Challenges in Treating Post-traumatic Stress Disorder and Attachment Trauma

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Introduction
Post-traumatic stress disorder (PTSD) is a cruel illness. Having survived experiences of helplessness and horror in the face of overwhelmingly stressful events, the PTSD sufferer subsequently re-experiences the traumatic events and emotions in her mind. These frightening intrusive post-traumatic memories are embedded in a cascade of adverse physiologic, psychological, and interpersonal consequences. Not uncommonly, the illness is as traumatic as the precipitating stressful events. Women suffering PTSD are often enjoined, “just put the past behind you!” They fervently wish to do so, but they cannot do it by an act of will. Even with the best of current interventions, women with PTSD might have a hard time recovering.

After a review of some diagnostic considerations, this article provides an overview of current treatment approaches for PTSD. But PTSD is only the tip of the trauma iceberg. The diagnostic formulation of PTSD in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) [1] best fits the prototype of circumscribed traumatic events, such as a motor vehicle accident or a rape. No doubt, such single-event stressors can be profoundly traumatic, and rape is among the stressors carrying the highest risk of PTSD. Yet many of the traumatized patients who are most challenging to treat have been exposed to multiple traumas over their lifetime. Not uncommonly, they function remarkably well despite their history of trauma until they encounter further stressful events in adulthood to which their history renders them particularly vulnerable. Most pernicious in creating such vulnerability are traumatic attachment relationships in childhood, in the context of which clinicians must contend with complex developmental psychopathology and pathophysiology. This article addresses the treatment challenges associated with this broader spectrum of trauma and concludes by considering the emotional challenges therapists face in treating traumatized women.

Diagnostic Considerations
Alternating between intrusive and avoidant symptoms in an all-or-none pattern is the hallmark of PTSD. It is little wonder that women experiencing terrifying intrusive post-traumatic symptoms become caught up in a pattern of strategic avoidance: they try not to think about the trauma; they do not talk about it; and they attempt to avoid persons and places that remind them of it. At worst, a pervasive pattern of avoidance might lead to social isolation and, thereby, completely undermine functioning. Moreover, avoidance invariably backfires in PTSD, as illustrated by research indicating that efforts to suppress distressing thoughts ironically increases their occurrence [2].

As an anxiety disorder, PTSD also includes hyperarousal, manifested by intense psychological distress and physiologic arousal, including exaggerated startle, in response to reminders of trauma. The hyperarousal is intertwined with intrusive symptoms and hypervigilance. Although DSM-IV-TR [1] groups avoidance and numbing in one symptom cluster, Foa et al.’s [3] study of female assault victims suggested that these are distinct processes. Numbing is a relatively passive and automatic process that occurs when more active, strategic efforts at avoidance are unsuccessful in failing to diminish hyperarousal. Of
course, avoidance and numbing both block necessary cognitive and emotional processing of trauma.

Unfortunately, sleep does not necessarily provide respite from symptoms of PTSD. Not only nightmares but also nocturnal panic and abnormal movements disturb sleep. Furthermore, anticipating nightmares or associating being in bed with being abused or assaulted, many traumatized women come to fear sleeping or being in bed. Hyperarousal, phobic avoidance, and fearful awakenings can become intermingled in vicious circles [4]. Chronic sleep disturbance can become one of the most incapacitating symptoms of PTSD.

The "post" in PTSD underscores the temporal aspects of the disorder. The trauma response begins with a potentially wide array of peritraumatic symptoms that occur in the immediate aftermath of exposure to a traumatic event, such as fearfulness, helplessness, agitation, irritability, confusion, or disorientation [5]. When they are sufficiently severe and impairing, peritraumatic symptoms shade into acute stress disorder (ASD), which might be diagnosed in the first month after trauma. ASD includes not only intrusive, avoidant, and hyperarousal symptoms but also dissociative symptoms including detachment, depersonalization, derealization, and amnesia. At the 1-month point, with the shift in diagnosis from ASD to PTSD, the dissociative symptoms that often accompany PTSD are diagnosed separately as a dissociative disorder.

Acute PTSD is diagnosed if symptoms persist beyond 1 month, and chronic PTSD is diagnosed if symptoms persist beyond 3 months. PTSD with delayed onset is diagnosed if the symptoms emerge long after the traumatic events, and such delayed onsets might range from many months to decades. ASD, acute PTSD, and chronic PTSD are distinguished for the purpose of forecasting chronicity. Consistent with this intention, there is some evidence that ASD predicts PTSD [6] and that continuation of PTSD symptoms beyond a few months predicts chronicity [7]. Nonetheless, although initial symptom severity (including peritraumatic symptoms) generally predicts subsequent disorder, the wide variability in outcomes raises questions about specifying exact timelines for transition from one discrete disorder to another, such that these fine diagnostic distinctions create an illusion of precision [8].

The DSM-IV diagnosis of PTSD is based on a prototype of a physically threatening single-event trauma and a syndrome that evolves in relation to that event. However, many women experience a multitude of traumatic events, often spanning childhood to adulthood, and different symptoms might evolve in relation to different events (e.g., flashbacks related to a rape; nightmares related to being locked in a closet in childhood; and avoidance of driving due to a motor vehicle accident). In addition, whereas threat to physical integrity is emphasized in DSM-IV, psychological assaults also can be profoundly traumatic. Such assaults range from verbal abuse to outright cruelty (e.g., terrorizing, humiliating, brainwashing) and might occur in child abuse as well as adult battering relationships. Patients tend to minimize the impact of such psychological abuse in comparison with physical and sexual abuse, but it can be profoundly damaging to the sense of self and, when occurring in childhood, carries a high risk of adult depression and suicidal states [9, 10].

Because the PTSD syndrome is so directly linked to traumatic events by virtue of re-experiencing symptoms, PTSD might be the most conspicuous form of trauma. Yet trauma can make a significant contribution to a wide range of psychiatric disorders, including dissociative disorders, mood disorders, substance abuse, eating disorders, and personality disorders [11]. Borderline personality disorder has received greatest attention in conjunction with trauma, and childhood sexual abuse in particular [12]. Yet trauma also contributes to a wide range of personality disturbances beyond borderline disorder [13]. Although it is not a diagnosis, the syndrome of deliberate self-harm (e.g., self-cutting, self-burning, nonlethal overdoses) is also common in conjunction with trauma and with childhood sexual abuse in particular. In addition, psychotic symptoms (hallucinations and delusions) are not uncommon in conjunction with PTSD [14] and dissociative disorders [15]. Hence, distinguishing trauma-related psychotic symptoms from primary psychotic disorders (e.g., schizophrenia, schizoaffective disorder) is a common diagnostic challenge. To complicate matters further, PTSD is not uncommon, albeit frequently undiagnosed, in patients with primary psychotic disorders [16].

PTSD might or might not be among the trauma-related disorders for which a patient seeks treatment. Commonly, for example, patients with a severe trauma history seek treatment for depression and suicidal states. When it is present, PTSD is often embedded in more extensive psychopathology and also accompanied by multiple general medical complaints [17]. Such complex psychopathology is not true comorbidity inasmuch as the various disorders are typically intertwined in a cascade rather than being independent of one another [18]. Herman [19] proposed the concept of "complex PTSD" for the amalgam of symptoms that crystallize around prolonged trauma in abusive relationships. Although this concept serves as descriptive shorthand for the contribution of severe trauma to diverse psychopathology, it is extremely broad and was not accepted into the diagnostic nomenclature, in which the potentially wide spectrum of symptoms are listed as associated features of PTSD [1].

Given that traumatized patients might present such a wide array of psychiatric and general medical complaints, we have found a number of brief, self-administered questionnaires to be useful screening devices. Questionnaires have been developed for assessing trauma history [20], PTSD symptoms [21], and dissociation [22] as well as post-traumatic sleep disturbance [4]. All of these questionnaires quickly pinpoint symptoms that can be clarified in focused clinical interviews, and a number of structured interviews have been developed to make more definitive diagnoses [23].
Treating Post-traumatic Stress Disorder

McFarlane [24] advocated that PTSD be construed as a disorder of transition that reflects an inability to modulate the acute stress response. A high level of acute distress predicts PTSD. However, it is important to keep in mind that most people exposed to potentially traumatic stressors, even those who are highly distressed at the time, do not go on to develop PTSD. Peritraumatic dissociative symptoms, however, confer a particularly high risk for PTSD [25]. In addition, peritraumatic pathophysiology is indicated by elevated heart rate and lowered cortisol levels around the time of trauma, and these physiologic signs also predict PTSD. Because cortisol secretion ordinarily serves to contain the adrenergic response to stress, vulnerability to PTSD might be common to these approaches. Foa [32] identified three key components of effective trauma treatment: emotional engagement with the trauma memory (eg, feeling and expressing the associated fear); constructing a coherent narrative account of the trauma; and altering negative cognitions about the self and the world. Foa and Rothbaum [7] have refined a treatment protocol for rape trauma, the core of which entails exposure to traumatic memories (imaginal exposure) and to avoided situations—eg, by returning to the vicinity of the rape when it is safe to do so (in vivo exposure). Patients become desensitized in the process of repeatedly recounting the traumatic event in several tape-recorded individual therapy sessions, and this process is augmented by listening to tape recordings between sessions as well as by in vivo exposure.

In addition to the therapeutic exposure, which entails engagement with the trauma memory and constructing a coherent narrative, Foa incorporates cognitive therapy into the process to address the negative cognitions. The importance of this cognitive component is demonstrated by findings that ongoing PTSD is highly related to negative views of the self, such as self-blame, as well as to negative views of the world as being extremely dangerous, the latter views carrying a sense of ongoing threat that fuels anxiety [33]. Cognitive restructuring treatment for PTSD [34] targets such negative beliefs, but it also entails imaginal exposure (ie, writing about the traumatic event and talking about it in therapy). Eye movement desensitization and reprocessing (EMDR) also involves bringing traumatic images to mind and putting them into words, as well as re-evaluating negative cognitions [35]. Although EMDR has much in common with other PTSD treatments that include exposure and cognitive restructuring, controversy has focused on one component of the intervention: after the patient brings the traumatic image to mind, she follows the therapist’s fingers moving back and forth in front of her eyes. This procedure appears to stimulate an array of shifting associations, over the course of which the vividness or distressing impact of traumatic images diminishes. Although research supports the effectiveness of the whole EMDR process [36], there is little evidence for any unique contribution of the eye movements to the outcome [37]. Perhaps the commonalities among approaches and their eclecticism bears greatest emphasis. In addition to helping the patient bring the trauma to mind and to talk about it, cognitive-behavior and EMDR therapists educate their patients about PTSD and its treatment and also incorporate techniques to help patients manage fear and anxiety (eg, relaxation, deep breathing, guided imagery).

Group therapy has been less researched but is widely employed in treating trauma. As Yalom [38] demonstrated, group therapy provides a unique opportunity for engendering a sense of universality, a recognition that one’s experiences are shared by others. Universality is a crucially important experience for women traumatized by rape, sexual abuse, and battering. Group therapy runs the risk of being overstimulating and disorganizing, and must be conducted with attention to structure and support [19].
However, properly conducted group therapy has been shown to be an effective intervention for rape trauma [39] and for childhood sexual abuse [40].

Research on the effectiveness of trauma treatment can be seen as a glass half full or half empty. To reiterate, many seeking treatment for trauma present with a wide range of trauma-related disorders (complex PTSD). However, many of the most methodologically sound studies have exclusion criteria that rule out these patients (eg, severe depression and suicidal states, psychotic symptoms, substance abuse, childhood sexual abuse as a primary problem, ongoing abusive relationships). In addition, many controlled studies include persons responding to single-event traumas rather than patients with a long history of extensive trauma. Even with these restrictions, the outcomes are often modest, with a substantial proportion of treated patients showing significant residual symptomatology and many continuing to meet criteria for ongoing PTSD. Similarly, our naturalistic follow-up study of specialized inpatient treatment for women with severe trauma-related psychopathology showed substantial improvement in most patients, but sustained impairment in a substantial minority as well as a tendency toward recurrence of symptoms over time [41]. Hence, we have no reason to be sanguine about psychosocial treatments for PTSD.

Psychopharmacologic treatment of PTSD is beyond the scope of this article and has been reviewed elsewhere [42, 43]. Given the panoply of symptoms and syndromes beyond PTSD that are associated with trauma, it is not surprising that a wide range of agents have been used, including antidepressants, antianxiety and antiaudrenergic agents, mood stabilizers, opioid antagonists, and antipsychotic agents. Although controlled studies are limited, selective serotonin reuptake inhibitors (SSRIs) have been found to be effective in the treatment of trauma related to sexual abuse [44] as well as to physical and sexual assault [45]. Yet pharmacologic treatment of PTSD has relied on agents employed in the treatment of other disorders, and the development of agents that are specific to the pathophysiology of PTSD is a high priority [27–42].

Attachment Trauma
Attachment trauma is trauma that occurs in the context of an attachment relationship. There is no doubt about the extent of trauma that can be inflicted in adult attachment relationships, such as battering relationships [46]. However, trauma in childhood attachment relationships—that is, abuse and neglect in relationships with parents and other caregivers—is especially pernicious in damaging the attachment system. Early attachment relationships can be construed as meeting biologic needs for protection [47], and these relationships not only provide a feeling of security but also foster physiologic regulation [48] as well as the development of neocortical structures required for affect regulation [49–50]. Therefore, attachment trauma in childhood entails a dual liability [50]: the traumatic attachment relationship not only inflicts marked distress but also simultaneously undermines the development of the capacity to regulate distress; that is, maltreated children are hampered in developing physiologic and affective self-regulation and in learning to rely on close relationships for distress regulation. A traumatic relationship with an attachment figure engenders fear and fails to alleviate it, placing the child in a situation that Main [51] characterized as fright without solution. Hence, maltreatment is associated with the most profoundly insecure attachment pattern, disorganized attachment, in which the child is unable to find any systematic strategy for relating to the attachment figure [52]. Therefore, in adulthood, women with a history of attachment trauma are inclined to employ desperate measures to regulate their emotional states, including alcohol and drug abuse; bingeing and purging; self-cutting; and, at worst, suicidal behavior [11].

Attachment trauma takes many forms. Childhood sexual abuse received needed attention belatedly [53]. Sexual abuse in early attachment relationships can be construed as betrayal trauma [54] that not only damages trust but also engenders a dissociative splitting of the mind in an effort to preserve the illusion of a much-needed safe attachment. However, sexual abuse is often intertwined with other forms of abuse and neglect, to the extent that sexual abuse is a marker for severe family dysfunction [12]. Although physical abuse has long been recognized as traumatic, psychological abuse—and cruelty in particular—is too frequently overlooked [10]. Psychological abuse is a direct attack on the self and the mind and, as noted earlier, its impact can be profoundly damaging. Moreover, the neglect of neglect is notorious [55], notwithstanding that its adverse impact might exceed that of abuse [56]. In educating patients about attachment trauma, it is useful to emphasize the combination of abuse and neglect as most harmful [11]. Simply put, the child or traumatized adult is often put in the position of feeling afraid and alone—that is, feeling helpless while lacking the experience of restorative comforting and protection. It is the combination of abuse and neglect that most undermines the developing capacity for secure attachment relationships and the concomitant opportunity to learn to regulate emotion.

Much of attachment trauma entails repeated episodes of multiple forms of abuse in combination with neglect. A particularly unfortunate adult outcome of such trauma is a propensity toward re-enactment [57]. A particularly troubling prototype of re-enactment is entering into battering relationships on the heels of a history of childhood abuse. Not uncommonly, such re-enactment contributes to a pattern of multigenerational transmission of abuse that can be extremely difficult to interrupt. Perpetual re-enactment contributes further to a regimen of extreme, repeated, uncontrollable stress that might eventuate in sensitization, evident in an increasingly lowered threshold of stress responsiveness. A significant part of the pathophysiology
of PTSD, sensitization has been demonstrated in the full range of stress response systems: noradrenergic, dopaminergic, opioid, and the hypothalamic-pituitary-adrenal axis [58]. The re-experiencing of symptoms of PTSD might further escalate the process of sensitization, to the extent that Post et al. [59] suggested that these symptoms be considered a medical emergency. Therefore, patients who are chastised for “making mountains out of molehills” must understand the contribution of their sensitized nervous system to the process. Of course, to the observer, only the molehill is evident, whereas the mountain of attachment trauma and its associated pathophysiology is obscured.

The concept of sensitization helps clinicians and their patients understand the basis for extreme stress reactivity characteristic of PTSD. But we can take this neurobiologic understanding one step further by appreciating how such reactivity undermines cognitive functions and effective coping. Mayes [60] summarized recent research that has begun to pinpoint how extreme stress eventuates in altered dynamics in arousal regulation that impairs the functioning of the prefrontal cortex. The prefrontal cortex plays a central role in executive functions—that is, planning and temporal ordering of responses in the context of ambiguity and novelty. These executive capacities are crucial not only for complex problem solving but also for adaptive social interactions. As arousal escalates, increasing levels of norepinephrine and dopamine interact to shift the balance between prefrontal executive control and posterior-subcortical automatic control over attention and behavior. Mild-to-moderate levels of arousal are associated with optimal prefrontal functioning, whereas extreme levels of arousal trigger a neurochemical switch that promotes posterior cortical-subcortical dominance. In the latter mode, vigilance, the fight-flight-freeze response, and amygdala-mediated memory encoding predominate. In effect, high levels of excitatory stimulation take the prefrontal cortex off-line.

This switch in attentional and behavioral control is adaptive in the context of danger situations that require rapid automatic responding. However, Mayes [60] pointed out that early stressful and traumatic experiences might permanently impair the dynamic balance of arousal regulation, lowering the threshold for this switch process. Hence, sensitized individuals might be prone to impaired prefrontal functioning in the face of stress, with automatic posterior-subcortical responding taking control of attention and behavior, undermining flexible coping. Therefore, restoring active coping in the face of reminders of trauma is one of the central challenges of treatment [61]. For example, patients in the throes of post-traumatic intrusive symptoms might be inclined to sit and rock or to huddle in a corner. With their prefrontal cortical functioning compromised, they need a simple coping strategy. Movement is basic. They can counter their inclination to freeze by getting up and walking around, which might be the first step toward restoring more active coping.

Treating Attachment Trauma
To the extent that attachment trauma eventuates in complex PTSD, treatment is likely to be long and arduous, involving sophisticated psychopharmacology as well as a host of psychosocial interventions—often including inpatient treatment episodes as well as outpatient treatment. Such trauma treatment is best viewed in terms of a phase-oriented approach, in which the initial phase of treatment is involved with ensuring safety, the middle phase involves processing the trauma, and the final phase involves re-establishing interpersonal connection and restoring functioning more generally [19].

This multifaceted treatment approach must balance processing trauma with containment [11]. Processing entails thinking, feeling, and talking about traumatic memories. The cornerstones of containment are secure attachment relationships and self-regulation. Establishing a treatment alliance and stable treatment frame as well as educating patients also contribute to containment. Patients should be encouraged to educate themselves about complex trauma and its treatment, and a number of comprehensive, well-researched books written for laypersons are available [19,62,63]. Trauma treatment often goes awry because there is insufficient containment for processing, and patients must be knowledgeable about this concern. However, for the patient with a history of attachment trauma, establishing containment poses a major challenge. The legacy of attachment trauma is impaired development of capacities for secure attachment and self-regulation. Therefore, effective containment might better be viewed as the optimal outcome of trauma treatment rather than a precondition for it.

One can only approach the treatment of attachment trauma by endeavoring to promote a secure attachment relationship that will foster self-regulation and enable the patient to process the trauma. We construe the processing of trauma in terms of “mentalization”—the capacity to understand oneself and others in terms of intentional mental states, such as desires, feelings, and beliefs [11,50]. We clinicians take our mentalizing ability for granted—it is part of our common-sense “folk” psychology. We could not imagine conducting psychotherapy without keen attunement to what is going on in our patient's mind, and the success of our work depends on engaging the patient in exploring her own mind. However, attachment trauma poses an obstacle to this process.

It is common knowledge that the capacity to mentalize is conspicuously absent in persons with autism [64]. However, researchers are now discovering that attachment trauma also undermines the development of mentalization [50,65]. The traumatized child finds it terrifying to be aware of the mind of her abuser with its malevolent intent. She becomes frightened of her own mental states—feelings, memories, and impulses. In the context of neglect, she has no opportunity to make mental sense of her experience. As Bowlby [66] described, she might have
Anxiety management techniques routinely incorporated into freeze mode, with prefrontal functioning going off-line. To have a lower threshold for switching into the fight-flight activity, and mentalizing trauma is especially challenging. Optimal level of arousal. Mentalizing is a complex cognitive thinkable and speakable—also requires establishing an logical neglect and lack of emotional attunement. Context of attachment trauma insofar as it entailed psychotherapy. Fostering a feel- ing of safety and security in the therapeutic relationship also will be crucial. Common therapeutic factors such as warmth, acceptance, and a calm demeanor are doubly important. But the therapist’s capacity to mentalize—to have the patient’s traumatized mind in mind—will not just provide security but also will facilitate the development of the capacity to form secure attachments that ultimately will be the basis for recovery and reconnection with others.

Conclusions
Treating PTSD stemming from any form of trauma is a challenge, and we must acknowledge the modest effectiveness of our treatments as we empathize with our patients’ courageous struggles to recover. When we endeavor to treat the multiple sequelae of attachment trauma, the challenges only escalate. Treating trauma poses occupational hazards that we therapists must heed [11]. The slow pace of improvement and not infrequent regressions can be demoralizing for us therapists as well as our patients. And we therapists are as likely to have a history of attachment trauma as our patients. We are subject to emotional contagion as well as to having our own traumatic memories evoked by the process. In our efforts to imagine and to empathize with our patients’ trauma, we are vulnerable to high levels of emotional arousal and to secondary traumatic stress. Like our patients, we therapists are vulnerable to excessive arousal that will compromise our prefrontal cortical functioning and our ability to mentalize—to have our patient’s mind in mind. To function effectively in the therapy sessions, and to remain healthy in the face of this stressful work, we therapists also need the containment provided by secure attachments and various methods of self-regulation. We also need education as well as a stable treatment structure and appropriate boundaries that protect us as well as our patients from overinvolvement. We, too, must rely on secure attachments to process our stressful experience. This processing might take place in relationships with colleagues, supervisors, or a psychotherapist. In short, we therapists must follow all our own prescriptions.

References and Recommended Reading
Papers of particular interest, published recently, have been highlighted as:

- Of importance
- Of major importance


Yehuda carefully teases apart differences between PTSD and depression in HPA-axis functioning and succinctly summarizes results of pertinent research.


Shalev neatly integrates the neurobiologic and psychosocial aspects of acute trauma and their implications for intervention.

Campbell R, Selt F, Barnes HE, et al.: Community services for rape survivors: enhancing psychological well-being or increasing trauma? J Consult Clin Psychol 1999, 67:847–858. This study illustrates the potential value of mental health interventions in helping rape victims cope not only with the assault but also with the stresses of medical and legal processes.


