similar entity under the name "personality change from catastrophic experience." These names may be awkward and unwieldy, but practically any name that gives recognition to the syndrome is better than no name at all.

Naming the syndrome of complex post-traumatic stress disorder represents an essential step toward granting those who have endured prolonged exploitation a measure of the recognition they deserve. It is an attempt to find a language that is at once faithful to the traditions of accurate psychological observation and to the moral demands of traumatized people. It is an attempt to learn from survivors, who understand, more profoundly than any investigator, the effects of captivity.

SURVIVORS AS PSYCHIATRIC PATIENTS

The mental health system is filled with survivors of prolonged, repeated childhood trauma. This is true even though most people who have been abused in childhood never come to psychiatric attention. To the extent that these people recover, they do so on their own.[21] While only a small minority of survivors, usually those with the most severe abuse histories, eventually become psychiatric patients, many or even most psychiatric patients are survivors of childhood abuse.[22] The data on this point are beyond contention. On careful questioning, 50–60 percent of psychiatric inpatients and 40–60 percent of outpatients report childhood histories of physical or sexual abuse or both.[23] In one study of psychiatric emergency room patients, 70 percent had abuse histories.[24] Thus abuse in childhood appears to be one of the main factors that lead a person to seek psychiatric treatment as an adult.

Survivors of child abuse who become patients appear with a bewildering array of symptoms. Their general levels of distress are higher than those of other patients. Perhaps the most impressive finding is the sheer length of the list of symptoms correlated with a history of childhood abuse.[25] The psychologist Jeffrey Bryer and his colleagues report that women with histories of physical or sexual abuse have significantly higher scores than other patients on standardized measures of somatization, depression, general anxiety, phobic anxiety, interpersonal sensitivity, paranoia, and "psychoticism" (probably dissociative symptoms).[26] The psychologist John Briere reports that survivors of childhood abuse display significantly more insomnia, sexual dysfunction, dissociation, anger,

suicidality, self-mutilation, drug addiction, and alcoholism than other patients.[27] The symptom list can be prolonged almost indefinitely.

When survivors of childhood abuse seek treatment, they have what the psychologist Denise Gelinas calls a "disguised presentation." They come for help because of their many symptoms or because of difficulty with relationships: problems in intimacy, excessive responsiveness to the needs of others, and repeated victimization. All too commonly, neither patient nor therapist recognizes the link between the presenting problem and the history of chronic trauma.[28]

Survivors of childhood abuse, like other traumatized people, are frequently misdiagnosed and mistreated in the mental health system. Because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete. Because of their characteristic difficulties in close relationships, they are particularly vulnerable to revictimization by caregivers. They may become engaged in ongoing, destructive interactions, in which the medical or mental health system replicates the behavior of the abusive family.

Survivors of childhood abuse often accumulate many different diagnoses before the underlying problem of a complex post-traumatic syndrome is recognized. They are likely to receive a diagnosis that carries strong negative connotations. Three particularly troublesome diagnoses have often been applied to survivors of childhood abuse: somatization disorder, borderline personality disorder, and multiple personality disorder. All three of these diagnoses were once subsumed under the now obsolete name *hysteria.*[29] Patients, usually women, who receive these diagnoses evoke unusually intense reactions in caregivers. Their credibility is often suspect. They are frequently accused of manipulation or malingering. They are often the subject of furious and partisan controversy. Sometimes they are frankly hated.

These three diagnoses are charged with pejorative meaning. The most notorious is the diagnosis of borderline personality disorder. This term is frequently used within the mental health professions as little more than a sophisticated insult. As one psychiatrist candidly confesses, "As a resident, I recalled asking my supervisor how to treat patients with borderline personality disorder, and he answered, sardonically, 'You refer them.' "[30] The psychiatrist Irvin Yalom describes the term "borderline" as "the word that strikes terror into the heart of the middle-aged, comfort-seeking psychiatrist."[31] Some clinicians have argued that the term "borderline" has become so prejudicial that it should be abandoned altogether, just as its predecessor term, *hysteria,* had to be abandoned.