



Rebuilding  
Shattered  
Lives

SECOND EDITION

Treating Complex PTSD and Dissociative Disorders

James A. Chu, MD



# Rebuilding Shattered Lives



# Rebuilding Shattered Lives

---

Treating Complex PTSD  
and Dissociative Disorders

Second Edition

James A. Chu, MD



WILEY

JOHN WILEY & SONS, INC.

This book is printed on acid-free paper. ∞

Copyright © 2011 by John Wiley & Sons, Inc. All rights reserved.

Published by John Wiley & Sons, Inc., Hoboken, New Jersey.

Published simultaneously in Canada.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, scanning, or otherwise, except as permitted under Section 107 or 108 of the 1976 United States Copyright Act, without either the prior written permission of the Publisher, or authorization through payment of the appropriate per-copy fee to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, (978) 750-8400, fax (978) 646-8600, or on the web at [www.copyright.com](http://www.copyright.com). Requests to the Publisher for permission should be addressed to the Permissions Department, John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, (201) 748-6011, fax (201) 748-6008.

**Limit of Liability/Disclaimer of Warranty:** While the publisher and author have used their best efforts in preparing this book, they make no representations or warranties with respect to the accuracy or completeness of the contents of this book and specifically disclaim any implied warranties of merchantability or fitness for a particular purpose. No warranty may be created or extended by sales representatives or written sales materials. The advice and strategies contained herein may not be suitable for your situation. You should consult with a professional where appropriate. Neither the publisher nor author shall be liable for any loss of profit or any other commercial damages, including but not limited to special, incidental, consequential, or other damages.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering professional services. If legal, accounting, medical, psychological or any other expert assistance is required, the services of a competent professional person should be sought.

Designations used by companies to distinguish their products are often claimed as trademarks. In all instances where John Wiley & Sons, Inc. is aware of a claim, the product names appear in initial capital or all capital letters. Readers, however, should contact the appropriate companies for more complete information regarding trademarks and registration.

For general information on our other products and services please contact our Customer Care Department within the U.S. at (800) 762-2974, outside the United States at (317) 572-3993 or fax (317) 572-4002.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books. For more information about Wiley products, visit our website at [www.wiley.com](http://www.wiley.com).

***Library of Congress Cataloging-in-Publication Data:***

Chu, James A.

Rebuilding shattered lives : treating complex PTSD and dissociative disorders / James A. Chu.—2nd ed.  
p. ; cm.

Includes bibliographical references and index.

ISBN 978-0-470-76874-7 (pbk. : alk. paper)

ISBN 978-1-118-01505-6 (ebk)

ISBN 978-1-118-01506-3 (ebk)

ISBN 978-1-118-01504-9 (ebk)

1. Adult child abuse victims—Rehabilitation. 2. Post-traumatic stress disorder—Treatment. 3. Dissociative disorders—Treatment. I. Title.

[DNLM: 1. Stress Disorders, Post-Traumatic—therapy. 2. Adult Survivors of Child Abuse—psychology. 3. Dissociative Disorders—therapy. WM 172]

RC569.5.C55C48 2011

616.85'8223906—dc22

2010037951

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

*This book is dedicated to the generations of staff and patients of the Trauma and Dissociative Disorders Program at McLean Hospital who have taught and inspired me, and to my family, friends, and colleagues who have provided me the support and love that have allowed me to grow, learn, and achieve at least a modicum of wisdom over the years.*



# Contents

---

<i>Foreword</i>	ix
<i>Introduction</i>	xiii
<b>Part I The Nature and Effects of Childhood Abuse</b>	
1 ♦ Trauma and Dissociation: 30 Years of Study and Lessons Learned Along the Way	3
2 ♦ Complex PTSD: The Effects of Chronic Trauma and Victimization	20
3 ♦ Falling Apart: Dissociation and the Dissociative Disorders	41
4 ♦ Derailed: Childhood Trauma, Attachment, and the Development of the Self	65
5 ♦ The Memory Wars: The Nature of Traumatic Memories of Childhood Abuse	78
<b>Part II Phase-Oriented Treatment for Complex PTSD</b>	
6 ♦ The Therapeutic Roller Coaster: Phase-Oriented Treatment for Complex PTSD	109
7 ♦ Staying Safe: The Paradox of Self-Care	129
8 ♦ Containment: Controlling Posttraumatic and Dissociative Symptoms	147

viii CONTENTS

9 ♦ The Therapeutic Dance: Relational Dilemmas in Treating Complex PTSD	160
10 ♦ The “Impossible” Patient: Chronic Disempowerment	175
11 ♦ Good Fences Make Good Neighbors: Maintaining the Treatment Frame	191

**Part III Special Topics in Treatment of Complex Trauma-Related Disorders**

12 ♦ The Rational Treatment of Dissociative Identity Disorder	207
13 ♦ Managing Crisis: Acute Care and Hospitalization	228
14 ♦ Psychopharmacology for Trauma-Related Disorders	246
15 ♦ Controversies and Future Directions in the Field of Trauma and Dissociation	255

<i>Afterword: Why We Do This Work</i>	273
---------------------------------------	-----

<i>Appendix 1: The Dissociative Experiences Scale (DES and DES-T)</i>	276
---	-----

<i>Appendix 2: The Somatoform Dissociation Questionnaire (SDQ-20 and SDQ-5)</i>	282
---	-----

<i>Appendix 3: The Multidimensional Inventory of Dissociation (MID)</i>	287
---	-----

<i>References</i>	299
-------------------	-----

<i>Author Index</i>	327
---------------------	-----

<i>Subject Index</i>	332
----------------------	-----

## Foreword

---

When I was asked to update the foreword I wrote in 1998 for *Rebuilding Shattered Lives*, I accepted with enthusiasm, eager to learn what Dr. James Chu had revised in his now-classic book on the treatment of complex PTSD and dissociative disorders. This revision does not disappoint and, in fact, builds on the first edition and adds to it the insights gained and information published since the original came out. As before, this revision provides clinical wisdom and clarity of discussion regarding the treatment of this challenging population of patients. It also provides support and sustenance to the clinician reader (whether novice or seasoned) facing the challenges these cases present and the dilemmas they often spawn. Dr. Chu's approach is grounded in theory and extensive experience and is thoughtful and thought-provoking but anxiety-diminishing. The guidance provided makes the process more transparent and hence more understandable to the treating clinician.

As in the first edition, Dr. Chu calls upon his considerable inpatient and outpatient experience with these patients and his familiarity with the pertinent literature to elucidate the treatment model and guidelines presented in this book. The model helps the clinician steer a reasonable course in providing treatment to traumatized and dissociative patients, a treatment that does not overwhelm the patient or the therapist and that manages the various risks associated with the treatment. It is a research and training-based model, calling for caution and reason regarding all strategies and techniques, those having to do with memory recovery in particular. It is also a stage-oriented treatment that, using the mnemonic SAFER for the work of the first stage, underscores self-care and symptom control, acknowledgment, functioning, expression, and relationship issues as essential preliminary tasks to be undertaken long before any directed focus is placed on abuse issues per se. Dr. Chu discusses the rationale behind the reworking and abreaction of traumatic material and emphasizes the importance of addressing and resolving the core abuse-related issues and beliefs that so often plague adult survivors. He shows how

for the truly traumatized this treatment is far from a search for the missing memories; instead, it is a process of life reconstruction and enhancement.

Dr. Chu is very effective in conveying the challenges posed by these patients (especially early in the treatment process) and cogently discusses ways to manage them. I find especially insightful and useful his discussions on the shift of therapeutic responsibility and chronic disempowerment, empathic confrontation, and relational issues and the therapeutic dance, as well as his sound advice regarding the treatment of dissociative identity disorder. Clinical examples provide realistic, graphic, and compelling illustration of the points under discussion and help familiarize and desensitize the reader to their appearance and management.

The book's additions are all in keeping with the major developments in the field of traumatic stress (in general and as pertains to complex developmental and dissociative posttraumatic stress disorders) and in the treatment advances that have occurred in the field since the book's original publication. Included are discussions of the quality of the child's earliest attachment relationships and its impact on overall development but especially the child's sense of self and self-esteem; the impact of insecure or disorganized attachment on the child's vulnerability to various forms of victimization, within and outside of the family; the relationship between disorganized attachment and dissociation, and the development of dissociative disorders; differences between normal event memory and memory for trauma including attention to their general accessibility and accuracy, whether they were ongoing or returned in delayed fashion as recovered memories; the application of evidence-based treatment strategies where feasible; clinical consensus about a progression of stages of treatment within which the therapist applies techniques hierarchically; a continued specialized focus on dissociation and dissociative process in many of these patients; and an update of information regarding the management of special issues such as patient self-care and self-injury/suicidality, strategies for the containment of posttraumatic and dissociative symptoms, chronic disempowerment and the "impossible" patient, boundary management, acute care requiring the use of hospitalization, and psychopharmacology. As before, Dr. Chu discusses a treatment that is at once relational, relying on the therapist's ability and willingness to be accessible to and active in interaction with the patient, and rational, requiring the establishment of boundaries and limitations and ongoing attention to their maintenance and to the patient's improvement. The therapist is encouraged to be mindful of self and of the client and to use the interaction as both a source of information about the client and his or her history and grist for the mill.

Dr. Chu is especially thoughtful and eloquent in his discussion of controversies and future directions in the field of trauma and dissociation and reasons that clinicians do this work. Complex trauma patients (with and without significant dissociation) make up a substantial percentage of outpatient and inpatient mental health populations, so it is thus important that therapists learn to treat this population. Additionally, much more information is now available about the intergenerational transmission of violence within families and communities; treatment of the sort described here, although time

and energy intensive, is very important work in disrupting the cycle of violence in our society. Nevertheless, not all therapists seek out or enjoy this treatment population, and it can generate burnout or lead to therapeutic transgressions and misadventures more quickly than many others. Dr. Chu's emphasis on the therapist's attention to self-knowledge and mindfulness, countertransference, and vicarious trauma in this treatment is invaluable in assisting those of us in the trenches to successfully continue in the work. The need for this work is immense, as is the reward. Thank you, Dr. Chu, for continuing to share your sustaining insight and wisdom in this updated edition.

Christine A. Courtois, PhD

Psychologist, Private Practice: Christine A. Courtois, PhD &  
Associates, PLC, Washington, DC

Author, *Healing the Incest Wound: Adult Survivors in Therapy  
and Recollections of Sexual Abuse*

Co-Editor with Julian Ford, PhD, *Treating Complex Traumatic Stress Disorders: An  
Evidence-Based Guide*

Associate Editor: *Psychological Trauma: Theory, Research,  
Practice, & Policy*



# Introduction

---

The past three decades have seen extraordinary changes in views concerning the traumatization of children in our society. Attitudes of both mental health professionals and the public moved from virtual denial of the existence and effects of child abuse in the 1970s to an almost fervid preoccupation with these issues in the 1980s. In the heady excitement of those days, at least three central tenets were held forth: (1) the abuse of children was a hidden social epidemic with untold human consequences; (2) abuse was the source of innumerable societal ills and mental illness and disability for abuse survivors; and (3) recognition and uncovering of abuse memories were the keys to both individual and societal health. New ways of recognizing and treating childhood abuse were invented, and specialized treatment programs emerged across the United States.

However, in the late 1980s and the 1990s, the pendulum began to swing in the opposite direction. Although many adults who had survived various kinds of childhood abuse were successfully treated, the treatment of those with particularly severe childhood traumatization proved to be complex. Aggressive attempts to help some severely traumatized patients explore and abreact their childhood abuse resulted in profound regression and lengthy, intensive, and expensive treatment. It slowly became clear that extraordinary pitfalls were associated with a simplistic focus on the childhood traumatic events. In addition to experiencing the traumatic events, many survivors of abuse grew up in devastatingly chaotic and disrupted home environments that led to massive disabilities. Their lives, their relationships, and often even their identities were shattered. They developed fundamental assumptions about the world as malevolent and about themselves as defective and powerless, leaving them poorly equipped to cope with even basic life functioning. Perhaps most important, they also learned to approach others with deep mistrust, making all relationships—including therapeutic relationships—tenuous and potentially dangerous.

In retrospect, it is easy to see how severely traumatized persons failed to benefit from a type of exploratory therapy that assumes basic trust and the ability to tolerate intense and dependent therapeutic relationships. In addition to sometimes painful and unsuccessful treatment, a premature emphasis on childhood abuse resulted in a fixation on the trauma as the central theme of the lives of some patients, with their identities becoming organized around their traumatization. Thus, rather than seeing the abuse as events to be overcome, these patients essentially began to see themselves as chronically victimized and disabled.

The 1990s brought further difficulties. Compounding the complexities of treating survivors of extensive early trauma, the mental health community gradually came to understand that in a small minority of patients the reports of their childhood abuse were inaccurate. Some of these patients—especially those who became fixated on their abuse—began to unconsciously embellish what they recalled, leading to ever more lurid accounts of childhood events. Others—especially those with impaired reality testing or who were extremely vulnerable to suggestion—began to believe that they had been abused despite all evidence to the contrary. In addition, a few cases were identified where patients and other persons falsely alleged that they had been abused as children as a means of meeting needs such as avoiding legal responsibility, obtaining compensation, or resolving their internal emptiness and their need for attention from others.

A backlash began to develop. A coalition of parents who claimed that they had been falsely accused of having abused their children—resulting in alienation from their children or even lawsuits against them—joined with skeptical academics in the psychiatric and psychological community to form the False Memory Syndrome Foundation (FMSF). The stated aims of the FMSF initially appeared to have some sense of legitimacy. After all, any false claim of child abuse against an innocent parent has enormous implications for creating heartbreaking emotional pain and suffering as well as disrupting familial ties. And, cognitive psychologists involved in the science of memory research were at least somewhat accurate in pointing out that many in the clinical community lacked knowledge concerning the vagaries of memory, leading them to reflexively believe in the literal accuracy of all patients' reports. However, despite paying lip service to the notion that child abuse is a serious societal problem, the FMSF pursued a well-funded and highly publicized agenda that tended to largely discredit many patients who reported childhood abuse and the professionals who treated them. The FMSF contended that there was no scientific evidence for traumatic amnesia and that misguided "recovered memory therapists" were fracturing families and destroying lives by inducing nontraumatized patients to falsely believe that they had been the victims of childhood abuse by their parents. In the public media, the scientific literature, and the courts, false memory proponents carried out systematic attacks on the validity of "repressed memory," on the diagnosis of dissociative identity disorder, on reports of organized abuse by satanic cults, and on the use of hypnosis and guided imagery in therapy.

What will be the result of these changes in how traumatized patients are viewed? Will the legacy of abuse be once again buried in denial and blaming the victim? Fueled by some instances of naïve or questionable therapeutic practices, some professionals

and members of the public have seemed to be willing to dismiss the damaging effects of abuse as predominantly “false memory” or as being a part of a “culture of self-pity,” all thought to be encouraged by overzealous or misguided therapists. Against this new wave of denial, some attitudes of concern for the traumatized must be preserved, and the awareness of the effects of traumatic experiences on some of the most vulnerable members of our society must not again be lost. There is some room for optimism, despite ongoing acrimony between clinicians who treat abuse survivors and those who view abuse memories as inherently flawed and unreliable.

Evidence suggests that the intensity of the battle has begun to wane. Some scientists and researchers representing conflicting views have begun to dialogue publicly and privately with progressive integration of views. The clinical community has continued to pursue its work with traumatized patients, albeit with more caution. Since the beginning of the past decade, most of the continuing debate concerning recovered memory and false memory has been restricted to academic discussions and courtrooms. In fact, the controversy has engendered greater sophistication in the understanding of the effects of traumatization, and committed clinicians have been tempered by the strife to become even more effective in their work with traumatized patients.

A large and growing body of knowledge and experience has contributed to developing treatment models and standards of care for the treatment of adult patients who have been severely traumatized in childhood and who present with complex posttraumatic and dissociative difficulties. The treatment is usually lengthy and seldom straightforward, often involving periods of crisis, instability, and personal chaos. However, experience has taught us that with skill, patience, and perseverance, even many of the most traumatized and damaged individuals can be helped to lead more productive and fulfilling lives. Because of the tenuous nature of their ability to sustain connection, work with these individuals requires an unusual level of involvement, and because of their multiple layers of symptoms and functional problems, the path toward recovery is often unclear. But the collective clinical experience of the past three decades and emerging treatment outcome research have demonstrated that thoughtful and skillful treatment often results in fruitful and gratifying therapeutic outcomes.

This book traces the advances of the recent past concerning the nature of childhood abuse and the treatment of its aftereffects. The main emphasis is on some of the most severely traumatized patients and the need to develop a sophisticated understanding of their difficulties, and how to implement a responsible, rational, and balanced treatment. The book is divided into three parts. Part One traces the history of recent findings concerning child abuse and its effects on psychological functioning and an overview of the nature of traumatic memory. Part Two contains the basic principles of the treatment of adults who have complex trauma-related difficulties, including detailed discussions of self-care, symptom control, and relational issues. Part Three discusses various special topics in traumatized patients, including the treatment of dissociative identity disorder, acute care interventions, psychopharmacology, and controversies and future directions in the field of trauma and dissociation.

This book is meant to be a hands-on resource for clinicians. In contrast to the early years in the trauma field, many texts and much literature about the effects and treatment of childhood maltreatment are now available. I have chosen to focus on the actual treatment process of working with complex trauma patients, with an emphasis on how to understand difficult clinical presentations and dilemmas and fruitfully resolve them; to wit, what should clinicians know, what should they do, and how should they go about doing that. Throughout this volume, I have also included many clinical vignettes of problems and impasses that face mental health professionals and many examples of psychotherapeutic interventions and approaches. These clinical situations are better illustrations of clinical wisdom than even the most erudite academic discussions. To protect the identities of the persons discussed, I have altered their descriptions and features and have combined many actual patient accounts to create composite case illustrations.

The field of trauma and dissociation has undergone more growth, change, and debate over the past years than has any other area in mental health studies, except perhaps the study of the neurobiology of mental illnesses. In many ways, the experiences, errors, and growth of the past years have laid a solid foundation for future clinical work, teaching, and research. As a whole, the trauma field has emerged from pervasive denial, progressed through overinvolvement, and led to a more sophisticated and balanced position grounded in clinical wisdom and scientific research. Although we have a much greater understanding of traumatized patients and an enhanced armamentarium of treatment interventions, much can still be learned. We must continue to wrestle with understanding and treating the difficult and complex problems that result from severe and chronic childhood trauma. We must recognize that not all of the extreme beliefs concerning childhood abuse may be factually accurate, but still acknowledge the tragedy and suffering of those who grow up in malevolent environments. We must develop and value new treatments, but continue to rely on the traditional foundations of psychotherapy. As clinicians, we must combine our best knowledge, skill, and expertise to be of maximal help to relieve the distress of those we hope to help.

James A. Chu, MD

Concord, Massachusetts

July 2010

# **PART I**

## **The Nature and Effects of Childhood Abuse**



# 1

---

## Trauma and Dissociation

### *30 Years of Study and Lessons Learned Along the Way*<sup>1</sup>

---

Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.... Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life.... They confront human beings with the extremities of helplessness and terror, and evoke the responses of catastrophe.

— Judith Lewis Herman, MD, *Trauma and Recovery* (1992b, p. 33)

Our current understanding of trauma and dissociation is relatively recent, beginning to emerge only about 30 years ago. Posttraumatic stress disorder and the dissociative disorders—as we currently understand them—were first codified in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III) in 1980. Given what we now know about the effects of severe and chronic trauma, it is extraordinary that so little about it was acknowledged or understood just a few decades ago. What contributed to this pervasive blindness to critical issues that affect the many traumatized persons in North American society? The answer to this question is complex and has historical precedents.

Since the late 19th century the pendulum has swung between recognition and denial of the abuse of children, particularly sexual abuse. Pierre Janet (1907) wrote extensively about the relationship between trauma (including childhood abuse) and dissociation. In his 1896 publication, *The Aetiology of Hysteria*, Sigmund Freud (1896) postulated a link between childhood sexual abuse and psychiatric illness, a theory that he subsequently disavowed (Simon, 1992). Clearly, the Victorian values of Freud’s time may have

<sup>1</sup> Portions of this chapter were adapted from “Trauma and Dissociation: 20 Years of Study and Lessons Learned Along the Way” (Chu & Bowman, 2000).

contributed to his disavowal of his “seduction hypothesis,” which implied that incest was commonly the underlying cause of a wide variety of symptoms that were ascribed to female “hysteria,” including fainting, nervousness, insomnia, weakness, muscle spasms, shortness of breath, irritability, loss of appetite, and diminished libido. However, the result of Freud’s disavowal was the subsequent denial of the reality of abuse by generations of psychiatrists, psychologists, and other mental health professionals. The noted psychoanalysts Elizabeth Zetzel and William Meissner (1973) captured this stance beautifully in one of their texts on psychoanalytic theory and practice:

The abandonment of the seduction hypothesis and the realization that the patient’s reports of infantile seduction were not based on real memories but fantasies marked the beginning of psychoanalysis as such. The importance of reality as a determining factor in the patient’s behavior faded into the background.... The focus of analytic interest turned to the mechanisms by which fantasies were created. (pp. 72–73)

Thus was the foundation laid for professionals to dismiss the realities of their patients’ reports for generations. As recently as the 1980s, respected psychiatrists might have interpreted a patient’s report of early sexual molestation by her father as “fantasies derived from Oedipal wishes” (meaning that the patient as a child had fantasized the incest because of her wish for a kind of sexual involvement with the parent of the opposite sex). This view implied that adult women were often unable to distinguish between fantasy and reality, and essentially blamed the patient for her own victimization. At that time, psychodynamic psychiatry was still dominated by classic psychoanalytic thinking, where conflicts about sexual drives, instincts, and fantasies were considered more important than the possible reality of occurrence of actual abuse. In fact, even when professionals believed that sexual abuse had occurred, the major emphasis was the resulting intrapsychic conflicts and not on the actual experience and aftereffects of the molestation.

Even among enlightened and sensitive professionals, the harsh facts concerning abuse are easily forgotten. For example, in spring 1992, a national organization released the results of a large-scale study, *Rape in America: A Report to the Nation* (National Victim Center, 1992). The grim statistics reported that one in eight women in this country were likely to be the victims of forcible rape during their lifetimes. Even more striking was the finding that nearly 30% of rape victims were less than 11 years old, and that more than 60% of rape victims were under the age of 17. These statistics actually *underestimated* the prevalence of rape, because although each victim was counted only once, some victims reported having been raped on multiple occasions (as is often the case in incestuous abuse). The results of the study were widely covered in the national press and on network and cable television news. Somewhat surprisingly, in the subsequent weeks, fewer and fewer professionals had any recollection of the essential results of this study—including clinicians who were interested in issues of childhood abuse. Only three months later, I informally polled an audience of more than 200 attendees at a national conference on sexual

abuse and found that not one person recalled hearing about the study or the results. While this might be partially ascribed to the process of normal forgetting (in which even important events are progressively unavailable to conscious memory), the all-too-human need to deny these findings is likely to have played a major role in the lack of recall.

When it comes to interpersonal trauma, psychiatrist Judith Lewis Herman, MD (1992b), has pointed to a universal desire to look the other way—a natural human desire not to have to share the burden of the immense human suffering that derives from trauma and to accept some responsibility to ameliorate it. The societal denial of pandemic childhood trauma can perhaps be best understood through Herman's theory that disturbing ideas, such as the etiologic link between child abuse and common adult psychiatric difficulties, can only be sustained in the context of societal support. It is indeed challenging for any society to have the maturity to be able to acknowledge that it has permitted some of its most vulnerable members to be severely abused and as a result to become profoundly impaired. The cultural implications of recognizing the extent of child abuse have strongly influenced the way that the field of trauma and dissociation is viewed and whether its findings can be acknowledged and accepted or denied and reviled. Herman has argued that any single individual does not have the ability to challenge entrenched cultural beliefs and norms, and that the support of a political movement is necessary to allow it to be truly seen and studied. The modern recognition and study of complex posttraumatic and dissociative disorders stemmed from two major political and sociologic phenomena: the Vietnam War and the Women's Movement.

Historically, wars have forced societal attention to focus on the widespread and profound impact of overwhelming violence and trauma in postwar eras. In the United States, after the Civil War, a syndrome labeled "soldier's heart" was described (Da Costa, 1871), which included rapid heartbeat and overall autonomic activation with startle responses and hypervigilance. Following World War I, many American and European soldiers were described as suffering from "shell shock," a condition described as "emotional shock, either acute in men with a neuropathic predisposition, or developing as a result of prolonged strain and terrifying experience" or "nervous and mental exhaustion, the result of prolonged strain and hardship" (Southborough, 1922, p. 92). During and following World War II, clear posttraumatic syndromes were defined. Kardiner (1941) described a "physioneurosis" that included flashbacks, amnesia, irritability, nightmares, and other sleep disturbances. Saul (1945) used the term "combat fatigue" that resulted from overwhelming stress combined with the inability to act, and was manifested by emotional distress along with irritability, nightmares, and increase in heartbeat, respirations, and blood pressure. The original *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was published by the American Psychiatric Association (APA) in 1952 during the Korean War, and the second edition (DSM-II) was published in 1968 during the Vietnam War. Both volumes recognized behavioral and emotional reactions to overwhelming fear or stress.

In the wake of the Vietnam War, an interesting paradox occurred. The war had become extremely unpopular, and by the fall of Saigon in 1975, most Americans were

either politically opposed to the conflict or at least relieved to see an end to it. Most clearly did not want reminders of the failed war, and unlike more recent attitudes toward the military, many civilians regarded veterans as somehow tainted by their association with the recent conflict. Public opinion was so negative that veterans were reluctant to talk about their experiences or wear their uniforms in public. However, even in this climate of disavowal, health care professionals and eventually the American public had to acknowledge that a large cohort of young men and women returned from the war profoundly changed and damaged. This phenomenon facilitated the subsequent adoption of PTSD in the DSM-III in 1980. The increasing public and professional acknowledgment of the aftereffects of trauma allowed Vietnam veterans to be treated with a level of compassion and sophistication not seen in other postwar eras.

In 1983, Congress mandated the National Vietnam Veterans Readjustment Study (NVVRS; Kulka et al., 1990). Although the survey found that the majority of combat veterans made a successful adjustment to peacetime life, the NVVRS found that a substantial minority of Vietnam theater veterans continued to suffer from a variety of psychological and life-adjustment problems. Approximately 30% had experienced some form of posttraumatic problems. Even more alarming was the finding that for many veterans (approximately 12%), their PTSD had become a chronic condition. In a more recent study of 1,377 American Legionnaires 14 years after the NVVRS, 11% continued to suffer with more psychological and social problems, including marital problems with higher divorce rates, parenting difficulties, general unhappiness and difficulties functioning, and more physical problems, including pain, fatigue, and infections (Koenen, Stellman, Sommer, & Stellman, 2008).

Just as the Vietnam War focused attention on the effects of combat-related trauma, the Women's Movement and the rise of modern feminism profoundly changed attitudes concerning trauma toward women and the welfare of children. The Women's Movement provided the political will and social support to draw attention to long-neglected issues such as domestic violence, rape, and child abuse. Not surprisingly, many of the pioneers in the burgeoning trauma field in the 1970s and 1980s were women, many of whom embraced feminist values. Ann Wolbert Burgess, RN, DNSc, co-founded a crisis intervention program for rape victims at Boston City Hospital in 1972 (see Burgess & Holmstrom, 1974) and subsequently went on to become a pioneer in the study of the sexual assault on children and their exploitation in child pornography (Burgess, Groth, Holmstrom, & Sgroi, 1978). Similarly, Christine Courtois, PhD, co-founded a campus rape crisis center at the University of Maryland in 1972 and discovered that some clients of the center reported past sexual assault, including long histories of incest. Courtois went on to study and treat the effects of childhood abuse, helping other clinicians who were struggling to find guidance and support when there was a profound dearth of information on the subject of abuse and publishing the first major text on treating victims of incest, *Healing the Incest Wound* (1988). Our current understanding is that early sexual abuse can have devastating posttraumatic effects, but Courtois noted, "the most accurate diagnosis for incest response was posttraumatic stress disorder, an idea that

seemed heretical at the time (1981) because PTSD was highly associated in the minds of clinicians with the Vietnam veterans” (p. xv).

In the 1970s, Herman began hearing many stories concerning incest in her adult women patients who had been diagnosed with borderline personality disorder. Despite the skepticism of the psychiatric establishment, she found the incest stories convincing and began a career of studying and treating sexual violence in our society. The result was the stunning book, *Father-Daughter Incest* (Herman, 1981), a scientifically credible work that documented the nature and undeniable harmful effects of sexual violation, which she saw as much more common than had been previously believed. Herman was one of the feminist pioneers who first understood the logical link between the trauma and betrayal of incest and the profound difficulties in functioning experienced by patients with borderline personality disorder.

## CHILDHOOD ABUSE: THE HIDDEN EPIDEMIC

The pioneers of the study of childhood abuse and its effects did much to fuel subsequent investigation of the effects of trauma, including understanding the development of post-traumatic and dissociative symptoms and disorders. Little was known in the 1970s and early 1980s about the prevalence or effects of childhood sexual abuse. Earlier estimates of prevalence had reported a very low incidence of incest (e.g., Weinberg’s 1955 estimate of an average yearly rate of incest of 1.9 cases per million children). Similarly, no real data existed concerning the effects of child sexual abuse. Kinsey and his colleagues downplayed any negative effects of incest: “It is difficult to understand why a child, except for its cultural conditioning, should be disturbed at having its genitalia touched” (Kinsey, Pomeroy, & Martin, 1948, p. 121). In fact, one of Kinsey’s co-authors, Walter Pomeroy, was later infamously quoted as saying, “Incest between adults and younger children can ... be a satisfying and enriching experience...” (Pomeroy, 1976, p. 10). Interestingly, Kinsey and his colleagues were surprised by their finding of a high rate of attempted sexual contact in childhood from their interviews with adult women. They found that 24% of the women recalled sexual advances by adult males when they were children, but the researchers downplayed the importance of this finding because most approaches did not result in actual sexual acts (Kinsey, Pomeroy, Martin, & Gebhard, 1953).

Modern research on the prevalence of childhood sexual abuse has yielded disturbingly congruent information concerning the rates of abuse. In 1986, psychologist Diana Russell, PhD, published *The Secret Trauma: Incest in the Lives of Girls and Women*, which reported the results of a landmark survey of the prevalence of sexual abuse in women in the general population. In interviews of 930 women in the San Francisco Bay area, more than one-third reported some kind of unwanted sexual contact in childhood. About half of the reported sexual abuse was incestuous abuse—sexual abuse perpetrated by a family member. These findings were considered surprisingly high when they were first reported but have stood up well in subsequent studies of general population samples in North

America (Briere & Elliott, 2003; Vogeltanz et al., 1999). Russell's work and subsequent studies have made it clear that the sexual abuse of girls is widespread and that it occurs among all ethnic groups and throughout all socioeconomic levels of our society.

Studies of the prevalence of the sexual abuse of boys have shown lower rates as compared to girls, but the rates are still high; when using a broad definition of sexual abuse (e.g., unwanted sexual contact in childhood), studies have found that one in six or seven adult men in the general population report some kind of childhood sexual abuse (Briere & Elliott, 2003; Elliott & Briere, 1995; Finkelhor, Hotaling, Lewis, & Smith, 1990).

Much of the research concerning the rates of childhood abuse has focused on sexual abuse, not only because of the extreme violation of boundaries and roles, but also because it is easier to quantify and study. There are far fewer ambiguities in defining sexual abuse as compared to physical abuse, emotional abuse, and neglect. However, the focus on this one type of childhood maltreatment does not imply that the potential aftereffects for other types of abuse are less serious. The few prevalence studies of physical abuse in childhood have suggested rates of 20% to 30% for both girls and boys (Briere & Elliott, 2003; MacMillan et al., 1997). These studies, combined with other research, lead to the unfortunate conclusion that both childhood physical and sexual abuse is widespread in our society and internationally (Finkelhor, 1994) and is perpetrated on both girls and boys. Although both physical and sexual abuse occurs among all children, girls are more likely than boys to be sexually abused, and, as shown in at least one study, boys were more likely than girls to be physically abused (MacMillan et al., 1997).

## BEHIND CLOSED DOORS: SHAME AND SECRECY

In addition to societal denial and disavowal, there are other powerful reasons why the abuse of children is frequently hidden. The nature of child maltreatment—particularly child sexual abuse—and the circumstances in which it occurs also lead to the tendency not to acknowledge its occurrence or its aftereffects. Almost invariably, children feel shamed and responsible for their own victimization. In two remarkable papers, psychoanalyst Leonard Shengold, MD (“Child Abuse and Deprivation: Soul Murder”; 1979), and psychiatrist Roland Summit, MD (“The Child Sexual Abuse Accommodation Syndrome”; 1983), elucidated the way those who are injured by childhood abuse come to blame themselves for having been victimized:

If the very parent who abuses and is experienced as bad must be turned to for relief of the distress that the parent has caused, then the child must, out of desperate need, register the parent—*delusionally*<sup>2</sup>—as good. Only the mental image

<sup>2</sup>“Shengold’s use of the word *delusionally* does not assume a psychotic process or a defect in perception, but rather the practiced ability to reconcile contradictory realities” (Summit, 1983, p. 184).

of a good parent can help the child deal with the terrifying intensity of fear and rage which is the effect of the tormenting experiences. The alternative—the maintenance of the overwhelming stimulation and the bad parental imago—means annihilation of identity, of the feeling of the self. So the bad has to be registered as good. (Shengold, 1979, p. 539)

The child faced with continuing helpless victimization must learn to somehow achieve a sense of power and control. The child cannot safely conceptualize that a parent might be ruthless and self-serving; such a conclusion is tantamount to abandonment and annihilation. The only acceptable alternative for the child is to believe that she has provoked the painful encounters and to hope that by learning to be good she can earn love and acceptance. The desperate assumption of responsibility and the inevitable failure to earn relief set the foundation for self-hate.... (Summit, 1983, p. 184)

Psychologist Jennifer Freyd, PhD (1994), has offered another recent interpretation concerning the children's denial of their own victimization—even to the extent of forgetting it—as a syndrome of “betrayal trauma”:

Betrayal trauma theory suggests that psychogenic amnesia is an adaptive response to childhood abuse. When a parent or other powerful figure violates a fundamental ethic of human relationship, victims may need to remain unaware of the trauma not to reduce suffering but rather to promote survival. Amnesia enables the child to maintain an attachment with a figure vital to survival, development, and thriving. (p. 304)

Children often fail to disclose abuse, even when they remember it. In addition to feeling shame and complicity, they may fear that the family unit would be disrupted, they may feel guilty for possible consequences to the perpetrator, and they may fear retaliation, which is often heightened by perpetrators' injunctions “not to tell” with threats of further harm to the victim or other family members (Swanson & Biaggio, 1985). Such patterns of intrapsychic and familial dynamics result in secrecy and shame. The abuse remains hidden behind closed doors and, in many cases of sexual abuse, concealed from other family members. It is not surprising that children not only often fail to disclose abuse, but when they do, they often recant their statements (Sorensen & Snow, 1991). Unspoken and unseen, damage done to victims of child maltreatment continues to grow and fester, often only emerging many years afterward as multiple and varied psychiatric symptoms and disorders and major impediments to healthy functioning.

Patterns of intrafamilial abuse are facilitated by many societies' emphasis on parental rights—to raise children as they see fit—as a cherished principle that supports familial and cultural values (Miller, 1983). Although it can be legitimately argued that this cultural tradition has many positive aspects, its inherently optimistic views of parental child-rearing capacities may be misguided. Through our clinical experience, we know

that the capacity to care for and raise children is substantially learned through having been adequately nurtured in childhood; that is, those who have had positive parenting are more likely to become good parents. In cases where parents have been the victims of childhood abuse or neglect, their parenting abilities may be massively flawed. The tragic result can be intergenerational cycles of human misery.

The potential harm to children who are raised by poorly equipped parents is compounded by the lack of any systematic training about parenting. This unfortunate tradition is long standing, existing more than a century ago, as evidenced by a quote by an English author, philosopher, and sociologist, Herbert Spencer, from an 1869 book on the home and families (Beecher & Stowe, 1869):

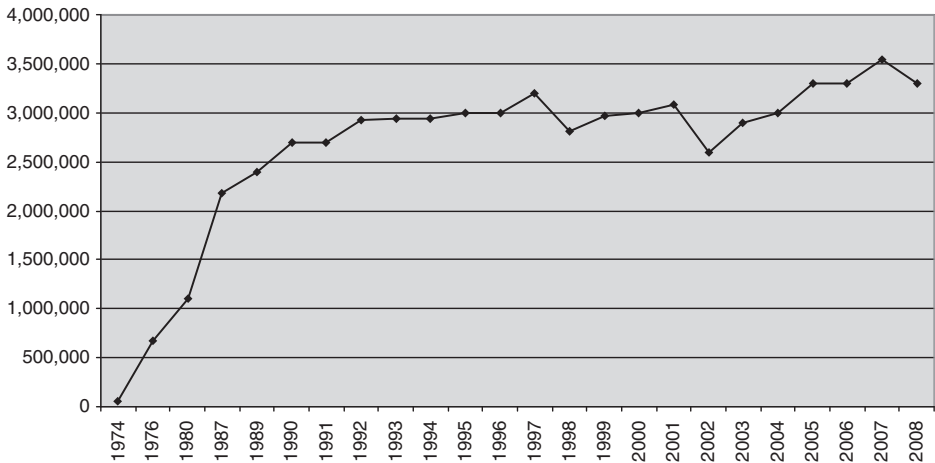
Is it not an astonishing fact that, though on the treatment of offspring depend their lives or deaths and their moral welfare or ruin, yet not one word of instruction on the treatment of offspring is ever given to those who will hereafter be parents? Is it not monstrous that the fate of a new generation should be left to the chances of unreasoning custom, or impulse or fancy? ... To tens of thousands that are killed add hundreds of thousands that survive with feeble constitutions, and millions not so strong as they should be; and you will have some idea of the curse inflicted on their offspring, by parents ignorant of the laws of life. (pp. 263–264)

It appears that little has changed from the time of this 19th-century observation, leaving some unfortunate children in potentially abusive families with parents who receive little help in their struggle to raise their children.

## **NATIONAL STATISTICS AND REPORTING OF CHILD MALTREATMENT**

In 1974, Congress enacted the first Child Abuse Prevention and Treatment Act (CAPTA; Public Law 93-247), requiring the states to enact mandatory reporting, investigation, and intervention concerning child maltreatment. Among those required to report suspected maltreatment are educators, law enforcement and criminal justice personnel, social services staff, medical personnel, mental health professionals, child daycare workers, and foster care providers. The number of annual reports rose rapidly, eventually leveling off at around 3.3 million reports each year (Figure 1.1).

CAPTA was amended in 1988 (Public Law 100-294), directing the Secretary of the Department of Health and Human Services (HHS) to establish a national data collection and analysis program that would make available detailed state-by-state child abuse and neglect information. HHS established the National Child Abuse and Neglect Data System (NCANDS) as a voluntary national reporting system, which produces annual reports concerning child maltreatment. As documented in *Child Maltreatment*



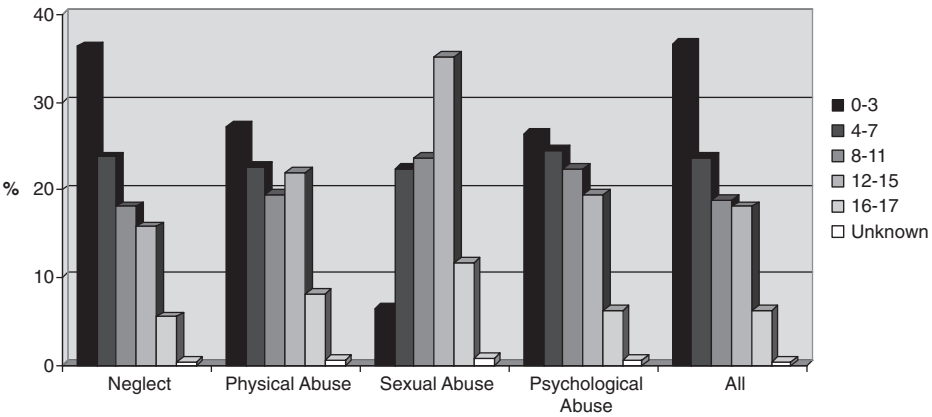
**Figure 1.1** Annual Reports of Child Maltreatment Reported to Child Protective Service Agencies

2008 (U.S. Department of Health & Human Services, 2010), there were approximately 3.3 million referrals involving the alleged maltreatment of approximately 6.0 million children received by child protective services agencies. Nearly 63% of the referrals were screened in for investigation by child protective service agencies, and of those, approximately 24% of the investigations determined at least one child to be a victim of abuse or neglect—approximately 772,000 children. Most were victims of neglect (549,000), but there were also substantial numbers of victims of physical abuse (124,000), sexual abuse (70,000), and psychological maltreatment (56,000). Many children suffered multiple types of maltreatment. In 2008, there were 1,740 deaths of children known to be related to abuse or neglect.

As alarming as these statistics may be, they represent only the tip of the iceberg. For example, using a very conservative lifetime prevalence of 5% for serious or damaging sexual abuse, I calculate that there would be more than 200,000 cases per year.<sup>3</sup> In the clinical arena, adult patients rarely report that they disclosed their childhood sexual abuse or that it was discovered around the time that it occurred. This observation is supported by a study analyzed by Finkelhor and his colleagues (1990) of 2,626 American men and women, in which many of those who were victims of sexual abuse never previously disclosed their experiences.

Despite the underestimating of actual prevalence, the NCANDS data elucidate the nature of child maltreatment and expose some commonly held fallacies concerning child abuse and maltreatment (Figure 1.2). For example, it's assumed that victims of abuse and

<sup>3</sup>There are approximately 67 million children in the United States under the age of 16. If unwanted sexual contact occurs in 1 in 20 children, 3.35 million would be victims during the course of their childhood. Assuming that all cases of sexual abuse occur only in one year during a child's lifetime, there would be 209,000 cases per year.

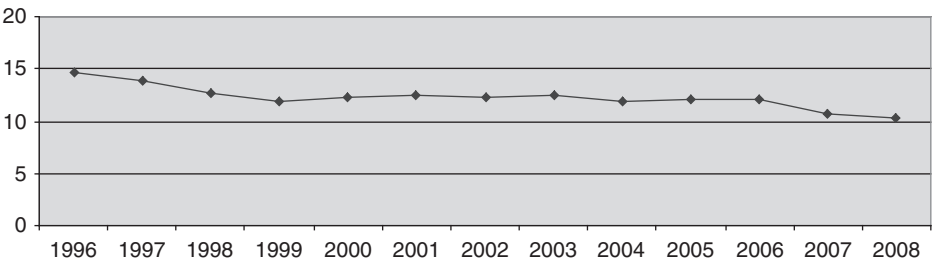


**Figure 1.2** Percent of Victims by Age and Type of Abuse

neglect—particularly sexual abuse—are older rather than younger children. In fact, the highest rates of maltreatment in 2008 were in the youngest age group (ages 0–3) and decreased with age. Even with sexual abuse, nearly 30% of victims were under age 8, and 53% were under age 12.

Most child maltreatment occurs within the home. Approximately 80% of perpetrators were parents; 6.5% were other relatives, and another 4.4% were unmarried partners of parents. Of the parents who were perpetrators, more than 90% were biological parents; the others were stepparents or adoptive parents. Mothers and fathers were roughly equally likely to be perpetrators of child maltreatment, although male parents or relatives were more likely to be perpetrators of sexual abuse as compared to female family members. All racial and ethnic groups were represented as both victims and perpetrators, with approximately half being white and one-fifth African-American and another one-fifth Hispanic.

Amid all the distressing statistics concerning child maltreatment in America, there may be some reasons to feel optimistic about the future. Despite the high numbers of traumatized children, the actual annual incidence of child maltreatment appears to be decreasing. In the 12 years up to 2008, NCANDS data show that the rate of child victimization may have fallen by nearly one-third (Figure 1.3).



**Figure 1.3** Annual Victimization Rate (cases/1,000 children)