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COMPLEX POST-TRAUMATIC STRESS DISORDER OF DOMESTIC VIOLENCE VICTIMS

The article is devoted to one of the most pressing socio-psychological problems of modern society – domestic violence. An analogy is drawn between the devastating consequences of hostilities for society, and the consequences for victims of domestic violence, which manifests itself at the mental level in the form of structural dissociation. The main signs of complex post-traumatic stress disorder, as well as methods and stages of psychotherapeutic assistance to victims of domestic violence are given.

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Violence, as one of the most pressing socio-psychological problems of modern society, is a destructive interaction between groups of people or individuals, during which some individuals, using overt or covert coercion, subdue and use the lives and resources of other individuals to satisfy their own needs.

Domestic violence is an implicit mechanism of redistribution of resources within the family, where a physically or emotionally dependent person is forced to give up his needs and act in the interests of the aggressor in order to save his own life, avoid suffering, or in the hope of satisfying his needs in the future, being in a relationship of belonging to the aggressor [1].

Obvious manifestations of domestic violence are bodily harm of varying severity, rape, damage to property, insults, threats, blackmail, deprivation of food and financial support. More veiled forms can be presented in the form of devaluation, control, coercion to undesirable actions, ignoring or lack of actions necessary for the maintenance of life, health and personal development.

Such phenomena as phobias, addictions, depressions, suicides, obsessive-compulsive disorders, abortions, psychosomatic diseases, eating behavior problems in our society are usually considered as traditional negative phenomena. However, these phenomena are direct signs of the existence of violence in the family and society.

In most cases, at the initial stage, violence is not only not manifested outwardly, but is not recognized either by the persons who are subjected to violent acts, or by the persons who produce various types of violence against members of their family, and is perceived as a norm of behavior. However, escalating violence over time becomes more and more obvious and destructive.

Open high-intensity violence at the global and regional levels manifests itself in the form of various armed clashes and wars, the result of which are the destroyed lives of people, numerous physical injuries, injuries and illnesses among survivors, destroyed infrastructure, huge economic losses, bitterness and division of relations between peoples and members one family.

Military psychiatrists usually diagnose post-traumatic stress disorder (PTSD) in combat participants and witnesses. PTSD is a severe mental condition that can result from exposure to a short-term, sudden traumatic event (or a time-limited series of shock events) resulting in a loss of physical integrity or the threat of death, where the person felt helpless and unable to act to protect themselves, or one who has been exposed to danger.

PTSD in the ICD-11 is characterized by symptoms such as:

– repeated experiences of traumatic events in the form of flashbacks, intrusions, nightmares presented in different sensory modalities and their combinations;

– avoidance of places, people, things, actions, thoughts, sensations, reminiscent of a traumatic experience;

– hypervigilance and heightened startle response due to constant subjective sense of threat.

The ICD-11 presents another type of mental trauma (literally: mental and behavioral disorders associated with stress) called complicated or complex post-traumatic stress disorder (CPTSD), which is caused not by a situational, but by a prolonged (continuing for a long time) trauma from which it

was impossible to get out. Such exposures include participation in hostilities, slavery, long-term physical, sexual and emotional abuse.

In addition to the main three root symptoms common with PTSD, and described in the ICD-11, CPTSD has 3 additional symptoms that belong to the category of «I-organization disorders»:

– difficulties in regulating emotions (especially fear and anger), manifested in dysphoria, suicidal thoughts, using one's own body (self-harm, compulsive overeating) and external resources (sexual activity, psychoactive substances) for emotional calm;

– violation of self-perception - self-esteem becomes consistently low, a person feels humiliated, worthless, ineffective and helpless. There is toxic shame, which explains the negative attitude of other people towards themselves («I am treated badly because something is wrong with me»), and toxic guilt as an attempt to take responsibility into one's own hands in order to be able to change the situation.

– violations in relationships, which are manifested in distrust, difficulties in self-disclosure, seeking help and support from other people. People with CPTSD are not able to notice danger in time and get out of traumatic relationships. The fear of intimacy is associated with the fear of attachment, because the person on whom the victim depended for a long time used him and harmed him [2].

While the association between military and catastrophic shock trauma and PTSD in the psychotherapeutic and psychiatric community is natural and obvious, the association between domestic violence and CPTSD is counterintuitive and latent. The introduction of this diagnosis makes visible the suffering of victims and survivors of domestic violence, explains the reasons for the ineffectiveness and frequent failures of therapy for this category of people, and also gives specialists a chance to identify this diagnosis and use more direct and effective ways to cope with this disorder.

The main signs of people suffering from CPTSD are:

– dissociation – perception of the events of one's life not in the first person; inconsistency of intonation, posture and gestures with the meaning of the story.

– the gap between development and achievements in various spheres of life;

– numerous failures in psychotherapy with different therapists, accompanied by the attitude «the therapist can not stand me»;

– complaints about sudden, difficult to bear emotional states that have no basis in real life context;

– increased control and anxiety, inability to relax;

– consistently low self-esteem: a feeling of being unnecessary, worthless, insignificant, rejected and unworthy of attention;

– difficulties with creating long-term and resourceful personal relationships.

Most often, CPTSD is confused with various forms of disorders of the hyperactive, anxiety, depressive, borderline, autistic, narcissistic, bipolar, co-dependent, obsessive-compulsive spectra.

People suffering from CPTSD most often perceive their condition as a norm, as a feature of character, and not as the consequences of unsatisfactory external conditions of their life and development, therefore, if they seek help, they cannot explain what exactly causes discomfort in their life.

CPTSD is based on psychic trauma – a neoplasm that has arisen in the psyche as a result of a traumatic event as an adaptive structure. O. Van der Hart in his theory of trauma calls this neoplasm structural dissociation. This disorder is formed as a result of repeated and repeated episodes of dissociation that occur in a state of extreme stress associated with violence [3].

The traumatic impact that led to CPTSD was so normal, gradual and constant in the physical world of the victim, and at the same time so unbearable for his psyche, that the only way to survive was to dissociate (split or repress) this experience.

Dissociation is a mechanism of reaction and adaptation to stressful situations, which suggests that the information received in the process of traumatic impact becomes inaccessible for associative access, or, in other words, it becomes mismatched (incongruent). Dissociation in this case will be expressed in the separation of mental processes. Normally, mental processes function in parallel and represent a continuum of behavior, affects, sensory sensations and cognitions.

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Domestic violence is abuse, neglect, deprivation of the basic psycho-physiological and social needs of a person who, due to age or other circumstances (pregnancy, disability, etc.), is dependent on another person. Therefore, in practice, most professionals in the helping professions use the term CPTSD as a synonym for attachment trauma, developmental trauma, early childhood trauma associated not only with violent actions of high intensity by persons in power over victims, but also with ignoring and lack of actions necessary to meet the needs of a healthy developing person. Situations of interpersonal violence, accompanied by chronic betrayal by the person who is the object of affection, although not directly related to the threat to life, increase the risk of complex traumatization. Personality development takes place in an environment where the main energy of a person is aimed at survival, and not at solving the usual problems of age development, that is, a person is not focused on getting pleasure, but focuses on avoiding pain.

Thus, the diagnosis of CPTSD is not a personality disorder, but arises as an adaptive structure in the psyche, in response to a traumatic external environment. Consequently, with a change in the external environment and adequate psychotherapeutic work, CPTSD can be overcome, restoring the natural processes of emotional and social development [4].

The most effective therapeutic directions for working with CPTSD in victims of domestic violence are approaches that pay special attention to attachment theory and relationships that arise in the «client-therapist» pair, as well as the integration of fragmented personality structures that have formed in the psyche as an adaptive survival function: gestalt-therapy, schema therapy, emotionally-imaginative therapy, emotionally focused therapy, somatic therapy by P. Levin, DPDH, prolonged exposure CBT, some body-oriented therapy techniques, psychodramas, constellation techniques and their combinations [1, 5].

The following main stages of treatment of victims of domestic violence with CPRSD can be distinguished.

1. Stabilization and development of a sense of security. Emphasis is placed on working with factors in the environment of the victim, which pose a threat to his physical and mental safety. Work is being done with internal structures that, in the absence of a real threat, reacting to triggers, launch a series of associations leading to inadequate reactions and/or retraumatization.

2. Reconstruction and reassessment of traumatic memories. This includes recovering the traumatic experience and reliving it in a safe environment, with the goal of integrating traumatic memories into autobiographical memory, with a change in cognitive representations of oneself and relationships with other people.

3. Work with the emotional and social competencies of the victim with their subsequent testing in real life conditions, with constant or booster support from the therapist [1].

The diagnosis of CPTSD is formed in victims of domestic violence as a result of being in long-term dependent relationships, the destructiveness of which is hidden and perceived as the norm. The constant frustration of healthy needs in relationships dependent on the aggressor leads to the gradual deprivation of the victim of vitality and resources, and over time reduces the chances of getting out of such relationships. If the attachment figure and the aggressor are the same person, then the attachment becomes an addiction. Therefore, the main psychotherapeutic direction in working with victims of domestic violence is to build reliable attachments with people who are resourceful for the victim [6].

The ability of mental health professionals to identify a diagnosis of CPTSD reflects both changes in the perception of the topic of domestic violence and recognition of the traumatic experience of their patients in order to more effectively help survivors of domestic violence.

Reducing the level of domestic violence is the most important factor in the prevention of a large number of mental disorders and the main tool for the improvement of society.

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DOMESTIC VIOLENCE: CHARACTERISTICS AND TYPES

The article reveals the concept of domestic violence and the mechanism of its action through the theory of attachment. The main features of domestic violence are considered: inequality, consistency, latency and escalation. The main forms of manifestation of domestic violence are given: physical, sexual, psychological and economic. The importance of prevention of domestic violence is argued as a way of interaction between family members, which has a deep psycho-traumatic effect both on the direct objects of influence – the victims of violence, and on the entire family system, including witnesses and the aggressors themselves.

«Domestic violence is an involuntary mechanism for the redistribution of resources within a family (or other system). The individual gives up his needs and desires and acts in the interests of the aggressor or the system as a whole in order to maintain belonging to the system and attachment relations» [1, p. 62].

The younger the child, the more his life and well-being depends on an adult. Attachment is the oldest biologically built-in mechanism for caring for offspring. The main task of such a mechanism is by any means to maintain attachment with a strong figure, in whose hands the necessary resources for survival and development are concentrated. Rejection (or, in other words, loss of attachment) is perceived by the child as the strongest threat to his existence. Therefore, the child is ready to endure anything, just to maintain this connection [2].

Man is a social being, and he can fulfill his needs only in interaction with other people. The child grows up, and the attachment mechanism retains its function and manifestation. An adult also strives to be accepted by important people on whom we are emotionally, physically, sexually or economically dependent.

The main features of domestic violence are: inequality, consistency, latency and escalation.

All violence is based on inequality. The basis for inequality arises where one person is really stronger than another, or has a belief about his superiority and about the normality of the use of violence.

The aggressor restructures the intra-family system of resource distribution in such a way that most of them are under his subordination. This is achieved by gradually changing the system of needs of the victim, where the needs of the aggressor are built into her needs. This whole system is reminiscent of parasitism that exists in living nature – a type of long-term relationship where one organism lives at the expense of another, gradually oppressing it, which often leads subsequently to

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