their own children or may fail to protect them. Contrary to the popular notion of a "generational cycle of abuse," however, the great majority of survivors neither abuse nor neglect their children.[47] Many survivors are terribly afraid that their children will suffer a fate similar to their own, and they go to great lengths to prevent this from happening. For the sake of their children, survivors are often able to mobilize caring and protective capacities that they have never been able to extend to themselves. In a study of mothers with multiple personality disorder, the psychiatrist Philip Coons observed: "I have generally been impressed by the positive, constructive and caring attitude that many mothers with multiple personality disorder have toward their children. They were abused as children and strive to protect their children against similar misfortunes."[48]

As survivors attempt to negotiate adult relationships, the psychological defenses formed in childhood become increasingly maladaptive. Doublethink and a double self are ingenious childhood adaptations to a familial climate of coercive control, but they are worse than useless in a climate of freedom and adult responsibility. They prevent the development of mutual, intimate relationships or an integrated identity. As the survivor struggles with the tasks of adult life, the legacy of her childhood becomes increasingly burdensome. Eventually, often in the third or fourth decade of life, the defensive structure may begin to break down. Often the precipitant is a change in the equilibrium of close relationships: the failure of a marriage, the birth of a child, the illness or death of a parent. The facade can hold no longer, and the underlying fragmentation becomes manifest. When and if a breakdown occurs, it can take symptomatic forms that mimic virtually every category of psychiatric disorder. Survivors fear that they are going insane or that they will have to die. Fraser describes the terror and danger of coming face to face as an adult with the secrets of her childhood:

> Did I truly wish to open the Pandora's box under my father's bed? How would I feel to discover that the prize, after four decades of tracing clues and solving riddles, was the knowledge that my father had sexually abused me? Could I reconcile myself without bitterness to the amount of my life's energy that had gone into the cover-up of a crime? . . .
>
> I believe many unexpected deaths occur when a person finishes one phase of life and must become a different sort of person in order to continue. The phoenix goes down into the fire with the best intention of rising, then falters on the upswing. At the point of transition, I came close to dying along with my other self.[49]

CHAPTER 6

A New Diagnosis

MOST PEOPLE have no knowledge or understanding of the psychological changes of captivity. Social judgment of chronically traumatized people therefore tends to be extremely harsh. The chronically abused person's apparent helplessness and passivity, her entrapment in the past, her intractable depression and somatic complaints, and her smoldering anger often frustrate the people closest to her. Moreover, if she has been coerced into betrayal of relationships, community loyalties, or moral values, she is frequently subjected to furious condemnation.

Observers who have never experienced prolonged terror and who have no understanding of coercive methods of control presume that they would show greater courage and resistance than the victim in similar circumstances. Hence the common tendency to account for the victim's behavior by seeking flaws in her personality or moral character. Prisoners of war who succumb to "brainwashing" are often treated as traitors.[1] Hostages who submit to their captors are often publicly excoriated. Sometimes survivors are treated more harshly than those who abused them. In the notorious case of Patricia Hearst, for instance, the hostage was tried for crimes committed under duress and received a longer prison sentence than her captors.[2] Similarly, women who fail to escape from abusive relationships and those who prostitute themselves or betray their children under duress are subjected to extraordinary censure.[3]

The propensity to fault the character of the victim can be seen even in the case of politically organized mass murder. The aftermath of the Holocaust witnessed a protracted debate regarding the "passivity" of the Jews and their "complicity" in their fate. But the historian Lucy Dawid-

owicz points out that "complicity" and "cooperation" are terms that apply to situations of free choice. They do not have the same meaning in situations of captivity.[4]

DIAGNOSTIC MISLABELING

This tendency to blame the victim has strongly influenced the direction of psychological inquiry. It has led researchers and clinicians to seek an explanation for the perpetrator's crimes in the character of the victim. In the case of hostages and prisoners of war, numerous attempts to find supposed personality defects that predisposed captives to "brainwashing" have yielded few consistent results. The conclusion is inescapable that ordinary, psychologically healthy men can indeed be coerced in unmanly ways.[5] In domestic battering situations, where victims are entrapped by persuasion rather than by capture, research has also focused on the personality traits that might predispose a woman to get involved in an abusive relationship. Here again no consistent profile of the susceptible woman has emerged. While some battered women clearly have major psychological difficulties that render them vulnerable, the majority show no evidence of serious psychopathology before entering into the exploitative relationship. Most become involved with their abusers at a time of temporary life crisis or recent loss, when they are feeling unhappy, alienated, or lonely.[6] A survey of the studies on wife-beating concludes: "The search for characteristics of women that contribute to their own victimization is futile. . . . It is sometimes forgotten that men's violence is men's behavior. As such, it is not surprising that the more fruitful efforts to explain this behavior have focused on male characteristics. What is surprising is the enormous effort to explain male behavior by examining characteristics of women."[7]

While it is clear that ordinary, healthy people may become entrapped in prolonged abusive situations, it is equally clear that after their escape they are no longer ordinary or healthy. Chronic abuse causes serious psychological harm. The tendency to blame the victim, however, has interfered with the psychological understanding and diagnosis of a posttraumatic syndrome. Instead of conceptualizing the psychopathology of the victim as a response to an abusive situation, mental health professionals have frequently attributed the abusive situation to the victim's presumed underlying psychopathology.

An egregious example of this sort of thinking is the 1964 study of battered women entitled "The Wife-Beater's Wife." The researchers, who had originally sought to study batterers, found that the men would not talk to them. They thereupon redirected their attention to the more cooperative battered women, whom they found to be "castrating," "frigid," "aggressive," "indecisive," and "passive." They concluded that marital violence fulfilled these women's "masochistic needs." Having identified the women's personality disorders as the source of the problem, these clinicians set out to "treat" them. In one case they managed to persuade the wife that she was provoking the violence, and they showed her how to mend her ways. When she no longer sought help from her teenage son to protect herself from beatings and no longer refused to submit to sex on demand, even when her husband was drunk and aggressive, her treatment was judged a success.[8]

While this unabashed, open sexism is rarely found in psychiatric literature today, the same conceptual errors, with their implicit bias and contempt, still predominate. The clinical picture of a person who has been reduced to elemental concerns of survival is still frequently mistaken for a portrait of the victim's underlying character. Concepts of personality organization developed under ordinary circumstances are applied to victims, without any understanding of the corrosion of personality that occurs under conditions of prolonged terror. Thus, patients who suffer from the complex aftereffects of chronic trauma still commonly risk being misdiagnosed as having personality disorders. They may be described as inherently "dependent," "masochistic," or "self-defeating." In a recent study of emergency room practice in a large urban hospital, clinicians routinely described battered women as "hysterics," "masochistic females," "hypochondriacs," or, more simply, "crocks."[9]

This tendency to misdiagnose victims was at the heart of a controversy that arose in the mid-1980s when the diagnostic manual of the American Psychiatric Association came up for revision. A group of male psychoanalysts proposed that "masochistic personality disorder" be added to the canon. This hypothetical diagnosis applied to any person who "remains in relationships in which others exploit, abuse, or take advantage of him or her, despite opportunities to alter the situation." A number of women's groups were outraged, and a heated public debate ensued. Women insisted on opening up the process of writing the diagnostic canon, which had been the preserve of a small group of men, and for the first time took part in the naming of psychological reality.

I was one of the participants in this process. What struck me most at the time was how little rational argument seemed to matter. The women's

representatives came to the discussion prepared with carefully reasoned, extensively documented position papers, which argued that the proposed diagnostic concept had little scientific foundation, ignored recent advances in understanding the psychology of victimization, and was socially regressive and discriminatory in impact, since it would be used to stigmatize disempowered people.[10] The men of the psychiatric establishment persisted in their bland denial. They admitted freely that they were ignorant of the extensive literature of the past decade on psychological trauma, but they did not see why it should concern them. One member of the Board of Trustees of the American Psychiatric Association felt the discussion of battered women was "irrelevant." Another stated simply, "I never see victims."[11]

In the end, because of the outcry from organized women's groups and the widespread publicity engendered by the controversy, some sort of compromise became expedient.[12] The name of the proposed entity was changed to "self-defeating personality disorder." The criteria for diagnosis were changed, so that the label could not be applied to people who were known to be physically, sexually, or psychologically abused. Most important, the disorder was included not in the main body of the text but in an appendix. It was relegated to apocryphal status within the canon, where it languishes to this day.

NEED FOR A NEW CONCEPT

Misapplication of the concept of masochistic personality disorder may be one of the most stigmatizing diagnostic mistakes, but it is by no means the only one. In general, the diagnostic categories of the existing psychiatric canon are simply not designed for survivors of extreme situations and do not fit them well. The persistent anxiety, phobias, and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder.

The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient's present symptoms and the traumatic experience is frequently

problem and a fragmented approach to treatment. All too commonly, chronically traumatized people suffer in silence; but if they complain at all, their complaints are not well understood. They may collect a virtual pharmacopeia of remedies: one for headaches, another for insomnia, another for anxiety, another for depression. None of these tends to work very well, since the underlying issues of trauma are not addressed. As caregivers tire of these chronically unhappy people who do not seem to improve, the temptation to apply pejorative diagnostic labels becomes overwhelming.

Even the diagnosis of "post-traumatic stress disorder," as it is presently defined, does not fit accurately enough. The existing diagnostic criteria for this disorder are derived mainly from survivors of circumscribed traumatic events. They are based on the prototypes of combat, disaster, and rape. In survivors of prolonged, repeated trauma, the symptom picture is often far more complex. Survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity. Survivors of abuse in childhood develop similar problems with relationships and identity; in addition, they are particularly vulnerable to repeated harm, both self-inflicted and at the hands of others. The current formulation of post-traumatic stress disorder fails to capture either the protean symptomatic manifestations of prolonged, repeated trauma or the profound deformations of personality that occur in captivity.

The syndrome that follows upon prolonged, repeated trauma needs its own name. I propose to call it "complex post-traumatic stress disorder." The responses to trauma are best understood as a spectrum of conditions rather than as a single disorder. They range from a brief stress reaction that gets better by itself and never qualifies for a diagnosis, to classic or simple post-traumatic stress disorder, to the complex syndrome of prolonged, repeated trauma.

Although the complex traumatic syndrome has never before been outlined systematically, the concept of a spectrum of post-traumatic disorders has been noted, almost in passing, by many experts. Lawrence Kolb remarks on the "heterogeneity" of post-traumatic stress disorder, which "is to psychiatry as syphilis was to medicine. At one time or another [this disorder] may appear to mimic every personality disorder. . . . It is those threatened over long periods of time who suffer the long-standing severe personality disorganization."[13] Others have also

vors of the Nazi Holocaust, observes: "The psychopathology may be hidden in characterological changes that are manifest only in disturbed object relationships and attitudes towards work, the world, man and God."[14]

Many experienced clinicians have invoked the need for a diagnostic formulation that goes beyond simple post-traumatic stress disorder. William Niederland finds that "the concept of traumatic neurosis does not appear sufficient to cover the multitude and severity of clinical manifestations" of the syndrome observed in survivors of the Nazi Holocaust.[15] Psychiatrists who have treated Southeast Asian refugees also recognize the need for an "expanded concept" of post-traumatic stress disorder that takes into account severe, prolonged, and massive psychological trauma.[16] One authority suggests the concept of a "post-traumatic character disorder."[17] Others speak of "complicated" post-traumatic stress disorder.[18]

Clinicians who work with survivors of childhood abuse have also seen the need for an expanded diagnostic concept. Lenore Terr distinguishes the effects of a single traumatic blow, which she calls "Type I" trauma, from the effects of prolonged, repeated trauma, which she calls "Type II." Her description of the Type II syndrome includes denial and psychic numbing, self-hypnosis and dissociation, and alternations between extreme passivity and outbursts of rage.[19] The psychiatrist Jean Goodwin has invented the acronyms FEARS for simple post-traumatic stress disorder and BAD FEARS for the severe post-traumatic disorder observed in survivors of childhood abuse.[20]

Thus, observers have often glimpsed the underlying unity of the complex traumatic syndrome and have given it many different names. It is time for the disorder to have an official, recognized name. Currently, the complex post-traumatic stress disorder is under consideration for inclusion in the fourth edition of the diagnostic manual of the American Psychiatric Association, based on seven diagnostic criteria (see chart). Empirical field trials are underway to determine whether such a syndrome can be diagnosed reliably in chronically traumatized people. The degree of scientific and intellectual rigor in this process is considerably higher than that which occurred in the pitiable debates over "masochistic personality disorder."

As the concept of a complex traumatic syndrome has gained wider recognition, it has been given several additional names. The working group for the diagnostic manual of the American Psychiatric Association has chosen the designation "disorder of extreme stress not otherwise specified." The International Classification of Diseases is considering a

Complex Post-Traumatic Stress Disorder

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

2. Alterations in affect regulation, including
   - persistent dysphoria
   - chronic suicidal preoccupation
   - self-injury
   - explosive or extremely inhibited anger (may alternate)
   - compulsive or extremely inhibited sexuality (may alternate)

3. Alterations in consciousness, including
   - amnesia or hypermnesia for traumatic events
   - transient dissociative episodes
   - depersonalization/derealization
   - reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation

4. Alterations in self-perception, including
   - sense of helplessness or paralysis of initiative
   - shame, guilt, and self-blame
   - sense of defilement or stigma
   - sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)

5. Alterations in perception of perpetrator, including
   - preoccupation with relationship with perpetrator (includes preoccupation with revenge)
   - unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
   - idealization or paradoxical gratitude
   - sense of special or supernatural relationship
   - acceptance of belief system or rationalizations of perpetrator

6. Alterations in relations with others, including
   - isolation and withdrawal
   - disruption in intimate relationships
   - repeated search for rescuer (may alternate with isolation and withdrawal)
   - persistent distrust
   - repeated failures of self-protection

7. Alterations in systems of meaning
   - loss of sustaining faith
   - sense of hopelessness and despair

similar entity under the name "personality change from catastrophic experience." These names may be awkward and unwieldy, but practically any name that gives recognition to the syndrome is better than no name at all.

Naming the syndrome of complex post-traumatic stress disorder represents an essential step toward granting those who have endured prolonged exploitation a measure of the recognition they deserve. It is an attempt to find a language that is at once faithful to the traditions of accurate psychological observation and to the moral demands of traumatized people. It is an attempt to learn from survivors, who understand, more profoundly than any investigator, the effects of captivity.

SURVIVORS AS PSYCHIATRIC PATIENTS

The mental health system is filled with survivors of prolonged, repeated childhood trauma. This is true even though most people who have been abused in childhood never come to psychiatric attention. To the extent that these people recover, they do so on their own.[21] While only a small minority of survivors, usually those with the most severe abuse histories, eventually become psychiatric patients, many or even most psychiatric patients are survivors of childhood abuse.[22] The data on this point are beyond contention. On careful questioning, 50–60 percent of psychiatric inpatients and 40–60 percent of outpatients report childhood histories of physical or sexual abuse or both.[23] In one study of psychiatric emergency room patients, 70 percent had abuse histories.[24] Thus abuse in childhood appears to be one of the main factors that lead a person to seek psychiatric treatment as an adult.

Survivors of child abuse who become patients appear with a bewildering array of symptoms. Their general levels of distress are higher than those of other patients. Perhaps the most impressive finding is the sheer length of the list of symptoms correlated with a history of childhood abuse.[25] The psychologist Jeffrey Bryer and his colleagues report that women with histories of physical or sexual abuse have significantly higher scores than other patients on standardized measures of somatization, depression, general anxiety, phobic anxiety, interpersonal sensitivity, paranoia, and "psychoticism" (probably dissociative symptoms).[26] The psychologist John Briere reports that survivors of childhood abuse display significantly more insomnia, sexual dysfunction, dissociation, anger, suicidality, self-mutilation, drug addiction, and alcoholism than other patients.[27] The symptom list can be prolonged almost indefinitely.

When survivors of childhood abuse seek treatment, they have what the psychologist Denise Gelinas calls a "disguised presentation." They come for help because of their many symptoms or because of difficulty with relationships: problems in intimacy, excessive responsiveness to the needs of others, and repeated victimization. All too commonly, neither patient nor therapist recognizes the link between the presenting problem and the history of chronic trauma.[28]

Survivors of childhood abuse, like other traumatized people, are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete. Because of their characteristic difficulties in close relationships, they are particularly vulnerable to revictimization by caregivers. They may become engaged in ongoing, destructive interactions, in which the medical or mental health system replicates the behavior of the abusive family.

Survivors of childhood abuse often accumulate many different diagnoses before the underlying problem of a complex post-traumatic syndrome is recognized. They are likely to receive a diagnosis that carries strong negative connotations. Three particularly troublesome diagnoses have often been applied to survivors of childhood abuse: somatization disorder, borderline personality disorder, and multiple personality disorder. All three of these diagnoses were once subsumed under the now obsolete name *hysteria.*[29] Patients, usually women, who receive these diagnoses evoke unusually intense reactions in caregivers. Their credibility is often suspect. They are frequently accused of manipulation or malingering. They are often the subject of furious and partisan controversy. Sometimes they are frankly hated.

These three diagnoses are charged with pejorative meaning. The most notorious is the diagnosis of borderline personality disorder. This term is frequently used within the mental health professions as little more than a sophisticated insult. As one psychiatrist candidly confesses, "As a resident, I recalled asking my supervisor how to treat patients with borderline personality disorder, and he answered, sardonically, 'You refer them.' "[30] The psychiatrist Irvin Yalom describes the term "borderline" as "the word that strikes terror into the heart of the middle-aged, comfort-seeking psychiatrist."[31] Some clinicians have argued that the term "borderline" has become so prejudicial that it should be abandoned altogether, just as its predecessor term, *hysteria,* had to be abandoned.

These three diagnoses have many features in common, and often they cluster and overlap with one another. Patients who receive any one of these three diagnoses usually qualify for several other diagnoses as well. For example, the majority of patients with somatization disorder also have major depression, agoraphobia, and panic, in addition to their numerous physical complaints.[32] Over half are given additional diagnoses of "histrionic," "antisocial," or "borderline" personality disorder.[33] Similarly, people with borderline personality disorder often suffer as well from major depression, substance abuse, agoraphobia or panic, and somatization disorder.[34] The majority of patients with multiple personality disorder experience severe depression.[35] Most also meet diagnostic criteria for borderline personality disorder.[36] And they generally have numerous psychosomatic complaints, including headache, unexplained pains, gastrointestinal disturbances, and hysterical conversion symptoms. These patients receive an average of three other psychiatric or neurological diagnoses before the underlying problem of multiple personality disorder is finally recognized.[37]

All three disorders are associated with high levels of hypnotizability or dissociation, but in this respect, multiple personality disorder is in a class by itself. People with multiple personality disorder possess staggering dissociative capabilities. Some of their more bizarre symptoms may be mistaken for symptoms of schizophrenia.[38] For example, they may have "passive influence" experiences of being controlled by another personality, or hallucinations of the voices of quarreling alter personalities. Patients with borderline personality disorder, though they are rarely capable of the same virtuosic feats of dissociation, also have abnormally high levels of dissociative symptoms.[39] And patients with somatization disorder are reported to have high levels of hypnotizability and psychogenic amnesia.[40]

Patients with all three disorders also share characteristic difficulties in close relationships. Interpersonal difficulties have been described most extensively in patients with borderline personality disorder. Indeed, a pattern of intense, unstable relationships is one of the major criteria for making this diagnosis. Borderline patients find it very hard to tolerate being alone but are also exceedingly wary of others. Terrified of abandonment on the one hand and of domination, on the other, they oscillate between extremes of clinging and withdrawal, between abject submissiveness and furious rebellion.[41] They tend to form "special" relations with idealized caretakers in which ordinary boundaries are not observed.[42] Psychoanalytic authors attribute this instability to a failure of psychological development in the formative years of early childhood. One authority

describes the primary defect in borderline personality disorder as a "failure to achieve object constancy," that is, a failure to form reliable and well-integrated inner representations of trusted people.[43] Another speaks of the "relative developmental failure in formation of introjects that provide to the self a function of holding-soothing security"; that is, people with borderline personality disorder cannot calm or comfort themselves by calling up a mental image of a secure relationship with a caretaker.[44]

Similar patterns of stormy, unstable relationships are found in patients with multiple personality disorder. In this disorder, with its extreme compartmentalization of functions, the highly contradictory patterns of relating may be carried out by dissociated "alter" personalities. Patients with multiple personality disorder also have a tendency to develop intense, highly "special" relationships, ridden with boundary violations, conflict, and the potential for exploitation.[45] Patients with somatization disorder also have difficulties in intimate relationships, including sexual, marital, and parenting problems.[46]

Disturbances in identity formation are also characteristic of patients with borderline and multiple personality disorders (they have not been systematically studied in somatization disorder). Fragmentation of the self into dissociated alters is the central feature of multiple personality disorder. The array of personality fragments usually includes at least one "hateful" or "evil" alter, as well as one socially conforming, submissive, or "good" alter.[47] Patients with borderline personality disorder lack the dissociative capacity to form fragmented alters, but they have similar difficulty developing an integrated identity. Inner images of the self are split into extremes of good and bad. An unstable sense of self is one of the major diagnostic criteria for borderline personality disorder, and the "splitting" of inner representations of self and others is considered by some theorists to be the central underlying pathology of the disorder.[48]

The common denominator of these three disorders is their origin in a history of childhood trauma. The evidence for this link ranges from definitive to suggestive. In the case of multiple personality disorder the etiological role of severe childhood trauma is at this point firmly established.[49] In a study by the psychiatrist Frank Putnam of 100 patients with the disorder, 97 had histories of major childhood trauma, most commonly sexual abuse, physical abuse, or both. Extreme sadism and murderous violence were the rule rather than the exception in these dreadful histories. Almost half the patients had actually witnessed the violent death of someone close to them.[50]

In borderline personality disorder, my investigations have also docu-

mented histories of severe childhood trauma in the great majority (81 percent) of cases. The abuse generally began early in life and was severe and prolonged, though it rarely reached the lethal extremes described by patients with multiple personality disorder. The earlier the onset of abuse and the greater its severity, the greater the likelihood that the survivor would develop symptoms of borderline personality disorder.[51] The specific relationship between symptoms of borderline personality disorder and a history of childhood trauma has now been confirmed in numerous other studies.[52]

Evidence for the link between somatization disorder and childhood trauma is not yet complete. Somatization disorder is sometimes also called Briquet's syndrome, after the nineteenth-century French physician Paul Briquet, a predecessor of Charcot. Briquet's observations of patients with the disorder are filled with anecdotal references to domestic violence, childhood trauma, and abuse. In a study of 87 children under twelve, Briquet noted that one-third had been "habitually mistreated or held constantly in fear or had been directed harshly by their parents." In another 10 percent, he attributed the children's symptoms to traumatic experiences other than parental abuse.[53] After the lapse of a century, investigation of the link between somatization disorder and childhood abuse has only lately been resumed. A recent study of women with somatization disorder found that 55 percent had been sexually molested in childhood, usually by relatives. This study, however, focused only on early sexual experiences; patients were not asked about physical abuse or a more general climate of violence in their families.[54] Systematic investigation of the childhood histories of patients with somatization disorder has yet to be undertaken.

These three disorders might perhaps be best understood as variants of complex post-traumatic stress disorder, each deriving its characteristic features from one form of adaptation to the traumatic environment. The *physioneurosis* of post-traumatic stress disorder is the most prominent feature in somatization disorder, the deformation of consciousness is most prominent in multiple personality disorder, and the disturbance in identity and relationship is most prominent in borderline personality disorder. The overarching concept of a complex post-traumatic syndrome accounts for both the particularity of the three disorders and their interconnection. The formulation also reunites the descriptive fragments of the condition that was once called hysteria and reaffirms their common source in a history of psychological trauma.

Many of the most troubling features of these three disorders become more comprehensible in the light of a history of childhood trauma. More important, survivors become comprehensible to themselves. When survivors recognize the origins of their psychological difficulties in an abusive childhood environment, they no longer need attribute them to an inherent defect in the self. Thus the way is opened to the creation of new meaning in experience and a new, unstigmatized identity.

Understanding the role of childhood trauma in the development of these severe disorders also informs every aspect of treatment. This understanding provides the basis for a cooperative therapeutic alliance that normalizes and validates the survivor's emotional reactions to past events, while recognizing that these reactions may be maladaptive in the present. Moreover, a shared understanding of the survivor's characteristic disturbances of relationship and the consequent risk of repeated victimization offers the best insurance against unwitting reenactments of the original trauma in the therapeutic relationship.

The testimony of patients is eloquent on the point that recognition of the trauma is central to the recovery process. Three survivors who have had long careers in psychiatric treatment can speak here for all patients. Each accumulated numerous mistaken diagnoses and suffered through numerous unsuccessful treatments before finally discovering the source of her psychological problems in her history of severe childhood abuse. And each challenges us to decipher her language and to recognize, behind the multiplicity of disguises, the complex post-traumatic syndrome.

The first survivor, Barbara, manifests the predominant symptoms of somatization disorder:

> I lived in a hell on earth without benefit of a doctor or medication. . . . I could not breathe, I had spasms when I attempted to swallow food, my heart pounded in my chest, I had numbness in my face and St. Vitus Dance when I went to bed. I had migraine headaches, and the blood vessels above my right eye were so taut I could not close that eye.
>
> [My therapist] and I have decided that I have dissociated states. Though they are very similar to personalities, I know that they are part of me. When the horrors first surfaced, I went through a psychological death. I remember floating up on a white cloud with many people inside, but I could not make out the faces. Then two hands came out and pressed on my chest, and a voice said, "Don't go in there."
>
> Had I gone for help when I had my breakdown, I feel I would have been classified as mentally ill. The diagnosis probably would have been manic depressive with a flavor of schizophrenia, panic disorder, and agoraphobia. At that time no one would have had the diagnostic tools to come up with a diagnosis of [complex] post-traumatic stress disorder.[55]

The second survivor, Tani, was diagnosed with borderline personality disorder:

> I know that things are getting better about borderlines and stuff. Having that diagnosis resulted in my getting treated exactly the way I was treated at home. The minute I got that diagnosis people stopped treating me as though what I was doing had a reason. All that psychiatric treatment was just as destructive as what happened before.
>
> Denying the reality of my experience—that was the most harmful. Not being able to trust anyone was the most serious effect. . . . I know I acted in ways that were despicable. But I wasn't crazy. Some people go around acting like that because they feel hopeless. Finally I found a few people along the way who have been able to feel OK about me even though I had severe problems. Good therapists were those who really validated my experience.[56]

The third survivor is Hope, who manifests the predominant symptoms of multiple personality disorder:

> Long ago, a lovely young child was branded with the term paranoid schizophrenic. . . . The label became a heavy yoke. A Procrustean bed I always fit into so nicely, for I never grew. . . . I became wrapped, shrouded. No alert, spectacled psychologist had trained a professional mind upon my dull drudgery. No. The diagnosis of paranoid schizophrenic was not offered me where I could look kindly back onto the earnest practitioner and say, "You're wrong. It's really just a lifetime of grief, but it's all right."
>
> Somehow the dreaded words got sprinkled on my cereal, rinsed into my clothes. I felt them in hard looks, and hands that inadvertently pressed down. I saw the words in the averted head, the questions that weren't asked, the careful, repetitious confines of a concept made smaller, simpler for my benefit. The years pass. They go on. The haunting refrain has become a way of life. Expectation is slowed. Progress looks nostalgically backward. And all the time a lurking snake lies hidden in the heart.
>
> Finally, dreams begin to be unlocking. Spurred on by the the fresh, crisp increase of the Still, Small Voice. I begin to see some of what those silent, unspoken words never said. I saw a mask. It looked like me. I took it off and beheld a group of huddled, terrified people who shrank together to hide terrible secrets. . . .
>
> The words "paranoid schizophrenic" started to fall into place, letter by letter, but it looked like feelings and thoughts and actions that hurt children, and lied, and covered disgrace, and much terror. I began to realize that the label, the diagnosis, had been a handmaid, much like the letter "A" Hester Prynne embroidered upon her breast. . . . And down all the days

> and all the embroidered hours, other words kept pushing aside the badge, the label, the diagnosis. "Hurting children." "That which is unseemly." "Women with women, and men with men, doing that which is unseemly." . . .
>
> I forsook my paranoid schizophrenia, and packed it up with my troubles, and sent it to Philadelphia.[57]