THE INTERNATIONAL JOURNAL OF HUMANITIES & SOCIAL STUDIES

The Hidden History of the Complex Trauma: From Denial to Recognition of the Complex Post-Traumatic Stress Disorder between Clinical Reality and Diagnostic Problems

Miriam Guttuso
Psychologist, University of Palermo, Italy
Aluette Merenda
Senior Researcher, University of Palermo, Italy

Abstract:
The paper is aimed at the analysis of recognition and legitimacy problems, historically present in the study of psychological trauma, as well as to opening reflections on the possibility that these difficulties are still current.
Recent contributions on the study of the developmental trauma disorder mainly highlight the importance of relational and cumulative aspects and during the developmental cycle when the subject experiences his/her traumatic events. Multiple exposures to interpersonal trauma in fact have a stronger impact on the first decade of life, resulting in predictable consequences on at least seven mental functioning areas. Several authors propose a new diagnostic label for the Complex Trauma, as its phenomenology and etiology are different from the Post Traumatic Stress Disorder ones.

Keywords: *developmental trauma disorder, denial, Complex-PTSD, cumulative outcomes, relational consequences*

1. Introduction. A Historical Overview on the Clinical Study of Psychic Trauma

The study of psychological trauma is characterised by a kind of "underground" history. Even though the basis for its conceptualisation, placed by Charcot, Breuer, Janet and Freud in the nineteenth century, actually the analysis of the relational traumatic impact is started in the last century (van der Kolk, McFarlane and Weisaeth, 2007).

Historically, several times a tendency to not legitimise the existence of psychological trauma and its consequences is shown. In the second half of the nineteenth century, studies on hysteria led at least temporarily to trace the origin of these disorders in psychological trauma. Starting from Charcot's studies, who had the merit of the recognition of the authenticity and objectivity of hysterical phenomena, Janet and Freud came independently to the conclusion that the origin of hysteria was to track down the psychic trauma (Herman, 2005).

Most of modern theories on Post-Traumatic Stress Disorders are directly based on Janet's theories, who is considered the pioneer of modern psycho-traumatology (Howell, 2011). For Janet the psychological trauma is an event not integrated into the individual psychological system that consequently becomes separated from the rest of the emotional experience, out coming in the related psychopathological symptoms. Janet was the first to track down the dissociation of the pathogenic process leading to trauma. This process, although allowing a temporary adaptation to the traumatic experience, determines the non-integration of traumatic memories that are separate from the state of consciousness and voluntary control. The memory traces of the trauma remain so hidden, in the form of "fixed ideas", that tend to reoccur and interfere through perceptions terrifying, obsessive worries and somatic symptoms recurrently (van der Kolk et al., 2007). Freud initially adhered to Janet's ideas, much to define the traumatic event as an experience whose subjective implications, in terms of ideas, knowledge and emotions associated with it, are such that the person is unable to manage or adapt to them at the moment (Simonetta, 2010). He will also share the idea that hysterical symptoms were resized when traumatic memories and feelings associated with them were verbally recovered and expressed (Herman, 2005). This method of treatment, at the basis of modern psychotherapy, led to one of the major contributions to the study of the traumatic origin of hysteria but, at the same time, it was its negation (Herman, 2005; Liotti and Farina, 2011). In 1896, starting from the stories of his patients, Freud claimed that the traumatic hysteria was to trace the sexual abuse during childhood (Freud, 2005). Before long, by the publication of Etiology of Hysteria, Freud denied the theory of trauma as the source of hysteria because of the social implications of his hypothesis (Liotti and Farina, 2011). This disease, in fact, was so widespread among women belonging to any social class that this hypothesis would involve the recognition that sexual abuse against children were endemic (Herman, 2005). This would be socially unacceptable and would have undermined the credibility of Freud, who in the second phase of his work denied the effect of traumatic experiences in developing real psychopathological and he interpreted hysterical symptoms as the symbolic expression of conflicts between repressed unconscious desires and Ego defenses. The great influence of psychoanalytic theory, associated with social and political factors, had resulted in the

complete absence of research on the traumatic effects on children's lives and the loss of interest in the psychological trauma (van der Kolk et al., 2007; Liotti and Farina, 2011).
The denial of the psychopathological effects of psychological trauma lasted until the First World War when, although it was observed the emotional impact of the conflict on the soldiers, the military and political authorities downplayed its significance. The discovery on symptoms similar to hysteria, caused by prolonged exposure to scenes of violent death, was hidden as well as research about causes and treatments, because of moralistic explanations that interpreted the reactions to trauma as signs of laziness and cowardice (Herman. 2005).
The rebirth of the pathological effects of the trauma began during Second World War, when the emotional consequences of the war could no longer be ignored.
In that period, one of the major contributions the study of psychological trauma and its effects is undoubtedly attributable to Kardiner. From Janet's contributions on psychological trauma and dissociation, Kardiner laid the foundation for modern diagnostic categories of post-traumatic stress disorders and pointed to the first guidelines for their treatment. He had the merit to make sense to a relational approach for the Post Traumatic Stress Disorder treatment, as a relational support that can reduce the subject's feeling of helplessness (Liotti and Farina, 2011).
After the Second World War, a medical perspective prevailed according to which the psychopathological symptoms were the result of a subjective predisposition; the idea that the traumatic event could actually produce a temporary psychopathological reaction predominated but its duration was due to the personality and the will of the subject (Bonomi, 2001). What therefore was considered traumatic was only an objective and strong event and whose psychopathological implications were attributable to a subjective predisposition (focal and internal trauma). Only subsequently it was important to consider the subjective experience to define a specific traumatic event and that event should not necessarily be objectively traumatic to be experienced as such by a subject (relational and cumulative trauma).
Jung defines trauma as a violent emotion or a complex of ideas and emotions, in relation to which the incident is a precipitating factor (Jung, 2001). This orientation also characterises the freudian psychoanalysis where the predominant theory of "internal trauma", according to which symptoms are not due to a real traumatic experience but are the result of intra-psychic conflicts of the individual (Strachey, 2001; Bonomi, 2001). So, this is a conception of trauma as a"focal" event, due to a objectively traumatic situation that does not take into account the subjective components and the relational aspects of the individual.
During last decades, instead, more emphasis to the relational aspects is given, allowing to assign a meaning to the trauma progressively wider within which attributed not only major or discrete traumatic experiences but also the minor trauma set and early relational failures that expose subject to chaotic and powerlessness feelings (van der Kolk et al., 2007).
Khan (2007) introduced the concept of "cumulative trauma", just to indicate events or situations characterised by a set of emotional stress acting quietly in the primary caregiver-child relationship and assuming a traumatic value cumulatively and retrospectively. The focal trauma may emerge as the "precipitate" of traumatic micro-events that accumulate over time then explode in a evident macro-trauma (Khan, 2007). Van Der Kolk, in agreement with the concept of "cumulative trauma" of Khan (2007), uses the expression "atmosphere traumatic" to describe the chronic trauma, as distinct and isolated traumatic episodes occurring constantly, that the subject is forced to live in contexts characterised by abuse and neglect. Such experiences have a devastating effect on child development, impacting on his ability to regulate the internal affective states and to organise appropriate behavioural responses to external stressors.

2. Toward Complex-Post Traumatic Stress Disorder

The historical evolution of the concept of trauma lies its influence on the current diagnostic classifications and therefore on the assessment and treatment of those disorders belonging to the spectrum of trauma. In the 70s, the pressures of two social movements, on the one hand the veterans of the Vietnam War and the other women who denounced their conditions of mistreatment lived at home, led to the official recognition of the possibility that the effects of psychological trauma could be a real mental disorder (Herman, 2005). In 1980, it was finally officially recognised the relationship between traumatic events and mental disorders within the international diagnostic systems; there is, in fact, the inclusion of the Post Traumatic Stress Disorder (PTSD) in the DSM-III (Farina and Liotti, 2011).
The process toward the identification of diagnostic criteria of PTSD has had the contribution of informal professionals' networks. Professionals, through the analysis of Kardiner's studies related to the survivors of the Holocaust and other traumatised victims made a list of the 27 most common symptoms of "traumatic neurosis", from which a system classification was presented (van der Kolk et al., 2007; Andreasen, 2007).
In the 90's, researchers from Harvard and Columbia University of New York, through studies to verify the validity of the symptoms of PTSD (promoted by the American Psychiatric Association for the drafting of the DSM-IV), came to the conclusion that the definition of PTSD was not sufficient to describe the complete plot of trauma effects (van der Kolk et al., 2007). The diagnostic category of PTSD, as formulated in the DSM-IV, was built in order to identify a general model to describe the reactions to traumatic events. For this reason, it includes only a limited range of emotional cognitive and behavioural reactions to stressful serious events (Andreasen and Wasek, 2007). Therefore, focus only on interference, apathy and excitement as PTSD characteristic symptoms can hugely limit the observation of the ways through people could react to trauma, as well as of the most appropriate treatment (van der Kolk et al., 2007). Being conceived to describe individual psychopathological reactions to a single or small number of traumatic events, specifically limited in a period of time, the PTSD diagnostic category seems not enough comprehensive to describe the complex and

changeable psychopathological configurations of traumatic experiences that happened in a long period of time (Liotti and Farina, 2011).
For this reason, van der Kolk (2007) introduces the concept of “Trauma Spectrum Disorders” to emphasise how different syndromes may constitute heterogeneous ways of adaptation to a childhood trauma. He describes multiple psychopathological configurations along a continuum in which, at one extreme lies the dissociative identity disorder (as a paroxysmal response to a dramatic traumatic event) and at the opposite one are placed different forms of anxiety and somatoform disorders (as a somatic response to traumatic events related to chronic psychological situations, as abuse and neglect); borderline personality disorder represents instead an intermediate degree of adaptation to trauma (van der Kolk et al., 2007).
At a diagnostic level, this classification shows the existence of a high degree of comorbidity. The high comorbidity between PTSD and mood disorders, dissociative and anxiety disorders, addiction and character disorders (Green, Lindy, Grace, Leonard, 2007; Davidson, Hughes, Blazer, George, 2007; Kulka, Schlenger, Fairbank, Hough, Jordan, Marmar, Weiss, 2007) does in fact increase the risk that “traumatised people are often wrong diagnosed and given an inadequate treatment (...). Because of the quantity and complexity of the symptoms that show, they are often treated in a discontinuous and incomplete way” (Herman, 2007a, p. 189). It could be argued that as well as knowledge about the effects of psychopathological trauma have been found historically discontinuous and fragmented, in the same way these gaps are reflected on the diagnosis and treatment. Frequently, infact, the relationship between the “here and now” of the symptoms displayed by patient and the traumatic experience is not clear (Herman, 2005). If, during the acute phase, it is easy to identify the relationship between the reactions of the subject and the traumatic event that has triggered, over time the relationship between the symptoms and personal history can become less obvious in the light of adjustments to long-time trauma (van der Kolk et al., 2007).
The issue becomes even more complex in those who have been traumatised in childhood. Numerous studies have in fact demonstrated that most psychiatric patients has been traumatised. For example, the borderline personality disorder, dissociative disorders and hetero and auto-aggressive behaviours are frequently associated with traumatic experiences in childhood (Herman, Perry and van der Kolk, 2007). When trauma occurs in the early life has strong impact on the maturation systems that regulate biological and psychological processes to be able to determine a breaking-up. This makes them more vulnerable to the development of a chronic alteration of emotional self-regulation, hetero and auto-aggressive behaviours, learning disorders, dissociative phenomena, somatization and distortion of the concept of Self and others (van der Kolk et al., 2007). In particular, since the Self arises from the interaction between the child and his caregivers, the trauma that occurs during this life-time interferes with the development of identity and with the ability to develop relationships of trust and cooperation (Cole, Putnam, 2007; Herman, 2007a).
Judith Herman was the first in the early 90’s to propose the inclusion of a new diagnostic category called Complex Post Traumatic Stress Disorder (C-PTSD). She was able to describe complex symptoms resulting from interpersonal and prolonged trauma (Herman 2007a, 2007b) but, despite the evidence provided by the experimental data and clinical observations, the committee on the drafting of the fourth edition of the DSM has not agreed. Its location could be the same for anxiety disorders, including dissociative, somatoform and personality ones (Chu 2011; Herman, 2011). However, thanks to pressure from researchers at Harvard, in the section on aspects of PTSD and related disorders, in DSM-IV was added that “in case of relational stressors (e.g., physical and sexual abuse in childhood, domestic violence, being taken hostage, prisoner, (...) it is possible that the clinical description differs from the traditional one and may present “disturbed affect regulation, aggression toward others and oneself, dissociative problems, somatisations and altered relationships with others and oneself” (APA, 2011, p. 11-12).

3. Toward Developmental Trauma Disorder (DTD)

Since 2009 different researchers are still trying to include in the DSM-V the “Traumatic Development Disorder” label, with its onset in childhood and adolescence (Farina and Liotti, 2011). To confirm the existence of this clinical reality is the fact that, after Herman, many others have proposed the inclusion of a number of diagnostic entities very similar to each other, as a consequence of a traumatic development such as: Extreme Stress Disorder Not Otherwise Specified (ESDNOS) (Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, and Resick, 2011), Post Traumatic Personality (PTP) (Classen, Pain, Field and Woods, 2011).
Twenty years after the first proposal for a diagnostic category that captures the complexity of the clinical complex trauma reality, researchers and clinicians continue to denounce the inadequacy of the current classification of the DSM and the need for a diagnosis for the trauma during childhood and even in adulthood (Chu, 2011).
Cicchetti, Toth and Putnam’s contributes (2007) on differential effects of trauma at different stages of human development helps to better understand the PTSD diagnostic category especially for traumatised adults; children develop, in fact, much more complex reactions that are not easy to frame in this kind of diagnosis. It has been shown that a high number of children with a post traumatic symptomatology, appears to be under-threshold because it does not fulfill the PTSD criterion A1 (i.e. it is possible considering as traumatic have lived as witnesses, directly or indirectly, events that led to the death or serious injuries, or threat of the physical integrity personal or of others) (Caretti and Craparo, 2008). Therefore, it is necessary to extend the definition of traumatic event to other forms of interpersonal trauma as: emotional abuse, neglect, abandonment, separation from the caregiver, domestic assistance violence. A growing number of researchers propose for these reasons the introduction of a new diagnostic label for complex trauma: Developmental Trauma Disorder (DTD). It was, in fact, shown that trauma has a cumulative and more pervasive impact when it occurs durin the first ten years of a child’s life, whereas its occurrence in an following developmental phase causes traumatic symptoms similar to PTSD and more circumscribed.
Child Traumatic Stress Network (CTSN) modified the criteria proposed for the C-PTSD, declining them in clinic of development and giving it the name of Developmental Trauma Disorder (DTD) (van der Kolk, 2008).The basic assumption of this new diagnosis is that

multiple exposures to interpersonal trauma determine clear and predictable consequences on child different functioning areas: attachment, affect regulation, biological level, dissociation, control of behaviour, cognition and sense of Self (Cook, Spinazzola, Lanktree, Blaustein, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson, and van der Kolk, 2008). Other theoretical contributions and experimental data have led to the identification of C-PTSD clinical description and diagnostic criteria corresponding to it. Complex trauma and its effects represents a clinical reality that needs more recognition, assessment and treatment beyond and despite difficulties of its formalization.

4. Conclusions and Research Paths

The path that led to the definition of psychological trauma was not at all linear but rather steep and not without difficulties due to the influences of individual, social, political and cultural factors. These factors have led to the cyclic alternation of moments of flowering and at same time forgetfulness (Herman, 2005). The result was the fragmentation of knowledge and thus unable to have an overall view and to find a language that adequately describes trauma and reactions associated with it. Several individual, interpersonal and cultural factors in mutual interaction may affect individual adaptation to trauma. Understanding the interactions of these various factors, once considered in terms of *out out*, allowed to increase knowledge on different aspects of trauma that so far appeared irreconcilable.

Despite the pressure provided by studies and research to the growth of knowledge on complex trauma as well as professionals, who need tools for a correct assessment and treatment, C-PTSD and DTD in the latest version of DSM's have not been introduced or the clinical picture.

The creation of a separate nosographic category dedicated to Trauma and Stressor Related Disorder that was thought to solve the problems about its location, was not obviously sufficient. This, probably, because of the critical debate still unresolved about its clinical definability and his continuity with some aspects of Borderline disorders (Pezzullo, 2010).

The risk assumes characteristics of truthfulness in the light of the clinical reality and it is moreover linked to the devastating social effects and costs of an unsatisfactory treatment. It is in fact essential that society and professionals commit themselves to the traumatised subjects. First of all, this means individuals are not responsible for the traumatic events they had and ignore the traumatic reality not allow to acquire the tools to help them to process their traumatic memories. Second, this is essential to avoid that they can become "anguished and violent people, unreliable and easily distracted workers, parents negligent and / or who abuse alcohol and drugs as support to face unbearable feelings" (van der Kolk et al., 2007, p. 49).

5. References

i. Andreasen, N.C. (2007). Post-traumatic stress disorder. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

ii. Andreasen, N.C., Wasek, P. (2007). Adjustement disorders in adolescents and adults. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

iii. APA (2011). DSM-IV. Manuale diagnostico e statistico dei disturbi mentali. In B. Farina e G. Liotti (a cura di), Dimensione dissociativa e trauma dello sviluppo. Cognitivismo Clinico, 8, 1.

iv. Bonomi, C. (2001). Introduzione storica all'idea di trauma psichico. Presentazione al Centro di Psicotraumatologia. Firenze.

v. Caretti, V., Craparo, G. (2008). Trauma e psicopatologia. Un approccio evolutivo relazionale. Roma: Astrolabio.

vi. Chu, J.A. (2011). Posttraumatic stress disorder: beyond DSM-IV. In B. Farina e G. Liotti (a cura di), Dimensione dissociativa e trauma dello sviluppo. Cognitivismo Clinico, 8, 1.

vii. Cicchetti, D., Toth, S. (2007). Rochester symposium on developmental psychopathology: disorders and dysfunctions of the self. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

viii. Classen, C.C., Pain, C., Field, N.P., Woods, P. (2011). Posttraumatic personality disorder: a reformulation of complex posttraumatic stress disorder and borderline personality disorder. In G. Liotti e B. Farina (a cura di), Sviluppi traumatici. Eziopatogenesi, clinica e terapia della dimensione dissociativa. Milano: Raffaello Cortina.

ix. Cole, P., Putnam, F.W. (2007). Effect of incest on self and social functioning: a developmental psychopathology perspective. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di.), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

x. Cook, A., Spinazzola, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., van der Kolk, B.A. (2008). Complex trauma in children and adolescents. In V. Caretti e G. Craparo (a cura di), Trauma e psicopatologia. Un approccio evolutivo relazionale. Roma: Astrolabio.

xi. Davidson, J.R.T., Hughes, D., Blazer, D.G., George, L.K. (2007). Posttraumatic stress disorder in the community: An epidemiological study. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

xii. Farina, B., Liotti, G. (2011). Dimensione dissociativa e trauma dello sviluppo. Cognitivismo Clinico, 8, 1, 3-17.

xiii. Freud, S. (2005). Etiologia dell'isteria. In J.L. Herman (a cura di), Guarire dal trauma. Affrontare le conseguenze della violenza, dall'abuso domestico al terrorismo. Roma: Magi.

xiv. Green, B.L., Lindy, J.D., Grace, M.C., Leonard, A.C. (2007). Chronic posttraumatic stress disorder and diagnostic comorbility in a disaster sample. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

xv. Herman, J.L. (2005). Guarire dal trauma. Affrontare le conseguenze della violenza, dall'abuso domestico al terrorismo. Roma: Magi.

xvi. Herman, J.L. (2007a). Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

xvii. Herman, J.L. (2007b). Father-daughter incest. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

xviii. Herman, J.L. (2011). Foreword. In B. Farina e G. Liotti (a cura di), Dimensione dissociativa e trauma dello sviluppo. Cognitivismo Clinico, 8, 1.

xix. Herman, J.L., Perry, J.C., van der Kolk, B.A. (2007). Childhood trauma in borderline personality disorder. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

xx. Howell, E.F. (2011). The dissociative mind. In G. Liotti e B. Farina (a cura di), Sviluppi traumatici. Eziopatogenesi, clinica e terapia della dimensione dissociativa. Milano: Raffaello Cortina.

xxi. Jung, C.G. (2001). The Question of the Therapeutic Value of 'Abreaction'. In C. Bonomi (a cura di), Introduzione storica all'idea di trauma psichico. Firenze.

xxii. Khan, M. (2007). Lo spazio privato del Sé. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

xxiii. Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., Weiss, D.S. (2007). Trauma and the Vietnam war generation: report of findings from the national vietnam veterans readjustment study. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

xxiv. Liotti, G., Farina, B. (2011). Sviluppi traumatici. Eziopatogenesi, clinica e terapia della dimensione dissociativa. Milano: Raffaello Cortina.

xxv. Pelcovitz, D., van der Kolk, B.A., Roth, S., Mandel, F., Kaplan, S., Resick, P. (2011). Developmental of a criteria set and a structured interview for disorders of extreme stress (SIDES). In G. Liotti e B. Farina (a cura di), Sviluppi traumatici. Eziopatogenesi, clinica e terapia della dimensione dissociativa. Milano: Raffaello Cortina.

xxvi. Pezzullo, L. (2010). Draft DSM-V: cosa cambia per il PTSD? Testo disponibile al sito: http://www.psicologiaemergenza.blogspot.it

xxvii. Putnam, F.W. (2007). Dissociation in children and adolescent: a developmental perspective. In B.A. van der Kolk, A.C. McFarlane e L. Weisaeth (a cura di), Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.

xxviii. Simonetta, E. (2010). Esperienze traumatiche di vita in età evolutiva. EMDR come terapia. Milano: Franco Angeli.

xxix. Strachey, J. (2001). The Function of the Precipitating Factor in the Etiology of the Neuroses: A Historical Note. In C. Bonomi (a cura di), Introduzione storica all'idea di trauma psichico. Firenze.

xxx. van der Kolk, B.A. (2008). Il disturbo traumatico dello sviluppo: verso una diagnosi relazionale per i bambini cronicamente traumatizzati. In V. Caretti e G. Craparo (a cura di), Trauma e psicopatologia. Un approccio evolutivo relazionale. Roma: Astrolabio.

xxxi. van der Kolk, B.A., McFarlane, A.C., Weisaeth, L. (2007). Stress traumatico. Gli effetti sulla mente, sul corpo e sulla società delle esperienze intollerabili. Roma: Magi.