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Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma

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This paper reviews the evidence for the existence of a complex form of post-traumatic disorder in survivors of prolonged, repeated trauma. This syndrome is currently under consideration for inclusion in DSM-IV under the name of DESNOS (Disorders of Extreme Stress Not Otherwise Specified). The current diagnostic formulation of PTSD derives primarily from observations of survivors of relatively circumscribed traumatic events. This formulation fails to capture the protean sequelae of prolonged, repeated trauma. In contrast to a single traumatic event, prolonged, repeated trauma can occur only where the victim is in a state of captivity, under the control of the perpetrator. The psychological impact of subordination to coercive control has many common features, whether it occurs within the public sphere of politics or within the private sphere of sexual and domestic relations.

KEY WORDS: complex PTSD.

INTRODUCTION

The current diagnostic formulation of PTSD derives primarily from observations of survivors of relatively circumscribed traumatic events: combat, disaster, and rape. It has been suggested that this formulation fails to capture the protean sequelae of prolonged, repeated trauma. In contrast to the circumscribed traumatic event, prolonged, repeated trauma can occur only where the victim is in a state of captivity, unable to flee, and under the control of the perpetrator. Examples of such conditions include prisons, concentration camps, and slave labor camps. Such conditions also

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exist in some religious cults, in brothels and other institutions of organized sexual exploitation, and in some families.

Captivity, which brings the victim into prolonged contact with the perpetrator, creates a special type of relationship, one of coercive control. This is equally true whether the victim is rendered captive primarily by physical force (as in the case of prisoners and hostages), or by a combination of physical, economic, social, and psychological means (as in the case of religious cult members, battered women, and abused children). The psychological impact of subordination to coercive control may have many common features, whether that subordination occurs within the public sphere of politics or within the supposedly private (but equally political) sphere of sexual and domestic relations.

This paper reviews the evidence for the existence of a complex form of post-traumatic disorder in survivors of prolonged, repeated trauma. A preliminary formulation of this complex post-traumatic syndrome is currently under consideration for inclusion in DSM-IV under the name of DESNOS (Disorders of Extreme Stress). In the course of a larger work in progress, I have recently scanned literature of the past 50 years on survivors of prolonged domestic, sexual, or political victimization (Herman, 1992). This literature includes first-person accounts of survivors themselves, descriptive clinical literature, and, where available, more rigorously designed clinical studies. In the literature review, particular attention was directed toward observations that did not fit readily into the existing criteria for PTSD. Though the sources include works by authors of many nationalities, only works originally written in English or available in English translation were reviewed.

The concept of a spectrum of post-traumatic disorders has been suggested independently by many major contributors to the field. Kolb, in a letter to the editor of the *American Journal of Psychiatry* (1989), writes of the "heterogeneity" of PTSD. He observes that "PTSD is to psychiatry as syphilis was to medicine. At one time or another PTSD may appear to mimic every personality disorder," and notes further that "It is those threatened over long periods of time who suffer the long-standing severe personality disorganization." Niederland, on the basis of his work with survivors of the Nazi Holocaust, observes that "the concept of traumatic neurosis does not appear sufficient to cover the multitude and severity of clinical manifestations" of the survivor syndrome (in Krystal, 1968, p. 314). Tanay, working with the same population, notes that "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" (Krystal, 1968, p. 221). Similarly, Kroll and his colleagues (1989), on the basis of their work with Southeast Asian refugees, suggest the need for an "expanded con-

cept of PTSD that takes into account the observations [of the effects of] severe, prolonged, and/or massive psychological and physical traumata." Horowitz (1986) suggests the concept of a "post-traumatic character disorder," and Brown and Fromm (1986) speak of "complicated PTSD."

Clinicians working with survivors of childhood abuse also invoke the need for an expanded diagnostic concept. Gelinas (1983) describes the "disguised presentation" of the survivor of childhood sexual abuse as a patient with chronic depression complicated by dissociative symptoms, substance abuse, impulsivity, self-mutilation, and suicidality. She formulates the underlying psychopathology as a complicated traumatic neurosis. Goodwin (1988) conceptualizes the sequelae of prolonged childhood abuse as a severe post-traumatic syndrome which includes fugue and other dissociative states, ego fragmentation, affective and anxiety disorders, reenactment and revictimization, somatization and suicidality.

Clinical observations identify three broad areas of disturbance which transcend simple PTSD. The first is symptomatic: the symptom picture in survivors of prolonged trauma often appears to be more complex, diffuse, and tenacious than in simple PTSD. The second is characterological: survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity. The third area involves the survivor's vulnerability to repeated harm, both self-inflicted and at the hands of others.

Symptomatic Sequelae of Prolonged Victimization

Multiplicity of Symptoms

The pathological environment of prolonged abuse fosters the development of a prodigious array of psychiatric symptoms. A history of abuse, particularly in childhood, appears to be one of the major factors predisposing a person to become a psychiatric patient. While only a minority of survivors of chronic childhood abuse become psychiatric patients, a large proportion (40-70%) of adult psychiatric patients are survivors of abuse (Briere and Runtz, 1987; Briere and Zaidi, 1989, Bryer *et al.,* 1987, Carmen *et al.,* 1984; Jacobson and Richardson, 1987).

Survivors who become patients present with a great number and variety of complaints. Their general levels of distress are higher than those of patients who do not have abuse histories. Detailed inventories of their symptoms reveal significant pathology in multiple domains: somatic, cognitive, affective, behavioral, and relational. Bryer and his colleagues (1987), studying psychiatric inpatients, report that women with histories of physical

or sexual abuse have significantly higher scores than other patients on standardized measures of somatization, depression, general and phobic anxiety, interpersonal sensitivity, paranoia, and "psychoticism" (dissociative symptoms were not measured specifically). Briere (1988), studying outpatients at a crisis intervention service, reports that survivors of childhood abuse display significantly more insomnia, sexual dysfunction, dissociation, anger, suicidality, self-mutilation, drug addiction, and alcoholism than other patients. Perhaps the most impressive finding of studies employing a "symptom check-list" approach is the sheer length of the list of symptoms found to be significantly related to a history of childhood abuse (Browne and Finkelhor, 1986). From this wide array of symptoms, I have selected three categories that do not readily fall within the classic diagnostic criteria for PTSD: these are the somatic, dissociative, and affective sequelae of prolonged trauma.

Somatization

Repetitive trauma appears to amplify and generalize the physiologic symptoms of PTSD. Chronically traumatized people are hypervigilant, anxious and agitated, without any recognizable baseline state of calm or comfort (Hilberman, 1980). Over time, they begin to complain, not only of insomnia, startle reactions and agitation, but also of numerous other somatic symptoms. Tension headaches, gastrointestinal disturbances, and abdominal, back, or pelvic pain are extremely common. Survivors also frequently complain of tremors, choking sensations, or nausea. In clinical studies of survivors of the Nazi Holocaust, psychosomatic reactions were found to be practically universal (Hoppe, 1968; Krystal and Niederland, 1968; De Loos, 1990). Similar observations are now reported in refugees from the concentration camps of Southeast Asia (Kroll *et al.*, 1989; Kinzie *et al.*, 1990). Some survivors may conceptualize the damage of their prolonged captivity primarily in somatic terms. Nonspecific somatic symptoms appear to be extremely durable and may in fact increase over time (van der Ploerd, 1989).

The clinical literature also suggests an association between somatization disorders and childhood trauma. Briquet's initial descriptions of the disorder which now bears his name are filled with anecdotal references to domestic violence and child abuse. In a study of 87 children under twelve with hysteria, Briquet noted that one-third had been "habitually mistreated or held constantly in fear or had been directed harshly by their parents." In another ten percent, he attributed the children's symptoms to traumatic experiences other than parental abuse (Mai and Merskey, 1980). A recent

controlled study of 60 women with somatization disorder (Morrison, 1989) found that 55% had been sexually molested in childhood, usually by relatives. The study focused only on early sexual experiences; patients were not asked about physical abuse or about the more general climate of violence in their families. Systematic investigation of the childhood histories of patients with somatization disorder has yet to be undertaken.

Dissociation

People in captivity become adept practitioners of the arts of altered consciousness. Through the practice of dissociation, voluntary thought suppression, minimization, and sometimes outright denial, they learn to alter an unbearable reality. Prisoners frequently instruct one another in the induction of trance states. These methods are consciously applied to withstand hunger, cold, and pain (Partnoy, 1986; Sharansky, 1988). During prolonged confinement and isolation, some prisoners are able to develop trance capabilities ordinarily seen only in extremely hypnotizable people, including the ability to form positive and negative hallucinations, and to dissociate parts of the personality. [See first-person accounts by Elaine Mohamed in Russell (1989) and by Mauricio Rosencof in Weschler (1989).] Disturbances in time sense, memory, and concentration are almost universally reported (Allodi, 1985; Tennant *et al.,* 1986; Kinzie *et al.,* 1984). Alterations in time sense begin with the obliteration of the future but eventually progress to the obliteration of the past (Levi, 1958). The rupture in continuity between present and past frequently persists even after the prisoner is released. The prisoner may give the appearance of returning to ordinary time, while psychologically remaining bound in the timelessness of the prison (Jaffe, 1968).

In survivors of prolonged childhood abuse, these dissociative capacities are developed to the extreme. Shengold (1989) describes the "mind-fragmenting operations" elaborated by abused children in order to preserve "the delusion of good parents." He notes the "establishment of isolated divisions of the mind in which contradictory images of the self and of the parents are never permitted to coalesce." The virtuosic feats of dissociation seen, for example, in multiple personality disorder, are almost always associated with a childhood history of massive and prolonged abuse (Putnam *et al.,* 1986; Putnam, 1989; Ross *et al.,* 1990). A similar association between severity of childhood abuse and extent of dissociative symptomatology has been documented in subjects with borderline personality disorder (Herman *et al.,* 1989), and in a nonclinical, college-student population (Sanders *et al.,* 1989).

Affective Changes

There are people with very strong and secure belief systems, who can endure the ordeals of prolonged abuse and emerge with their faith intact. But these are the extraordinary few. The majority experience the bitterness of being forsaken by man and God (Wiesel, 1960). These staggering psychological losses most commonly result in a tenacious state of depression. Protracted depression is reported as the most common finding in virtually all clinical studies of chronically traumatized people (Goldstein *et al.,* 1987) Herman, 1981; Hilberman, 1980; Kinzie *et al.,* 1984; Krystal, 1968; Walker, 1979). Every aspect of the experience of prolonged trauma combines to aggravate depressive symptoms. The chronic hyperarousal and intrusive symptoms of PTSD fuse with the vegetative symptoms of depression, producing what Niederland calls the "survivor triad" of insomnia, nightmares, and psychosomatic complaints (in Krystal, 1968, p. 313). The dissociative symptoms of PTSD merge with the concentration difficulties of depression. The paralysis of initiative of chronic trauma combines with the apathy and helplessness of depression. The disruptions in attachments of chronic trauma reinforce the isolation and withdrawal of depression. The debased self image of chronic trauma fuels the guilty ruminations of depression. And the loss of faith suffered in chronic trauma merges with the hopelessness of depression.

The humiliated rage of the imprisoned person also adds to the depressive burden (Hilberman, 1980). During captivity, the prisoner can not express anger at the perpetrator; to do so would jepordize survival. Even after release, the survivor may continue to fear retribution for any expression of anger against the captor. Moreover, the survivor carries a burden of unexpressed anger against all those who remained indifferent and failed to help. Efforts to control this rage may further exacerbate the survivor's social withdrawal and paralysis of initiative. Occasional outbursts of rage against others may further alienate the survivor and prevent the restoration of relationships. And internalization of rage may result in a malignant self-hatred and chronic sucidality. Epidemiologic studies of returned POWs consistently document increased mortality as the result of homicide, suicide, and suspicious accidents (Segal *et al.,* 1976). Studies of battered women similarly report a tenacious suicidality. In one clinical series of 100 battered women, 42% had attempted suicide (Gayford, 1975). While major depression is frequently diagnosed in survivors of prolonged abuse, the connection with the trauma is frequently lost. Patients are incompletely treated when the traumatic origins of the intractable depression are not recognized (Kinzie *et al.,* 1990).

Characterological Sequelae of Prolonged Victimization

Pathological Changes in Relationship

In situations of captivity, the perpetrator becomes the most powerful person in the life of the victim, and the psychology of victim is shaped over time by the actions and beliefs of the perpetrator. The methods which enable one human being to control another are remarkably consistent. These methods were first systematically detailed in reports of so-called "brainwashing" in American prisoners of war (Biderman, 1957; Farber *et al.,* 1957). Subsequently, Amnesty International (1973) published a systematic review of methods of coercion, drawing upon the testimony of political prisoners from widely differing cultures. The accounts of coercive methods given by battered women (Dobash and Dobash, 1979; NiCarthy, 1982, Walker, 1979), abused children (Rhodes, 1990), and coerced prostitutes (Lovelace and McGrady, 1980) bear an uncanny resemblance to those hostages, political prisoners, and survivors of concentration camps. While perpetrators of organized political or sexual exploitation may instruct each other in coercive methods, perpetrators of domestic abuse appear to reinvent them.

The methods of establishing control over another person are based upon the systematic, repetitive infliction of psychological trauma. These methods are designed to instill terror and helplessness, to destroy the victim's sense of self in relation to others, and to foster a pathologic attachment to the perpetrator. Although violence is a universal method of instilling terror, the threat of death or serious harm, either to the victim or to others close to her, is much more frequent than the actual resort to violence. Fear is also increased by unpredictable outbursts of violence, and by inconsistent enforcement of numerous trivial demands and petty rules.

In addition to inducing terror, the perpetrator seeks to destroy the victim's sense of autonomy. This is achieved by control of the victim's body and bodily functions. Deprivation of food, sleep, shelter, exercise, personal hygiene, or privacy are common practices. Once the perpetrator has established this degree of control, he becomes a potential source of solace as well as humiliation. The capricious granting of small indulgences may undermine the psychological resistance of the victim far more effectively than unremitting deprivation and fear.

As long as the victim maintains strong relationships with others, the perpetrator's power is limited; invariably, therefore, he seeks to isolate his victim. The perpetrator will not only attempt to prohibit communication and material support, but will also try to destroy the victim's emotional ties to others. The final step in the "breaking" of the victim is not com-

pleted until she has been forced to betray her most basic attachments, by witnessing or participating in crimes against others.

As the victim is isolated, she becomes increasingly dependent upon the perpetrator, not only for survival and basic bodily needs, but also for information and even for emotional sustenance. Prolonged confinement in fear of death and in isolation reliably produces a bond of identification between captor and victim. This is the "traumatic bonding" that occurs in hostages, who come to view their captors as their saviors and to fear and hate their rescuers. Symonds (1982) describes this process as an enforced regression to "psychological infantilism" which "compels victims to cling to the very person who is endangering their life." The same traumatic bonding may occur between a battered woman and her abuser (Dutton and Painter, 1981; Graham *et al.,* 1988), or between an abused child and abusive parent (Herman, 1981; van der Kolk, 1987). Similar experiences are also reported by people who have been inducted into totalitarian religious cults (Halperin, 1983; Lifton, 1987).

With increased dependency upon the perpetrator comes a constriction in initiative and planning. Prisoners who have not been entirely "broken" do not give up the capacity for active engagement with their environment. On the contrary, they often approach the small daily tasks of survival with extraordinary ingenuity and determination. But the field of initiative is increasingly narrowed within confines dictated by the perpetrator. The prisoner no longer thinks of how to escape, but rather of how to stay alive, or how to make captivity more bearable. This narrowing in the range of initiative becomes habitual with prolonged captivity, and must be unlearned after the prisoner is liberated. [See, for example, the testimony of Hearst (1982) and Rosencof in Weschler, 1989.]

Because of this constriction in the capacities for active engagement with the world, chronically traumatized people are often described as passive or helpless. Some theorists have in fact applied the concept of "learned helplessness" to the situation of battered women and other chronically traumatized people (Walker, 1979; van der Kolk, 1987). Prolonged captivity undermines or destroys the ordinary sense of a relatively safe sphere of initiative, in which there is some tolerance for trial and error. To the chronically traumatized person, any independent action is insubordination, which carries the risk of dire punishment.

The sense that the perpetrator is still present, even after liberation, signifies a major alteration in the survivor's relational world. The enforced relationship, which of necessity monopolizes the victim's attention during captivity, becomes part of her inner life and continues to engross her attention after release. In political prisoners, this continued relationship may take the form of a brooding preoccupation with the criminal careers of

specific perpetrators or with more abstract concerns about the unchecked forces of evil in the world. Released prisoners continue to track their captors, and to fear them (Krystal, 1968). In sexual, domestic, and religious cult prisoners, this continued relationship may take a more ambivalent form: the survivor may continue to fear her former captor, and to expect that he will eventually hunt her down; she may also feel empty, confused, and worthless without him (Walker, 1979).

Even after escape, it is not possible simply to reconstitute relationships of the sort that existed prior to captivity. All relationships are now viewed through the lens of extremity. Just as there is no range of moderate engagement or risk for initiative, there is no range of moderate engagement or risk for relationship. The survivor approaches all relationships as though questions of life and death are at stake, oscillating between intense attachment and terrified withdrawal.

In survivors of childhood abuse, these disturbances in relationship are further amplified. Oscillations in attachment, with formation of intense, unstable relationships, are frequently observed. These disturbances are described most fully in patients with borderline personality disorder, the majority of whom have extensive histories of childhood abuse. A recent empirical study, confirming a vast literature of clinical observations, outlines in detail the specific pattern of relational difficulties. Such patients find it very hard to tolerate being alone, but are also exceedingly wary of others. Terrified of abandonment on the one hand, and domination on the other, they oscillate between extremes of abject submissiveness and furious rebellion (Melges and Swartz, 1989). They tend to form "special" dependent relations with idealized caretakers in which ordinary boundaries are not observed (Zanarini *et al.*, 1990). Very similar patterns are described in patients with MPD, including the tendency to develop intense, highly "special" relationships ridden with boundary violations, conflict, and potential for exploitation (Kluft, 1990).

Pathologic Changes in Identity

Subjection to a relationship of coercive control produces profound alterations in the victim's identity. All the structures of the self—the image of the body, the internalized images of others, and the values and ideals that lend a sense of coherence and purpose—are invaded and systematically broken down. In some totalitarian systems (political, religious, or sexual/domestic), this process reaches the extent of taking away the victim's name (Hearst and Moscow, 1982; Lovelace and McGrady). While the victim of a single acute trauma may say she is "not herself" since the event, the victim of chronic trauma may lose the sense that she has a self. Survivors

may describe themselves as reduced to a nonhuman life form (Lovelace and McGrady, 1980; Timerman, 1981). Niederland (1968), in his clinical observations of concentration camp survivors, noted that alterations of personal identity were a constant feature of the survivor syndrome. While the majority of his patients complained, "I am now a different person," the most severely harmed stated simply, "I am not a person."

Survivors of childhood abuse develop even more complex deformations of identity. A malignant sense of the self as contaminated, guilty, and evil is widely observed. Fragmentation in the sense of self is also common, reaching its most dramatic extreme in multiple personality disorder. Ferenczi (1933) describes the "atomization" of the abused child's personality. Rieker and Carmen (1986) describe the central pathology in victimized children as a "disordered and fragmented identity deriving from accommodations to the judgments of others." Disturbances in identity formation are also characteristic of patients with borderline and multiple personality disorders, the majority of whom have childhood histories of severe trauma. In MPD, the fragmentation of the self into dissociated alters is, of course, the central feature of the disorder (Bliss, 1986; Putnam, 1989). Patients with BPD, though they lack the dissociative capacity to form fragmented alters, have similar difficulties in the formation of an integrated identity. An unstable sense of self is recognized as one of the major diagnostic criteria for BPD, and the "splitting" of inner representations of self and others is considered by some theorists to be the central underlying pathology of the disorder (Kernberg, 1967).

Repetition of Harm Following Prolonged Victimization

Repetitive phenomena have been widely noted to be sequelae of severe trauma. The topic has been recently reviewed in depth by van der Kolk (1989). In simple PTSD, these repetitive phenomena may take the form of intrusive memories, somato-sensory reliving experiences, or behavioral re-enactments of the trauma (Brett and Ostroff, 1985; Terr, 1983). After prolonged and repeated trauma, by contrast, survivors may be at risk for repeated harm, either self-inflicted, or at the hands of others. These repetitive phenomena do not bear a direct relation to the original trauma; they are not simple reenactments or reliving experiences. Rather, they take a disguised symptomatic or characterological form.

About 7-10% of psychiatric patients are thought to injure themselves deliberately (Favazza and Conterio, 1988). Self-mutilization is a repetitive behavior which appears to be quite distinct from attempted suicide. This compulsive form of self-injury appears to be strongly associated with a his-

tory of prolonged repeated trauma. Self-mutilation, which is rarely seen after a single acute trauma, is a common sequel of protracted childhood abuse (Briere, 1988; van der Kolk *et al.,* 1991). Self-injury and other paroxysmal forms of attack on the body have been shown to develop most commonly in those victims whose abuse began early in childhood (van der Kolk, 1992).

The phenomenon of repeated victimization also appears to be specifically associated with histories of prolonged childhood abuse. Widescale epidemiologic studies provide strong evidence that survivors of childhood abuse are at increased risk for repeated harm in adult life. For example, the risk of rape, sexual harassment, and battering, though very high for all women, is approximately doubled for survivors of childhood sexual abuse (Russell, 1986). One clinical observer goes so far as to label this phenomenon the "sitting duck syndrome" (Kluft, 1990).

In the most extreme cases, survivors of childhood abuse may find themselves involved in abuse of others, either in the role of passive bystander or, more rarely, as a perpetrator. Burgess and her collaborators (1984), for example, report that children who had been exploited in a sex ring for more than one year were likely to adopt the belief system of the perpetrator and to become exploitative toward others. A history of prolonged childhood abuse does appear to be a risk factor for becoming an abuser, especially in men (Herman, 1988; Hotaling and Sugarman, 1986). In women, a history of witnessing domestic violence (Hotaling and Sugarman, 1986), or sexual victimization (Goodwin *et al.,* 1982) in childhood appears to increase the risk of subsequent marriage to an abusive mate. It should be noted, however, that contrary to the popular notion of a "generational cycle of abuse," the great majority of survivors do not abuse others (Kaufman and Zigler, 1987). For the sake of their children, survivors frequently mobilize caring and protective capacities that they have never been able to extend to themselves (Coons, 1985).

CONCLUSIONS

The review of the literature offers unsystematized but extensive empirical support for the concept of a complex post-traumatic syndrome in survivors of prolonged, repeated victimization. This previously undefined syndrome may coexist with simple PTSD, but extends beyond it. The syndrome is characterized by a pleomorphic symptom picture, enduring personality changes, and high risk for repeated harm, either self-inflicted or at the hands of others.

Failure to recognize this syndrome as a predictable consequence of prolonged, repeated trauma contributes to the misunderstanding of survi-

vors, a misunderstanding shared by the general society and the mental health professions alike. Social judgment of chronically traumatized people has tended to be harsh (Biderman and Zimmer, 1961; Wardell *et al.*, 1983). The propensity to fault the character of victims can be seen even in the case of politically organized mass murder. Thus, for example, the aftermath of the Nazi Holocaust witnessed a protracted intellectual debate regarding the "passivity" of the Jews, and even their "complicity" in their fate (Dawidowicz, 1975). Observers who have never experienced prolonged terror, and who have no understanding of coercive methods of control, often presume that they would show greater psychological resistance than the victim in similar circumstances. The survivor's difficulties are all too easily attributed to underlying character problems, even when the trauma is known. When the trauma is kept secret, as is frequently the case in sexual and domestic violence, the survivor's symptoms and behavior may appear quite baffling, not only to lay people but also to mental health professionals.

The clinical picture of a person who has been reduced to elemental concerns of survival is still frequently mistaken for a portrait of the survivor's underlying character. Concepts of personality developed in ordinary circumstances are frequently applied to survivors, without an understanding of the deformations of personality which occur under conditions of coercive control. Thus, patients who suffer from the complex sequelae of chronic trauma commonly risk being misdiagnosed as having personality disorders. They may be described as "dependent," "masochistic," or "self-defeating." Earlier concepts of masochism or repetition compulsion might be more usefully supplanted by the concept of a complex traumatic syndrome.

Misapplication of the concept of personality disorder may be the most stigmatizing diagnostic mistake, but it is by no means the only one. In general, the diagnostic concepts of the existing psychiatric canon, including simple PTSD, are not designed for survivors of prolonged, repeated trauma, and do not fit them well. The evidence reviewed in this paper offer strong support for expanding the concept of PTSD to include a spectrum of disorders (Brett, 1992), ranging from the brief, self-limited stress reaction to a single acute trauma, through simple PTSD, to the complex disorder of extreme stress (DESNOS) that follows upon prolonged exposure to repeated trauma.

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