

## Disorders of extreme stress not otherwise specified (DESNOS) – a case study

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### Summary

The examinations of people who experienced frequent trauma have shown that their psychophysical problems are much more complex than those described in the diagnostic criteria for PTSD. This resulted in the creation of a new diagnostic concept of Disorders of Extreme Stress Not Otherwise Specified (DESNOS). Diagnostic criteria for DESNOS comprise alterations in personal activity after frequent traumatic events affecting six areas of functioning: alteration in regulation of affect and impulses; attention or consciousness; self-perception; relations with others; systems of meaning; somatization.

The main purpose of the presented paper is to focus on the specific functioning of people after experiencing frequent trauma characteristics that could be diagnosed as DESNOS. The first part of the paper deals with diagnostic criteria for DESNOS and the concept of its treatment. The second part is a case study describing the therapeutic approach to the patient with domestic violence history diagnosed as DESNOS.

chronic trauma / Complex-PTSD / DESNOS / domestic violence / therapy

### INTRODUCTION

The origin of Disorders of Extreme Stress Not Otherwise Specified (DESNOS) is tightly connected with the history of Post Traumatic Stress Disorder (PTSD). Numerous research studies on Post Traumatic Stress Disorder clearly showed that diagnostic criteria for PTSD did not fully represent the whole spectrum of psychophysical problems of people that had been exposed to prolonged and multiple traumas. That fact attracted the attention of many researchers, including Briere and Courtoise [1, 2, 3] among others. The conclusions led to the diagnostic concept of Disorders of Extreme Stress Not Otherwise Specified (DESNOS). The clinical profile of DESNOS correlates with a description of the functioning

of a woman exposed to domestic abuse, which is exemplified in the following article.

### The Concept of DESNOS

DESNOS was conceptualized to describe the alterations in functioning of individuals exposed to chronic trauma. Judith Herman [4] called the new clinical finding Complex PTSD and indicated that Complex Post Traumatic Stress Disorder occurred in individuals, e.g. abused women, who had experienced chronic trauma, and it entailed alterations in six areas of functioning, such as: regulation of affect and impulses, attention or consciousness, self-perception, one's view of the perpetrator, relations with others, system of meaning. Further research on Complex Post Traumatic Stress Disorder resulted in the development of this concept. The names Complex PTSD and DESNOS were implemented. Pelzovitz and Van der Kolk [5] grouped symptoms associated with DESNOS into a 48-item

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structured clinical interview assessing changes of the presence of DESNOS using seven subscales, measuring its current as well as lifetime prevalence. Such a symptom constellation was called DESNOS, while the instrument for comprehensive assessment of DESNOS was called SIDES (Structured Interview of Disorders of Extreme Stress). It is estimated that the concept of DESNOS entails numerous symptoms not found in PTSD [5]. The findings resulted in including the DESNOS symptom constellation into DSM IV –Field Trial [6]. Although DESNOS is not identified as a distinct diagnosis in DSM-IV, it stands as “Non-Specified Disorder Associated with Post Traumatic Stress.” In ICD-10, disorders characteristic of DESNOS are constituted as a diagnostic category called lasting personality changes following catastrophic stress (e.g. having been exposed to traumatic events.)

It is debated whether Complex PTSD, as a formal diagnostic unit, should be included into the DSM-V classification currently in preparation. C-PTSD is to be described as chronic difficulties in many emotional areas and interpersonal functioning due to chronic traumatic experience. As an example of a typical patient diagnosed with DESNOS, the authors [8] put forth a woman who had never been taken proper care of as a child, who in her childhood had been sexually abused by her father, who also physically abused her mother. In her adolescence, she witnessed serious injuries of her friends after a car crash under the influence of alcohol. As an adult, she was raped and she lived with partners that abused her emotionally and physically.

### Symptoms of DESNOS

DESNOS diagnostic criteria entail [8]:

Alterations in regulation of affect and impulses:

- extreme emotional reaction, inappropriate to the situation,
- self-destructive behaviour, such as: eating disorders, self-injury,
- suicidal preoccupation,
- sexual impulses or extreme sexual inhibition,
- problems in expressing or modulating anger.

Disturbances in attention and consciousness:

- dissociative episodes and depersonalization,
- amnesia or hyperamnesia due to traumatic experience.

Disturbances in self-perception:

- negative views of themselves,
- feeling helpless, ineffectual,
- shame, ignominy, feeling guilty, blaming themselves,
- feeling dirty, disgraced, or marked with a stigma (stigmatization).

Disturbances in relationships:

- lasting lack of trust,
- revictimization,
- victimization of others.

Somatization:

- persistent pain,
- difficulties in digestive, circulatory and cardiopulmonary systems,
- conversion symptoms,
- sexual symptoms

Disturbances in meaning system:

- loss of belief,
- sense of helplessness and anguish.

### The treatment of DESNOS

The clinical picture of DESNOS is multi-phased and it touches on almost all aspects of human functioning, therefore while planning therapeutic options, multiple approaches must be taken into account. The literature [7, 8] signifies the fact that proper diagnosis of the spheres of alterations described as DESNOS is essential in order to plan treatment. The treatment of DESNOS differs from the treatment of PTSD. While the PTSD therapy focuses on direct psychological consequences of traumatic experiences and specific traumatic memories, DESNOS therapy entails treatment of both traumatic experiences and other problems such as: inability to regulate emo-

tions, dissociation and interpersonal problems [5]. Therapists treating chronic trauma should focus on the form of present trauma, how it is evident in their daily life and effects of trauma on individuals. Therapists ought to help their patients identify their current situation, both physical and emotional state, as well as avoid confrontation with reality due to past trauma. The concept of treatment of DESNOS that may be found in literature constitutes a multifaceted diagnosis entailing pinpointing problems in a patient's life and devising a practical treatment that is to be conducted in three stages: 1) stabilization, 2) processing and grieving of traumatic memories and 3) reconnection.

The phase of stabilization is comprised by mainly psycho-educational therapy. A therapist provides patients with basic information about the effects of trauma on individuals, both in the short- and long-term. Psycho-education helps patients identify the effects of trauma in their lives. This phase pays attention to the patients' physical well-being and aims at regulating their daily body functions such as sleeping and eating. A therapist deals with the patients' external environment in which they function. Safety is an important issue, and it should be checked whether patients coming for help feel safe. This is the phase of treatment where attention is to be paid to such aspects of therapeutic relations such as trust, safety, taking responsibility, developing boundaries as well as developing capacities for self-care and self-soothing.

The second phase of treatment employs deep exploration into traumatic memories in order to convey them into a coherent narrative, while at the same time desensitizing of the intense negative affects associated with these memories. A very important aspect of therapy is to reveal the entire history of abuse. A clinician must bear in mind that only a small portion of the history of abuse is unveiled at the first meeting. In the beginning, a traumatic experience, e.g. sexual abuse in childhood is revealed. At this stage, clinicians should pay particular attention to signs of possible dissociation. While processing traumatic memories, patients may split off some aspects of their experience from their affects, beliefs, and somatic experiences. A therapist's task is to detect dissociation in their presence in factual reality. Asking gentle questions

like: "What's happening right now with you?", "Where are you?" is very helpful. Patients need to acquire such techniques to combat dissociation outside sessions.

The third phase of treatment shifts patients back into the world of relationships. It entails developing their sense of themselves in the outside world and exploring different activities.

## CASE STUDY

A patient X signed up for therapy stating as her main problem both physical and mental abuse by her husband. She was a 29-year-old married woman with a 3-year-old child and had been living with her husband for five years. Her husband started to abuse her after the wedding, but, according to the patient, she had noticed signs of his aggression and inappropriate behaviour (e.g. overcontrol, inability to compromise, mood fluctuation) earlier. There were incidents of physical abuse, when her husband smacked her a few times. She was notoriously ridiculed and humiliated by her husband, also in public. She had been planning to divorce him for years, but the fear and threat of losing a child restrained her. During the therapy she divorced him and received full parental custody over the children. The woman admitted having been always accompanied by violence. She was born when her mother was in her 2<sup>nd</sup> year of studies. Her mother pawned her off on the grandparents, as she was studying far from her town. The grandfather abused alcohol and he was often agitated. X let it be known that her grandparents used to take her to a neighbour of theirs where she stayed from morning till evening. The patient's father was aggressive towards her mother, her and siblings as long as she can remember. He was a violent man; he physically abused his wife, called her names and ridiculed her. Her mother hid the situation from her neighbours, pretending everything was normal. During adolescence, the patient tried to commit suicide twice. She ran away from home a few times. At the age of 17 she moved out to her grandmother's, only to return home at the age of 18, because her mother was afraid of the opinion of local society and wanted them all to live under one roof. When she was 16, she looked for help. She

wrote a letter to Children's Ombudsman Office describing her case, full of abuse. When Local Committee on Children's Rights representatives arrived at their home, her mother denied all the information she had supplied; furthermore, the mother castigated her for revealing their secrets. X treated her marriage as a way of separating herself from the dysfunctional family home.

### The diagnosis

Despite the separation from her husband and cessation of violence, the patient's health half a year after the divorce was still unsatisfactory. The analysis of the history of her life as well as the assessment of trauma with the help of SIDES (the instrument to comprehensively assess the presence of DESNOS) and a Traumatic Questionnaire "O" allowed us to detect Complex Post Traumatic Stress Disorder. Alterations in all categories of diagnostic criteria for DESNOS were exposed. There were alterations in the regulation of affect and impulses (which were exhibited in extreme reactions) tendencies to a somber mood, periodical suicidal preoccupations, ever accumulating anger. In her interpersonal relationships, the patient had the feeling of being used or being pushed by others. X suffered from sexual inhibitions; not only did she shun herself from any contacts with men but she felt panic and fear of men, anticipating she would be hurt in these relationships. Other alterations revealed a frequent re-living of her past traumatic experience present in her consciousness in the form of intrusions (in everyday situations she experienced dissociations). In the self-perception sphere, the patient blamed herself for traumatic experiences – she assumed responsibility ("It was me who revealed the secrets, I need not have looked for help, and I hate my father but I should not"). X had the sensation of being alienated from society: "I am different, I have gone through so much, I will never be normal, nobody is able to understand me, I am worse than others." In the sphere of relationships she shunned herself from society, simultaneously yearning for and fearing any relationship. The patient formulated beliefs that were not constructive ("Life does not have any meaning, I am doomed to be alone, All men do harm, I will always be unhappy"). She fre-

quently experienced somatic difficulties in her digestive system, headaches and decreased immunity.

### The treatment

The patient came for therapy while experiencing physical abuse from her husband. She was afraid of divorce, but she deemed it the only way to extricate herself from abuse. Her husband's threats that he would take the child should the divorce proceed made her feel scared. At this stage of therapy the objectives of psychological help were to offer support, give her all the necessary information and begin psycho-education about the effects of experiencing abuse. After the divorce (it went very smoothly) and achieving custody of her child, she started to complain about persistent depression, problems in relationships with others, and constant fear and uneasiness that she would not cope with the upbringing of her child all by herself. Goals were set with the patient stating that she wanted to come to terms with all that had happened, strengthen her self-evaluation and learn to deal with the traumatic past.

The treatment began with "Phase One", entailing stabilization, which focused on establishing a sense of safety and stabilization through eliminating the source of violence. The next step was to eliminate her catastrophic preoccupations about her present situation (e.g. "I will not be able to cope with the upbringing myself"). The goal was to help her eliminate thoughts and aggressive behaviour such as: isolating herself from the society, depression, periodical suicidal preoccupations, concentrating on negative aspects. Psycho-education regarding violence and its' impact was also incorporated. During therapeutic sessions, treatment of somatic difficulties was also addressed. The patient felt tired, she frequently caught upper respiratory system infections, and she suffered from frequent headaches. After therapy she developed the capacities for self-soothing, which she practised at home.

Phase Two encompassed the work of exploring the traumatic memories in depth, and then desensitizing her from them. The analysis of her life exposed trauma from her childhood and revealed problems indicating DESNOS. The work

to normalize the emotions associated with trauma that had accompanied her since childhood was initiated. Some faulty beliefs that reinforced her depressed affect and perpetuated a negative picture of herself and men were unveiled. The patient disclosed memories and recognized the effects directly associated with traumatic experiences from the past. After some time she let herself experience these effects and have needs that earlier, even in her childhood, no grown-up had ever detected nor did she ever acknowledge them herself. During that work, she found and processed many childhood memories and beliefs constituting the source of suffering that undermined her treatment, such as: "I will not handle that by myself, I only attract bad men, and I am no good." The fear associated with her maternity memories was stirred, e.g. "You are stubborn as a mule, like your father." The patient sought some positive aspects of her father, who she rejected and did not accept; she looked for her other features that had been mentioned by her friends or colleagues. During the therapy she found out that the person she was, as described by her father and mother, differed from the one that was liked and accepted by her friends and colleagues. The patient integrated these two different pictures, at the same time gaining knowledge of manipulations done by both her father – the perpetrator of violence, and her mother – the victim identified with the perpetrator. The patient assumed that her father's opinion was an effort to discredit her so as to let him get away with abusing the family, whereas her mother's opinions were aimed at keeping the secret and preserving the good image of the family in the local community. Additionally, this therapy exposed her husband's manipulations that had aroused her shame, guilt and inflicted self-aversion.

After some time the patient met a man. It was a difficult moment in her psychotherapy. This new acquaintance reactivated all traumatic experiences in relationships with men: fear of being hurt, distrust, suspicion, apprehension. Former memories, at times in the form of dissociation, coincided with the present relationship. During meetings with the new man, the woman felt that she "was floating away" and that she heard her ex-husband's voice and his contemptuous remarks. She tried to separate her traumatic ex-

perience from reality, getting aid from psycho-education and her earlier sessions with rerunning of the trauma. The patient understood that, paradoxically, dissociations made her feel safer: "When I am floating away, I am not close to R, therefore, I am safe." At therapeutic sessions, she searched for other means of controlling the situation and regaining the feel of control in relationships with men.

In the third phase, the objective was to integrate the patients into the outside world. The patient discovered that she possessed a variety of constructive virtues, which she had not detected earlier nor had she ever paid any attention to. These were virtues that might strengthen social relationships, which she neglected as a result of being isolated by her husband and fears of being rejected or assumptions of others' reluctance towards her. This phase was just the beginning of the work on her self-perception. Previously, she had built self-perception based on her parents' or her husband's words. Now, she started to develop her own sense of herself as something other than a victim, based on her capabilities, knowledge and her roles as a mother and professional. Not only did it allow her to see a different image of herself but it also strengthened her self-perception. Needless to say, the internalization of the new image was not automatic; often, the patient returned to the former image, the image that had been built by her parents. The process of reconstructing the trauma step by step and having her see the inherent power in her as a child, then a teenager, then a woman bringing her child up on her own, earning a living and coping with all sorts of problems was long and arduous. In the last phase of the therapy, attention was shifted onto the realm of relationships in order to stimulate social relationships, find new intimate relationships and stay active in a professional sphere. Crises that appeared during the therapy were the consequences of visiting her parents and subsequent harm they inflicted on her. Her father and mother still discredited her, blamed her for the dissolution of her marriage, and induced the feeling of helplessness in her (e.g. "You won't get by, You won't cope with the upbringing of your child without a husband"). The patient realized they were wrong; nevertheless, she suffered emotionally. She evolved defence mechanisms

– she avoided visiting her parents, and she put up certain boundaries during discussions with them. Her new intimate relationship fell apart. She explained she recognized some disturbing behaviour in her partner, indicating the features she did not accept, e.g. silence in conflict situation, insinuations. In one of the sessions she declared: “I do not know if I will ever trust a man, it’s possible I should be alone.” This particular problem remained unsolved in the therapy. The patient may have problems trusting men due to her traumatic past experience. Might it be the effect of the imperfect capacities of therapists? Might it be the consequences of prolonged trauma that is beyond any possible correction? After a one and a half-year-long therapy all alterations were recapitulated, prior expectations were verified and the therapeutic contract was terminated. Control check-up using SIDES and Symptoms Questionnaire “O” revealed a significant decrease of symptoms associated with DESNOS. The patient herself summed it all up: “I want to try it by myself now.”

## CONCLUSIONS

Therapeutic work was based mainly on Cognitive-Behavioural Science techniques. While planning therapeutic help, functioning aspects of the patient such as dysregulated defence mechanisms, instilled core beliefs and the necessity to alter them were taken into account. Processes being developed during the sessions such as dissociation, anti-dissociation, and periodical resistance were constantly analyzed. While analyzing the therapeutic process, it is worth paying attention to the specificity of therapeutic relationship. Often times the patient emphasized the fact that she found it difficult to trust her therapist; she doubted the wisdom of starting the therapy. An especially important task at the beginning of the therapeutic process was establishing a safe therapeutic alliance, which was achieved via nondirective listening to the patient and clear identification of her past traumatic experiences.

The concept of DESNOS helps to clarify the psychopathology of patients exposed to trauma of extended duration when they come for therapy. Awareness of the difficulty in functioning and characteristic background of individuals

that meet criteria for DESNOS aids in effective treatment planning and focuses the attention of the therapist on possible challenges in the therapeutic process.

Based on the introduced therapeutic considerations and the analysis of the case, some principles come to mind that may be useful when planning and implementing therapeutic means on individuals with trauma of extended duration:

- Cessation of aggression in these case does not put an end to problems in the biopsychosocial functioning of individuals.
- It is vital that a specific diagnostic process should be performed evaluating the effects of long-term trauma on the functioning of individuals who meet criteria for DESNOS.
- The treatment for simple PTSD and DESNOS requires different approaches, as the treatment for DESNOS entails exploring past traumatic experiences in depth, focusing on those events that have had impact on shaping the personality and that ultimately have led to the point that all resources are exhausted and individuals can no longer cope with trauma.
- The treatment of DESNOS is conducted in phases as suggested in the available literature. Different therapeutic strategies are associated with each phase, which makes it clearly delineated
- However, one must admit there is a pessimistic note: not all consequences of prolonged trauma are reversible, and at times a therapist faces the fact that “some things cannot be undone” mainly due to the traumatic exposure of extended duration or a pervasive effect of dysregulation in early childhood.

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