The Post-Traumatic Stress Disorder Sourcebook

A Guide to Healing, Recovery, and Growth

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CHAPTER 1

PTSD Basics

Humpty Dumpty sat on a wall
Humpty Dumpty had a great fall
All the king's horses and all the king's men
Couldn't put Humpty Dumpty together again

WHAT IS PTSD?

Post-traumatic stress disorder (PTSD) results from exposure to an overwhelmingly stressful event or series of events, such as war, rape, or abuse. It is a normal response by normal people to an abnormal situation.

The traumatic events that lead to PTSD are typically so extraordinary or severe that they would distress almost anyone. These events are usually sudden. They are perceived as dangerous to self or others, and they overwhelm our ability to respond adequately.[2]

We say that PTSD is a normal response to an abnormal event because the condition is completely understandable and predictable. The symptoms make perfect sense because what happened has overwhelmed normal coping responses.

THE HUMAN FACE

In another sense, however, the mental and physical suffering in PTSD is beyond the range of normalcy and indicates a need for assistance.[3] People with PTSD call to mind the Humpty Dumpty nursery rhyme. They often report feeling:

- shattered, broken, wounded, ripped, or torn apart
- like they'll never get put back together
- bruised to the soul, devastated, fallen apart, crushed

- shut down, beaten down, beaten up
- changed: I used to be happy-go-lucky, now I'm serious and quiet; My life seems to be divided into two periods: before the trauma and after; It really threw me; my life was derailed; nothing seems sacred or special anymore.
- as though they are in a deep black hole, damaged, ruined, different from everybody else, losing their mind, going crazy, doomed, dead inside, "on the sidelines of life's games"[4]

WHAT CAUSES PTSD?

As Table 1.1 indicates, PTSD could be caused by a wide range of events, grouped into three categories. As a general rule, Intentional Human causes are the most difficult to recover from,[5] followed by Unintentional Human causes. Acts of Nature are the least complex and typically resolve more quickly than the other categories.

WHAT SPECIFICALLY IS PTSD?

A trauma is a wound. PTSD refers to deep emotional wounds. In 1980, following the Vietnam experience, the American Psychiatric Association formally defined PTSD, categorizing it as one of the anxiety disorders. Table 1.2 lists the diagnostic criteria, or requirements for determining if one has PTSD, as described in the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association. A discussion of these criteria will follow.

DSM CRITERIA EXPLAINED

At first, PTSD might seem quite confusing. However, you'll soon realize that the symptoms are very understandable. They make sense, and seeing this is, in itself, somewhat curative. The explanations that follow will help to clarify these criteria.

Exposure to Stressor

PTSD is the only DSM condition where the occurrence of a stressor is part of the diagnosis. Unlike other anxiety disorders that are simply described by their symptoms, PTSD requires the occurrence of a catastrophic event. You might wish to refer again to Table 1.1 for a listing of such events. PTSD can result from any severe stressor, and the symptoms are similar if the stressors are severe enough.

Table 1.1
POTENTIALLY TRAUMATIC EVENTS/STRESSORS

I. Intentional Human (man-made, deliberate, malicious)

- Combat, civil war, resistance fighting
- Abuse
  - sexual—incest; rape; forced nudity, exhibitionism, or pornography; inappropriate touching/fondling or kissing
  - physical—beating, kicking, battering, choking, tying up, stalking, forcing to eat/drink, threatening with weapon, elder abuse by own children
  - emotional—isolation, threats to leave or have affair, intimidation, degrading names, economic neglect, minimizing or denying abuse, taking away power/control, destroying property, torturing pets, neglect (leaving alone, not feeding or bathing)[6]
- Torture (the worst form is sexual because it combines physical, emotional, and spiritual cruelty)
- Criminal assault, violent crime, robbery, mugging, family violence/battery
- Hostage, POW, concentration camp, hijacking
- Cult abuse
- Terrorism
- Bombing (e.g., Hiroshima, Oklahoma City)
- Witnessing a homicide, sexual assault, battering, torture, etc.
- Sniper attack
- Kidnapping
- Riots
- Participating in violence/atrocities (e.g., Nazi doctors, soldiers, identifying with the aggressor)
- Witnessing parents' fear reactions
- Alcoholism (due to its effects on family members)
- Suicide or other form of sudden death
- Death threats
- Damage to or loss of body part

II. Unintentional Human (accidents, technological disasters)

- Industrial (e.g., a crane crashes down)
- Fires, burns (e.g., oil rig fire)
- Explosion
- Motor vehicle accidents, plane crash, train wreck, boating accidents, shipwreck
- Nuclear disaster (e.g., Chernobyl, Three Mile Island)
- Collapse of sports stadium, building, dam, or sky walk
- Surgical damage to body or loss of body part

III. Acts of Nature/Natural Disasters

- Hurricane
- Typhoons
- Tornado
- Flood
- Earthquake
- Avalanche
- Volcanic eruption
- Fire
- Drought, famine
- Attack by animal (such as a pit bull)
- Sudden life-threatening illness (e.g., heart attack, severe burns)
- Sudden death (e.g., loss of unborn child)

Table 1.2
PTSD DIAGNOSTIC CRITERIA*

A. **Exposure to Stressor.** The person must be exposed to a traumatic event involving both of the following:
(1) person experienced, saw, or learned of event(s) that involved actual or threatened death, serious injury, or violation of the body of self or others
(2) person's response involved intense fear, helplessness, or horror (in children, the response may involve disorganized or agitated behavior)

B. **Event Re-experienced.** The trauma is persistently re-experienced in at least one of the following ways:
(1) recurrent, intrusive recollections of event (images, thoughts, or perceptions—in children repetitive play may express themes or aspects of the event)
(2) recurrent, distressing dreams of event (children may have no recognizable content in dreams)
(3) acting or feeling as if the trauma were recurring (sense of reliving, illusions, hallucinations, and dissociative flashback episodes, including those on awakening or when intoxicated—children may reenact the trauma)
(4) intense psychological distress upon exposure to internal or external cues that symbolize or resemble an aspect of the trauma
(5) physiological reactivity upon exposure to such cues

C. **Avoidance.** Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness that was not present before the trauma, as indicated by at least three of the following:
(1) efforts to avoid thoughts, feelings, or conversations that remind one of the trauma
(2) efforts to avoid activities, places, or people that arouse recollections
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities that used to be pleasurable
(5) feeling of detachment/estrangement from others
(6) restricted range of affect (e.g., can't have loving feelings, especially those associated with intimacy, tenderness, or sexuality)
(7) sense of foreshortened future (e.g., does not expect to have career, marriage, children, or normal life span)

D. **Arousal.** Persistent symptoms of increased arousal that were not present before the trauma. At least two of the following occur:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. **Duration of symptoms in Criteria B, C, and D is more than one month.**

F. **Life Disrupted.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

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Thus, the PTSD resulting from rape or violent crime is quite similar in appearance to the PTSD resulting from combat.

Of the three categories of stressors in Table 1.1, Intentional Human traumas are usually the worst. PTSD symptoms resulting from such stressors are usually more complex, are of longer duration, and are more difficult to treat for a number of reasons. Such traumas are typically the most degrading and cause the most shame. They often involve feelings of being stigmatized, marked, different, or an outcast (as in rape). Man-made traumas also are most likely to cause people to lose faith and trust in humanity, in love, and in themselves. By contrast, natural disasters are, typically, less difficult to recover from. Survivors often bond. Often heroism and community support is evident. Survivors often feel a reverence or awe for nature that leaves faith in humanity intact.

Categories may be combined in traumatic stress. For example, a hurricane (a natural disaster) might cause the collapse of improperly built homes (unintentional or intentional trauma).

We shall discuss the next three symptom groups in the sequence in which they logically occur (B, D, C). That is, people re-experience the trauma in distressing ways, and become very aroused as a result. They then make various attempts to avoid the PTSD symptoms.

Event Re-experienced

In one sense, PTSD can be viewed as a fear of the unpleasant memories of the traumatic event that repeatedly intrude into one's awareness. Intrusive recollections can occur in the form of thoughts, images, or perceptions. These intrusions are unwelcome, uninvited, and painful, and the person wishes that they could put a stop to them. They often elicit feelings of fear and vulnerability, rage at the cause, sadness, disgust, or guilt. Sometimes they break through when one is trying to relax and one's guard is down. Sometimes a trigger that reminds one of the trauma will start the intrusions. For example, a survivor of a Russian prisoner-of-war camp often daydreams, absorbed in unpleasant memories and out of touch with his surroundings. A number of cues can trigger this re-experience, including thin soup, walking in the woods, Russian music, a harsh rebuke by a supervisor, or any unpleasant confrontation.[7] Sometimes there is no apparent connection to the thoughts or feelings that are replayed.

Nightmares are a common form of re-experiencing the trauma. The nightmares might be fairly accurate replays of the traumatic event, or they might

symbolically depict the trauma with themes of threats, rescuing self or others, being trapped or chased by monsters, or dying.

Flashbacks are a particularly upsetting form of re-experiencing the traumatic event. In flashbacks, we feel that we are going back in time and reliving the trauma. Typically, flashbacks are visual re-experiences. However, they can also involve sensations, behavior, or emotions. For example, a war veteran hits the ground when a car backfires, sees a battle recurring, begins to hear sounds of battle, and feels hot, sweaty, and terrified. Later, he does not remember the incident. Flashbacks can last from seconds to hours, and even days. They are usually believed to be real, then forgotten, but sometimes the person will realize that the flashback was not reality. Flashbacks are often triggered by insomnia, fatigue, stress, or drugs.[8]

Experiencing the intrusive memories is very distressful, both psychologically and physically. Although one might not realize that a cue triggers the distress that accompanies intrusive thoughts, some searching can usually find a trigger. The trigger might be either a cue in the environment, such as the backfiring car that reminded the veteran of gunfire, or an internal trigger, such as a nauseous feeling that is similar to one experienced after a rape.

Arousal

Like other anxiety disorders, PTSD is characterized by extreme general physical arousal, and/or arousal following exposure to internal or external triggers. The nervous system has become *sensitized* by an overwhelming trauma. Thus, two things happen. General arousal becomes elevated, while the nervous system overreacts to even smaller stressors. Signs of arousal include:

- Troubled sleep includes difficulty falling or staying asleep, twitching, moving and/or awakening unrested. Awakenings may be due to nightmares. Fear of nightmares might then lead to fear of going to sleep, especially if one was violated in bed.[9]
- Irritability or outbursts of anger might be displayed as smashing things, heated arguing, flying off the handle, screaming, intense criticizing, or impatience. Unresolved anger is fatiguing. It might be mixed with shame, frustration, betrayal, or other uncomfortable emotions that lead to moodiness and explosions of pent-up anger. One might then feel embarrassed or guilty.
- Difficulty concentrating or remembering. It is difficult to concentrate and remember when one is still battling for control of intrusive memories.

- Hypervigilance. People who have endured a trauma will be on guard against intrusive memories. They are also likely to be unusually cautious to ensure that further injury does not occur. Hypervigilance might be demonstrated as:
  - feeling vulnerable, fearful of lots of things, unable to feel calm in safe places
  - fear of repetition
  - anticipating disaster: needing to sit in the corner of a room with back to the wall—looking for exits, places to hide (one fireman carried around a fire extinguisher for a year after being burned by a petroleum ball)[10]
  - rapid scanning, looking over one's shoulder
  - keeping a weapon or several weapons
  - being overprotective or overcontrolling of loved ones
- Exaggerated startle response means you are easily frightened. A sensitized nervous system will overreact to frightening or even unusual stressors. Thus, one might jump, flinch, or tense when someone appears suddenly or from behind, when a sudden noise occurs, when someone wakes you up when sleeping, or when someone touches you. Eye blinking may become more rapid. One who was struck in a head-on car accident will now jerk the steering wheel when she sees another car approaching.[11]

In addition to the above symptoms, symptoms of a sensitized nervous system might include:

- elevation of certain stress hormones in the blood[12]
- elevated heart rate (either resting or in response to stress)
- elevated blood pressure
- hyperventilation (i.e., expelling CO_2 too fast, usually caused by rapid, shallow "chest breathing," but can also result from deep breathing); tight chest or stomach
- lightheadedness
- sweating
- tingling, cold, or sweaty hands

These might occur generally, or in response to a trigger.

Avoidance (Numbing)

Because the intrusive thoughts and accompanying arousal are so unpleasant, people with PTSD desperately try to avoid all reminders of the trauma. They might

refuse to talk about it. They might block from their mind thoughts, images, or feelings about the event. They might avoid activities, places, people, or keepsakes that arouse recollections. Some might become housebound in attempts to avoid fearful encounters. Some turn to drugs or overwork to avoid their painful feelings, while others simply shut down all feelings in order to avoid their pain. Some live in a fantasy world, trying to pretend that nothing bad happened.[13]

Some shut out memories of painful periods in their lives (amnesia). Thus, one cannot remember when their spouse died in a car accident. Another who was abused has gaps in her memory of childhood.

When memories are so painful, it makes sense that one would try to numb them. However, one cannot numb painful memories without also numbing joyful memories. One must suppress *all* feelings in order to numb painful feelings. So people with PTSD often avoid even pleasant activities, including those that were pleasurable before the trauma—such as travel, babies, hobbies, or relaxation. You might hear people say, "I don't know how to have fun or play anymore." Without feelings, these people naturally feel uninvolved with life.

Not surprisingly, people with PTSD commonly feel detached or estranged from others. People who have endured combat, rape, disaster work, and other forms of trauma often assume that they are now different and that no one could possibly relate to their experiences. They might feel that they can't tell others about what happened or what they did for fear of judgment, and the secrets and fear of being shunned leads to their feeling disconnected from others. Because they no longer feel comfortable in social situations, they might avoid gatherings—or they might go but find no pleasure in them. Of course, to connect with others, people need to be emotionally open. This is difficult when one is still struggling to contain memories of the past.

Restricted range of affect refers to the "psychic numbing" or "emotional anesthesia" that one does to try to escape from the painful memories. As we mentioned, anything that numbs pain acts as a general anesthesia. Thus, one with PTSD might have trouble laughing, crying, or loving. Feeling numb and closed down, this person might wrongly assume they have lost their capacity to feel or be compassionate, intimate, tender, or sexual. Certain family or work environments such as the military or emergency service work might encourage the suppression of feelings. However, at some point the healthy experience and expression of grief and pain must occur if one is to become a healthy emotional person.

As trauma can lead one to feel disconnected from others, it can also lead one to feel disconnected from his or her future. This is called *a sense of foreshortened future*, which means that trauma victims can't envision or look forward to a normal, happy life. They might not expect to have a career, marriage, children, community connections, or a normal life span—so it is difficult to make plans for the future. Instead, their pessimistic expectations for the future might include disasters, repetition of the trauma, dying young, or simply finding no joy. This outlook has been called the "doomsday orientation"—no matter how good life seems, trouble is coming.[14] Said one with PTSD, "I can't get past the past, so how can I think about the future?" If people are stuck in the past—preoccupied with unresolved pain, guilt, anger, grief, or fear and desperately trying to block these feelings out—they will often lack the energy or interest to plan for the future. If they worry that intrusive memories can spoil their moods at will, they will hardly make plans for a joyful future. Said another with PTSD, "I placed my memories behind prison doors and stand guard. I realized, however, that it is I who is the prisoner. I am so tired of standing guard that I no longer seem to care." It is a sad irony that when one tries to block out the past, one blocks out both the present and future as well.

Duration

The symptom picture described in B, C, and D must persist for at least one month for a diagnosis of PTSD. PTSD is specified as *acute* if the diagnosis resolves within three months, *chronic* if the diagnosis persists beyond three months, and *delayed* if the onset of PTSD occurs at least six months after exposure to the stressor. It has been observed that a large percentage of PTSD cases improve considerably within three months.

Impaired Social and Occupational Functioning

The diagnosis of PTSD means that symptoms are significantly interfering with your relationships or work. Communication is disrupted by numbing, pulling inward, avoiding people and social situations, or by hostility and anger. Work suffers due to absenteeism, fatigue, or impaired concentration.

CHAPTER 2

Making Sense of the Bewildering Symptoms

Understanding Anxiety and Dissociation

This chapter describes two of the major symptoms of PTSD—anxiety and dissociation, to include the role of memory networks and the triggering of trauma-related memories.

ANXIETY

PTSD is considered an anxiety disorder. Many of PTSD's arousal symptoms are common to anxiety. There is no mystery about this condition. Anxiety is comprised of worrisome thoughts plus excessive emotional and physical arousal.

Normally, when the brain perceives a threat, it sets off a chain of physical changes that prepare the body for fight or flight. Messages are sent via nerves and blood-borne hormones to the body's various organs. Muscles tense, the heart beats faster and more strongly, and the rate of breathing increases. The brain becomes sharper and able to react more quickly. This is called the *stress response,* or just stress. Stress is very adaptive in the short-term. It prepares the body for emergencies. The energy of the stress response is designed to be worked off physically; the body then returns to the resting state.

In anxiety, the mind stays vigilant, ever on alert. This, in turn, keeps emotions and the body aroused. Chronic or severe arousal changes the nervous system. We say that the nervous system becomes *sensitized* from overstimulation. The brain's alarm centers stay on alert and sound the alarm for smaller threats than usual, while the body takes longer to return to the resting state. A traumatic event (or

even an overload of smaller stressors) can change the structure and function of nerve cells. The amounts of neurotransmitters (chemical messengers) in the brain can change, as can the number of receptor sites for these chemicals on the nerves. A vicious cycle is set off whereby worry maintains physical and emotional arousal and arousal maintains worry. It feels like worry and arousal cannot be shut off. Anxiety seems to take on a life of its own, and is not always proportional to what is going on in your life. Anxiety accounts for a bewildering array of symptoms:

- *physical*: tension, fatigue, trembling, tingling, nausea, digestive tract problems, hyperventilation (rapid breathing), pounding heart, suffocating feelings, even panic attacks
- *emotional fatigue*: irritation, moodiness, fear, exaggerated emotions, loss of confidence
- *mental fatigue*: confusion, inability to concentrate, remember, or make decisions
- *spiritual fatigue*: discouragement, hopelessness, despair

The symptoms of anxiety are merely an exaggerated stress response. They lessen as we retrain our nervous system to be calmer. They increase as we tell ourselves that they are unbearable and must stop.

Avoidance is a hallmark of anxiety. We try to flee the things that trigger it. This brings temporary relief, but at quite a cost. First, we maintain the fear of the triggers. We don't allow ourselves to let the fear in and watch it subside as we relax. So we don't learn to master our fears. Each time avoidance is rewarded with short-term anxiety reduction, we will tend to use it again in the future. The distractions that we use to escape the fear, such as work, will become associated with the fear through conditioning. Soon the distractions become triggers by association. The antidote to avoidance is to face the things we fear and flow with the symptoms until the stress response runs its course and we retrain our nervous system to be less reactive. This is learned in a gradual fashion.

Although PTSD is considered an anxiety disorder, also viewing it as a dissociative disorder helps us to better understand the symptoms. In order to understand dissociation, let's first understand normal "associated" consciousness.

NORMAL "ASSOCIATED" CONSCIOUSNESS

In normal consciousness or awareness, people are fully engaged in life's experiences. They are mindful of their surroundings, are tuned in to people, and feel all

their feelings. Despite feeling various emotions or being in different situations, they always feel like the same person. When normal memories are triggered or intentionally retrieved, they can examine them and then put them away at will. Distractions from present awareness are either pleasant or at least controllable. For example, if you are paying your bills and your mind drifts off to Bermuda, you can bring your mind back to the task at hand if you choose to. If adding numbers brings back an unpleasant memory of failing math, you might think about it for a moment and then bring your focus back quickly to the bills.[15] In other words, your mind functions in a smooth, integrated way. Memories are filed away in an organized way. They can be retrieved and smoothly put away again.

DISSOCIATION

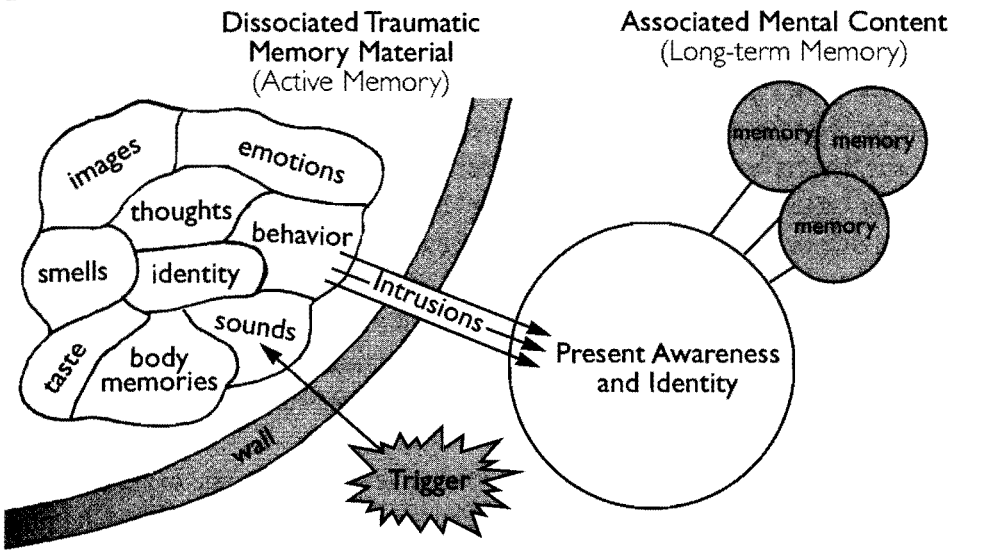
Have you ever observed an antelope clamped in a lion's jaws? It seems to stop struggling as its consciousness shifts. Where does its consciousness go?[16] There seems to be an innate mechanism—called *dissociation*—that allows mammals to temporarily escape distressing experiences. Thus, we can mentally escape a present distressing experience, as the antelope did, by mentally "going away." Or, we can temporarily escape a traumatic memory by separating and walling off the memory. Instead of being smoothly connected to all other memories, the highly charged traumatic memories become dissociated or isolated. While the memory may be walled off for awhile, it is not filed in long-term memory. Instead of taking its place alongside other memories on file, the traumatic memory remains "on the desktop" where it repeatedly intrudes upon awareness and cannot, it seems, be put away for long. Dissociated traumatic memory material is said to be walled off, split off, fragmented, separated off, or compartmentalized such that the information does not become integrated with the rest of one's memory material, nor is it fully connected to present awareness.

Traumatic memories contain many aspects: thoughts, images, feelings, behaviors, and physical sensations. Wrapped up in the trauma material may be a unique sense of identity, or who you are, since people often feel very different during the trauma. So you might feel like a different person since the trauma or when traumatic memories intrude into your awareness.

MEMORY NETWORKS

A simplified picture helps to show how associated and dissociated memories are stored in the brain (see Figure 2.1).

Figure 2.1
AWARENESS AND MEMORY



Associated Mental Content

On the right of the wall is normal *associated* mental material. Normal memories are smoothly connected or integrated. Lessons learned and useful ideas from previous life experiences can be blended into present awareness and coping efforts. So a person who has had a very safe and secure childhood might approach a new challenge with the thought, "I'm safe; I'll probably be alright." Across all memories is the sense that you are the same person. Scientists have learned that under normal conditions various parts of the brain are activated to process memories in an organized way (see Appendix 3). That is, the brain connects diverse aspects of a single memory to form an integrated whole. That memory is also filed alongside other memories in a way that a person can place it in time and space. Normal memories are processed logically and verbally. They are understood and make sense, and are then filed away. Although the memories contain appropriate emotions, they can be recalled without overwhelming emotion.

Dissociated Traumatic Memory Material

On the left is *dissociated* trauma material. Notice several aspects of this material.

The "walled off" material is highly unstable. The parts of the brain that would normally file traumatic memories in long-term storage were overwhelmed during

the trauma. So traumatic memories remain near the forefront of awareness, easily triggered by reminders of the trauma—or even things associated with the *trigger.* For example, a woman who was raped on an elevator two years ago now re-experiences terror when she approaches any elevator. Since she got into the elevator after parking her car, parking garages have also become frightening. In fact, she feels frightened almost any time she parks her car, even when outside. A new association has been formed between the elevator and the act of parking. Now either can trigger intrusive memories. Sometimes traumatic memories can be triggered by stressful emotions that might seem unrelated to the trauma. For example, a firefighter "trapped" in traffic remembers being helpless to rescue a child in a burning building; one who was abused as a child experiences intrusive memories when his boss criticizes him. These are called *state-dependent memories,* and the process called *mood-dependent retrieval.* A trigger may or may not be obvious as it passes through our awareness.

The "wall" is highly permeable. It is like a leaky dam. We expend much energy trying to maintain the wall, but memories keep seeping through, into awareness.

The dissociated material is highly emotional and relatively nonverbal. Unlike normal memories which are rather logically and verbally processed before storage, trauma material is walled off prior to complete processing. If verbal processing is done at all it is usually quite incomplete, and thoughts related to the trauma will usually be automatic, unspoken, unchallenged, and disorganized. During a trauma a person might have thought, "I am completely vulnerable." Now any stressful situation automatically triggers the same thought. The person may not even be aware of the unspoken thought. Instead, she just feels the intense emotions resulting from the thought. In this case, the very ideas that would help the person cope with traumatic memories are already stored in the associated memories. Normally, for example, she knows that all situations are not unsafe, especially when proper precautions are taken. However, the intrusive traumatic material, separated from this adaptive thinking, dominates her experience.

Trauma material is not only walled off from associated adaptive material, but the traumatic memory itself might be fragmented into various aspects. The aspects of memory include thoughts, images, emotions, behavior, identity, and physical sensations. Physical sensations include sounds, smells, tastes, and "body memories" (tactile or touch sensations, pain, and kinesthetic—the sensation of movement, tension, or position). Because of this fragmentation, a trigger does not usually set off all aspects of a memory. For instance, emotions from a traumatic

memory might flood awareness without images or other memory aspects. Sheila was enjoying dinner with a group of friends. She became unaccountably anxious and sick to her stomach. She didn't realize that a man in the group was wearing the same cologne as the man who raped her. In this case, only fragments of the unprocessed memory (i.e., the emotions and physical sensations) were triggered by the fragrance.

Trauma material is like a screaming, emotional two-year-old trying to escape from a playpen in the middle of the living room while you try to watch a television program. You wish for a few moments of peace but the more you ignore the child, the more the child demands attention, and the more effort it takes to concentrate on the show. Seeing a child on television reminds you of your own child. Eventually you give the child attention and the intrusions stop. This suggests how recovery will occur in PTSD.

Triggers

Many triggers in the present environment can activate traumatic memory material and stimulate intrusions. *Triggers* are cues—often harmless—that have become associated with the original trauma. In some way, they remind us of the trauma or recall traumatic memories. The association may be obvious or subtle. They may trigger most of the memory or just certain fragments of it. Often, they trigger intrusions against our will. Recognizing triggers, and realizing that their power to elicit intrusions is understandable, are steps toward controlling PTSD symptoms. Table 2.1 lists a range of triggers and the traumatic memories they can stir up.

Some people find it helpful to understand triggers by their twelve categories.

1. *Visual*: seeing blood or road kill reminds one of wounded bodies; black garbage bags reminds a veteran of body bags; a secretary sees her boss standing over her and is reminded of her abusive father.
2. *Sound* (auditory): a backfiring car sounds like gunshot to combat veteran; sounds during lovemaking with spouse remind one of sexual abuse.
3. *Smell* (olfactory): the smell of semen or another's body during intercourse, or the smell of aftershave reminds one of sexual assault.[17]
4. *Taste* (gustatory): eating a hamburger reminds one of an automobile accident that occurred as one drove away from a fast food restaurant.
5. *Physical or Body*
   - *Kinesthetic* means the sensation of movement, tension, or body position.

Table 2.1
TRAUMATIC EVENTS AND TRIGGERS

Trigger	Original Traumatic Event
dark clouds; strong winds	tornado
entering subway tunnel	trench warfare or tunnel rats in Vietnam
lasagna or milk cartons	firemen recovering bodies of eighty children buried in school cafeteria by tornado
firecracker	combat, gun shots
popcorn popping	helicopter in Vietnam, small arms fire
campfire, cooking, barbecue grill	burn victim or fireman who rescued burn victim
rumbling truck	earthquake
aging, hospitalization	POW camp—loss of freedom, family, and purpose; helplessness
warm damp day	Vietnam
rain, clouds in sky	flood
bedroom, lying down, closing eyes	rape
asthmatic breathing	hand held over mouth of rape victim
nausea from illness or something eaten	date rape (which led to nausea)
neighbors	child dies in neighborhood auto accident, neighbors at scene
fuel at gas station	airplane crash rescue worker
perpetrator on television	violent robbery
pretzels	eaten at frat party before being raped
boss criticizes	abuse by father
depression, guilt, anniversary month, becoming a parent	miscarriage
throat swab during medical exam leads to nausea and shakiness[18]	oral rape
physical intimacy (emotional expressiveness elicits fear of losing control)	sexually abusive, raging father
cold snowy weather, uniformed security guards, hunger, watery soup, walking along roads in winter, German vehicles, any unpleasant confrontation or rebuke by supervisors	POW in Germany
fire fighting, police, other paramilitary jobs	soldiering
elevator	sexual assault
SCUBA diving, beach	rescue workers searching for bodies following airliner crash in ocean
injection, vaginal exam	torture
seeing a crime on television	policeman seriously wounded
rushing, overload, stress	a disastrous decision made under pressure, without time to think

Thus, running when tense might be reminiscent of trying to flee a beating; trying to do progressive muscle relaxation (tensing muscles, lying on one's back with eyes closed) might trigger memories of sexual abuse.

- *Tactile* or touch: pressure around wrists or waist, being gripped, held, or otherwise restrained (perhaps even a hug) reminds one of torture or rape; feeling someone on top of you; a man accidentally kicked in bed by his wife while sleeping recalls torture; being touched during sexual relations with a spouse in the same place or in the same way as occurred during abuse will likely trigger traumatic memories.
- *Pain* or other internal sensations: surgical pain, nausea, headaches, or back pain might trigger memories of torture or rape. Elevated heartbeat from exercising might remind one of a similar sensation during a bombing.

6. *Significant dates or seasons*
   - anniversary dates of the trauma
   - seasons of the year with their accompanying stimuli (temperature, lighting, colors, sounds)
   - other dates (e.g., a mother becomes distressed on the date when her murdered son would have graduated)
7. *Stressful events/arousal*: sometimes changes in the brain due to trauma cause it to interpret any stress signals as recurrence of the original trauma.[19] At other times, seemingly unrelated events are actually triggers. Examples include:
   - A woman visits her spouse in the hospital which triggers a flashback of abuse. As a little girl she was treated in the same hospital, following the abuse.
   - An argument with a spouse triggers memories of parents arguing violently.
   - Criticism from a boss reminds a person of being abused by his father.
   - A frightening dream with no apparent related theme activates the fear of a traumatic memory. (Of course, a nightmare of the trauma would understandably elicit strong feelings of distress.)
   - Athletic competition reminds an athlete of being abused when she performed poorly.
8. *Strong emotions*: feeling lonely reminds one of abandonment; feeling happy reminds a woman of a rape that occurred after having dinner with

her best friends; anything that makes one anxious, out of control, or generally stressed, such as PMS. Some memories are state-dependent, meaning that the brain activates them only when the emotional state is the same as the original memory.[20] Thus, if one was drunk when raped, she may feel symptoms only when drinking; if raped when sober, then drinking might provide an escape from the symptoms.[21]

9. *Thoughts*: rejection by a lover leads to the thought "I am worthless," which triggers the same thought that occurred when one was abused as a child.
10. *Behaviors*: driving reminds a person of a serious accident.
11. *Out of the blue*: Sometimes intrusions occur when you are tired, relaxing, or your defenses are down. Often a thought or something you're not aware of will elicit symptoms; so might the habitual act of dissociating during stressful times.
12. *Combinations*: often triggers contain several memory aspects at once. For example:
    - walking to the parking lot on a dark summer's night (visual + kinesthetic + season) triggers a memory of violent crime.
    - fireworks (sounds plus flarelike sight) triggers combat memories.
    - intercourse (weight, touch, sounds, relaxing, the smell of aftershave or semen, the pressure of a hug or a squeezing sensation on the wrists) triggers memory of rape.

WHY DOES DISSOCIATION OCCUR?

Dissociation is a defense against extremely distressful, painful experience. The mind walls off trauma material to try to contain it in much the same way as the body walls off infection. Dissociation is most likely to occur if the trauma was severe, repeated, or occurred at a very young age. We might regard dissociation as a very understandable coping mechanism.

As long as we wall off painful material, we gain some protection. However, the protection is temporary. Without exploration and processing, the material remains negatively and emotionally charged and will intrude in distressing ways. Intrusions are the mind's way of telling us that painful material needs processing. If we can view intrusions as such, then we will likely experience less distress when they occur.

WHEN DOES DISSOCIATION OCCUR?

Dissociation might occur during traumatic events that seem too painful to cope with. For example, a teenager who was raped reported that she felt as if she were on the ceiling during the rape, looking down and feeling sorry for the person being raped. In this way, called *depersonalization*, she could "separate" herself from the trauma. Her usual self was watching the event from afar, while another part of her was walled off in the trauma memories. This defense is entirely understandable. It protects for awhile. Yet notice what has happened. Walled off material has been created. This material will eventually intrude in a distressing way until it has been processed enough to take its place among other memories on file. The sense of self has been split as well. Another way to dissociate during the traumatic event is called *derealization*. Here the person looks at the event as if it is not really happening—a dream, far away or covered by fog. Dissociation at the time of the trauma will make healing more difficult.

Dissociation can also occur later in life as an escape from stress. We might simply be trying to escape an everyday stressful situation or we may be reacting to intrusions or triggers. We are more likely to dissociate in the present if dissociation happened at the time of the trauma. Dissociation at the time of trauma is more likely when the victim is very young or if the offense was repeated or horrific. One seems to learn to use dissociation as a defense. We are also more prone to dissociate in the present if we are tired, drunk, sleepy, anxious, or depressed.[22]

THE VARIETIES OF DISSOCIATION

People dissociate in many ways that do no harm. For example, immersing yourself in a book, movie, or play and "tuning out" your surroundings is generally a harmless escape. Daydreaming is another way to escape from reality. Usually, these are harmless because they are pleasant and under our control. We become concerned when dissociation occurs often, is not under our control, becomes distressing, or makes us feel detached from life. Let's take a look at the more distressing forms of dissociation. All signal that the person is elsewhere, not focused in the present, and is using energy to contain troubling material. All signal that the person is trying to distance himself from the unacceptable.

In *depersonalization*, one feels as if they are an outside observer of self (e.g., on ceiling looking down, across the room watching a movie of self).

Amnesia means forgetting all or parts of the trauma. Some forget the entire trauma. Some forget only the most stressful aspects of the trauma, such as the

moment when one was thrown from a car. Some experience gaps in their life story, for example, an entire year of school during which abuse occurred, or for all the years before it occurred. Others simply have a poor general memory, as if remembering anything might invite more intrusions. Amnesia is not explained by normal forgetfulness, but is more severe and distressing.

Dissociative Flashbacks

After people try for so long to wall off traumatic memories, they eventually break through into awareness. *Dissociative flashbacks* pull us away from the present and into the memory. We suddenly and vividly experience the memories as if they are happening in the present. For instance, Bob was a combat veteran of the Vietnam war. While at a Fourth of July celebration, a teenager carelessly threw a firecracker near his young daughters. Bob immediately flashed back to the war, pounced on the teenager and was choking him when bystanders pulled him off. He later had no recollection of the flashback.[23] As people explain what happened he begins to think he is going crazy. He is not. It is simply the result of walled-off material that has never been processed. As with other intrusive memories, one might re-experience many aspects of a traumatic memory or just certain aspects. One may or may not act as if they are back in the situation. Some still retain some awareness of present reality during flashbacks, as though they were watching a movie of the trauma. Some remember having the flashback.

Fugue

Fugue is a form of amnesia where a person suddenly travels to another town with no recollection of how they got there. They may start a new life and forget their old identity.

Dissociative Identity Disorder (DID)

DID is the most severe dissociative state. Here people form at least two different personality states, or identities, in order to cope with unacceptable material. Ellen was a happy little girl until her father began to sexually abuse her. She could not figure out how a father who was often loving to her could also mistreat her. Her young mind could not make sense of this, nor was she old enough to seek help or talk about it. It seemed that part of her must be bad to deserve this. As she developed, Ellen formed two identities. Ellen was the good and outwardly happy girl that most people knew. At other times, particularly when trauma-related triggers occurred, she switched to an identity known as Trixy—a seductive,

promiscuous woman who frequented bars to be picked up. Trixy is a way to contain the unacceptable trauma material. To Ellen, it seems that the trauma "didn't happen to me—it happened to someone else," in this case, Trixy. In DID, there may be many more personality states (sometimes called *alter egos* or *alters*). Each feels like a different person and may have a different self-image. This is why DID used to be called multiple personality disorder. However, there is only one person and one personality—but the aspects of the personality have not yet been integrated. There may be a host identity that knows the other identities, and may be influenced by the alters' voices. The host is often compulsively good, logical, depressed, and overwhelmed. There may be an angry identity who blows up at people. Alternate identities might differ in age, may conflict with or deny knowing each other, or may hold different fragments of memories. The identities might have names (like Barbara) or symbolic names (The Tramp, The Crazyman, etc.). Identities might sound or speak differently. DID almost always results from a history of horrific childhood trauma. If, for example, a close relative repeatedly abuses a child before her personality integrates and parents are not there to help the child integrate the experience, then DID could occur. In treatment, the individual learns to challenge the distortions (e.g., "I must have deserved this") and to accept and integrate all aspects of the personality.

The above forms of dissociation are rather dramatic. However, dissociation is not always so. Some may just seem to "go away" or "space out" when triggers or intrusive thoughts occur or when present situations are stressful. If the skill was learned during the trauma as a protective defense, it makes sense that one would use the device in the present.

HOW DO WE KNOW WHEN ONE IS DISSOCIATING?

While it may not always be apparent which form dissociation takes, a number of signs suggest that one is trying to avoid the unacceptable. Page 24 provides a listing of such signs, which are likely to continue until the trauma material is processed.

IS DISSOCIATING BAD?

It depends. Dissociation is something most people do. At times it can be helpful. You might "escape" from work for a few moments to daydream about a romantic evening. The famous concentration camp survivor, Viktor Frankl, mentally escaped the prison at times to consider a brighter future.

INDICATIONS OF DISSOCIATION

- body becomes still or stiff
- person is slow to respond to others
- things seem to move in slow motion or fast-forward
- emotions become flat, numb; no feelings
- not feeling expected pain
- out of touch with surroundings
- drifts off, goes away, spaces out (gets spacey), blanks out, loses track of what's happening
- stares off into space, blank stare
- downward stare
- eyes darting anxiously from side to side, or rolling upward
- eyes blink rapidly or flutter
- far away or dazed look
- tunes out
- not involved in present
- feels like an observer of the present situation, rather than a participant
- inattention
- memory lapses
- fantasies, excessive daydreaming
- overactivity or withdrawal
- being on autopilot (automatism behavior), feeling like a robot
- falling asleep
- disoriented
- misses conversation
- derealization (people or world don't seem real; feel like a stranger in a familiar place; don't recognize yourself in the mirror; world seems like a dream, veiled, like you're not really there)
- feels like one is watching things from outside his/her body
- life split before and after (I'm a different person since the trauma)
- twitching or grimacing
- clouding of alertness; foggy feeling (if you're suppressing traumas, you can't focus your thoughts; your mind goes blank)
- unusual, inexplicable behavior (hitting the ground when a car backfires; a dependable woman suddenly leaves the house for two days)
- attempts to remain grounded in the present (stroking side of chair, tapping, jiggling leg)
- self-soothing (rocking back and forth)
- things look or sound different: colors are faded or brighter, tunnel vision, "wide-angle view," sounds are louder or more muffled than expected, things seem far away or unclear/fogged

Dissociation provides some relief, and some protection from overwhelming pain. In that sense, dissociation serves a useful purpose. On the other hand, continually blocking out memories requires enormous energy that can leave one fatigued and irritable. In numbing out the painful memories we also lose pleasant memories and feelings. Inevitably, distressing intrusions will occur. Dissociation also delays or prevents healing because it keeps us from coming to terms with the walled-off material and prevents us from associating it with mastery and control experiences. Dissociation might be likened, then, to a baby's bottle or security blanket. Both served a useful function at one time.

WHAT CAN I EXPECT IF DISSOCIATION IS NOT MANAGED?

As a rule, unprocessed trauma material will continue to intrude until it makes sense, until you have processed it to the point where it can settle into long-term memory. We shall learn shortly how this is done.

CHAPTER 3

Associated Features

To complete our understanding of PTSD, we must understand a variety of symptoms that commonly occur following a traumatic event. In this chapter, we'll discuss thirteen associated features.

1. SELF-RECRIMINATION

Time and again we see traumatized people feel shame and guilt, whether they are responsible for the event or not. Although shame and guilt are similarly defined in the dictionary, guilt usually implies a feeling of responsibility, and shame has come to mean a feeling of badness, of worthlessness to the core. Soldiers who return from war often experience survivor's guilt. Upon examination, we often see questions of worth arise ("Why did I survive when John was a much finer human being?"). Victims of sexual abuse or rape often feel responsible ("I must have done something to cause it—if I had been more careful it would not have happened."). Often shame and guilt are experienced as a result of what the survivor sees as inappropriate behavior. For example, a child in the Oklahoma City bombing stepped on an electrical cord, and assumed that she set off the explosion. A firefighter reflexively runs from an exploding building. Five seconds later he returns to try to find his buddy. Years later he reproaches himself for being a coward. The question often arises, "What kind of person would do that?" The answer, fair or not, is often, "One who is worthless, useless, unlovable, bad to the core." That is a difficult—and very erroneous—belief to live with.

Often people feel shame and guilt for what they did not do. Children who are victims of repeated sexual abuse self-recriminate, thinking, "Why didn't I do something to stop it?" Or the sibling thinks, "Why didn't I do something to

rescue her, when I knew it was going on?" A police officer freezes for an instant as criminals open fire. His buddy is shot and he later thinks, "If I had returned fire immediately, he might still be alive."

Sometimes people with PTSD feel guilty for being unable to control their symptoms ("I must be a wimp to be depressed") or behaviors ("I can't believe I blew up at my wife like that—what's wrong with me?").

Guilt can be adaptive if it is realistic and if it leads to improvements in our behavior or character. Self-condemnation is never helpful. Unprocessed guilt and shame will make recovery very difficult. Fortunately, a number of very effective approaches can help to neutralize these emotions. We'll discuss them in chapter 22.

2. SHATTERED ASSUMPTIONS

Each of us holds basic assumptions that give order to our chaotic world and make stress bearable. A number of researchers have indicated that PTSD is due to the shattering of views of self, the world, and other people. In the now famous musical *Les Miserables,* Fantine is left by the man she loves with a newborn. In a stunned and socially isolated state she is accused of being a whore at work and thrown out on the streets, where she later takes up prostitution to feed her child. In poignant song she recalls a time when men were kind, when God was loving and forgiving, when the future was bright. Then all went wrong. Life killed her dreams, shredded her hope, and filled her with shame. Such are the changes often experienced by trauma victims. Table 3.1 lists several ways that people typically think before and after traumatic events. These assumptions summarize the work of Janoff-Bulman, Epstein, and others.[24] The shattered, post-trauma assumptions are often imbedded in the walled-off material, so they are not well challenged or integrated.

3. MOOD DISTURBANCES

Mood disturbances are common among those with PTSD, including:

- *Depression.* This follows logically from lowered self-esteem, hopelessness, shame, loss, feeling permanently damaged, and pessimism. Thus, victims of trauma might be at risk for suicide until such negative thoughts and feelings have been resolved.

Table 3.1
SHATTERED ASSUMPTIONS

Pre-Trauma Assumptions	Post-Trauma Assumptions
	Views of Self
Invulnerability (It can't happen to me; I'm not vulnerable, I'm safe and secure, I know what to expect, I can control things.)	Recurrence preoccupation (It will happen again; I'm vulnerable and helpless, fragile, threatened, endangered, insecure; I'm no longer safe.) I can't succeed in relationships. I can't control my behavior, symptoms, or sanity.
I see myself in a positive light (decent, worthwhile, good, competent, guiltless).	I'm bad, unworthy, shameful ("tramp mentality"), incompetent, weak, different from others, permanently damaged. Self-questioning. I can't count on myself anymore. Abused people conclude, "I'm an object existing for the needs of others—my needs are irrelevant." Self-denigration, shattered identity (don't know who I am anymore; identity split into before and after trauma).
I will have a happy future.	My life-long goal of protecting others feels shattered. I am unworthy of a good life. I can't conceive of a happy future anymore or of finding love. I am not good enough.
	Views of the World
The world is meaningful, fair, good, predictable, orderly, comprehensible, pleasurable, rewarding, kind, and safe. It makes sense and follows accepted social laws.	It just doesn't make sense. The world is confusing ("Why did this happen to me? What's the meaning of life?"). I can't believe in a God who permits this. God hates me.
People get what they deserve—if I'm cautious I can prevent disaster. Bad things won't happen to me.	What I do just doesn't matter. I have no control.
	Views of Others
People are good, trustworthy, comprehensible, worth relating to.	I can't trust people anymore—they're bad, exploitive, hurtful, etc. I can't relate to others; I feel alienated and isolated. Nobody understands.

- ***Anxiety***
- ***Hostility.*** This is an attitude of dislike and distrust of others. It might show up as irritability, rage, or angry outbursts at:
  - those who didn't go through the trauma and can't understand
  - a perpetrator
  - those who did not protect the victim (such as parents)
  - secondary victimizers (those who are supposed to protect you but hurt you instead, such as police or insensitive doctors)
  - family members who happen to be nearby
- *Grief for losses.* This may not always be obvious for reasons we'll discuss later.

4. ADDICTIONS

Substances such as alcohol, cocaine, barbiturates, opiates, amphetamines, or other drugs are frequently abused in attempts to relieve the pain. Such self-medication provides only temporary relief from symptoms and interferes with healing.

5. IMPULSIVE BEHAVIORS

In further attempts to escape the pain, people with PTSD might take impulsive trips, suddenly be absent from work, or make sudden changes in lifestyle (compulsive shopping, eating, or sudden changes in sexual behavior).[25]

6. SOMATIC (BODILY) COMPLAINTS

When trauma material cannot be processed and verbally expressed, the pain is often expressed physically, frequently around body areas that were physically traumatized. Often the physical pain serves as a distraction from emotional pain. Physical complaints can include:[26]

- chronic pain—headaches, heart pains, painful joints, back pain, pelvic pain
- hypertension
- allergies, asthma, rheumatoid arthritis, skin problems
- heavy limbs, lump in throat, fainting, numb or tingling body parts, hypochondriasis

- exhaustion—trying to contain the symptoms of PTSD is fatiguing, making one vulnerable to more physical (and psychological) symptoms[27]
- gastrointestinal disturbances include ulcers, irritable bowel/spastic colon (the term "gut-wrenching" is apt to describe traumatic events[28])

It is often observed that physical complaints are more likely to occur in people who were traumatized in preverbal childhood. The physically painful part of dissociated memory might then intrude as present pain. Other physical complaints are simply the common symptoms of anxiety and a sensitized nervous system.

7. OVERCOMPENSATIONS

In an effort to regain lost control, some people with PTSD become driven for success, achievement, or fitness.[29] This can be a positive outcome of trauma, although it might also distract from healing.

8. DEATH ANXIETY

A brush with death or serious injury will understandably lead to fear of recurrence until that fear is processed and completed.

9. REPETITION COMPULSION

Freud observed that people will often reenact traumas in attempts to master and complete them. (We hope this time to make things right.) This might take several forms:

- Many combat vets go into police, fire protection, emergency medical services, or crisis intervention, perhaps in an attempt to transfer their experience in a meaningful way.
- High-risk behaviors might include skydiving, rock climbing, scuba diving, or reckless speeding. As with high-risk professions, living on the edge creates an adrenaline rush that might ward off depression and the feeling of helplessness experienced during trauma. At the same time, stress-triggered opiates in the brain act like a natural pain killer.
- A woman abused as a child marries an abuser and stays with him.
- A man who was abused as a child enlists in the military, seeking to do violence against the enemy.[30]

- Someone who was forced to go without food as a child might develop problems with eating such as bingeing and purging.

Repeating the trauma gives an oddly comforting feeling of familiarity, predictability, and control. However, the original trauma is rarely resolved by such acts.[31] In fact, these acts might help one continue to avoid the original trauma.

10. SELF-MUTILATION (self-injury or self-injurious behavior)

One of the ironies of PTSD is that victims might further harm themselves. As Matsakis observes, self-mutilation includes "burning, hitting, cutting, excessive scratching, using harsh abrasives on skin or scalp, poking sharp objects into flesh, head banging, pulling out hair or eyebrows for noncosmetic purposes, inserting objects into body orifices," excessive fasting, self-surgery, excessive tattooing, or refusing needed medication.[32] This seems like such a paradox. Why in the world would those who are already in intense pain further injure themselves? It seems to make no sense, yet it does. Most often, it follows a history of protracted childhood trauma (such as physical and/or sexual abuse), not a single exposure.[33] The person harms himself in response to overwhelming, dissociated pain. At least sixteen reasons account for this complex behavior. Self-mutilation:

1. *Expresses pain that can't be verbalized.* It can be expected when the abused child was told to keep the offense a secret, or when the abuse happened before the child learned to talk. The nonverbal outcry says, "Something terrible has happened." It may be a plea for help.
2. *Attempts to convert emotional pain to physical pain.* Physical pain can be localized, displaced, and released, providing a temporary distraction from psychic pain.
3. *Paradoxically relieves pain.* Stress triggers natural painkillers in the brain, temporarily easing psychic and physical pain. This so-called stress-induced analgesia might also help explain why trauma victims become addicted to trauma-related stimuli.[34]
4. *Is a way to feel alive.* Numbing and dissociation feel dead. Perhaps feeling pain is better than feeling nothing. Physical pain grounds one in reality and counters dissociation. It returns focus to the present, providing relief from intrusions. Some people report that blood provides a soothing, warm sensation that relieves stress and reminds them they are still alive.

5. *Provides an illusory sense of power, a sense of mastery and control of pain.* Reversing roles and assuming the role of the offender, the person might think, "This time when I am hurt, I am on the controlling end. I can determine when the pain begins and ends."[35]
6. *Attempts to complete the incompleted.* The idea of repetition compulsion states that we repeat what we've experienced until we've completed old business—processing it and learning a better way. Unfortunately, simply reenacting the abuse doesn't change the trauma material. Complete processing of the material does.
7. *Is a way to contain aggressive tendencies and pain.* The person thinks, "If I discharge my anger and hurt on myself, then I won't hurt anybody else." Maybe it is the only way to stop anger, at least for a time. Learning constructive ways to express emotions is the antidote for this approach.
8. *Vents powerful emotions that cannot be vented directly* (e.g., I can't rage at the powerful perpetrator, so I vent on myself instead).
9. *Makes the body unattractive to spare further abuse.* This harmful defense makes sense to a child who was powerless to stop sexual abuse. Excessive thinness or weight might accomplish a similar purpose.
10. *Might become associated with pleasant moments.* Following abuse, some abusers become remorseful, attentive, and loving for a time. Thus, victims might be conditioned to think that pain signals the beginning of good times.
11. *Imitates what the child has seen.* Children naturally imitate behavior that is modeled by adults. They learn to abuse if their parents are abusive, just as they will learn kindness if the parents model that.
12. *Can be an attempt to attach to parents.* Children have a deep need to attach to parents, even if they are rejecting. In order to gain the abusive parent's approval, the child might internalize his punishing attitudes. The child's thinking might be, "I'll show I'm good and devoted to Mom by doing what she does to me." This makes more sense when we realize that abusers often isolate the victims, making them more dependent on them for approval. Need for approval causes the victim to identify with the aggressor. A child might confuse abuse with emotional closeness, especially if abuse was the only form of attention the parent showed. The child might think, "If I keep hurting myself, eventually they will love me."

13. ***Can mark a return to the familiar, understandable past.*** The child thinks, "I don't understand loving, soothing behavior, but I do understand pain. It does not always feel good, but at least it is predictable."
14. ***Is consistent with one's view of self.*** People treat themselves consistent with their self image. Abuse teaches the victim, "I'm worthless, bad, no good, an object—so it makes sense to treat myself like an object." Self-punishment consistently follows from feeling blameworthy, bad, or inadequate.
15. ***Is consistent with one's view of a maimed world and a nonexistent future.***[36]
16. ***May ensure safety if it results in hospitalization.***

The fact that you hurt yourself does not mean you are insane. You are simply repeating what you learned to cope with intolerable pain. As you learn productive ways to meet your needs you'll no longer need to do this. The antidote is learning to honor yourself and soothe yourself in healthy ways.

11. OTHER ADDICTIONS AND SELF-DESTRUCTIVE BEHAVIORS

Other self-destructive behaviors include eating disorders, accident proneness, compulsive exercise, gambling, sex/prostitution, and shopping. Of course, suicidal tendencies could be included here. Although these behaviors can be complex, understanding them in light of PTSD can help make them less confusing. Much of our discussion of self-mutilation sheds light on these as well.

Flannery estimates that 80 percent of prostitutes come from homes with abuse and/or alcoholism.[37] In alcoholic or abusive homes, children often learn that sex is separate from love, and is useful for purposes other than love. Thus, a prostitute might use sex as the only means of survival she knows. Or she might use it to control men and relationships, a form of repetition compulsion. Prostitution is also consistent with one's core beliefs about self:

- "Sex is not only the only thing I'm good *at,* it's the only thing I'm good *for.*"
- "What am I worth? Nothing, except for the morale of the troops."

Flannery adds that sex addiction is not really an attempt to appease the sex appetite, but is an attempt to rework and master trauma. The victim hopes that this time sex will provide self-esteem, a sense of being lovable, and relief from the pain of rejection, abandonment, and loneliness. Of course, isolated from love, sex provides none of these. Nor does the addiction resolve the problems of dissociated material.

Much like self-mutilation, compulsive gambling can provide an adrenaline rush, a sense of control, and distraction from the pain of dissociation. The vet who starts barroom brawls does so for similar reasons. The abused child who becomes an abusive spouse might wish to stop. Yet following the abuse, they feel a sense of control, a calmness attributable to the release of endorphins in the brain. Food becomes another way to soothe pain for overeaters.[38]

A final form of self-destruction that we'll discuss is revictimization. Repetition compulsion only partially explains why a woman would stay in an abusive relationship. Abuse tends to leave one feeling stunned, numbed, and unable to protect oneself.[39] The adult who was abused as a child will often seek a powerful authority figure to rescue her. Too often this is another abuser who can spot defenseless prey. Abusers typically isolate their victims, making them feel helpless, dependent upon them, and grateful for "any shred of affection." The victim increasingly views the abuser as powerful and respected. It becomes harder and harder to leave the relationship,[40] as the cycle of victimization continues.

12. ALEXITHYMIA

Alexithymia is another name referring to the general shutting down of feelings. One becomes like a robot, capable of functioning but expressing little feeling. One might describe bodily symptoms to the doctor but be unable to connect them to emotional pain. Recall that traumatic memories are highly emotional. To permit any feelings will also invite negative emotions into awareness. So we dread and bottle up all feelings, even love, joy, and relaxation. People make us feel, so people might be avoided. Since empathy requires feelings, giving or receiving love will be challenging. People with alexithymia may appear overly intellectual or businesslike. They will deny that anything is wrong ("Nothing bad happened; I didn't do anything wrong; It didn't bother me; It bothered me then, but not now because I don't think about it"). When resulting from trauma, alexithymia is a defense against painful dissociated material.[41] Some hold the view that showing feelings is a sign of weakness rather than a normal aspect of being human and a necessary step in healing. This view tends to promote alexithymia.

13. CHANGES IN PERSONALITY

Changes in personality may result from traumatic events. These changes may be substantial, especially if the events are severe, repeated, or happen early in life. As

already suggested, an individual might become chronically distrustful, cynical, angry, irritable, aggressive, destructive, socially withdrawn, perfectionistic, dependent, anxious, moody, or depressed. Self-esteem often drops. Three common personality disorders—antisocial, borderline, narcissistic—and dissociative Identity disorder are described in Appendix 4.

CHAPTER 4

Frequently Asked Questions

We'll complete our overview of PTSD by answering some commonly asked questions.

WHO GETS PTSD?

Anyone can get PTSD. The best predictor is the stressful event. PTSD is most likely if you are close to a severe event. A longer duration of the event, or events, increases the chances of PTSD, although a single exposure to an extreme event could also lead to PTSD.[42]

It is estimated that at least 40 percent of Americans have experienced at least one major trauma,[43] and that 8–12 percent of U.S. adults will experience PTSD at some point in their lives. These figures might increase with certain changes in society such as rising crime rates and the weakening of the family unit. Certain populations are at risk including children and people whose work exposes them to trauma. The latter group includes the armed forces, police, firefighters, rescue workers, emergency medical service workers, dispatchers, and disaster workers. However, anyone can be exposed to potentially traumatic events.

ARE THERE FACTORS THAT MAKE US MORE VULNERABLE TO PTSD?

The primary cause of PTSD is the stressful event. The risk for PTSD increases if the events

- are sudden and unpredictable[44]
- last a long time
- recur or are thought likely to recur—especially if there is insufficient time or resources to recover

- contain real or threatened violence (e.g., sexual abuse combined with violence is generally more traumatizing than sexual abuse alone)
- involve multiple forms (e.g., after an earthquake, a plane with relief supplies crashes into a village)
- occur in early years before the personality is fully integrated. Abuse from family members is generally more destructive than abuse from strangers because a child's most significant relationships are involved.

Consensus is emerging, however, that a variety of secondary factors can increase the risk of developing PTSD following exposure to traumatic events. These factors become more influential as the severity of the traumatic event decreases.[45] They include pre- and post-trauma vulnerabilities and initial distress following the trauma.

Pre-Trauma Vulnerabilities

Individual differences. People are different; we meet traumatic events at varying degrees of preparedness. There is no shame in this. Some of the risk factors include:

- A history of prior traumatization (e.g., Vietnam veterans with PTSD were more likely to have experienced childhood abuse than those without PTSD. This is understandable since present traumas are likely to reactivate unresolved traumas from the past.)
- Underdeveloped protective skills, problem-solving skills, self-esteem, resilience, creativity, humor, discipline, ability to express emotion to others, ability to tolerate distress. (All are learnable. PTSD can stimulate us to develop these skills.)[46]
- Personality and habitually negative thought patterns (e.g., pessimism, depression, introversion). These also are modifiable.
- Biology. Some people appear to have overreactive nervous systems. Heredity and a history of drug abuse appear to influence this factor.

Family characteristics. For optimal mental health, children need to bond to warm, loving adults in a secure, predictable setting. Here they can learn to trust others and themselves. They learn to experience and express emotions appropriately and safely. Given reasonable demands, they discover that the world is

predictable and that they can cope. They learn that in difficult times they can share their burden with others who will support them. Yet a variety of family environments can predispose the child to insecurity, shame, guilt, secrecy, distrust, alienation, or bottling of emotions—all of which increase vulnerability to PTSD. Consider a few of the possibilities:

- Watching parents divorce, children might conclude: The world is not safe; people don't stand by you, so don't trust.
- By watching parents cope with stress, a child might learn to blame others, take out anger on others, use illegal drugs to self-medicate, or avoid emotions.
- Parents with PTSD can indirectly transmit their wounds.[47]
  - A combat vet may parent according to the following rules of war, thereby teaching his children the same rules:
    - destroy your enemies lest they destroy you
    - don't show feelings such as grief or tenderness
    - do whatever it takes to protect yourself
    - it's safer to disguise your intentions

    Fearing angry outbursts, the children of such vets learn to keep quiet. Since the outbursts are unpredictable, they learn to feel unsafe and out of control. They have no way of knowing the cause of their father's pain, but self-esteem will be disrupted if they do not realize that they are not causing the problem.
  - A police officer protects his family but is emotionally disengaged. He takes the children to the park but is worried about danger instead of enjoying the experience with them. Another enmeshes the family ("We must always stick together for protection; avoid outsiders; don't leave home; never argue"). In both situations, the children learn to be anxious and distrustful.
- An abusive, alcoholic father threatens to harm a child if she tells. The child learns to be secretive and ashamed. The child learns to "look normal" rather than heal.

Recent life stressors. These can weaken resistance. Accumulated stressors might include recent divorce, illness, financial pressures, natural death of a friend or relative, or losing a job.

Pre-trauma vulnerabilities might have limited you in the past, and probably have limited your growth since the trauma. Sometimes the trauma highlights the opportunity to grow in these areas, which is why trauma can present certain positive aspects.

Initial Distress at the Time of Trauma

PTSD is more likely to develop if one:

- dissociates[48]
- has the perception that they were responsible or acted inappropriately—how one thinks about the traumatic event is crucial, a point we shall repeatedly return to
- perceives that they are alone or isolated (e.g., a batterer threatens to kill his wife if she tells anyone; an abused child feels different from her friends and is too ashamed to talk with anyone)

Post-Trauma Factors

Recovery environment. Lack of support from family, friends, and community can make the victim feel more alone, helpless, or worthless. Ideally, support systems will be believing, uncritical, and supportive. They will encourage you to take care of yourself and express your feelings—they can feel and accept your pain, even if they don't understand it. Risk factors include:

- *Emotional unavailability.* Some adults feel threatened by pain. They don't know how to talk about it. Perhaps they too were victims and feel their unresolved memory material will be triggered by your trauma.
- *The victim's being disbelieved, stigmatized, shamed, or shunned.* Think of a rape victim who is blamed or rejected by her husband, or our troops returning from Vietnam.[49] The rejection adds to the wound, while the victim is denied the healing balm of sharing one's burdens. In contrast, consider cultural homecoming or decompression rituals such as the Native American sweat lodge or homecoming parades for soldiers which help integrate individuals into society.
- *Secondary victimization.* This occurs when those who are supposed to help instead inflict further harm.
  - The police or lawyers treat a victim of rape as if she asked for it or could have prevented it had she been more careful.

- A physician minimizes the symptoms, belittles one seeking assistance, or even refuses to render treatment ("There's nothing wrong with you, it's all in your head.").
- *Conspiracy of silence.* Perhaps the wife tells the child to keep silent about the father's incest for fear that he will be thrown in jail.

Lack of treatment. This reinforces the victim's belief that she is alone and different from others. By contrast, some organizations provide group meetings and education to help prevent the development of PTSD, and provide follow-up individual counseling.

Ineffective coping. Some people keep the pain inside—unexpressed and unprocessed. They might then turn to drugs or alcohol to kill the pain, or to self-destructive behaviors. None of these solve the root problem—painful dissociated material. Effective copers take care of themselves and seek necessary help.

WHAT COURSE WILL PTSD TAKE?

Horowitz has described the normal sequence of the traumatic stress reaction and recovery:[50]

1. *Outcry.* This stage involves strong, distressing emotions. One freezes or feels stunned, overwhelmed, or frightened. Perhaps one begins to feel strong emotions after having coped with an emergency, maybe when home relaxing. Strong anger might have helped them to cope.
2. *Avoidance and denial.* One thinks, "Oh, no! It can't be true." One feels numb/blunted. They withdraw, avoid potential supporters, constrict emotionally, and stare blankly into space. In a frantic attempt to keep life as usual, they compulsively return to pre-trauma tasks that were important then (perhaps work, sports, sex, or cleaning). But the world looks gray. Feeling physically and emotionally numb, unable to talk about it, they might turn to drugs for relief.
3. *Intrusions.* Intense emotions and thoughts related to the stressful event begin to break into awareness, accompanied by signs of arousal. The strong waves of thoughts and emotions might wane for a time, giving one hope of coping. But they return. Arousal is signaled by startle reactions, hypervigilance (excessive alertness, looking around for threats), and com-

pulsive repetition of actions that are linked to the event (constant searching for lost persons or situations, reenacting the event, and rehearsing ideal responses to regain control).

4. *Working through until completion.* Eventually, one faces the reality of the event, experiences all thoughts and feelings, talks it through with others, corrects erroneous thoughts, comes to terms with the experience, grieves, and restores equilibrium. New commitments are made to live, accept self, accept losses, find the silver lining in the trauma (e.g., find resiliency, wisdom, or compassion), grow beyond the pre-trauma condition, and move on.

If one gets stuck at a step before completion, then the symptoms of PTSD will continue, including swinging between stages. If stuck, Horowitz recommends early treatment so that maladaptive coping does not get fixed. Treatment involves going through the four stages to find out where one is stuck, and then progressing through to completion.

Most people will experience at least some symptoms of PTSD following a severely stressful event. As a general rule, about half of all adults diagnosed with PTSD will recover within three months.[51] Others will continue to experience PTSD for months to years if not treated. Without treatment, many people who do not meet the full criteria for PTSD will continue to experience symptoms for decades; people might indeed manage their symptoms for decades only to find them multiplying during retirement years. Perhaps one finally becomes exhausted from a lifetime of battling. Perhaps a hospital stay or failing health triggers old memories of helplessness and loss of control.[52]

PTSD usually begins within three months of the trauma, although there might be a delay of months to years. However, so-called delayed PTSD is rare. Careful examination will usually detect PTSD early on, although the symptom profile and associated features might change over the course of the disorder.[53] Some people experience periods of remission followed by recurrence.

IS IT A SIGN OF BEING CRAZY OR WEAK THAT I AM STILL BOTHERED BY THE TRAUMA AFTER ALL THESE YEARS?

PTSD symptoms are simply a sign that the trauma overwhelmed your coping abilities at the time and that you have not yet learned effective ways to cope or reduce the symptoms. As you learn new skills, you will likely feel much better.

WHAT ARE THE COSTS AND CONSEQUENCES OF PTSD?

Wilson summarizes that PTSD impacts one's psychology, self-concept, development, and attachment capacities (including the capacities for intimacy, love, bonding, and sexuality).[54] Untreated, PTSD is associated with greater rates of the following:

- depression
- anxiety disorders (e.g., panic disorders, phobias)
- suicide
- low self-esteem
- guilt
- personality disorders
- dissociative disorders
- cynicism
- revictimization
- family disruption (e.g., conflict, divorce, secondary wounding)
- impaired relationships
- social isolation
- sexual dysfunction or sexual acting out
- unemployment
- drug addictions
- eating disorders (e.g., anorexia, bulimia)
- medical illness
- homelessness
- loss of religious faith
- child and spousal abuse
- difficulty handling stress
- violence

Just a few notes will suffice for explanation.

Suicide

Suicide may be viewed as an attempt to escape overwhelming pain. The rate for incest victims is two to three times higher than rates for the depressed; the latter comprise the majority of suicides. Suicide attempts among rape victims occur ten times more frequently than the population average.[55] It is apparent that sexual abuse violates not only the body but the mind and soul as well. It sends the message that a victim is but an object. The lasting danger is that the victim accepts that message and fails to realize that things can get better. Battered women also attempt suicide at alarming rates, consistent with findings that women are on average more distressed by troubled relationships than are men.

Revictimization

Incest victims are more likely to be sexually victimized in later years and to marry abusive spouses. Here is a complex irony. There is a great need to protect oneself.

Yet experience might have taught the victim that self-protection is futile. One who dissociates is not in contact with lessons of the past. Vulnerable and in need of assurance, one becomes a "sitting duck" for an abuser.[56]

Intergenerational Secondary Wounding

PTSD victims can infect their families. For example, children of Vietnam vets can feel neglected by emotionally absent fathers who transmit the expectation of silence. Children of Holocaust survivors might also bear scars of their parents' wounds. Through their parents they might learn to fear separation, avoid intimacy, or overachieve. They might experience Holocaust-related nightmares, anxiety, concentration difficulties, aggression, and psychosomatic disorders. Frequently children of victims wish to empathize and understand their parents but the parents remain emotionally closed. The children might then take on the symptoms themselves as a way to feel close. In short, any parental difficulties can be passed on to the family. The difficulties are compounded by the family's frustration at being unable to help the victim.[57]

Sexual Dissatisfaction[58]

Many symptoms common to PTSD interfere with the enjoyment of wholesome sexual intimacy: difficulty trusting, guilt, depression, self-loathing, emotional numbness, preoccupation with emotional survival, disgust, drug abuse, and anger, to name several. The challenge is even greater when inappropriate sexuality was part of the traumatic experience. For example, home is no longer safe to incest survivors, who are most often females. Unhelped survivors are more likely to enter sexualized relationships to replace deeper intimacy, and often become pregnant during teen years. They are more likely to experience sexual dysfunction and report that they do not like being a woman. They will often experience flashbacks during sexual closeness.[59] In relationships they might experience great ambivalence about sex. They often find sex aversive and wish to avoid it. At other times they need and seek closeness. So they might flip-flop between avoidance and excessive sexuality. Partners might interpret the flashbacks or the wish to avoid sex as rejection.[60]

WILL TIME HEAL THE WOUNDS?

Perhaps. Some people seem to recover without treatment within a few months. For others, however, "work hard and forget" does not necessarily work.[61] Often effects can be prolonged and may worsen without treatment. The good news is

that research has taught us much about PTSD, including many strategies that help people to heal, recover, and grow.[62]

WHAT ABOUT TRAUMATIC BRAIN INJURY?

Sometimes injuries to the brain can cause PTSD symptoms. Head injury can occur if someone is knocked out or whipped around, or if someone experienced a coma or concussion. Such conditions might be a result of violence, a car accident, or other traumatic events. The victim might look the same but act differently.

Many of the symptoms of head injury are similar to PTSD including concentration difficulties, aggression, depression, anxiety, irritability, mood swings (being demanding or verbally abusive), amnesia (usually loss of recent memory), fatigue, disrupted sleep, headache, decreased sexual interest (although 5 to 10 percent will exhibit increased interest), and shame.

However, additional signs might suggest brain injury. Look for:

- slowed processing (slowed memory storing or retrieval)
- difficulty with abstract or complex thinking (e.g., a person can't explain what "people who live in glass houses shouldn't throw stones" means)
- decreased muscle strength
- seizures (sometimes looks like a fainting spell)
- loss of coordination
- difficulty with vision, speech, hearing, smell, or taste

Brain injury is best treated by a neuropsychologist, who is trained to detect abnormalities that might not be obvious on normal medical tests. State head injury foundations can assist in care of the victim and support of the family.

WHAT ABOUT FALSE MEMORIES?

The accuracy of trauma memories is one of the most controversial aspects of PTSD. Perhaps no one has summarized the research on this topic better than Dr. Jon G. Allen of the Menninger Clinic. He relates that a full range of recall is possible. Some people remember the gist of the trauma reasonably accurately and consistently. Some remember parts of the trauma consistently with varying degrees of precision. Some totally forget the trauma, and some of these later have varying degrees of recall. Sometimes the recall occurs spontaneously. Sometimes

recall is prompted by a psychotherapist or hypnotist. Sometimes this recall can be relatively accurate, and sometimes totally false. Allen points to the need for caution in evaluating the accuracy of traumatic memories. We recall that traumatic memories are often stored in fragmented, dissociated bits, which are not filed in memory in proper perspective with respect to time. Trying to reconstruct them might lead to interpretation and the changing of details over time. Spontaneously recalled memories tend to be more reliable than those suggested by a therapist or gained through hypnotism because some people are somewhat prone to suggestion.[63] Thus it is generally considered unethical for a therapist to try to persuade a client that abuse has occurred, or to even suggest it.