

PTSD

The background of the page features a silhouette of a man and a woman embracing. The man is on the left, and the woman is on the right, her head resting on his shoulder. They are set against a gradient background that transitions from a bright yellow at the top to a dark grey at the bottom, suggesting a sunset or sunrise.

UNDERSTANDING A VICTIM'S RESPONSE TO TRAUMA

BY FRANK OCHBERG, M.D.



Posttraumatic Stress Disorder (PTSD) is three reactions at once, all caused by an event that terrifies, horrifies, or renders one helpless. The triad of disabling responses is:

- recurring, intrusive recollections;
- emotional numbing and constriction of life activity; and
- a physiological shift in the fear threshold, affecting sleep, concentration, and sense of security.

By definition in the *DSM IV*,¹ the official lexicon of psychiatric diagnoses, this syndrome must last at least a month before PTSD can be diagnosed.

Furthermore, a severe trauma must be evident and causally related to the cluster of symptoms. There are people who are fearful, withdrawn, and plagued by episodes of vague, troubling sensations, but they cannot identify a specific traumatic precipitant. (Some clinicians assume this means abuse occurred and was repressed. The pattern of PTSD reactions thus may be used, illogically and erroneously, to “prove” a hidden trauma.) PTSD should only be diagnosed when an event of major dimension—a searing, stunning, haunting event—has clearly occurred and is relived, despite strenuous attempts to avoid the memory.

Recurring, Intrusive Recollections

The core feature of PTSD, distinguishing the condition from anxiety or depression, is the unavoidable echo of the event, often vivid, occasionally so real that it is called a

flashback or hallucination. The survivor of a plane crash feels a falling sensation, re-visualizes the moment of impact, then fears going crazy because his or her mind and body return uncontrollably to that harrowing scene. A victim of the “cooler bandit,” whose modus operandi was to rob urban convenience stores at gunpoint and force the clerks into refrigerated storage rooms, had nightmares for more than a year. She still has moments during the day when she sees the bandit’s brown eyes above the mask that hid the rest of his face. She was sure she would be killed at the moment when he threw her to the floor. Even though no shots were fired and the robber was eventually apprehended, her sensations of terror, her feelings of impending doom, still return with sudden images of that unforgettable night.

There are important distinctions among traumatic memories. Some are clearly memories. The beholder knows this is a recollection, painful but not terrifying. Through time and (often) through telling and re-telling of the trauma story, the memory is muted, modulated, and mastered. It no longer has a powerful, disruptive presence. It is a piece of personal history.

On the other hand, that personal history may burst forth into awareness, and a trauma survivor may feel and act as though bombs are falling, a rapist is ready to strike, or the death of a loved one is witnessed again. Incidentally, the loss of a loved one and the consequent bereavement is not, by definition, a source of PTSD, unless the death evoked images of terror or horror. Tragic loss is often an aspect of PTSD, but shocking imagery is not usually part of natural death.

Therefore, as painful as the loss of a spouse or child may be, the diagnosis of PTSD is reserved for only those losses accompanied by haunting death imagery.

Some repetitive recollections include regrettable acts by the person with PTSD. A patient of mine killed a boy in Vietnam. It was self defense, in combat, but indelible and inexcusable in my patient's overactive conscience. Guilt—crushing guilt—was a major component of his intrusive recollection.

When the trauma reappears in the mind, some individuals experience an altered state of consciousness. They enter a trance, a dissociative disorder that can be dangerous to themselves or others. The war veteran confuses his wife with a Viet Cong woman who tried to kill him many years ago, and he smothers her with a pillow; or he leaps from the window; or he runs from the room with a weapon and is shot by police. These are relatively rare situations and, according to most experts, beyond the boundaries of PTSD. PTSD may include flashbacks and hallucinations, but neither is necessary for the diagnosis. When prolonged flashbacks and prolonged hallucinations—particularly auditory hallucinations that command violent activity—occur, other diagnoses may be involved, such as Dissociative Disorder and Brief Psychotic Disorder. These may co-exist with PTSD. (See box on page 13.)

Emotional Numbing and Constriction of Life Activity

Emotional anesthesia, or numbing, may protect a person from overwhelming distress between memories, but it also robs a person of joy and love and hope. While

participating in a national PTSD research effort, I interviewed dozens of soldiers, decades after their service in Vietnam. The presence of this second of the three PTSD diagnostic criteria, this loss of emotional tone, struck me as the most tragic legacy. Marriages suffered, child raising was impaired, life was hollow. To these veterans, “survivor” meant being no more than a survivor and considerably less than a fully functioning human being. Painful memories might have subsided. Anxiety attacks were tolerable. But the capacity for feeling pleasure was gone. These PTSD victims were anhedonic, meaning not necessarily sad or morose, just incapable of delight. And they no longer participated in activities that used to be fulfilling. Why bowl or ride horses or climb mountains when the feeling of fun is gone? Some marriages survived, dutiful contracts of cohabitation, but devoid of intimacy and without the shared pride of watching children flourish—even when the children were flourishing.

These symptoms of PTSD—numbing and avoidance—are less prominent, less visible, and less frequent than the more dramatic memories and anxieties. Early on, most survivors of trauma will consciously avoid reminders and change familiar patterns to prevent an unwanted recollection. For example, some ex-hostages from a notorious train hijacking in the north of Holland avoided all trains for weeks. Some only avoided the particular train on which the hostage incident had occurred. Others took that train, but changed to a bus for the few miles near the site of the trauma. This aspect of PTSD, numbing and avoidance, is adap-

tive to a point, then becomes a serious impediment to recovery.

It can also mislead an interviewer of a survivor into seriously underestimating the severity of a traumatic event. There is a popular belief that victims of rape, kidnapping, and other violent crimes should be full of feeling, tearful, shuddering, even hysterical, after the assailant leaves. When feelings are muted, frozen or numb, the survivor may not be believed. When testimony in court is mechanical and unembroidered, jurors may assume that damages were minimal or never incurred. I have testified as an expert for the prosecution (and for the plaintiff in a civil suit) on several occasions to explain this phenomenon. The victims were numb or avoidant or both, and therefore did not come forward immediately. When they did come forward, they appeared, to untrained observers, to be indifferent, unconcerned, and unharmed, when, in fact, they were in a state of profound posttraumatic stress.

This dimension of PTSD includes psychogenic amnesia. Along with loss of emotional tone and limited life pursuits are holes in the fiber of recollection. For example, an opera singer, battered by her husband, could not recall the most serious beatings. She was finally ready to divorce him, and she needed to testify in court at a settlement hearing. After several supportive sessions, including hypnosis, she remembered him choking, almost strangling, her. Eventually, all of the memories returned, and she could joke, “He not only threatened my life but my livelihood! No wonder I put that out of my mind.” A female police officer shot and killed a man who threatened her and her partner with

Other Responses to Trauma

Acute Stress Disorder. Used to describe early effects of trauma lasting more than two days, but no more than four weeks. To be diagnosed with ASD, a trauma survivor must have the PTSD triad of intrusive recollections, avoidance, and anxiety, and also must have at least three of the following five dissociative symptoms:

- *A sense of numbing*, detachment, and absence of emotional responses;
- *A reduction in awareness of surroundings*, being in a daze;
- *De-realization* (the immediate environment seems unreal, as though it were a movie or a play);
- *De-personalization* (the self is experienced as altered, unreal, an actor, a fictional character); and
- *Dissociative amnesia* (gaps in memory that cannot be explained by head injury, drug use, or other physical causes)

For victim service providers, it is important to know that ASD and PTSD are closely related conditions, almost indistinguishable, except for timing. ASD refers to debilitating recollections, numbing, avoidance, and anxiety up to a month after a traumatic episode, and PTSD refers to the continuation of those symptoms thereafter.

Adjustment Disorder. A relatively mild, relatively brief disruption of functioning. Mood may be anxious or depressed or both. Conduct, especially in children, may be impaired. The diagnosis is often applied during marital and occupational difficulties and need not be linked to a major trauma.

Psychosis. Usually defined as a break with reality. Brief psychotic disorder may include hallucinations and delusions unrelated to the trauma. Voices may order the person to harm another or himself, even though the trauma had no such content. Delusions are fixed, false beliefs, often of persecution or grandiosity or both. Delusions may be intricate and bizarre, with or without accompanying hallucinations.

Dissociation. An altered state of consciousness. One is not oneself, but not out of touch with reality. People can travel long distances for no apparent reason, converse with strangers, appear normal, have no hallucination and no delusion, but eventually return to their original self and original awareness, baffled by finding themselves in a city hundreds of miles from home.

Medical Disease. Many traumatized people will develop physical diseases or exacerbate pre-existing conditions. Hypertension, heart attack, stroke, ulcers, and asthma can follow intense events.

Dissociative Identity Disorder. Known until recently as Multiple Personality Disorder, more than 90 percent of sufferers are female and more than 90 percent were abused as children, often in father-daughter incest. The child victims are usually quite young, five or six being the common age. One way that little girls defend themselves psychologically is by going into a trance. Little Mary says to herself, "Daddy isn't doing this to me, he's



doing it to Belinda." Belinda exists, at first, only during abusive episodes, in an altered state of consciousness. As she matures, Belinda's personality develops. She becomes a separate self who may or may not communicate with Mary. If this separation into two personalities is effective, Mary may then generate three or four—or dozens—of "alters" in response to abuse and other life traumas. Why are there so few male "multiples"? It may be that men end up in prison rather than in a therapist's office. It may be that they respond aggressively rather than passively to parental abuse. There is certainly confusion and controversy in the field. But no one should doubt that father-daughter incest is a pervasive problem and that the emotional damage is profound. The worse trauma is often the incest secret, not the sexual activity itself. Whether or not dissociative identity disorder occurs, there will be problems with intimacy, self-esteem, and trust. The PTSD elements of flashback and anxiety are not as prominent as the distorted relationships with father and mother and the damage to a coherent sense of self. Multiple selves are the ultimate incoherence.

a gun. She could remember everything vividly except for the sound of her pistol firing. Obviously, the gun went off and the sound was audible. She repressed that piece of memory for many years, eventually recalling it as her PTSD subsided.

Physiological Arousal

The final dimension of PTSD is a lowered physiological threshold for anxious arousal. Unexpected noises cause the person to shudder or jump. The response is automatic and not necessarily related to stimuli associated with the original trauma.

A bank teller who was robbed, held hostage, then kidnapped, was not exposed to gunfire or loud sounds during her ordeal. But six months later, she was visibly startled and upset by the rumble of a train. It is as though the alarm mechanism that warns us of danger is on a hair trigger, easily and erroneously set off. A person with PTSD may live with so many false alarms that he or she cannot concentrate, cannot sleep restfully, and becomes irritable or reclusive.

PTSD impairs the enjoyment of intimacy and isolates the sufferer from loved ones—the ideal human source of reassurance and respect. Often, the anxiety takes familiar shape: panic and agoraphobia. Panic is a sudden, intense state of fear, frequently with no obvious trigger, in which the heart beats rapidly, respirations are quick and shallow, and fingertips tingle. There is light-headedness, there may be sensations of choking or smothering, and the person feels he or she is dying or going crazy or both. It is a seizure of the autonomic nervous system. It mimics a heart attack. Panic lasts a few minutes but

is so debilitating that one is upset for several hours. After experiencing a few panic attacks, a person will often avoid places where an attack would be particularly embarrassing, such as shopping malls and supermarkets. The term agoraphobia, from the Greek words for market (agora) and fear (phobia), literally means fear of the marketplace. But it applies to many settings that are shunned by those with a particular pattern of anxiety. Extreme agoraphobia causes self-imprisonment in one's house or even a single room within a home.

PTSD has not only a variety of dimensions and components, but vastly different effects and implications. Some trauma survivors are continually reminded of their victimization and experience relief when they tell the details to others. Some survivors are humiliated by their dehumanization or laden with guilt for harming another person. They refuse to discuss details. Some are dazed, moving in and out of trance-like states. Some are full of fear, hypervigilant, easily startled, unable to concentrate, wary of strangers. The syndrome may be evident soon after the trauma or may emerge years later.

Who Gets PTSD?

What do we know about vulnerability to posttraumatic stress disorder? Long before there was a PTSD diagnosis, there was a body of theory and research regarding coping. Scientists described copers as those who faced major life transitions and major life disruptions while still achieving four goals:

- they successfully accomplished necessary tasks;

- they maintained relationships with significant others;
- they preserved self-esteem; and
- they kept anxiety within tolerable limits.

Populations of copers and non-copers were studied among students adapting to out-of-town colleges, children entering puberty, soldiers with extensive third-degree burns at an Army hospital, and many other populations. The coping mechanisms that enabled some to thrive while others failed or suffered included denial, role rehearsal, information gathering, positive use of fantasy or imagination, and the ability to anticipate and devalue failure. For example, soldiers with 50 percent body burns who denied—kept from conscious awareness—the realization that they would be disfigured and that their recovery would be painful had a better rate of survival than those who, early on, recognized grim reality. Of course, there comes a time when unfortunate consequences must be accepted. Copers delayed such acceptance until their conditions had stabilized and physical healing had begun.

Two employees of the U.S. Information Agency were captured and held in isolation near Lebanon for 18 months by terrorists of the Popular Front of the Liberation of Palestine. I interviewed both men six months after their release. The one who coped well occupied his mind while in captivity by visualizing the designs for a house, down to the last detail. He categorized favorite restaurants (including the one in which our interview took place), anticipating future menus. He exercised and kept his spirits up. I recall our conver-

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sation as pleasant for both of us.

The second interview, with the other victim, was far less comfortable. This man spoke guardedly, fearing foreign agents would overhear. He had no sense of humor and smoked nervously. During captivity, he counted bricks in his cell and paced. He had no way of occupying his mind. The men were treated equally in confinement and released the same week. One celebrated freedom. The other was disabled and diminished.

I do not recall that either had flashbacks, nightmares, or intrusive recollections. Probably neither would have qualified for the PTSD diagnosis (which was defined two years later). But one was a copier and the other was not. One had conscious and unconscious coping mechanisms: denial of danger, use of fantasy, positive thinking. The other, literally a plodder, failed to cope.

Most current research shows that the intensity and duration of traumatic events

correlates positively with the occurrence of PTSD. But individuals exposed to the same extreme stress will vary in their responses. Heredity could play an important role. Just as some children are born shy and others exhibit a bolder temperament, some of us are born with the brain pattern that keeps horror alive, while others quickly recover. As a varied, interdependent human species, we benefit from our differences. Those with daring fight the tigers. Those with PTSD preserve the impact of cruelty for the rest of us.

An interesting experiential (rather than hereditary) theory posits that minor traumas, successfully resolved in childhood, protect against major psychological stressors later on, much as an attenuated virus creates immunity to full-blown infection. Other theories emphasize the presence or absence of social supports, sustaining religious and spiritual beliefs, use of drugs and alcohol, co-existing medical and emotional disorders, and the age of the trauma

survivor. When children are traumatized, they often regress. A pre-schooler will wet the bed, even though he or she has been toilet-trained for a year. A verbal child may not speak. Severe childhood traumas will disrupt personality development, and therefore pose major lifelong challenges. I tell patients with PTSD that there is nothing abnormal about those who suffer. It is a normal reaction to abnormal events. Anyone could have PTSD, given enough trauma.

Conclusion

A relatively recent area of clinical science, traumatic stress studies teaches us that victims of violence have several distinguishable patterns of emotional response. These patterns are easily recognized once their outlines are understood. Seeing the logic in a set of psychological consequences re-humanizes and dignifies a person who may feel de-humanized and robbed of dignity.

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¹ The Diagnostic and Statistical Manual, The American Psychiatric Association. Washington, DC. 1994.