

a paper:

Post Traumatic Stress Disorder

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I. NATURE OF DISRUPTIVE TRAUMA

Baldwin offers that “Traumatic experiences shake the foundations of our beliefs about safety, and shatter our assumptions of trust.” Because the events are so disruptive and outside most people’s norm, they provoke abnormal responses, though often “typical and expectable.” Post traumatic dysfunctional emotional syndromes are often “...normal responses to abnormal events.”¹ Key are continued feelings of profound helplessness in the face of perceived lethal or grossly disfiguring peril, whether actual or potential.²

McLay, Klam and Volkert report the routine use in the US Military of a “PCL” [Post Traumatic Stress Disorder Check List] administered to all soldiers immediately and 3 months after a combat deployment tour. The PCL screens for such dysfunctional emotional symptoms related to traumatic experiences, of which onset of a frequent, severe and ongoing insomnia may be a prime predictor for PTSD. The more the symptoms, the greater the risk: “Insomnia; Repeated Memories; Anger; Hypervigilance; Exaggerated Startle; Upset at Reminders; Feeling Cut Off; Concentration Problems; Repeated Dreams; Avoiding Thoughts; Physiological Reactions; Loss of Interest; Feeling Numb; Flashbacks; Avoiding Activities; Feeling Futureless; Blocked Memories.”³

II. FORMAL DIAGNOSIS OF PTSD

The DSM-IV defines “309.81 Post Traumatic Stress Disorder” as meeting criteria in 5 categories: A – exposure to a traumatic event that is perceived as both life threatening and inducing a terror that is beyond control. B – the trauma event is persistently re-experienced as if happening in the present. C – persistent avoidance of stimuli associated with the trauma and experiences a general numbing of response to those stimuli. D – persistent increased post trauma hyper-arousal. E – Duration of symptoms of more than 1 month. F – clinically significant distress or impairment in social, occupational or other important areas of functioning.⁴

If the same symptoms are present for “a minimum of 2 days and a maximum of 4 weeks” and “occur within 4 weeks of the traumatic event,” the diagnosis is “308.5 Acute Stress Disorder.”⁵ If the same symptoms last for more than one month, the diagnosis changes to “309.81 Post Traumatic Stress Disorder.”⁶ PTSD is characterized by 3 symptom clusters: “**Intrusions**, such as flashbacks or nightmares, where the traumatic event is re-experienced. **Avoidance**, when the person tries to reduce exposure to people or things that might bring on their intrusive symptoms. **Hyperarousal**, meaning physiologic signs of increased arousal, such as hyper vigilance or increased startle response.”⁷

¹ 1, Baldwin, “About Trauma,” Introduction, para 1-2.

² 1, Baldwin, “About Trauma,” Introduction, para 6.

³ 2, McLay et al, “Insomnia is the Most Commonly Reported Symptom,” p 760, Table II.

⁴ 3, DSM-IV-TR, “309.81 Post Traumatic Stress Disorder,” p 218-220.

⁵ 3, DSM-IV-TR, “308.3 Acute Stress Disorder,” Category G, p 222.

⁶ 3, DSM-IV-TR, “309.81 Post Traumatic Stress Disorder,” Category E, p 220.

⁷ 1, Baldwin, “About Trauma,” PTSD Symptoms, para 2.

III. INCIDENCE

Morrison observes that PTSD is most commonly found in survivors of military combat, but is also diagnosed where people have survived other major traumatic events, natural and man-made, including “rape, floods, abductions, airplane crashes, threats posed by kidnapping and hostage situations, inappropriate sexual experiences (particularly in children), learning of severe actual or threatened trauma in others to whom we are close. Normally excluded from the PTSD constellation are ordinary upsetting life injuries, such as “bereavement, divorce and serious illness,” unless the deaths or life-threatening illnesses of loved ones are beyond the bounds of normal loss according to the PTSD criteria.⁸

About 1/4th of survivors of heavy combat and 2/3rd of former POW’s experience PTSD. Traumatic experiences of natural disasters are less likely to produce PTSD. Older adults are less likely to develop PTSD than younger ones. Up to 1/2 of PTSD patients recover within several months, but others can be incapacitated for years.⁹ Being a young male living in an inner [US] city risks PTSD (23%), compared with the incidence in the general population (1%). Early childhood traumatic experiences, especially if prolonged and repeated, predispose to PTSD in adulthood.¹⁰

IV. COMORBIDITY

PTSD in returning US combat soldiers often lead to substance abuse, chronic unemployment, homelessness, divorce and a suicide rate approaching twice the national civilian average.¹¹ But the isolation and withdrawal underlying PTSD often impede people from seeking out and staying with therapy help. Patients may in fact prefer their secondary symptoms – “insomnia, addictions, phobias, violent behaviors, grief issues, social skills deficit, dependent relationships, and so on” – to intervention that obliges facing the underlying traumas. Marshall and Dobson observe that these secondary problems “are often the result of an individual’s attempt to manage a PTSD.”¹²

V. SURVIVOR’S GUILT

Common in PTSD is “survivor’s guilt” or “personal responsibility” for the traumatic event happening, “I should have prevented it.”¹³ DSM-IV Criteria A for PTSD requires that “the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.” There is a real or perceived threat to life or limb. Further, “the person’s response involves intense fear, helplessness, or horror” in adults.¹⁴ I offer that unrealistic “survivor’s guilt” may then represent a subconscious retrograde adaptation to exert control and make meaning over what was so horrifically uncontrollable and disturbingly meaningless.

⁸ 4, Morrison, “DSM-IV Made Easy,” 309.81 Post Traumatic Stress Disorder, p 269, para 1.

⁹ 4, Morrison, “DSM-IV Made Easy,” 309.81 Post Traumatic Stress Disorder, p 269, para 2.

¹⁰ 1, Baldwin, “About Trauma,” PTSD “Risk Factors,” para 1.

¹¹ 5, Green, “When The War Never Ends,” p 48, “Countless Victims,” para 1.

¹² 6, Marshall and Dobson, “Treatment of PTSD in War Veterans,” p394, para 1.

¹³ 4, Morrison, “DSM-IV Made Easy,” 309.81 Post Traumatic Stress Disorder, p 269, para 2-3.

¹⁴ 3, DSM-IV-TR, “309.81 Post Traumatic Stress Disorder,” Category A criteria, p 218-219.

VI. DISSOCIATION

Candel and Merckelbach observe that dissociation can be seen as an effective subconscious way of coping with PTSD. These include “depersonalization, derealization, amnesia, and identity disturbances,” all of which are subconscious emotional protective mechanisms that help diminish the horror and helplessness of severe trauma. Their presence in patients around the initial trauma period may even be a predictor of who is more at risk for developing PTSD. Short term peritraumatic dissociation can be adaptive, reducing the wounds of pain and humiliation, but can be damaging if long term. Prolonged dissociation can contribute to emotional numbing and avoidance of stimuli that remind of the trauma.¹⁵ But it also interferes with activities of daily living, relationships, vocation and social function. Being stuck in this condition prevents the work of healing of mind and soul from being done to restore a new normal of living.

VII. LOSS OF OLD NORMS, FINDING NEW NORMS & MEANING MAKING

Although full recovery from PTSD aims to alleviate both the underlying emotional trauma and the secondary symptoms, the reality is that few such patients ever have complete and permanent relief.¹⁶ Given this, Baldwin observes that recovery from PTSD involves making new meaning, “We create meaning out of the context in which events occur.”¹⁷ The American Psychological Association notes that shock and denial are common responses to traumatic events and disasters, serving as protective mechanisms that allow people time to work through and process trauma. Shock is “a sudden and often intense disturbance of your emotional state that may leave you feeling stunned or dazed.” Denial “involves your not acknowledging that something very stressful has happened, or not experiencing fully the intensity of the event,” rendering you “temporarily feel[ing] numb or disconnected from life.”¹⁸

I offer that, if PTSD is also understood as a grieving of the loss of one’s pre-traumatic experience life norm, then working through the “stages of grief” as identified by Elisabeth Kubler-Ross may also offer relief of symptoms and establishment of a new post-traumatic experience life norm. In the grief process, getting stuck in one stage is generally thought to prevent progress to the next: denial; anger; bargaining; depression; acceptance.¹⁹

Marshall and Dobson note the importance of these factors in the counselor-PTSD patient relationship: trust; building a sense of control; negotiating areas of focus; safety limits and the patient’s recovery goals. They recognize the tension between family, society and war veterans themselves holding the often unrealistic expectation that soldiers should return to their pre-combat life norm versus the realistic appraisal that they

¹⁵ 7, Candel and Merckelbach, “Peritraumatic Dissociation as a Predictor of Post-traumatic Stress Disorder: A Critical Review,” p 44, para 1.

¹⁶ 6, Marshall and Dobson, “Treatment of PTSD in War Veterans,” p394, para 2.

¹⁷ 1, Baldwin, “About Trauma,” Introduction, para 5.

¹⁸ 8, American Psychological Association, “Tips For Recovering From Disasters and Other Traumatic Events,” para 2-3.

¹⁹ 9, Elisabeth Kubler-Ross, “Five Stages of Grief.”

http://www.businessballs.com/elisabeth_kubler_ross_five_stages_of_grief.htm

often can not. Thus the need for working through PTSD issues to find new functional life norms. Marshall and Dobson offer a therapy acronym, “RECOVER” - “Relationship building; Emotional connection [evaluation of feelings] with the event; Cognitive [evaluation of objective facts rationally] connection with the event; Old values – new values; Verify and strengthen sense of self; Establish a meaning for the event within a total life experience; Re-establish appropriate self-management and social skills.”²⁰

VIII. STANDARDS OF TREATMENT FOR PTSD

The UK National Health Service gives an overview of PTSD treatment, typically a combination of psychotherapy and medications: **Cognitive Behavioural Therapy (CBT)** offers “learning skills that help you to change negative thought processes... and the use of mental imagery of the traumatic event to help you work through the trauma, and to gain control of the fear and distress.” **Eye Movement Desensitization and Reprocessing (EMDR)** “involves making several sets of side-to-side eye movements while recalling a traumatic incident,” that “appears to help reduce distress for many with PTSD... and [thus] helps you to have more positive emotions, behavior and thoughts.”²¹

The most widely prescribed **Medications** are “Selective Serotonin Reuptake Inhibitor[s] (SSRI’s) such as paroxetine...” that help reduce symptoms of depression, anxiety and insomnia common in PTSD. Caution must be taken in prescribing benzodiazepines (such as Valium or Ativan) for PTSD. Although effective for emergency relief of anxiety, insomnia and irritability, the “high incidence of substance dependence in people with PTSD” can produce life-threatening interactions.²²

The UK National Institute for Health and Clinical Excellence (NICE) offers these guidelines published in 2005 in “The Management of PTSD”²³ - “Mild symptoms of less than four weeks –watchful waiting. Everyone else should be offered trauma-focused CBT or EMDR on an individual outpatient basis. Children and young people should be offered trauma-focused CBT adapted for their age and circumstances. Drug treatments should not be used as a routine first line treatment in preference to trauma-focused psychological treatment, but should be considered in adults who do not wish to take part in psychological treatment. Debriefing sessions (single sessions focusing on the traumatic incident) should NOT be routine practice...”²⁴ Rather, ongoing professional counseling and collaboration with other support resources within an empathetic helping relationship with the patient should be offered as needed.

²⁰ 6, Marshall and Dobson, “A General Model For the Treatment of Post-Traumatic Stress Disorder in War Veterans,” p 390, para 3.

²¹ 10, NHS Choices, "Post-Traumatic Stress Disorder." “Treatment,” p 3, para 3.

²² 10, NHS Choices, "Post-Traumatic Stress Disorder." “Treatment,” p 3, para 3.

²³ 11, NICE, “Post Traumatic Stress Disorder (PTSD) – The Management of PTSD in Adults and Children in Primary and Secondary Care.”

<http://www.nice.org.uk/nicemedia/live/10966/29769/29769.pdf>.

²⁴ 10, NHS Choices, "Post-Traumatic Stress Disorder." “Treatment,” p 3, para 4.

IX. FAITH BASED SUPPORT FOR PTSD

“Bridges to Healing” of Military Ministry, a division of Campus Crusade for CHRIST, trains pastoral caregivers in many US Churches in the care of traumatized soldiers and their families. Their mission statement reads, “Equipping Churches to be ‘Bridges to Healing’ for returning warriors, veterans, and their families... Recent events here on the Home Front show the urgent need to reach out with respect and love to the military in our midst.” Their “Bridge to Healing” video describes “...the plight of many service members across the U.S. as they return from harm’s way,” the purpose of which is “...to make Christians across America aware of the special spiritual needs of our service members who return from war. It exhorts us to reach out sensitively and relevantly and become a ‘Bridge to Healing’ between the combat trauma sufferer and the love of GOD, The Ultimate Healer.”²⁵ Video clips from “Bridges to Healing” effectively present this call for help.²⁶

In the Faith community, individual and family counseling can embrace the larger needs of both emotional and spiritual care. A dedicated ministry team at the parish level – although **NOT** a substitute for professional psychological counseling - should offer fellowships of friendship, community and story sharing. Returning veterans and their families need to experience the love, support and faith in GOD from fellow Believers in caring and helping relationships one-on-one in their lives and homes.²⁷ Church retreat facilities are called to offer a quiet time and place for reflection, a safe space for talking and spiritual guidance. Giving people permission to ask and wrestle with “Why, GOD?” questions opens opportunities for Clergy and laymen to walk with PTSD veterans to face and work through their triggers to find their new norms for life.²⁸ The Church is uniquely positioned to embrace this mission in cooperation with professional counseling providers.

X. IN CONCLUSION

PTSD results from a real or perceived overwhelming life-threatening or disfiguring danger to life or limb, accompanied with a deep sense of profound horror and helplessness. PTSD is marked by intrusions in forms of flashbacks or nightmares that relive the traumatic insult; avoidance that seeks to avoid triggers that induce symptoms; hyperarousal in the forms of hyper-vigilance or heightened startle response. PTSD has been increasingly diagnosed over the last several decades in returning combat veterans, but is by no means limited to military traumatic experiences.

Combat veterans with PTSD have a high incidence of substance abuse, chronic unemployment, homelessness, divorce and a suicide rate up to twice the national civilian average. Patients tend to isolate and withdraw, often preferring secondary symptoms that may represent conscious and subconscious attempts to cope. I offer that unsubstantiated survivor’s guilt may represent a retrograde subconscious adaptation to exert control over

²⁵ 12, Military Mission, “Bridges to Healing.” <http://www.militaryministry.org/>

²⁶ 13, Military Mission, “Bridges To Healing” video clips.

<http://www.youtube.com/watch?v=pcb75JOyGHk>.

²⁷ 5, Green, “When the War Never Ends,” p 49, “Helping Wounded Warriors,” para 2-4.

²⁸ 5, Green, “When the War Never Ends,” p 50, “Lightening the Load,” para 3-6.

the uncontrollable and meaning over the meaninglessness. Various dissociations are effective in the short term to blunt the pain and horror of PTSD-inducing events, but reinforce maladaptive behaviors that compound isolation and withdrawal, and thus the condition itself.

I offer that loss of old norms of living post the traumatic event may require a grieving through the classic stages of grief to find a new life norm. Counseling must take into account this need within a therapy relationship of trust, building a sense of control for the patient, negotiating areas of focus, safety limits and the patient's recovery goals. Common psychotherapy treatments - such as Cognitive Behavioral Therapy and Eye Movement Desensitization Reprocessing – at times with carefully selected medications are the recognized standards of care for PTSD. However, secondary behavioral and social symptoms must often be attended to before counseling options can hope to be offered effectively.

Although never a substitute for professional psychological counseling, Faith community based ministries are expanding to fill a need that secular counseling alone often can not fully meet. One such program is “Bridges to Healing.” Returning veterans who have been emotionally traumatized by war, and their families, desperately need fellowship support, community and safe places to share their stories that address spiritual as well as emotional needs. PTSD sufferers and their loved ones need the safe space to wrestle with the “Why, GOD?” questions arising from their traumatic experiences. The Church is uniquely positioned to embrace this mission in partnership with professional counseling providers.

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