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Survival Skills as a Risk factor for Suicide in Complex PTSD

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Abstract

Suicidality is not a diagnostic criterion for PTSD, however in severely traumatised individuals this problem occurs quite often due to the victim's identity diffusion, fragility, disrupted or shattered self-cohesion, and broken attachment. In this study, we described five found types of the survival skills in 24 severely traumatized individuals: betrayal/detachment, untrustworthiness of the perceptions, traumatic moment, mobilization for danger, and non-aliveness/vitality.

Key words: Suicidality, Torture, Hopelessness, Self-at-worst, Survival skill

Introduction

We can conceptualise suicidality as an outcome of the disturbed self-cohesion which causes the individual's broken spirit to thrive making an affective state flat and non-expressive – inert, lifeless, empty, worthless, and vacuous. In DSM-5 [1] suicidality is not diagnostic criterion for PTSD, however, in clinical practice working with severely traumatized patient this problem is quite common. Severe psychological trauma (complex trauma) often impacts all aspects of the self-structure – one's image of the body; the internalized images of others; and one's values and ideals – and leads to a sense that self-coherence and the self's goals are invaded, assaulted and systematically broken down [2].

Severe trauma usually overwhelms one's ordinary human adaptations to life and generally involves threat to the life or bodily integrity [1]. A close personal encounter with severe violence, threats and death, confronts trauma victims with the extremities of hopelessness and helplessness, terror, disconnection, disempowerment, and evokes the response of inescapable catastrophe [3]. The vulnerable self-structure of the severely traumatized individuals could be evidenced in the following: (1) difficulties in self-regulation, such as self-esteem maintenance, affect tolerance, sense of self-cohesion and continuity, or the sense of personal agency; (2) appearance of symptoms, such as frequent upsurges of fears and anxiety, depression, or irritability; and (3) the individual's reliance on primitive or less-developed forms of the self-object relatedness with attachment figures [2].

As the self-structure and its organization are damaged, the aftermath of the severe trauma may occur in various forms and degrees of the self-dissolution, disintegration, and self-destructiveness. Thus, the suicide can be seen as an "emergency solution" in order to escape from the vulnerable and unhealthy self. Severely traumatized individual presents "self-at-worst" state without a safety net, and such shattered self has been afflicted with the sense of emptiness and a painful intensity of traumatic memories. The suicide is a desperate attempt to "fil a gap" as self has "nothing inside" [4,5]. For the clinicians is important to notice the patient's use of negative terms describing loss of self-structure and fragmented body-mind-self relations [6].

In some extreme cases of the trauma-induced dissociation, the patients would report dissociated parts of the body and that their own body become "strange" or "foreign" to them. Severe trauma may lead to a sense of de-centering of the loss, loss of groundedness, and a sense of sameness, continuity of the ego-fragility, leaving scars on the one's "inner agency" of the psyche [7]. Fragmentation of self-identity has consequences in the patient's psychological stability, well-being, and one's psychic integration resulting in proneness to disintegrated personality as a whole [3,8-10].

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Method

Participants

The study was conducted with 24 severely traumatized patients (six women and eighteen men prisoners of war during conflict in former Yugoslavia) considered as the treatment resistant following severity and complexity of their PTSD symptomatology. The group subjects mean age was 45 years (SD=8, range 24-66) and all of them have already been prescribed with medication due to the PTSD and/or other trauma-related disorders (depression, personality disorders, psychosis). Participants reported having no pre-trauma mental health issues. They reported medium duration of the time spent in prison was 1.3 years (range between 1-37 months), and 80% of the subjects reported having experience a mean of 18 different types of torture experience.

Measures

All participants were screened by using the Structural Interview for DSM-IV-TR (SCID), translated and Standardized MMPI, Posttraumatic Stress Diagnostic Scale (PDS), Beck Depression Suicidal Ideation (DSI), and Torture Questionnaire. Clinical interviews and assessment had been made by the trained clinicians (clinical psychologists or registrars in psychiatry). This short article is focused on survival skills that have existed a long after the traumatic experience is over.

Procedure

Clinical interviews and psychometric testing have focused attention on the personality disturbances (thoughts, emotions, and behaviour), distorted relationships and attachment with the others. In particular, we examined the levels of survival skills during the traumatic experience of torture with hypothesis that their existence at present time are a factor for treatment resistant condition of PTSD and a construct of the "self-at-worst" which might cause suicidal ideation, attempts, and/or self-harm.

Albeit the traumatic experience is over, due of being tortured, the severely traumatized individuals lost desire for aliveness and vitality with hostile and mistrustful attitudes towards the own self and others – chronic feeling of being on the edge [11]. The chronicity of the symptoms in complex trauma coexists with a high level of betrayal and destructive sense of value in ideas, ambitions and activity of daily living. The quality of reality drains from the "here-and-now" and suicide seems more realistic than living under persistent nightmares, flashbacks, and consciousness remains fixed upon it.

Results

The participant in this study reported eighteen different types of torture they have experienced. Among the psychological torture, the most evident has been a verbal abuse (100%), followed by witnessing torture (87%), threats of further torture (87%), threats to family (83%), threats to death (75%), rape[1] (54%), and isolation from other prisoners (50%). Among the physical torture, the most evident has been beating (96%), then forced standing (83%), being used as a labourer (72%), food deprivation (62%), water deprivation (54%), and burning by cigarettes (46%).

[1]Among six women included in the study, five of them reported being raped. However, among male prisoners eight of them also reported of being raped describing profound guilt and shame regarding this matter. All of raped men stated that they had never talked to anyone of their family or close friends about this traumatic experience.

Across the reported type of torture there were significant differences between the genders:

- Males had mostly been exposed to physical torture (beating) accompanied with a verbal abuse, had been used as a labourer, were injured, or exposed to food, water and sleep deprivation, forced to witness torture of others, saw injured or killed person;
- Females had mostly been pulled by hair (100%), were exposed to the sexual assault, traumatic news about a family member, threatened to further rape, or had been interrogated about husband or male family member. Women also spent much less time imprisoned (maximum reported was 2 ½ months).

There were 17 (71%) of the participants who reported thoughts (ideation) of committing suicide during their imprisonment (100% of female reported this), but no suicidal attempt was reported due to the constant surveillance by their captors. However, 8 out of 17 participants reported at least one post-trauma suicidal attempt because they feel hopeless and their life is meaningless.

All of participants reported some kind of survival skill from traumatic past being brought into "here-and-now" circumstances, which has caused clinically significant impairment in their social, occupational, emotional and other areas of daily functioning. We summarized survival skills into five main groups:

- Persistence of the betrayal/detachment;
- Persistence of untrustworthiness of perceptions;
- Persistence of the traumatic moment;
- Persistence of the mobilization for a danger; and
- Persistence of the non-aliveness/vitality.

Persistence of the Betrayal/Detachment

Severe trauma can induce destruction of desire, loss of faith, unwillingness to thrive and have a future [12]. Betrayal of "what is right?" is particularly destructive to a sense of victim's self-continuity, of values and ideals, ambitions, and activities. In such circumstances when some major ideals have been betrayed, the trustworthiness of every external idea or inner cohesion comes into the question. The loss of self-values and self-respect, as well as respect of the entire outer world, delivers a loss or lack of energy and motives for living. Alienation from valued images of relatedness, attachment and togetherness may contribute to the fact that life existence is without of any value. Safe and non-violent attachments to others become virtually impossible for a severely traumatized individual. Among 24 participants in this study, 16 of them (66.7%) reported being disturbed in areas of attachment and relatedness.

The persistence of betrayal/detachment survival skill is characterised by chronic condition of the hopelessness and social withdrawal. The trauma victim is kept deeply inside – superficially preoccupied with the own failure and condition that "no hope

and cannot be changed", as patient usually says. More often, such "no hopes" merely externalise the inner impulses that lead to the entire disappointment with the self and others. Their "reality" is an unfortunate experience in the past ("here-and-then") which has been more influential than the current normal circumstances in life. Similarly, preoccupation with failures in the past urges the suicidal thoughts – with or without attempt – point pervasive hopelessness even if patient presents a façade of optimism [12]. A general lack of initiative (motives) is an indication that the trauma victim is in deep unfortunate condition; his insight is very painful bringing despair, unwillingness and discouragement to go through the hardship of again working through a new problem.

Persistence of Untrustworthiness of Perceptions

Severe trauma strikes the most basic functions of the trauma victim, including his perceptions and judgment. Among the participants, 11 or 45% of them reported characteristics of the untrustworthiness in own perceptions, and three of the trauma victims reported significant alteration of the self-awareness (dissociative state) and confusion about self-identity. In clinical practice, it is common that extremely horrible experience attacks the basic mental state of intention, anticipation, and perception. The cumulative effect of severe, prolonged or repeated attacks on mental function is to undermine the trauma survivor's trust in own perception, making confusing existence and reality of the objects or events [12-16].

Because of extreme stress experience in the past, the hypervigilance is a rational response and everything must be checked to be sure that it is what it appears to be, leading the individual to the obsessive-compulsive state of mind. Some loss of the trustworthiness of own perceptions may be also purely physiological (due to physical injury during traumatic experience), dissociative, or a result of the patient's inability to filter out trivial or harmless sensations from the reality [17,18]. This could be a result of the consistently suppressed emotions and thoughts about the danger making the trauma survivor's post-trauma time and day-to-day functioning miserable, and in limbo.

In essence, this condition is characterised by the self-outside relationship with the patient's subjective state of unreality in which there is a feeling of estrangement, either perception of the own self or the external environment. Untrustworthiness is essential features in a form of detachment or estrangement from own self. This condition is characterised by unpleasant state of disturbed perception in which external objects or parts of one's body are experienced as changed in their quality, remote or automatized. However, clinical examination reveals that the patient's reality is intact but severely traumatized individual is unable to overcome it.

Persistence of Traumatic Moment

Trauma survivor is unaware (unconscious) about the trauma moments imprinted into memory system during the traumatic experience. As long as the traumatic moment persists as a reliable nightmare, consciousness remains fixed upon it. The experimental quality of reality drains from "here-and-now" circumstances finding often suicide or self-harm as better "solution" than to continue with dysfunctional state. This is an aspect of the detachment of the trauma survivor from the post-trauma life and it is intimately connected with the persistence of an emotional numbness developed during the traumatic experience.

Traumatic memories are not narrative but rather it is an experience which co-occurs either as a full sensory replay of traumatic event(s) in dreams or flashbacks with all things seen, smelled, and felt intact and present, or as disconnected fragments [12,15,19,20]. These fragments could appear as an inexplicable rage, terror, or disconnected body states and sensations; sensations of the suffocation in war-prison cell or being tumbled over and over by rushing toward a shelter – but without any memory of either a cell or a shelter. In other instances, the memories of facts may be separately preserved without any emotions, meaning or sensory content. The severely traumatized individual is often able to give an utterly blind statement of a fact slipped into another context. Such context is in fact relived and not remembered as the trauma victim loses authority over his memories imprinted during traumatic experience.

Persistence of Mobilization for Danger

Vigilance, the mental and physical preparation for the attack is the most disturbing trauma-survivor's behaviour which invades everyday life so profoundly. One of our patients reported that since his release from war-prison, he has always slept in a room corner opposite the door "expecting that the perpetrator could enter the room any time". The patient appeared with self-defensive responsiveness and for him there was no place to completely shed vigilance. The sound of door-lock in any other room created an explosion of his uncontrollable fear and he would immediately hit to the ground floor unaware of his automatic reaction. The most evident sign of the vigilance was the patient's intolerance to having anyone come unannounced from behind. Exposed to the continuous threats of danger, the trauma survivor remains mobilized for his survival skills indefinitely without having physical calm or comfort.

Over the time, the trauma survivor's body may appear in developing various somatoform symptoms associated to the original trauma experience (pain on different body parts, tremors, chocking sensations, rapid heartbeat, gastrointestinal disturbances, or sexual impotence). Some severely traumatized individuals may become so accustomed to their vigilance that they categorically deny the connection between bodily symptoms and the nature of trauma in which these symptoms had been formed [13,15,21,22]. Persistence of expectations for danger is inescapable terror, without the possibility to make any future plan, but rather lay focus on the "now-moment", as it was during the traumatic experience in order to survive.

Persistence of Non-Aliveness/Vitality

When trauma survival loses all sense of meaningful personal narrative, he then develops some contaminated identity or punishing identity. Dysfunctional sense of aliveness/ vitality is driven by the unconscious needs and wishes from the past, which play a greater role on the traumatized individual than the present time. Pathological forms of the aliveness/vitality are identified by the disturbances or alterations in the normally integrative functions of the memory, identity, or consciousness. In essence, these pathological forms represent one's failure to integrate aspects of the perception, memory, identity, and consciousness into the present time, showing "feelings of strangeness", or

"spacing out" [22]. The patient does not have control over the past (in fact his past controls the patient) experiencing a sense of hopelessness and loss of control over the body and mind. This makes for a dual function within the same individual, delaying integration into the present time as trauma itself is regarded as one's discontinuity of life existence.

The duplicity makes diffuse impairment of the sense of truth and contributes both victim's alienation from the own self and great dependency from the inner conflict drives. In essence, the traumatic past holds a huge role in determining here-and-now existence; the patient's presentness is defective and a raptured practice of everyday life, which seems difficult an unlikely to move from the influence of the past. The trauma experience is mirrored and, when having a memory about the past, whatever happening now is actually a conviction of the past.

Severe trauma causes the patient's loss of desire for aliveness and vitality, hostile or mistrustful attitudes towards the self and others, a chronic feeling of being "on the edge" [5,10,12]. This sense of vulnerability can lead victim to the anticipatory danger and catastrophic expectations due to the complex self-organization and perpetuate feelings of the patient's disconnectedness.

When an individual has been tortured or personal boundaries violated or otherwise assaulted (starvation, water or sleep deprivation, witnessing torture or killing others) the body and mind react with a fear and rage, and the mind undergoes a distinctive kind of non-aliveness. This could lead to the self-hate state which constitutes the individual's inability or lack of desire to re-store self-continuity which is seriously damaged. With duplicity as the individual's response to the self-hate, the individual alienates himself in twofold ways: by forcing to falsify his feelings instrumented by inner conflict drives, and beliefs of endangering by the external world. The entire response in fact is determined by the self-hate and realisation of the trauma victim's inability to comply with the external demands appropriately unless responding in self-hate response with the suicidal ideations of the self-harm. In another way, the trauma victim's unconscious reactions are ultimate response saying that the self in its duplicity is unnatural and cannot be transformed into pre-trauma functions.

Discussion

Suicidality is not diagnostic criterion for PTSD; however, clinical experience steps forward to understand development of the suicidal thoughts in severe traumatized individuals. Needless to say, the severe and prolonged trauma causes a significant impact upon one's personality and self-structure. Because of the timeless and unintegrated nature of the traumatic memories, trauma victims remain embedded in the trauma as a contemporary experience, instead of being able to accept it is secondary and belongs to the past [3]. The meaning of the traumatic past evolves over time, and often includes feelings or irretrievable loss, anger, betrayal, and hopelessness. Thus, clinicians treating severe traumatized individuals should be aware that suicidality may constitute one of the most important clinical symptoms cluster to evaluate.

During traumatic event(s), the trauma victims had experienced feelings of worthlessness and dehumanization leading them to rely on their *survival skills* which have usually continued a long period after the trauma is over. It should be emphasised that *prolonged* psychological effects of trauma are often experienced such as the original trauma happens at the present time. Persistence of the *survival skills* is a dreadful condition as the trauma survivors, in essence, are *re-processing* the traumatic event(s) and still have *traumatic exposure* such as the original traumata occurs again.

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