The Experience of Mental Death: The Core Feature of Complex PTSD

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Abstract

Exposure to extreme interpersonal stress, exemplified by the experience of torture, represents a threat to the psychological integrity of the victim. The experience is likely to result in mental death, in the loss of the victim's pre-trauma identity. Mental death is characterized by loss of core beliefs and values, distrust and alienation from others, shame and guilt, and a sense of being permanently damaged. Mental death is a primary feature of a distinct post-trauma syndrome, complex PTSD, that is refractory to standard exposure therapies. We identify cognitive mechanisms that mediate the symptoms of complex PTSD, and suggest how current treatments need to be modified in order to obtain enhanced treatment outcomes.

The Experience of Mental Death: The Core Feature of Complex PTSD

For the last two decades, researchers have debated whether DSM definitions of post-traumatic stress disorder (PTSD; American Psychiatric Association, 1980, 1986, 1994) adequately describe the range of symptoms that arise subsequent to the experience of different kinds of traumatic events. Herman (1992) and others have argued that the experience of prolonged totalitarian control in association with organized violence— whether in a political, criminal, or domestic context—causes a disorder that is more severe, more complex, and more enduring than is the DSM-defined PTSD that may be caused by exposure to any traumatic event. The term 'complex trauma syndrome' (Herman, 1992) describes the shared symptom manifestations following different types of complex trauma. In this article, we argue that it is indeed necessary to define at least two patterns of PTSD and suggest that the critical factor determining whether a person develops a more severe and complex form of PTSD is the extent to which trauma causes "mental death" within a person. Our aims in this article are to describe the experience of mental death, to identify the conditions that cause and maintain mental death, and to suggest how treatments for the complex post-trauma syndromes associated with mental death need to be modified if a mental corpse is to be brought back to life.

Mental Death: An Overview

Mental death occurs in the context of totalitarian control, which is characterized by entrapment and wanton harm-doing by people to people. While there are many different forms of totalitarian control and each form is associated with mental death (as will be discussed subsequently), totalitarian control is most fully and most horrifically

exemplified by the experience of torture. Torture entails the deliberate infliction of severe physical and mental pain and suffering through cruel, inhuman or degrading treatment and punishment (United Nations, 1984). The techniques used in modern torture are far more extensive than the traditional forms of physical cruelty that are often associated with the word torture. In addition to physical methods, modern torture uses sophisticated psychological and psycho-pharmacological maltreatment to cause psychological change in individuals (Allodi & Cogwill, 1982; Amnesty International, 1984; Duncan, 1996; Ramsay, Gorst-Unsworth, & Turner, 1993), especially by damaging a person's sense of self (Petersen, Abildgaard, Jess, Marcussen, & Wallach, 1985; Petersen & Jacobsen, 1985; Philip, 1989/90; Solzhenitsyn, 1974). Torture methods can be selected to maximize changes to personality, core beliefs, and the ability to trust others while minimizing physical scars and other obvious evidence of maltreatment (Petersen & Jacobsen, 1985).

When used in a political context, torture has as its goal the creation of a <u>living dead</u>, whose brokenness is intended to serve as a deterrent to others; it is a means of exercising systematic control over individuals, groups, and the entire community (Philip, 1989/90; Turner & McIvor, 1997; Williams, 1990). According to one torture survivor, following torture "the individual loses his/her ability to react normally; and they especially lose their ability to process and articulate their experiences, … resulting in numbing or a paralysis, and mental death" (Anonymous, 1989, p. 5). The capacity of torture to destroy a person's identity, the essence of mental death, is well-documented in the torture literature (Abildgaard, Daugaard, & Marcussen, 1984; Allodi & Cogwill, 1982; M. Basoglu & Marks, 1988; Behnia, 1997; Benfeldt-Zachrisson, 1985; Genefke,

Marcussen, & Rasmussen, 2000; Petersen et al., 1985; Petersen & Jacobsen, 1985; Philip,

1989/90; Ramsay et al., 1993).

People who have experienced mental death as a result of torture are very likely to

meet diagnostic criteria for PTSD (prevalence rates exceed those of non-tortured

refugees; Holtz, 1998), but they are also likely to experience additional symptoms. The

so-called "torture syndrome" is marked by existential dilemma, guilt, shame, distrust,

attachment problems, damage to beliefs about safety and justice, and somatization

(Abildgaard et al., 1984; Baker, 1993; Basoglu & Marks, 1988; Benfeldt-Zachrisson,

1985; Cunningham & Cunningham, 1997; Eberly & Engdahl, 1991; Engdahl, 1987;

Engdahl & Eberly, 1990; Genefke et al., 2000; Gorst-Unsworth, 1992; Gorst-Unsworth &

Goldenberg, 1998; Gorst-Unsworth, Van Velsen, & Turner, 1993; Moore & Boehnlein,

1991; Magawaza, 1999; McIvor & Turner, 1995; Ortiz, 2001; Petersen et al., 1985;

Petersen & Jacobsen, 1985; Philip, 1989/90; Quota, Sarraj, & Punamaki, 1997; Ramsay,

Gorst-Unsworth, & Turner, 1993; Reeler, 1994; Silove, 1999; Somnier, Vesti, Kastrup, &

Genefke, 1992; Turner, McFarlane, & Van der Kolk, 1996; Turner & McIvor, 1997;

Wenzel, Griengl, Stompe, Mirzai, & Kieffer, 2000). The fact that these symptoms are

reliably associated with the experience of torture, but are not reliably associated with

post-trauma stress syndromes not involving totalitarian control, suggests that these

symptoms are directly linked to at least some of the conditions that are intrinsic to torture.

As Lifton (1988, p. 8) suggests, "if we want to understand what has happened to victims

and cope with post-traumatic stress reactions, we must understand more about the deed of

the victimizers." Torture trauma research offers insights into specific processes that

cause long-term personality change, changes in core beliefs and assumptions, and the ability to relate to others.

At a general level, torture shares characteristics with other multiple, severe, prolonged interpersonal traumas. These characteristics include: (a) the victim is entrapped in an aversive situation as a result of human action rather than as a result of natural causes (Herman, 1992), (b) the harm done to the victim is intentional rather than accidental (Ehlers et al., 1998; Ehlers, Maercker & Boos, 2000; Frederick, 1986; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), and (c) dehumanizing procedures are used to deconstruct the victim's identity (Eitinger, 1980a; Eitinger & Weisaeth, 1998; Frankl, 1961, 1984, Philipp 1989/90).

Specific torture techniques purposefully employed to attack the victim's identity such as the good guy/bad guy and impossible choice techniques exemplify intentionality and dehumanization. In the good guy/bad guy technique, one of two perpetrators initially adopts the role of a person who is supportive, helpful, and understanding while the other perpetrator maltreats the victim. The initial aim is to cause the victim to form an attachment to the 'good' perpetrator, and when this aim is achieved, the two perpetrators swap roles. The effect of this procedure is not only to impair the ability to form attachments, but to induce debility, dependency and dread in the victim, a method described as undermining a person's core beliefs and behaviors (Farber, Harlow, & West, 1957). The impossible choice method places the victim in a situation where, regardless of the victim's actions, something aversive will happen to the victim and/or another person. This procedure actively undermines the victim's beliefs regarding personal agency and autonomy, and results in what Ehlers et al. (1998, 2000) call mental defeat. The term

mental defeat describes the perception that one has lost autonomy as a human being, lost

the will to exert control and maintain identity, and lost the belief that one has a free will.

Mental defeat is most likely to occur when a victim is unable to escape continuous threats

and violent treatment by other humans, such that the victim experiences helplessness,

powerlessness, and uncontrollability (Frederick, 1986; Herman, 1992a,b).

Other torture methods are applied with the aim of achieving psychological

fragmentation and the deconstruction of the person's identity. The maltreatment of Soviet

dissidents in mental institutions with psychological and psycho-pharmacological methods

(Solzhenitsyn, 1974) illustrates the purposely induced fragmentation of cognitive and

identity structures. Likewise, methods such as brainwashing, self-accusations, solitary

confinement and sensory deprivation have been used in re-education camps with the aim

of creating a weakening of psychological structures and a path to 're-form' the dissidents'

ways of thinking and acting (Frank, 1978; Group for the Advancement of Psychiatry,

1956; Mendelson, et al., 1960). In summary, inescapable captivity with long-term abusive

and dehumanizing maltreatment as in torture is likely to cause changes in identity,

damage the ability to relate to others (Frederick, 1986), and is associated with complex

and diffuse symptom manifestations (Herman, 1992).

Torture Syndrome and Complex PTSD

The set of symptoms known as torture syndrome are not specific to the experience

of torture. Rather, they are common among persons exposed to any more or less extreme

form of totalitarian control. Herman (1992b) observed the relationship between

totalitarian control and a complex form of PTSD among adult survivors of severe

childhood abuse or domestic violence (Burgess, Hartman, McCausland, & al., 1984;

Gelinas, 1983; Terr, 1991; Van der Kolk, Perry, & Herman, 1991; Walker, 1979). But it is clear that exposure to totalitarian control in the form of imprisonment in concentration camps (Berger, 1977; Eitinger, 1980a, 1980b, 1999; Ryn, 1983, 1990; Thygeson, 1980), rape (Burgess & Holmstrom, 1974), and the experience of being a refugee (Eberly & Engdahl, 1991; Engdahl, 1987; Engdahl & Eberly, 1990; Gorst-Unsworth, Van Velsen, & Turner, 1993; Qouta, Sarraj, & Punamaki, 1997; Reeler, 1994) are all associated with symptom complexes that closely resemble torture syndrome.

This pattern of results provides strong support for Herman's (1992a, 1992b) hypothesis that people who have experienced multiple, severe, prolonged, and inescapable aversive events while under the totalitarian control of one or more victimizers develop more symptoms, more complex symptoms, and more stable symptoms than do people exposed to other traumatic events. This Complex PTSD, which has also been named Disorders of Extreme Stress (DES) or Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Van der Kolk, 1996) entails systematic and pathological changes in the victim's affect regulation, consciousness, self-perception, identity, perception of the perpetrator, relations to others, and system of meaning (Herman, 1992a, 1992b; Van der Kolk, 1996; Van der Kolk & McFarlane, 1996). If we can accept that these changes are characteristic of the experience of totalitarian control, then it is important to question whether existing nosologies are likely to prove helpful in identifying persons with this characteristic syndrome. As Suedfeld, (1990, p. 27; see also Van der Kolk & McFarlane, 1996) has argued, recognizing cases of Complex PTSD "would improve our ability to anticipate and plan what preventive actions can be taken to block the development of post-trauma symptoms or to eliminate them if they develop."

Complex PTSD and Standard Nosologies

In response to concerns that DSM-III-R and ICD-9 definitions of PTSD were inadequate definitions of complex post-trauma syndromes, subsequent editions of both nosologies revised the information presented in their respective sections on post-trauma syndromes. In DSM-IV, the changes were limited. Rather than change diagnostic criteria for PTSD or define different forms of PTSD, DSM-IV provided information in the "associated descriptive features" section about symptoms that are associated with exposure to a severe interpersonal stressor, that is, symptoms associated with the experience of totalitarian control. In so doing, DSM-IV treats symptoms of exposure to totalitarian control as if they are additional to the core post-trauma syndrome rather than a different post-trauma syndrome, and appears to accept the contention of Mollica and Caspi-Yavin (1992) that such terms as torture syndrome tell us nothing more than is already contained in the term PTSD. The effect of this position is that a person, having experienced totalitarian control, who presents with "impaired affect regulation, dissociative symptoms, somatic complaints, feelings of ineffectiveness, shame, despair or hopelessness, feeling permanently damaged, a loss of previously sustained beliefs, hostility, social withdrawal, feeling constantly threatened, impaired relationships with others, and a change from the individual's previous personality characteristics" (American Psychiatric Association, 1994, p. 425) but who does not present with persistent re-experiencing of a traumatic event, would not be diagnosed with a post-traumatic stress disorder.

Changes made in ICD-10 (World Health Organization, 1992) were more positive. ICD-10 introduced a new category, Enduring Personality Change After Catastrophic

<u>Experience</u> (F62.0), to describe people presenting with a hostile and mistrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of being on edge, as if constantly threatened, and estrangement. These symptoms, which must be present for at least two years, are distinct from those that define PTSD, but do not adequately represent the symptoms that develop subsequent to the experience of totalitarian control.

The inadequacy of current nosologies is repeatedly demonstrated by research on the consequences of torture (Arcel, Genefke & Kastrup, 2000; Cunningham & Cunningham, 1997; Genefke, Marcussen, & Rasmussen, 2000; Gorst-Unsworth & Goldenberg, 1998; Harvey, 1996; Magawaza, 1999; McIvor & Turner, 1995; Ortiz, 2001; Turner & McIvor, 1997, Wenzel et al. 2000). However, it is only research of this kind that is capable of evaluating the adequacy of current nosologies because it is only research of this kind that assesses whether or not the symptoms listed in the "associated descriptive features" section are present in individual cases. A literature search across multiple databases found that the vast majority of research on the impact of a broad range of traumata was restricted to assessing only the PTSD symptoms listed in the DSM-IV or ICD-10 criteria sets. Such research is thus incapable of determining whether and how complex and non-complex forms of PTSD may differ in such key characteristics as course, severity, and treatment-responsiveness. However, research that has been conducted on persons who have experienced totalitarian control consistently indicates that a post-traumatic disorder is more likely to be observed (Engdahl, 1987; Hauff & Vaglum, 1993; Holtz, 1998; Mollica et al., 1993; Mollica & Jalbert, 1989; Mollica, Wyshak, & Lavelle, 1987; Resnick et al., 1993; Speed, Engdahl, Schwartz, & Eberly,

1989), will be more severe when it is observed (Hubbard, Realmuto, Northwood, &

Masten, 1995), and will be more treatment-resistant (Dunmore, Clark, & Ehlers, 1997,

1999; Ehlers et al., 1998; Ehlers & Steil, 1995) than other forms of PTSD.

<center>The Specific Consequences of Totalitarian Control</center>

We suggested that the essence of mental death is the loss of identity, defined as

the perception of sameness and continuity of the self—and the self in relation to others—

based on the relative constancy of one's assumptions, beliefs, values, attitudes, and

behavior (Drever & Froehlich, 1975). Torture and other forms of totalitarian control

undermine identity by causing change in four identity domains. First, totalitarian control

causes a person to act and live in ways that are inconsistent with the person's core beliefs,

assumptions, and values, which leads to a discontinuity of identity and can cause the

person to feel shame and guilt during, and subsequent to, the traumatic events. Second,

totalitarian control causes a person to perceive others differently from how they were

previously perceived, especially in terms of diminishing a person's capacity to trust and

become attached to other people. Third, totalitarian control causes major change to a

person's view of the world, including beliefs related to social order, justice, and safety.

Finally, as a result of these changes to identity, totalitarian control causes a change in a

person's behavior such that continuity is lost between pre-trauma and post-trauma

patterns of behavior and consequently perceptions of self.

These changes to identity are further illustrated by research on the experience of

refugees, whose experience frequently resembles—and overlaps—that of torture victims.

This overlap exists because state-organized violence includes systematic harassment,

detention, disappearances, interrogation, searches, and other ways of terrorizing a

community. These acts and torture "share similar repressive intentions and must be understood in similar psychological and political terms" (Turner & McIvor, 1997, p. 205). People become refugees in order to escape state terror or such other gross human rights violations as the genocides in Bosnia and Rwanda, the concentration camps in the former Yugoslavia, and other war-like situations (Silove, 1999). According to the Victorian Foundation for Survivors of Torture (VFST 1993), 70% of refugee entrants to Australia who attended a specialist service had experienced psychological and/or physical violence. "Most of Australia's humanitarian entrants will not have experienced one single traumatic event, but rather have been exposed to a prolonged climate of political and civil repression, armed conflict, and dislocation" (VFST, 1993, p. 29).

As with other victims of organized violence, the traumas experienced by refugees result from intended human actions and carry a purpose, meaning and effect which are rarely present in traumas not involving totalitarian control (Benfeldt-Zachrisson, 1985; Cunningham & Cunningham, 1997; Harvey, 1996; McIvor & Turner, 1995; Peterson et al., 1985; Reeler, 1994). In many cases, the refugee has suffered atrocities committed by people who were neighbors and "friends" living in the same community, people with whom the refugee may have had friendly contact prior to a political change. This experience of trusted persons becoming victimizers interferes with the victims' ability to relate to others by creating distrust and changed beliefs in social order. The consequent alienation interferes with a person's ability to receive and utilize social support in coping with trauma (Ehlers et al., 1998; Ehlers, Maercker, & Boos, 2000) and may endure for a lifetime. Among Holocaust survivors, for example, impairment of trust was among the most persistent of symptoms (Sadovoy, 1997).

Where refugees have experienced a period of captivity entailing threatened or actual violence, they experience an intensification of the helplessness, powerlessness, and lack of control that are characteristic of traumatic events (Frederick, 1986; Herman, 1992). The experience of helplessness can be internalized in the sense that the person's self-efficacy or resourcefulness beliefs are undermined following repeated failures to exert control (cf. King, King, Keane, & Fairbank, 1999). The inability actively to cope with the situation means that the ability to process the experience constructively is diminished and gives way to increased perceptions of futility. This phenomenon was described by Wenzel et al. (2000) as mental exhaustion.

The pervasive feelings of guilt and shame reported by refugees and torture survivors are understandable in terms of the procedures used to cause mental death (Genefke & Kastrup, 2000; Genefke et al., 2000; Wenzel et al., 2000). A survivor feels guilt not only for having survived an event that claimed the lives of others, but also for his/her actions or lack of actions during the trauma. In addition to being powerless to affect events, many refugees and torture survivors have been forced, directly or indirectly, to contribute to the atrocities taking place. Lifton (1988) introduced the term 'self-condemnation' to describe the guilt and shame experienced by survivors forced to participate in committing atrocities; Ortiz (2001) reported survivors' feelings of being 'contaminated.' Williams (1988) argued, based on experience with over two thousand cases, that guilt is largely responsible for survivors' poor recovery from trauma.

The relationship between shame and post-trauma symptoms has received less research attention than has guilt. Leskela, Dieperink, and Thuras (2002) found that shame-proneness was positively correlated with PTSD symptom severity, a finding that

accords with clinical reports about the effects of torture (Lifton, 1988; Ortiz, 1991), but

the nature of the association has yet to be explained. Varvin (1998) argued that shame

occurs both as a result of exposure to shameful maltreatment and as a result of an inner

conflict related to how the survivor coped with the maltreatment. Amati (1977, 1993)

agreed that a person's style of coping with torture can lead to shame based on a conflict

between a need to protect self and a need to protect others. Protection of self comes at the

expense of behaving 'shamefully' towards others, and causes the self-protecting victim to

become alienated from the self and others. Amati argues that shame interferes with the

ability to cope with trauma, and is sometimes self-perpetuating because the shameful

behavior has engendered distrust among members of the survivor's community (Ortiz,

2001; Ramsay et al., 1993).

Current Models of Complex PTSD

Dimensional models have been developed by Turner and McIvor (1995, 1997)

and by Silove (1999) to explain the effects of refugee and torture trauma. Turner and

McIvor (1995, 1997) describe the post-trauma symptoms of refugees along four

dimensions: (a) incomplete emotional processing; (b) depressive reactions related to

losses and adverse life events; (c) somatic symptoms; and (d) effects on personal

meaning, beliefs and value systems, and an 'existential dilemma.' Silove (1999; see also

McCann & Pearlman, 1990) proposed that torture affects adaptive functioning across five

dimensions: safety, justice, attachments, identity role and existential meaning. These

models describe the effects of severe interpersonal trauma but do not describe the

mechanisms responsible for the effects. In the following section, we outline how the

experience of totalitarian control may cause the syndrome known as Complex PTSD.

A Cognitive Theory of Complex PTSD

In his cognitive theory of emotional disorders, Beck (1974, p. 4) suggested that "as an initial step in understanding a baffling condition such as depression, we can attempt to arrange the various phenomena into some kind of understandable sequence." When he suggested the primacy of cognition in arranging the phenomena of depression, his aim was not to imply that depressotypic cognitions cause other depression symptoms, but to indicate that "deviant cognitive processes [are] intrinsic to the depressive disorder" (Beck, Brown, Steer, Eidelson & Riskind, 1987, p. 10) and are useful in making other symptoms understandable. We see the concept of mental death playing the same role in complex PTSD: it is intrinsic to the disorder and helps us to understand the range of symptoms associated with the disorder, but is neither a cause nor a consequence of the disorder.

Mental death refers to a loss of identity, but it needs to be understood that the extent of loss may vary across individuals and within individuals over time; it is never absolute as in physical death. The processes that lead to mental death are those that impact adversely on those things that define identity, namely, the relative constancy of one's assumptions, beliefs, values, attitudes, and behavior. In order to understand these processes, we draw on several theories of cognitive processing. Our choices are based on the large body of evidence pointing to the importance of cognitive processes in explaining post-trauma syndromes and on a close articulation between what specific theories attempt to explain and the specific characteristics of complex PTSD that require explanation. Our aim is to identify mechanisms which mediate relationships between the

characteristics of the experience of totalitarian control and the experience of mental death.

In general terms, research on adaptation to severe trauma has underscored the importance of cognitive processing in mediating trauma outcomes (Creamer, 1995; Danieli, 1982; Ehlers & Steil, 1995; McIvor & Turner, 1995; Turner & McIvor, 1997; Van der Kolk & McFarlane, 1996). The way individuals construe their experience during and subsequent to trauma influences coping ability, the severity of symptoms, and longer-term adaptation (Dunmore, 1997; Ehlers et al., 1998; Ehlers & Steil, 1995; Van der Kolk & McFarlane, 1996). Negative perceptions of an event exacerbate post-trauma reactions (Horowitz, 1999; Van der Kolk, McFarlane, & Weisath, 1996), and are more important than the severity or intensity of a trauma in determining symptom severity (Foa, Steketee, & Olasov-Rothbaum, 1989). Perceptions of mental defeat are particularly detrimental to post-trauma functioning (Dunmore, Clark, & Ehlers, 1997, 1999).

The influence of cognition on adaptation is complex in that the individual not only has to come to terms with the traumatic event itself, but also with the inner chaos that is caused by the changes in beliefs about self and world that are prompted by that event (Horowitz, 1999; Janoff-Bulman, 1989, 1992; Janoff-Bulman & Frieze, 1983; Silove, 1999). Associated with this upheaval is a reduction of the victim's perceived ability to predict and control situations and their outcomes and to rely on their previous life experiences as a guide to current and future behaviors (Kelly, 1955). The consequences of losing predictability and control are not only central to such adverse post-trauma sequelae as anxiety and extreme distress (Horowitz, 1999), but are also important in

terms of the effects of learned helplessness on depression and anxiety (Peterson &

Seligman, 1983).

The Effects of Totalitarian Control on Personal Constructs

While Kelly's (1955) personal construct theory was not developed to explain

responses to traumatic events, elements of his theory are particularly applicable to the

conceptualization of post-trauma reactions. Kelly proposes that people actively construe a

framework of constructs that they then use to explain everyday life and the world of their

relationships. Based on their construals, people make predictions about the consequences

of behavior and behave accordingly (Bannister & Mair, 1968). Kelly also argues that

events which are highly divergent from what was predicted challenge the structure of

core personal constructs. When events differ from what was anticipated, constructs may

be revised and a person may make different predictions about the consequences of

behavior and then behave differently in the future. Where only minor constructs need

revision, changes in prediction and behavior may be minimal, but when core constructs

are affected (as in when a person is exposed to totalitarian control), subsequent

predictions and behavior may barely resemble those that preceded them (Kelly, 1955).

This hypothesis that events which are inconsistent with how a person has construed the

world cause changes in a person's construal of the world has been taken up by Horowitz

(1999) in his theory of changes in core beliefs and by Janoff-Bulman (1992) in her theory

of shattered assumptions.

Kelly's (1955) postulate of alternative constructivism holds that people not only

change their construals in response to unpredicted experiences, but are able also to

change their construals about themselves and their environment as a result of an

intentional process. Kelly (1955, p. 21) argued "that man can enslave himself with his own ideas and then win his freedom again by reconstruing his life." When applying his theory to trauma, we suggest that mental death arises from reconstruals caused by the experience of totalitarian control, but adaptation to the trauma occurs when individuals can again reconstrue their interpretation of traumatic experiences.

The development of alternative perspectives on their experience has been a feature of how Holocaust Survivors coped with their traumas. Suedfeld, Fell and Krell (1998) analyzed the complexity—including the ability to describe their experience from more than one perspective—of videotaped narratives of Holocaust survivors. Survivors' integrative complexity increased from the 'early Holocaust' to the 'late Holocaust' and thereafter. The results show that post-traumatic construals are not static, and that changes in construal are associated with ongoing adaptation following trauma.

Changed Construals are Reflected in Changed Core Beliefs

Changes in core beliefs are a feature of post-trauma reactions, and traumatic experiences can shatter an individual's core assumptions (Horowitz, 1999; Janoff-Bulman, 1992). According to Janoff-Bulman and colleagues (Janoff-Bulman, 1989, 1992; Janoff-Bulman & Frieze, 1983), people form core assumptions about the self and the world through early life experiences, and these assumptions are embedded in a personal 'theory' referred to as an 'assumptive world.' The assumptive world is defined as a cognitive structure which determines a person's behavior. When a traumatic event occurs, a person's assumptive world may be shattered, which entails shifts from one pole of a dimension (e.g., "the world is a safe place") to the opposite pole of that dimension (e.g., "the world is a dangerous place"). Shattering events are outside the range of normal and

predictable life experiences, especially events that threaten a person's mortality. "It is the

recognition of our fragility as physical creatures that threatens our psychological

integrity" (Janoff-Bulman, 1992, p. 60).

According to Janoff-Bulman (1992), three core assumptions about the self and the

relationship to the world are shattered by traumatic events: that the self is invulnerable;

that the world is meaningful (i.e., orderly and comprehensible); and that the self is

autonomous and positive (Janoff-Bulman & Frieze, 1983). These assumptions contribute

to a view of the world as controllable (an autonomous agent can act effectively on an

understandable world). Hence, when these assumptions are shattered through traumatic

experiences, the foundations for the person's perceptions of control are damaged and the

individual loses faith in his/her ability to understand and predict events.

Similar hypotheses about the impact of trauma on core beliefs have been posited

by Herman (1992, 1993) and Horowitz (1999), who suggest that traumatic events modify

core cognitive schemas and cause personality change. Silove (1999) suggests that

constructs related to identity, safety, trust, attachments, justice and existential issues are

affected by torture, and that changes to these constructs are responsible for the behavioral

changes evident in persons with torture syndrome. According to Kelly (1955), changes to

these personal constructs would mean that a person is unable to interact with the world in

a predictable fashion, and to be confident that interactions with the world are based on

tested and validated appraisals of previous experience.

Changed Construals are Reflected in Loss of Predictability and Control

Jones and Barlow (1990) argue that absence of predictability and control are core

features of traumatic events. The exercise of totalitarian control inevitably entails loss of

predictability and control for the victim (Basoglu & Marks, 1988), and the relationship

between the experience of unpredictability and uncontrollability and different forms of

maltreatment has been demonstrated (Basoglu, Mineka, Paker, Aker, & Livanou, 1997;

Ehlers, Maercker, & Boos, 2000). Predictability refers to the ability to forecast that and

when an event will occur, and to knowledge about some characteristics of the forecast

event. Control refers to the ability favorably to influence the outcome of an event. When

a situation is construed as potentially controllable and entailing gain, the situation will be

perceived as challenging rather than threatening (Lazarus & Folkman, 1984). When

situations are perceived as uncontrollable and unpredictable, they are stressful, likely to

precipitate a pathological response (Basoglu & Mineka, 1992; Jones & Barlow, 1990),

and are associated with the disintegration of core beliefs and assumptive worlds

(Horowitz, 1999; Janoff-Bulman, 1992). For people who have come to see, and need to

see themselves as in charge of their lives, "the idea that [one] isn't (and maybe has never

been) can only be felt as a shock and a threat. The idea that this sense of control is an

illusion, a form of self-deception, does not compute" (Claxton, 1994).

Construals Change in Response to Threat

The DSM-IV defines traumatic events only in terms of "a threat to the physical

integrity of self or others" (American Psychiatric Association, 1994, p. 427) and the

concept of threat as harm has traditionally focused on the risk of physical harm, including

death or annihilation, which threatened both the physical and the psychological integrity

of a person (Janoff-Bulman & Frieze, 1983). However, torture research has highlighted

the role that non-physical attacks have on a victim, and the experience of totalitarian

control exemplifies threat to the psychological integrity of the self, which can be separate

from and/or additional to threats to the physical integrity of self or others. The threat to

psychological integrity can occur through serious attacks on identity, or as a critical

challenge to a person's 'faiths' or belief system (Kelly, 1955). A critical challenge to

personal 'faiths' anticipates the shattered assumptions or core beliefs observed in

traumatized persons (Janoff-Bulman, 1992; Horowitz, 1999). Ehlers and colleagues

(1998, 2000) argued that psychological integrity is threatened both by threats to physical

integrity and by attacks on identity. They found that perceptions of mental defeat, that is,

perceptions of loss of autonomy, choice and free will, and the perception that one's

identity cannot be maintained, are predictive of PTSD and symptom severity (Ehlers et

al., 1998).

Kelly's (1955) definition of threat is consistent with what is experienced by

torture victims. According to Kelly, threat results when an individual experiences events

that strongly challenge existing constructs and which presuppose major disruption to the

individual's overarching construct structure. These challenges create internal conflicts

represented by the need to abandon strongly held beliefs versus the need to adopt beliefs

that are consistent with the new experiences. In Janoff-Bulman's (1992, p. 63) words:

"the internal and external worlds are suddenly unfamiliar and threatening" because

formerly held assumptions and new beliefs are difficult or impossible to reconcile.

Specific Cognitive Processes Affected in Complex PTSD

People with Complex PTSD perceive themselves as mentally defeated, alienated,

and permanently changed (Dunmore et al., 1997; Ehlers et al., 1998; Ehlers et al., 2000).

During and subsequent to the experience of totalitarian control, they appear to have lost

their ability to plan, develop, and apply constructive coping strategies (King, King, Foy,

Keane, & Fairbank, 1999), and to process complex trauma-related information (Suedfeld et al., 1998). Each of these changes affects the outcome of exposure to totalitarian control.

Mental Defeat, Alienation and Permanent Change

Research by Ehlers and Dunmore (Dunmore et al., 1997; Ehlers et al., 1998; Ehlers et al., 2000) has demonstrated that the experience of totalitarian control damages an individual's perception of self as an autonomous being, and perceptions of lost autonomy predict the development of PTSD. Victims' perceptions of mental defeat, alienation and permanent change were related to more severe presentations of PTSD. The perception of lost autonomy during victimization corresponded with the ending of efforts to maintain identity, and a loss of the belief that one could exercise free will and choice. However, not all survivors who experience a loss of autonomy experience mental defeat, which suggests that mental defeat represents a more severe form of damage to the self (Ehlers et al., 1998, 2000), perhaps an intermediate step on the way to mental death or complete loss of identity.

Active Coping

Severe traumas (including totalitarian control) reduce people's appraisals of their inner resources and of their ability to influence traumatic situations; these appraisals are associated with diminished active coping, which in turn is correlated with poorer trauma outcomes (King et al., 1999). Perception of control and coping style are related. An active coping style enhances positive evaluations of control and increases the likelihood of successful coping. A study of American prisoners of war in Vietnam showed that passive coping was linked with an increased risk of mental health problems following captivity

(King et al., 1999). Active coping involves mental planning during and after the event.

Mental planning, defined as considering or planning to minimize physical and/or

psychological harm, to make the traumatic experience more bearable, or to exert

influence on the perpetrator, is a protective factor that is incompatible with mental defeat

(Ehlers et al., 1998).

However, research results are inconsistent. In their study of rape victims, Ehlers et

al. (1998) found that more mental planning was related to lower levels of PTSD. By

contrast there was no relationship between coping strategy and level of PTSD among

victims of political imprisonment (Ehlers et al., 2000). As the authors explain, this null

result may be due to their failure to assess the mental processes involved in making

choices about coping or to assess the outcome of coping attempts. Alternatively, some

torture methods specifically aim to destroy resource beliefs by frustrating the victim's

attempts to exert control (Petersen & Jacobsen, 1985). As a consequence of such

treatments, the individual's resources for coping with and processing the experience

constructively are diminished, and are likely to give way to the perception that attempting

to influence the situation is futile. Appraisals of futility resemble the concept of learned

helplessness (Peterson & Seligman, 1983) with similar consequences, namely a paralysis

of coping beliefs and actions.

<u>Resource Appraisals</u>

Appraisals of the availability/depletion of resources affect adaptation during and

following traumatic experiences (King, et al., 1999, Suedfeld et al., 1998). Within the

same person, appraisals can be associated with maladaptation when resources are

appraised as severely depleted (when the person is mentally exhausted; Wenzel et al.,

2000), and with adaptation when they have later been appraised as having been rebuilt

(Suedfeld et al., 1998). This dynamic relationship between resource appraisals and

adaptation is illustrated by a study of the adaptation of Holocaust Survivors. During the

early Holocaust period, when survivors were first confronted with the full impact of

systematic persecution and a complete breakdown of justice and citizenship, a low level

of coping resources (complexity) was perceived. Following Antonovsky's (1987) model,

Suedfeld et al. (1998) suggest that three components of adaptation were compromised:

comprehensibility, manageability (i.e., active coping), and the meaningfulness of actions

(futility). Nonetheless, by the Late Holocaust, when survivors still faced the full

destructive force of their oppressors, survivors reported a significant increase in their

perceived resources. Survivors were able to achieve some form of adaptation to their

changed life circumstances by mustering their coping resources. The change from low to

higher resourcefulness during two consecutive traumatic stages indicates that coping

approaches and resources are not static even while trauma is occurring, a point also made

by Joseph (1999) and supported by Beardslee's (1989) research with other populations.

As Muraven and Baumeister (2000) suggest, resources act like a reservoir that can be

depleted and replenished.

<u>Demands on Cognitive Processes</u>

During and following exposure to totalitarian control, multiple demands are

placed on an individual's cognitive processes. The demands include not only an

immediate responses to events, but, over time, a grappling with the experience of

alienation, of loss of identity, of changed relationships, and of living in an unpredictable

and uncontrollable world. These demands require the processing of trauma-related

information, which in all cases is a particular challenge because traumatic memories are

more fragmented and disorganized than other memories (Foa, Riggs, Massie, &

Yarczower, 1995) and require more processing resources. Information processing

theories suggest that greater disorganization entails a higher risk for developing PTSD

(Foa & Kozak, 1986), but such disorganization also implies a final challenge for

treatment.

<div align="center">Implications for Therapeutic Interventions</div>

People who develop complex PTSD following the experience of totalitarian

control respond less well to exposure therapy than do people with standard PTSD (Ehlers

et al., 1998, 2000). This poorer response is understandable for two main reasons: the

symptoms of complex PTSD imply that a person with this disorder will have greater

difficulty, even than those typically associated with PTSD (van der Kolk, van der Hart, &

Burbridge, 2002), in engaging in any form of psychotherapy, including exposure therapy,

and exposure therapy is not designed to address the specific mechanisms affected by the

experience of mental death (Kinzie, 2001).

There is increasing evidence indicating that in addition to the specific effects of

any given psychological treatment, non-specific factors common to effective

psychological therapies make a substantial contribution to treatment effectiveness (Groth-

Marnat, Roberts, & Beutler, 2001). These common factors include positive expectations

for the treatment and the development of an effective working alliance or therapeutic

relationship between the client and therapist (Andrews, 2001; Frank, 1978). For people

who have experienced mental death, neither of these conditions is likely to be initially

present or easily achieved. Although there is no direct evidence of this, the person with

complex PTSD is likely to believe that participation in treatment will prove futile and will have incredible difficulty developing trust in the therapist (Lemaire & Despret, 2001). In the context of an exposure therapy, negative expectations about treatment effectiveness and inability to trust the therapist reduce the chance that the client will do what they prefer to avoid doing.

We know of no treatment regimen that has been developed specifically for people with complex PTSD, but several treatment approaches may be adapted for use with this population to augment the effectiveness of exposure. First, approaches that use the client's relationship with the therapist to understand the client's relationships with other people may be apposite in the initial phase of treatment. Based on the experience of Holocaust survivors, mistrust is the most refractory of symptoms, and an approach that makes the capacity for trust the initial focus of treatment may be expected to enhance the effectiveness of other treatment components. Examples of relevant treatments are the versions of cognitive therapy designed to treat people with personality disorders (Beck & Freeman, 1990), and the interpersonal therapies, including time limited dynamic psychotherapy (Strupp & Binder, 1984). Second, treatments that have been designed to assist individuals with identity problems and problems of affect regulation may be especially useful. For example, there is substantial overlap in the clinical presentation of people with complex PTSD and borderline personality disorder, and each of these disorders has an identity problem as a key feature. Both psychodynamic and cognitive behavioral (Linehan, Heard, & Armstrong, 1993; Turner, 2000) therapies have demonstrated effectiveness with borderline personality disorders.

In each case, treatments need to be adapted to meet other specific needs of persons with complex PTSD. For example, Ehlers and colleagues (2000) suggested that people who have experienced mental defeat need interventions that target perceptions of mental defeat and help survivors to reappraise their experiences. People who report symptoms of alienation and permanent change require interventions that help them to rebuild positive interpersonal interactions and rediscover previous interests or resume rewarding activities (Ehlers et al., 2000).

Silove (1999) underlined the need for restructuring personal constructs related to trust, safety, identity role, attachments and existence, the domains most damaged by trauma experiences. This idea is consistent with information processing theories which suggest that persons with any form of PTSD have difficulty in constructively processing traumatic events (Creamer, 1995; Foa & Kozak, 1986; Joseph, Williams, & Yule, 1993). It is also consistent with Janoff-Bulman's (1992) proposition that coping with victimization requires that people rebuild their assumptive worlds, including their core beliefs and their views of themselves as worthwhile, strong, and autonomous persons (Janoff-Bulman, 1989, 1992).

Following Kelly (1955), rebuilding will entail the development of alternative constructs and perspectives so that the individual can accommodate diametrically opposed perspectives on the world. How to help people who once believed that the world is a benevolent place but now believe that it is an evil one to integrate their previous and current beliefs is an important challenge, and one that appears crucial to a positive post-trauma adaptation (Suedfeld et al., 1998). It is in facilitating this more complex view of the world that Linehan's (1993) treatment for borderline personality disorder may prove

helpful, as it aims to facilitate the integration of the opposed beliefs of persons with fragmented identities. Linehan (1993) argued that persons with borderline personality disorder need to develop their capacity for dialectical thinking, to hold a perspective that integrates polarities and contradictions.

Conclusion

People who have experienced severe aversive events while under the totalitarian control of other people are likely to experience mental death, a loss of the identity that they had prior to their interpersonal trauma. Mental death is associated with a characteristic set of symptoms, including guilt and shame, distrust and alienation from others, ineffectiveness and loss of autonomy, loss of core beliefs and values, and a sense of being permanently damaged. These symptoms define a form of complex PTSD that arises from threats to psychological rather than physical integrity. Complex PTSD does not respond well to standard exposure treatments for PTSD. Treatments that are specifically designed to help a person to reconstrue their life and restore their identity are likely to prove more useful in overcoming this debilitating condition.

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