Post-Traumatic Stress Disorder (PTSD) in Abuse Victims & Survivors

Research has compared the symptoms suffered by combat soldiers, prisoners of war, and refugees to that of survivors of family violence. Battered wives and abused children, as well as rape and incest survivors, often struggle with symptoms of PTSD.

What exactly is PTSD?

- Symptoms of PTSD include: intrusive thoughts, flashbacks, nightmares, indecision, inability to concentrate, memory problems, lowered sex drive, hypervigilance, and depression.
- Those who have endured long-term, or repeated trauma were most likely to be affected with PTSD—and this is often the case for survivors of family violence.
- The intensity of the PTSD is determined in part by the amount of trauma a person has suffered, as well as the severity of the stressors themselves.
- PTSD is not merely a psychological construct, but a biophysiological condition brought on by life-threatening experiences. Treatment for PTSD can include medication, therapy, and EMDR, a technique that has been found to be superior to traditional treatment (medication and therapy alone).

Problems in diagnosing PTSD

- Abuse survivors, particularly battered women, are commonly misdiagnosed and mistreated due to professionals’ lack of knowledge of the long-lasting effects of victimization.
- “ADD and post-traumatic stress disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders . . . have many symptoms in common, such as hyperarousal, hypervigilance, and impulsivity.”
- Criteria for PTSD have been and remain controversial, as there is considerable overlap between symptoms of PTSD and symptoms of depression and anxiety.
- A further complication in accurate diagnosis is concomitant substance use. Many trauma survivors self-medicate with drugs and alcohol, attempting relieve their PTSD symptoms. Thus, the PTSD diagnosis is sometimes lost when too much focus is placed on an addiction that is secondary to the disorder.

PTSD can result from a single traumatic event or repeated, prolonged trauma.

- Some research distinguishes between PTSD resulting from a single traumatic event (such as rape, catastrophic accident, or a natural disaster) as Type I, and PTSD resulting from prolonged, repeated trauma as being Type II. Researchers and practitioners have seized upon this concept, finding it clarifies appropriate and different levels of intervention for each type of trauma.
- The Type II syndrome includes symptoms of denial and psychic numbing; self-hypnosis and dissociation; and alternate extremes of behavior ranging from extreme passivity to outbursts of rage. These symptoms are exhibited in both adult victims and child witnesses to domestic violence.

Complex Post-Traumatic Stress Disorder (CPTSD).

Survivors of long-term, repeated abuse suffer many of the same symptoms of PTSD, but their symptoms may be more subtle, making an accurate diagnosis extremely difficult. One leading clinical researcher advocates the use of a new term, Complex Post-Traumatic Stress Disorder (CPTSD) to better describe the Type II Syndrome:
Even the diagnosis of “post-traumatic stress disorder,” as it is presently defined, does not fit accurately enough. The existing diagnostic criteria for this disorder are derived mainly from survivors of circumscribed traumatic events. They are based on the prototypes of combat, disaster, and rape. In survivors of prolonged, repeated trauma, the symptom picture is often far more complex. Survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity.13

Evidence of long-term effects. Many of the symptoms of PTSD (intrusive thoughts, flashbacks, nightmares, indecision, inability to concentrate, memory problems, lowered sex drive, hypervigilance and depression) were present in survivors who had been free from their abusive relationships for over a decade.14

What distinguishes CPTSD from simple PTSD? People with CPTSD exhibit alterations in six specific domain areas, with unique and distinctive alterations in each respective domain, as noted below.

1. Affect (emotional state reflected in facial expression or body language), such as: Persistent dysphoria, chronic thoughts of suicide, self-injury; explosive or extremely limited anger, and compulsive or extremely inhibited sexuality.
2. Consciousness: Amnesia (blocking out memory) regarding traumatic events, transient dissociate episodes, or reliving experiences either in the form of intrusive thoughts or ruminative preoccupation.
3. Self-perception: A sense of helplessness or paralysis of initiative; shame, guilt and blame; a sense of defilement or stigma; and a sense of complete difference from others.
4. Perception of the perpetrator: Acceptance of the belief system or rationalizations of the perpetrator, preoccupation with the abuser (including a preoccupation with revenge), or a sense of special or supernatural relationship.
5. Relations with others: Isolation and withdrawal, disruption in intimate relationships, persistent distrust, or repeated failures of self-protection.
6. Systems of meaning: A sense of hopelessness and despair, or a loss of sustaining faith.15

In one study of abuse survivors over a decade after the abusive relationship had ended, long-term effects were found in all of the six domains identified.16 This analysis lends credence to the necessity of a CPTSD diagnostic criterion and provides proof of long-term evidence for a chronic PTSD-like state.

Adult abuse victims most at risk for developing PTSD

- Those with cumulative traumatic exposures have greater vulnerability for the development of PTSD.
- Abused women had higher PTSD scores than and nonabused women, even though both groups shared a history of childhood abuse experiences.
- The presence of psychological abuse in the adult experience of domestic violence was the strongest predictor for development of PTSD in survivors.17

Why is understanding PTSD important in helping abuse victims?

“Explaining PTSD as a syndrome, for example, can reassure a survivor that she is not going crazy and help her understand her symptoms as a typical response to physical injury and psychological terror. . . . By mapping the expectable effects of assault and the internal as well as external roadblocks to recovery, diagnosis can also helpfully guide professional interventions.” 18

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