaining the partner's intentions collaboratively, with a measure of intimacy.
- I have devised a crisis intervention that aims to remedy that shortcoming.

# A disorder-specific crisis intervention
**(Continued)**

- Typically, patients are loudly preoccupied with desire, mistrust, worthlessness and powerlessness in various relationships, including trivial or hallucinated ones. They are usually unaware of the link with their lingering intention to cope or to ascertain someone's trustworthiness in the relationship that matters singularly.
- ***The technique***
  1. The therapist empathizes with the shifting concerns in the patient's scenario and nudges the patient along. Hoping to elicit tangential associations to the relationship that matters.
  2. The therapist recognizes the object of rising need and fear and speaks to that with empathy and a hint of hope.
  3. The patient responds with a sudden lull in his unstoppable, irrational activity.
  4. In that lull, ***the clinician proposes*** that this is no way to live and that ***there is indeed a better method*** to become certain of the partner's intentions, and of others' in the future. The clinician offers to coach the sufferer about testing trustworthiness in the troubled relationship ***effectively, in the manner of intimacy.***

# A disorder-specific crisis intervention
**(Continued)**

- ***Engagement in that proposition*** replaces the patient's irrational pursuit and ***symptoms cease*** for the duration of that engagement.
- Over the course of the next day or two, the patient typically breaks off and then reestablishes this therapeutic engagement.
- Modulation of particular symptoms with medication, grounding, etc., is useful to facilitate engagement and reengagement in the therapeutic proposition, but such measures become unnecessary for hours at a time, when the engagement is in effect.
- Ending a crisis with the experimental intervention has ***a cumulative value,*** beyond reduction of symptoms. It treats crises as stepwise lessons in management of the risks of intimacy and as the patient's introduction to more methodical lessons later, in anticipation of crises.

# A study of this intervention's efficacy

- I investigated this intervention's efficacy with this study:
  - Laddis, A. (2010). Outcome of crisis intervention for borderline personality disorder and post traumatic stress disorder: a model for modification of the mechanism of disorder in complex post traumatic syndromes. *Annals of General Psychiatry*, 9:19 (27 Apr 2010) http://www.annals-general-psychiatry.com/content/9/1/19 *The hypothesis*
- The hypothesis for this study is that all symptoms of behavioral disorder will show greater improvement with the experimental intervention than with treatment-as-usual within eight to 24 hours from initiation of treatment.

# Brief Psychiatric Rating Scale

**Table 2 - BPRS total and subscale scores**

| | Experimental (N=32) | | Control (N=26) | |
|---|---|---|---|---|
| | Baseline | Followup | Baseline | Followup |
| | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) |
| Total BPRS | 34.8 (9.7) | 14.3 (8.2)** | 26.9 (8) | 23 (7.9) |
| Withdrawal - Retardation | 6.6 (4.0) | 1.8 (2.2)** | 3.2 (3.1) | 2.9 (2.6) |
| Thinking Disorder | 4.4 (4.6) | 1.3 (1.8) | 1.7 (2.5) | 1.8 (2.9) |
| Anxiety – Depression | 14.2 (4.4) | 7.5 (3.7)** | 14.0 (2.6) | 11.6 (3.2) |
| Hostility – Suspicious | 4.3 (3.0) | 1.5 (2.2)** | 3.4 (3.3) | 3.8 (2.3) |
| Activation | 5.4 (3.7) | 2.3 (2.9)* | 4.6 (2.9) | 2.9 (1.9) |

* $\leq$.05 ** $\leq$.001

# Client observation (pilot)

**Table 3 - Client observation total and item scores**

| | Experimental (N=32) | | Control (N=26) | |
|---|---|---|---|---|
| | Baseline | Followup | Baseline | Followup |
| | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) |
| Total Client Observation | 19.7 (4.2) | 7 (4.8)** | 12.8 (3.6) | 9.0 (3.2) |
| Repetitively self-defeating behavior | 4.8 (.4) | 1.7 (1.3)* | 3.6 (1.1) | 2.3 (1.3) |
| Self-absorbed or entranced | 2.0 (1.3) | 1.3 (1.8)** | 2.1 (1.6) | 1.7 (1.5) |
| Misperceptions of reality | 2.6 (2.3) | 0.7 (1.1) | 0.5 (1.2) | 0.4 (1.0) |
| Ever shifting priorities | 3.8 (1.8) | 1.3 (1.3)** | 3.4 (1.0) | 2.3 (0.9) |
| Is needy, with ever shifting wants | 3.9 (1.8) | 1.4 (1.3)** | 3.3 (1.3) | 2.3 (1.2) |

* ≤.05 **≤.001

# Client self-observation (pilot)

**Table 4 - Client self-observation total and item scores**

| | Experimental (N=32) | | Control (N=26) | |
|---|---|---|---|---|
| | Baseline | Followup | Baseline | Followup |
| | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) |
| Total Client Self-observation | 32.3 (6.8) | 19.3 (6.8)* | 35.7 (6.2) | 24.7 (5.0) |
| Mentally overloaded, overwhelmed | 4.5 (1.1) | 2.3 (1.3)* | 4.5 (0.9) | 3.2 (1.2) |
| Vigilance | 3.7 (1.5) | 2.0 (1.3) | 4.3 (1.1) | 2.7 (1.2) |
| Circular rumination | 4.3 (1.4) | 2.7 (1.5)* | 4.1 (1.5) | 3.0 (1.3) |
| Helplessness and depression | 4.5 (1.1) | 3.0 (1.1) | 4.4 (1.1) | 3.1 (1.1) |
| Irrational urges | 3.7 (1.9) | 1.9 (1.6) | 4.0 (1.0) | 2.3 (1.1) |
| Intrusive flashbacks | 3.1 (2.1) | 2.2 (1.8) | 3.7 (1.5) | 2.5 (1.3) |
| Dissociative symptoms | 1.7 (2.1) | 0.8 (1.3) | 2.6 (1.8.) | 1.6 (1.2) |
| Inability to make judgments of priorities | 3.5 (1.9) | 2.1 (1.6) | 4.3 (0.9) | 3.0 (1.1) |
| Inability to make judgments of trust | 3.4 (1.9) | 2.4 (1.8) | 3.8 (1.0) | 3.3 (1.2) |

*≤.05

# The Cochrane Review

- Cochrane Review identified 1958 studies in the literature. It included this study among fifteen which "merited closer inspection".

  The Review critiqued the study for lacking randomization. All patients had been included in the order of admission, however, all experimental subjects were treated in one crisis stabilization unit and all controls in another comparable unit.

  Borschmann R, Henderson C, Hogg J, Phillips R, Moran P. Crisis interventions for people with borderline personality disorder. Cochrane Database of Systematic Reviews 2012, Issue 6. Art. No.: CD009353. DOI: 10.1002/14651858.CD009353.pub2.