PERCEIVED TRAUMA: ITS ETIOLOGY AND TREATMENT

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ABSTRACT

Female adolescents in treatment for emotional disturbances are often diagnosed as suffering from borderline personality disorder. The usual treatment plan for such a diagnosis is based upon limit setting and boundary reinforcement. When this fails to produce results, the diagnosis comes into question. The present paper investigated 86 female adolescents who were being treated for problems associated with differentiation and emancipation in an inpatient setting. A treatment variation was introduced which suggested that these females were more likely to be suffering from a variety of post-traumatic stress disorder (PTSD). When their ritualistic behavioral repetitions were addressed by cognitive behavioral approaches, the behavior decreased. The struggle with boundary issues and references to the historical context of misery and deprivation became less frequent when the focus shifted to current behavior. Two groups emerged through the analysis of data. No difference in behavior or response to treatment could be established, but one group lacked a specific troubling experience which is essential for a diagnosis of PTSD. Maladaptive social behavior (e.g., splitting and projection) were accepted as confounding factors associated with cognitive style rather than "borderline" symptoms. With the new approach, recidivism decreased 14% and the number of outbursts diminished 10% to 12%. The altered treatment approach confirmed the hypothesis that these adolescents were experiencing the effects of trauma (actual or perceived) rather than some disabling personality disorder.

The DSM-III borderline personality disorder (BPD) diagnosis (American Psychiatric Association, 1980) is frequently used as a treatment hypothesis for young women who avoid conflicts by impulsive behavior (Kernberg, 1989; Rinsley, 1988). In a survey of a 10-bed inpatient psychiatric ward for female adolescents, the average admissions over three months for BPD was 7.57. Sixty-five percent of those patients said they had been physically or sexually abused before the age of 11. Sixty percent of those discharged were readmitted within a year. This suggested the possibility of an alternative treatment hypothesis. The

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ritualized activity style of post-traumatic stress disorder (PTSD), with its cyclic anxiety and depression, appeared to be the more likely choice (Luborsky, Singer, & Luborsky, 1975).

Post-traumatic stress disorder (PTSD) is currently defined in relationship to “an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone” (DSM-III-R; American Psychiatric Association, 1987, p. 146). As will be borne out by the following data, a substantial percentage of the treatment sample could identify no single precipitating event. Even allowing for the highly infectious nature of teenage interaction, the similarity of symptoms could not be explained by the existing restricted definition of PTSD. If the PTSD criterion were expanded to include neglect and perceived abuse (several events that combine to generate a stable perception of trauma), then the observed similarity within the sample would make clinical sense.

The purpose here is to suggest a move from the limitations of a single, objective event to a more useful concept for the adolescent population. Without destroying the boundaries of the existing criterion, it would be useful to allow for perceptions of abuse or attack on the psychosocial level, where identity or trust is eroded. This would be of benefit to the treatment of some adolescents (Earl, 1987b). If PTSD is broadened to allow for consideration of clusters of events, this would enhance the treatment possibilities. Because character disorders such as BPD are considered to be resistant to treatment, avoiding such damaging diagnostic considerations (Shapiro, 1990) allows for a wider range of productive treatment approaches, while reserving the more drastic diagnosis of character disorder for more residual traits.

Perceived trauma (PT) is presented as a treatment hypothesis to be included in the existing decision tree (DSM-III-R; American Psychiatric Association, 1987). The expansion is a natural one since currently the clinical implementation admits a certain ambiguity within the development of PTSD. Such nonevent experiences as “battle fatigue” and “shell shock” are considered within the category, particularly for men whose military encounters preceded Vietnam (Williams, 1987). These experiences suggest prolonged exposure to a sequence of events, none of which by itself may be life-threatening or traumatic, but in concert are perceived as such. In noncombat situations, similar psychological distress is thought of as “burnout.” Continual exposure to a “toxic” environment, or one in which the developing individual is devalued over time, can produce symptoms similar to those outlined in the PTSD criterion (DSM-III-R; American Psychiatric Association, 1987, pp. 146–148; Earl, 1987a).

For many practitioners, the behavior associated with nonevent traumas is understood to be generalized self-destructive behavior (border-
line personality disorder) rather than a pattern of decompensation associated with perceived trauma. To dismiss the client who presents with cycles of anxiety and depression as well as some disorganized thinking or dissociation after a nonviolent mugging as having a borderline personality disorder is to cheat that client of a beneficial treatment intervention. This is particularly true of the adolescent, whose sense of the normal may not be well enough established to resist the allure of a traumatic perception (Linday, 1986). Titchener (1982), a leading authority on the subject of disabling trauma, stated that “the traumatized human becomes a reflection of the violence wrought upon him and remains so until there are dynamic changes in adaptive resources.”

The dysfunctional symptoms that spring from trauma are varied enough to make a reliable catalogue difficult to assemble. Context is therefore offered since the validating perceptions of intrusion and threat are frequently unavailable (Herman, 1980; Silver, 1986). The therapist must rely upon an evidenced pattern. Figley (1986) presents three major criteria for defining trauma: the event must be sudden, dangerous, and overwhelming. This, however, is not useful when assessing perceived trauma in the adolescent client.

Trauma is validated when an event is (1) unexpected and well outside the range of common human experience; (2) persistently reexperienced in one of four defined ways as per DSM-III-R (p. 146); (3) able to provoke a persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness; and (4) able to stimulate persistent symptoms of increased arousal not present before the trauma (DSM-III-R). The point of demarcation remains an identified event. Perceptions of a theme that may underlie several encounters are not considered, and yet they are the more potent disablers (e.g., “shell shock” and “battle fatigue”). Event-centered trauma (PTSD) has been well documented:

Reports from skilled self-observers, professionals in mental health fields, tell us with some amazement how long it took them to confront and work through the effects of a traumatic experience in their own lives. Our work with the survivors of the Buffalo Creek disaster (Titchener & Kapp, 1976; Titchener, Kapp, & Winget, 1978), at the Beverly Hills Supper Club, at the sites of several tornadoes, and from previous studies of accident victims have shown that the traumatic syndrome is not a derivation or mere elaboration of a preexisting neurosis, but an illness in itself (Titchener, 1982).

In the absence of such an obvious interruption in the client’s sense of security, the diagnosis is harder to verify, though the symptoms can be as profound when predictability is offended (Watzlawick, 1976).
Interest in the symptoms that can accompany traumatic events goes back many centuries (Segal, 1974; Smith, 1981; Veith, 1965), with hysteria frequently seen as a primary coping mechanism (Figley, 1986). This confounds diagnostic precision even more, since many consider hysteria to be a pathological condition (Shapiro, 1959). Any construct that reaches back in time requires redefinition, and adaptive styles must reflect the age in which they are described. There has always been the difficulty of context when considering the symptoms that accompany trauma. The point at which dysfunction becomes pathological appears to be cohort specific and in many cases restricted to personal expectations (Laudenslager & Reite, 1984).

Bateson (1972) and his associates in the family therapy movement enabled clinicians to conceptualize ailments in the context of systemic forces. Any valid therapeutic intervention must locate the individual within the system. Validation of client perception is currently accepted as an important ingredient in successful treatment procedures (Mason, 1983; Miller, 1990; Zane & Milt, 1984). It is within this context that perceived trauma is introduced. The sequence that led from shell shock to battle fatigue to PTSD is useful in applying perceptions of neglect and abuse to the life experiences of the adolescent. When expectations have been violated, the stability of the developmental sequence is altered (Smith, 1980). In addition, perceptions of role (Bem, 1981) and gender schemata (Markus, Crane, Bernstein, & Siladi, 1982) are disrupted (Wethington, McLoed, & Kessler, 1987). The approach to treatment offers the best indication of the clinical difficulty to be overcome (personality disorder vs. perceived or experienced trauma).

The core of the development of PTSD or of the dysfunctional behaviors associated with perceived trauma is the intrapsychic or “cognitive” processing of presented stimuli (Horowitz, 1976). The models for PTSD generated by the University of Cincinnati Traumatic Stress Study Center (Green, Wilson, & Lindy, 1985) apply to perceived trauma as well, and include the variables of (1) traumatic stressor characteristics, (2) individual traits, and (3) elements in the recovery environment. The model for trauma is cognitive, as is the more successful intervention approach. To the extent that cognitive-behavioral therapy (Foreyt & Rathjen, 1978; Marmor, 1979; Wachtel, 1977) is useful, the altered clinical approach is supported (Quarentelli & Dynes, 1973; Williams, 1980).

THE STUDY

The expansion of post-traumatic stress disorder (Figley, 1986; Michelle & Ascher, 1987; Williams, 1987) to include nonevent experiences

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(perceived trauma) is largely validated by treatment outcome. The rationale for undertaking the present study was the inability to differentiate between girls who had suffered a specific trauma and those who presented similar symptoms but who had not experienced such an incident. The latter group presented the perception of a pattern of accumulated stressors similar to those offered in the diagnosis of "war neurosis" (Glass, 1969), the original "gross stress reaction" (DSM-I; American Psychiatric Association, 1952), "exhaustion" or "combat fatigue" (Figley, 1978). For this reason the construct of perceived trauma was put to clinical trials.

Two hypotheses were explored. The first was conducted to validate the absence of a statistical difference between groups (treatment vs. comparison) as well as the absence of factors within each group that might be of statistical significance. The second hypothesis centered on cognitive styles, presuming that there would be no significant difference between and within sample groups.

METHOD

The treatment group consisted of 85 adolescent girls, 60 of whom described a specific event (such as physical abuse or sexual assault) to justify a diagnosis of PTSD, and 25 who had experienced no such incident to account for their symptoms. The comparison group consisted of 90 girls of similar age and economic background who were randomly selected from a local high school. Thirty-three of the treatment group had been pregnant, and 28 of the comparison group had been or were pregnant. None of the girls were raising infants at the time of the study, although seven of the treatment sample had offspring being raised by relatives; five of the comparison group reported a similar situation.

Each subject was interviewed using a standardized questionnaire and then administered the Cognitive Styles Inventory (Wells, 1984). A random sample of each group was given the MMPI.

RESULTS

Factor analysis yielded no statistical difference between the comparison and treatment groups on the dimensions of the structured interview. Thirty-six of the comparison group reported a traumatic event (physical abuse or sexual assault). Within the treatment group, 25 did not identify a single incident to account for their symptoms.
This was the primary difference found within or between the groups. The first hypothesis of no within-group difference had to be rejected.

The second hypothesis was tested through the use of the Cognitive Styles Inventory (CSI; Wells, 1984). The CSI has been standardized to identify extreme traits of hysterical and compulsive/obsessive styles of cognition. The primary factors used were respect for rules and response to affect. No statistical difference emerged between the groups.

A slight difference appeared when the treatment group was compared to the nontreatment group on four MMPI scales. The treatment group had higher scores on the Depression, Psychopathic-Deviate, Masculinity-Femininity, and Hypomania scales. The lack of clear statistical significance does not negate the differences observed in these scales. What appears to be most operative in this profile is the process of socialization and the adjustment of expectations which are typical aspects of adolescence. The affective intensity associated with this stage of development may also account for the difference in feminine identity. Nevertheless, the second hypothesis pertaining to a difference in cognitive styles within or between groups had to be accepted. No such difference emerged.

DISCUSSION

The only difference within or between the groups concerned the presence or absence of an identifiable traumatic event. Thirty percent of the treatment population could identify a theme or series of events but no single event. The fact that these young women responded to the treatment usually applied to victims of trauma is considered a valuable indicator of the existence of perceived trauma. Perceived trauma, as a concept, contains elements of an unstable and possibly unrealistic belief system as well as unfulfilled expectations which appear to be associated more with age than with cognitive style.

When the treatment plan was shifted from the imposition of boundaries or limit-setting to one that encouraged the styles of conflict resolution associated with trauma, recidivism decreased by 14% (returning to an institutional setting within 18 months of discharge). Outbursts fell by 10% to 12% when measured across living situations. These percentages may lack statistical significance, but their direction and strength confirm the clinical findings that the trauma model may be useful in treating some adolescents who present with impulsive behavioral difficulties.

Confounding variables associated with this study appear from the use of available subjects; this is likely to introduce a bias in the sample. The largest possible source of distortion is due to the age of the pop-
ulation. Adolescents present with exaggerated affect, distorted belief systems, inflated self-importance, and other characteristics that appear in the spectrum of the borderline personality disorder. More research is needed in this area, but the findings of this study support the concept of perceived trauma as a treatment hypothesis for some adolescents experiencing emotional disturbances.

REFERENCES


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