traumaclinic
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CONTINUOUS TRAUMATIC STRESS (CTS): DEFINITION, CLINICAL PICTURE AND INTERVENTION

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OVERVIEW

In South Arica, the use of violence is a common means of resolving conflict. Much of this acceptance comes as a result of the use of violence during apartheid. However, this acceptance has been challenged by government and society. As a result, government has enacted laws which criminalise violence such as intimate partner violence as well as corporal punishment that is often seen in schools (Abrahams & Jewkes, 2005). Considering the high prevalence of violence occurring between intimate partners and in schools, many children witness violence on a daily basis. This is often combined with added experiences that affect children's emotional and societal functioning in a negative way. These experiences include callous punishment, deficient social support systems, a lack of affection and inadequate parental supervision, which are all associated with consequent violent behaviour. The fact that many children often have no other experiences other than witnessing acts of violence and death is another aspect that needs to be taken into account when developing trauma theory.

1. DEFINITION AND CLINICAL PICTURE OF CTS

1.1. History

First literary outlines of the South African coined term continuous traumatic stress (CTS) were formed by Stalker and the Sanctuaries Counselling Team (1987) and were originally devised by mental health activists during apartheid in the 1980's who studied the effects of incessant exposure to violence and the mental health results (Eagle & Kaminer, 2013). It was observed that treatment of clients was hindered by the reality that clients faced future victimisation and often were living under dangerous circumstances. The researchers dealt with clients who encountered imprisonment, torture, being physically harmed and shot at and additionally faced imminent victimisation as well as a lack of safe spaces to recover in. This in turn played a significant role in the development of traumatic stress symptoms. These types of recurring stress situations were different than the symptoms included in the definition of Post-Traumatic Stress Disorder (PTSD) which focused on traumatic events in one's past that continue to impose on the present. Current diagnoses for traumatic stress upholds the presumption that exposure to traumatic events have occurred in the past.

The need for a diagnosis which captures the clinical picture of this stress exposure stems from the short-comings of the PTSD diagnosis which fails to capture the adverse responses of certain trauma survivors. Victims of violence specifically in the South African context often experience multiple traumatic events in their lifetime. Due to extremely high rates of social crime, CTS predominantly occurs in neighbourhoods where there is a constant threat of community and criminal violence (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola 2005). People in these neighbourhoods are often from disadvantaged backgrounds which lends them to be unprotected.

1.2. CTS and the link to PTSD

The notion of continuous traumatic stress somewhat relates to the symptomology of posttraumatic stress disorder (PTSD) however distinguishes itself in terms of impact,

presentation and recovery. The most specific difference to PTSD being that continuous traumatic stress relates to multiple events which are on-going in an individual's immediate environment. As a result of lack of space to be distressed there is an increase in negative resilience, avoidance and higher arousal (Kolk et al., 2005).

Many individuals and communities experience trauma on a daily basis. Therefore, the idea of CTS aims to account for the ongoing stressors that occur in the lives of many individuals living in situations of constant prospective victimisation (Diamond, Lipsitz, & Hoffman, 2013; Eagle & Kaminer, 2013). Continuous traumatic stress is known to occur in situations in which danger and risk present erratically and are predominantly faceless. However, these events are invasive and substantive (Eagle & Kaminer, 2013). Continuous trauma exists in a variety of contexts such as conflict-affected areas, neighbourhoods with chronic community violence, as well as refugee settings (Eagle & Kaminer, 2013). Often individuals living in war torn or conflict ridden situations are diagnosed with PTSD. However, the appropriateness of this diagnosis has come into question. The reasoning behind this is because the diagnosis of PTSD was conceived to explain the psychological, emotional and behavioural consequences of trauma that has occurred in the past, hence the prefix 'post' traumatic (Diamond et al., 2013).

The definition and outline of PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) emphasises that this disorder is diagnosed for people having witnessed or experienced a traumatic event in the past and usually focuses on a single event (American Psychiatric Association (APA), 1994). This representation of traumatic exposure does not account for continuous trauma in its complexity with multiple traumatic events occurring throughout the life of individuals (Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009). The PTSD diagnosis was first devised to understand symptoms war veterans displayed as a result of the Vietnam War in 1970 which makes an unsuitable comparison for the trauma exposure in South Africa (Van der Kolk et al., 2005). It has therefore been suggested that continuous trauma should be identified as a response in the context of repeated, ongoing trauma, rather than as a separate diagnosis.

1.3. Defining CTS

The anxiety associated with CTS is not so much about the experience of traumatic stress, but about whether the individuals' observation of threat is realistic or not (Diamond et al., 2013). It is therefore expected that those living in these threatening conditions experience increased levels of psychological distress. People often experience intrusive thoughts, hyper-arousal, have a negative affect and are left with feelings of hopelessness. A defining feature of continuous trauma is the realistic estimation of threat occurring in the future (Eagle & Kaminer, 2013). Therefore, a clinician would have to weigh up an individual's interpretation of threat in relation to the evident reality about their environment. People experiencing continuous trauma are often unsure about what constitutes immediate threat as well as what the possibility of their victimisation is, which leads to constant questioning about whether or not their perception of threat is warranted (Diamond et al., 2013; Eagle & Kaminer, 2013). This type of probing on their own behalf provides a distinguishing factor between those experiencing continuous trauma responses from diagnosable paranoia.

In addition, the absence of protection from eminent danger and threat is proposed to be a significant factor that separates CTS from work-related traumatic stress (i.e. from someone working in emergency services who also witnesses traumatic incidents). The lack of social order and failure of justice systems to protect communities from those perpetrating violence and crime plays a significant role in the distress felt by these individuals and communities (Eagle & Kaminer, 2013).

There are various models which propose different explanations as to why traumatic events often lead to symptoms associated with trauma exposure (Diamond et al., 2013; Ehlers & Clark, 2000). However, some research has also indicated that these responses may be normal and even natural, and may not necessarily be psychopathological (Bonanno, 2004; McHugh & Treisman, 2007). Unlike individuals experiencing post-traumatic stress, who are experiencing symptoms in relation to a past experience, those with CTS are experiencing ongoing, repeated trauma. In addition, the psychological effects of ongoing trauma also persist over longer periods, making it more indicative of psychopathology. In situations of CTS, individuals usually find themselves in danger in the present, and therefore their reactions of avoidance and hyper-arousal can be viewed as a protective, adaptive and as an innate response (Diamond et al., 2013).

1.4. Clinical Picture of CTS

Other symptoms of CTS include noticeable numbness or dissociation and desensitisation to trauma. Considering that CTS occurs as a result of continuous exposure to traumatic events, and not as a response to one singled out event, individuals do not report re-living past events and the element of perceived danger or a ‘false alarm’, which are required symptoms for the diagnosis of PTSD (Diamond et al., 2013; Eagle & Kaminer, 2013). In contrast CTS is described by a realistic and inescapable anticipation of danger as the threat of violence is current and substantive also described as a state of ‘permanent emergency’ (Eagle & Kaminer, 2013). Although symptomology of PTSD and CTS are comparable, the maladaptive ‘false alarm’ response of PTSD differs from the CTS ‘permanent emergency’ response.

Definitions of CTS are therefore context specific and significant to the space where on-going victimisation takes place (Suglia, Ryan & Wright, 2008). Community space and residential area are important indicators in the development of CTS rather than personal relationships which play a more vital role in disorders such as in complex trauma. Close interpersonal relationships have been recognised as key sources in the development of disorders of extreme stress such as ‘cumulative trauma’, ‘complex trauma’ and developmental trauma disorder (Herman, 1992). However, considering the loss of safety and trust which all of the above mentioned mental health conditions share, the main concern in CTS is a social environment that facilities violence beyond interpersonal structures and results in a realistic and constant threat of one’s safety and life in the future.

Individuals exposed to constant threat experience this violence from an early age in life and may have never experienced a safe environment which raises the question of a developmental impact community violence may have (Herman, 1992). The discussion that focuses on a recovery within the actual context of an ongoing threat may alter the meaning-making process of violence as these experiences inhibit the development of a true sense of safety and thereby influence the impact, presentation and recovery pattern of individuals as opposed to those in a more protected environment. Onset of continuous traumatic stress is therefore specific to individuals growing up in violent communities, experiencing and/or witnessing violence on a regular basis and furthermore recovering within the same context of an on-going threat. Environmental exposure to trauma is causal to weakening coping skills and resilience and leading to the development of maladaptive symptoms.

2. INTERVENTION VERSUS TREATMENT: TRAUMA RECOVERY AND FOSTERING RESILIENCE

While there are several evidence-based treatments for those affected by PTSD, there are currently no evidence-based intervention or treatment strategies for those affected by CTS (Murray et al., 2013). Although no formal treatments have been established, there are several suggestions for interventions for those affected by CTS. What makes treatment of CTS difficult is that the process of therapy must happen in stability (Eagle & Kaminer, 2013). Therefore, the person must be out of the traumatic situation which is hard to establish when living in violent societies with ongoing victimisation where trauma is not “post”. Nevertheless, it is possible to adapt some of the skills used in the treatment of PTSD and apply them in cases of continuous traumatic exposure. It is furthermore important to increase protective factors in order to develop adaptive and effective coping skills (Eagle & Kaminer, 2013).

2.1. Summary of interventions

Perpetrating violence is one way in which people regain power in ongoing victimising situations (Weierstall et al., 2013). Individuals who perpetrated violence after being victimised showed reduced symptoms of PTSD, decreased fear of threat and overall improved psychosocial functioning. Due to the collapse in protective forces and social structures, individuals often find agency by engaging in the same violence and threat (Eagle & Kaminer, 2013). Although it is easy to pathologise this kind of revictimisation, it can again be seen as an adaptive response to this particular context. There is, however, an important distinction to be made between the psychological motivation and effect of perpetrating violence in these situations.

Appetitive aggression involves a positive sense of enjoyment as a result of perpetrating violence while reactive or facilitative aggression is driven by the avoidance of threat and fear (Elbert, Weierstall, & Schauer, 2010; Weierstall & Elbert, 2011). Appetitive aggression becomes adaptive when violence is perceived as beneficial and this is what increases psychosocial functioning. Thus, this kind of violence becomes an effective tool for overcoming circumstances of continuous trauma exposure. Nevertheless, using violence as means for overcoming traumatic stress remains problematic and alternative ways of coping and improving resilience are necessary.

Although Trauma Debriefing was a widely used tool for the prevention of PTSD after incidences of trauma, it has more recently been rejected as a method on the bases that more harm can be done by retelling traumas (Ormerod, 2002). In the case of CTS a single trauma can elicit the need to bring up all previous traumas, which can leave the individual feeling more traumatised and defeated. It is therefore useful, in therapy, to focus on the last trauma for which the person is being referred and come up with strategies to cope with that one rather than every trauma from the past because in normal life for those living in continuous traumatic stress, past traumas are past. However, it has also been suggested that in circumstances of continuous trauma exposure it may be more beneficial to identify effective coping strategies that rely on recognising when the threat of trauma is at its highest and implement planned safety mechanisms (Eagle & Kaminer, 2013).

Murray et al. (2013) developed a four step Trauma Focused Cognitive Behavioural Therapy (TF-CBT) model for working with young people in situations of continuous trauma exposure. What is important when applying this treatment is to continuously asses the reality of ongoing threat and danger and perceived threat and danger as a result of traumatic memories (Eagle & Kaminer, 2013; Murray et al., 2013). Because of the nature of CTS, where violence and threat is ongoing, it is assumed that danger is real. It is therefore important to work within a framework that acknowledges the reality of ongoing victimisation rather than attempting to re-label fears and decrease appropriate anxiety. Nevertheless, it is equally important to enhance self-appraisal so that the individual is able to assess the level or risk at any given time.

The first step in TF-CBT is to identify safe or safer places within ongoing threat (Murray et al., 2013). Once this has collaboratively been established, the therapist can teach the individual skills such as relaxation. In addition, concrete safety planning strategies can be developed and rehearsed in therapy. For example, the threat of gang violence may be higher after 9pm. A planned safety strategy would include avoiding leaving the house after 9pm. There may also be certain areas within the community where gang activity is more prevalent and this could be added as an “unsafe” space and make the home a safe space. Following on this, the second step includes enhancing engagement and the support of other members of the community to create better resilience.

The third step works towards growing the individual’s ability to identify real danger versus trauma reminders (Murray et al., 2013). Although the retelling of traumas can be harmful while there is ongoing threat, trauma narratives help to process and contextualise trauma experiences when they can be told in a safe space such as therapy. This in turn helps the individual to get a better perspective on current threat as opposed to past traumatic memories. The last step involves the therapist as an advocate for available service providers in the individual’s community. This allows the individual to access resources on an ongoing basis beyond the therapist’s availability.

The conservation of resources (COR) theory, as a community intervention, looks at identifying resources within communities and also takes into account the role of the environment in coping with traumatic stress (Hobfoll, 2001). COR theory defines the relationship between the environment and resilience in the face of trauma in terms of resources; loss and threat of resource loss, and the lack of gaining resources after there has

been an investment in resources. Thus, resilience in communities with continuous trauma exposure can be improved when resources are available or enhanced at both the individual and societal level. CTS arises from living in environments with high levels of crime, experiencing or witnessing violence throughout the lifespan from an early age and later on in adult life. Furthermore, the processing of violent events usually takes place in the environment of threat which hinders an individual's recovery and post traumatic growth, both seen as signs of resilience (Van der Kolk et al., 2005).

2.2. Resilience and trauma recovery

Resilience is present when there is post-traumatic growth (Harvey, 2007). It is understood as both a prerequisite for recovery after trauma as well as being an indicator of recovery from trauma. That is not to say that those who recover from trauma and show signs of resilience no longer show signs of distress. Considering that natural recovery from trauma without intervention is the rule rather than the exception, resilience is defined as a separate construct to recovery (Mancini & Bonanno, 2006). Thus, recovery includes some ongoing symptoms of distress whereas resilience is the ability to effectively manage this distress.

An ecological perspective on trauma takes into account individual differences in responses to trauma and resilience in the face of trauma (Harvey, 1996). The ecological model looks at a variety of environmental and community factors which play a part in the development of and recovery from CTS. It further considers how interventions of trauma can both facilitate and hinder recovery from CTS, and how community work can be a tool for improving resilience by creating an 'ecological fit' with the individual. In this light, communities with high prevalence of continuous traumatic exposure can work towards a community action that fosters resilience.

The various ecologies include the ontogenic or individual system, the microsystem (the immediate environment such as peers and family), the mesosystem (direct impact of the extended environment such as school or work place), the exosystem (indirect impact of the extended environment), the macrosystem (the socio-political context and culture) (Moore, 2003). These systems fall within the chronosystem, the time dimension, and are connected. Relational patterns exist between individual, family, community and society. For example, cultural responses to trauma will impact the way an individual understands a traumatic event. The response of the immediate environment such as family will determine how well the individual copes with the traumatic event, and the socio-political context may constrain access to resources when dealing with the traumatic event.

Thus, ecosystemic thinking can also be applied when considering intervention and prevention strategies for trauma recovery and fostering resilience. According to the ecological model which describes the interaction of person, event and environment, there are four possible outcomes after trauma (Harvey, 1996). Firstly, there are those that received some kind of clinical intervention and recovered as a result. Then there are those who received the same treatment but did not recover. Thirdly, there are individuals who received no formal treatment and recovered spontaneously from trauma. And lastly, there are those that did not receive any treatment and did not recover. The ecological model does not describe recovery from trauma in terms of successful completion of a therapeutic

process or the absence of PTSD symptoms. It understands trauma recovery as a multidimensional process.

This process includes having authority over traumatic memories (Harvey, 1996). For example, a person should be able to choose to remember the traumatic events and contextualise memories in a meaningful way. This in turn allows the person to integrate memory and affect and recall trauma with emotion rather than numbness or separation. In order for this to be possible there needs to be a tolerance of affect where the feelings of fear and threat related to trauma are no longer overwhelming and where there is a significant amount of mastery over symptoms.

An important distinguishing factor in this definition of trauma recovery is the rebuilding of self-esteem and self-cohesion so that the individual views their identity as a whole in a positive light (Harvey, 1996). Another critical feature in recovery is the reestablishment of safe attachment, especially in cases of continuous traumatic exposure where ongoing victimisation is a reality. Lastly, recovery is optimised when the individual can make meaning of their trauma and move on from their experience. The ecological model informs the need for community intervention, the role of the environment and existing social support structures, and resilience. It is important for community interventions like these to be culturally appropriate and relevant to the context so that they can become part of daily life within the setting (Harvey, 2007).

Review

Continuous Traumatic Stress (CTS) emerged in South African literature in response to the massive exposure to violence during apartheid. As a consequence of apartheid, many communities have been disadvantaged which has resulted in a lack of protection for many living under these circumstances. Communities face chronic violence and conflict and have no immediate solution to overcome their situation. As an innate, natural response to protect themselves people facing these conditions develop adaptive responses of hyper-arousal and dissociation.

CTS has been linked to PTSD, however, it is distinguishable from PTSD in the following way: Individuals' experiencing CTS do not report re-living past events and the element of perceived danger or a 'false alarm'. In contrast, CTS is described by a realistic and inescapable anticipation of danger as the threat of violence is current and substantive, also described as a state of 'permanent emergency'.

Although there are no known interventions that are specific to CTS, there are a variety of interventions that can be applied. Trauma Focused Cognitive Behavioural Therapy (TF-CBT), the conservation of resources (COR) theory and the ecological model have all been used as interventions for coping with CTS depending on context and availability of resources.

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