

Posttraumatic Stress Disorder (PTSD) <http://www.atlantapsychotherapy.com/articles/berman1.htm> **Lauren Berman, PhD**

Although Freud (Freud, 1906) described the impact of trauma on the psyche in his original works of the 19th century, it wasn't until 1981 that Posttraumatic Stress Disorder (PTSD) was officially recognized as a valid disorder. Historically, trauma-related symptoms were attributed to malingering or weaknesses in constitution. Traumatized individuals were diagnosed as borderline personality disordered, as clinically depressed, anxious, phobic, or sometimes as schizophrenic.

Today, PTSD is recognized as affecting between 1% and 14% of the population (DSM-IV, 1994). Its symptoms can be severely disabling and can last for many years. The symptoms of posttraumatic stress disorder are best understood by viewing them in 3 categories (Herman, J.L., 1992):

hyperarousal (the persistent expectation of danger), **intrusion** (the interference of past trauma into present day existence), and **constriction** (the shutting down of normal responses in order to block or prevent the intrusion of trauma into the present).

Hyperarousal is akin to being in danger on a chronic basis- 24 hours per day, 7 days per week for years. Imagine being hypervigilant to danger on a chronic basis. As a result, you might be jumpy—loud noises or sudden movements might startle you to such an extent that you have a visibly exaggerated reaction. You might have difficulty falling asleep. You are likely to be hyperaroused even during sleep and might awaken more easily. You might experience troubled sleep disturbed by nightmares or creepy feelings that an intruder is present. You would likely feel irritable and snap at people when only meaning to set a limit. You might have trouble paying attention to the task at hand because the ever present danger is on your mind, distracting you from your work. Finally, you would be on the lookout—the sentry who never gets relief from guard duty, who can only rely on him/herself to spot danger.

Intrusive experiences are among the most disturbing sequelae of trauma because they make past trauma present in everyday life. It is as if the trauma will not let you forget that it is not yet processed. Traumatic memories appear to be encoded and stored differently from other memories. Often, they are not available in verbal, narrative form. Traumatic memories remain out of context. Instead, they are encoded as vivid sensations or images. One trauma survivor wrote:

It is amazing to me that for all the things I don't remember, I have other memories so vivid, that I could describe the memory in each sense. The other day, I was having a flashback.... I cannot see myself at all. But I can describe the colors and textures of the linens and furniture. Those lime green and yellow sheets that have once again become fashionable, but will never appear in my bedroom. I see that dim yellowish light that always cast a flickering light in the bedroom, from one of those hanging 70's kind of lamps... a brownish wood and rattan. I can hear the ice clink as it melts in his glass of scotch beside the bed, and the birds outside the bedroom window. If I look carefully, I can see the fruit trees in the backyard.... Mango, orange and lemon.

If the story of the trauma does become available to the trauma survivor, it is often strangely detached from the emotion or missing something essential. The same survivor wrote, "I remember lying there, not really moving, not really sure what to do. Why can't I ever remember thinking anything?? If I could only remember being scared, afraid, angry... then maybe it would be OK... It's like since I can't remember those feelings, I must have thought it was OK... Now that...is scary!"

Traumatic memories remain unprocessed long after the traumatic event ends. As a result, the memories revisit the trauma survivor in states of wakefulness and sleep. They occur as "distressing recollections" and they come as nightmares or recurrent dreams.

Traumatic events also intrude into the consciousness as flashbacks or hallucinations. Indeed those suffering from Dissociative Identity Disorder (DID) – previously known as Multiple Personality Disorder (MPD) - are often incorrectly diagnosed as schizophrenic because they report auditory hallucinations. Some clients report these hallucinative experiences as "conversations in my head."

Trauma is not just relived in dreams, cognitions, and memories but also in behavior. Behaviors reflective of traumatic intrusions are called reenactments. Reenactments can take many forms but they are usually unconscious attempts to master or resolve the trauma. Reenactments can occur in dissociative states or in consciousness. They can occur in disguised form or in exact replica of the trauma. A young man was living a heterosexual lifestyle fully seeing himself as heterosexual. He was a traditional person who lived a sedate life. Yet he participated in a secret compulsion. He would go to the park at night and have anonymous gay sex in the bushes. In the morning he would hate himself for what he had done and vow never to do it again. Yet the urge would creep up on him and he would feel compelled to pursue it. After entering therapy, he connected this compulsive behavior to the sexual abuse he suffered at the hands of an adult neighbor who took him on scouting campouts. Linking intrusions to their historical roots in trauma allowed this client to "de-fuse" his current-day PTSD experience.

Constriction serves two functions. The first is to separate the memories of the trauma from the pain associated with the trauma in order to keep them from overwhelming the psyche. The second is to restrict the individual's exposure to people, places, things or events which might trigger distressing memories. Constriction reflects the complete powerlessness and helplessness which occurs during the traumatic event. The traumatized individual simply shuts down.

Behaviorally, constriction can manifest itself by avoidance. This, too, can take on a compulsive quality. A traumatized individual may avoid people, places, events, or things associated with the traumatic event. One woman who, as a child, was sexually abused by an uncle during vacation trips to Florida experienced panic attacks when she approached the state line. She persistently avoided trips to Florida in her adult life. Thru therapy she was able to modify her behavior by changing the emotional association between her trauma and the present-day trips.

Traumatized individuals also avoid thoughts, feelings or conversations which remind them of the trauma. One way that many clients avoid these thoughts and feelings is to dissociate. Dissociation can take many forms. There can be a disconnection between the events and their meaning. Here the event and its affect are dissociated from each other.

Dissociation can also take the form of numbing or loss of bodily sensations. This is common in sexual abuse survivors, particularly those who have also experienced physical abuse. One woman was sexually abused as a child by her older brother and physically abused by her father. She was also an amazing child athlete. She reported one occasion of being hit in the face by a softball on the field but having no sensation of pain. Her cheek was swollen, her coach was calling her to get off the field yet she went running to first base.

Dissociation can also be experienced as a state of mental numbing. This state is akin to the trance experienced under hypnosis. The tendency to dissociate is one reason why many trauma survivors are revictimized. They live in and out of a state of perceptual distortion and may not recognize danger signals in their environment. This increased risk for revictimization becomes understandable within the context of the process of being "groomed" to tolerate victimization, which is frequently the consequence of repeated trauma experiences.

Trauma can have wide-ranging impact. It can produce any number of symptoms, which in turn can create difficulties in everyday life. These effects can persist for many years after the initial traumatic episode. When symptoms of hyperarousal, intrusion, or constriction are present it is valuable to assess for trauma history. Advances in the treatment of PTSD during the past 30 years allow many possibilities for the positive resolution of traumatic symptomatology for survivors who seek psychotherapy.

References:

- American Psychiatric Association. (1994). Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, DC: Author.
- Freud, S. (1906). "My views on the part played by sexuality in the aetiology of neuroses." Three essays on the theory of sexuality. Vol. 7, pp. 269-279.
- Herman, J.L. (1992). Trauma and Recovery. New York: Basic Books.