

Posttraumatic Stress Disorder: Helping Yourself or a Loved One After the Trauma

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Goal: Healing, which means to be able to remember what happened without reliving the feelings.

How to get there:

Do:

1. Let the survivor know that what they are experiencing is normal. They are not crazy.
2. Let the survivor know it is okay to talk about the trauma when they are ready, and that talking about it is one of the best ways to heal.
 - a. Talking will help the survivor to sort out the mixed feelings and trim off the emotions of the memory.
 - b. Talking helps the survivor feel understood and accepted, less isolated and alone.
 - c. Talking will help the survivor make sense out of what happened.
3. Often the survivor will have to “peel the onion,” meaning discuss the event little by little, taking one level of distress at a time.
4. Allow them to talk about it to the person they want to; the survivor may not want to discuss it with family and close friends. They may choose other survivors, counselors, or ecclesiastical leaders.
5. Continue to invite and encourage their participation in hobbies and activities without pressure.
6. If needed, allow a physician to evaluate the need for medications to reduce anxiety and intrusive memories, and to help with sleep and appetite.

Don't

1. Force them to talk if they don't want to. This can be re-traumatizing. Take it at their pace with gentle encouragement for them to seek help.
2. Tell them to "just get over it." If you are impatient or irritated, talk it out with someone else. Take care of yourself.
3. Blame, criticize, judge, or be shocked.

What are examples of trauma?

- Natural disasters: earthquakes, floods, hurricanes, tornadoes, volcanoes
- Accidents: fire, vehicles, work related,
- War
- Interpersonal violence: physical or sexual, family, acquaintance, stranger. PTSD is more prevalent with interpersonal violence.
- Anything that is shocking to the client: i.e. an affair, unexpected realization or discovery.

Type I trauma: sudden, distinct traumatic experience which produces fully detailed, etched-in memories (Think of the twin towers falling over and over.)

Type II trauma: Long-standing and repeated traumatic ordeals produce defensive and coping strategies to ward off repeated assaults: massive denial, numbing, dissociation, identification with the aggressor, and aggression turned against self.

Does everyone exposed to trauma develop PTSD?

- Between 10 and 20 percent of those exposed to trauma develop PTSD.
- Inherited temperament affects one's response to stressors. Twin studies support a small inherited predisposition.
- Variables that affect formation of PTSD: degree of life threat (exposure to gruesome deaths, bodily injury, or bodies; extreme environmental or human violence or destruction; intense emotional demands; extreme fatigue; weather exposure; hunger or sleep deprivation; emotional/physical strain; chronic poverty, homelessness, unemployment, or discrimination; recent or subsequent major life stressors or emotional strain; duration of trauma; degree of displacement in home continuity; potential for recurrence; degree of moral conflict inherent in the situation; role of the person in the trauma; and the proportion of the community affected

Prevalence

- Perhaps up to one-fifth of adult women have been raped. One study estimated that 1.3 million women have rape-related PTSD and 211,000 will develop it each year.
- From 9 to 13 percent of all couples experience severe violence during their lives.
- About 10 percent of the population experience PTSD.
- From 20 to 50 percent of those with PTSD get better on their own.
- Thirty percent of those diagnosed with PTSD have it 10 years later.
- Nine thousand people got counseling after the Oklahoma City bombing; 250,000 were estimated to need counseling in New York City after September 11, 2001..

- Most people do not seek counseling due to the stigma, lack of education, and avoidance. Some may go to ecclesiastical counseling.

Diagnosis

A. Prior to the last month, the person was exposed to a traumatic event in which both of the following were present: the survivor experienced/witnessed/was confronted with an event that involved the death of another person(s) or potential death of the survivor or serious potential or actual injury to the survivor or a threat to the physical integrity of the survivor or others; or had developmentally inappropriate sexual experiences in childhood (e.g., sexual abuse), in which case there need not be threatened or actual violence or injury, AND the survivor's response to this event involved intense fear, helplessness, or horror OR, in children, disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in at least one of the following symptom categories within the last month: 1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. 2. recurrent distressing dreams of the event; 3. acting or feeling as if the event were recurring (including a sense of reliving the experience, non-psychotic hallucinations of the event, and flashbacks); 4. intense distress upon exposure to internal or external cues that symbolize/resemble the traumatic event; and 5. physiological reactivity (e.g., sweating, flushing, dizziness, increased heart rate, shortness of breath) upon exposure to internal or external cues that symbolize or resemble the traumatic event.

Three or more of the following (avoidance, numbing symptoms): 1. efforts to avoid thoughts, feelings, or conversations associated with the trauma; 2. efforts to avoid activities, places, or people that might stimulate or trigger recollections of the trauma; 3. inability to recall an important aspect of the trauma; 4. markedly diminished interest or participation in significant activities; 5. feelings of detachment/estrangement from others; 6. restricted range of affect (e.g., unable to have loving feelings); and 7. Sense of foreshortened future (e.g. survivor does not expect to have a career, marriage, children, or a normal life span).

Persistent symptoms of increased arousal that were not present before the trauma as indicated by at least two of the following: 1. difficulty falling or staying asleep, 2. irritability or outbursts of anger, 3. difficulty concentrating, 4. hypervigilance, and 5. exaggerated startle response.

These symptoms caused clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Children do more repetitive play and may have nightmares that get generalized into monsters. They may have physical symptoms such as headaches and stomachaches.

Associated Features

Problems with emotions

- Emotional regulation and tolerance: the ability to calm oneself (self-soothing, placing events in perspective, self-distraction).
- Survivor's guilt (I should have done more. I should have died instead.)

- Helplessness and control issues, loss of self-confidence and belief that their efforts will lead to success, or an unwarranted anxious desire to control everything. (I have no control over my life; I must have control over everything or terrible things happen.)
- Desensitization to the unacceptable. Accepting abuse as normal (trying to find normalcy through denial and numbing).
- Identity issues—I just do what others want me to do to survive.
- Dissociative symptoms (doing things and not remembering them, amnesia).
- Shame, feeling permanently damaged, despair, and depression.
- A loss of previously sustained beliefs (My world is shattered; I don't know how to make sense of things or how to predict my experience.)

Physical difficulties or stress-related conditions: headaches, ulcers, gastro-intestinal problems, high blood pressure, fibromyalgia/chronic fatigue, asthma, arthritis.

Interpersonal difficulties

- Estrangement from others (Relationships are counterfeit or mean nothing in the grand scheme of things.)
- Emotional enmeshment (can't connect with others emotionally in an equitable and reciprocal fashion: too demanding or overly dependent, emptiness, neediness).
- Boundary issues (demarcation between self and others)—Who is responsible for what (feelings)? Problems with effective help seeking and self-assertion.
- Trust (You will hurt me.)
- Abandonment and fear of rejection (Good things don't last; if you knew about me you'd reject me; everything I love goes bad or away.)
- Overly reactive emotional responses to normal interpersonal challenges.
- Avoidance of relationships and the possibility of learning appropriate attachment, social withdrawal.

Helper Considerations

- Need to prevent exposure to secondary trauma from hearing the details of the survivor's trauma. Could lead to symptoms in the helper: anger, depression, anxiety, sleep problems, intrusive images, cynicism, loss of trust, compassion fatigue, or numbing.
- Don't let your empathy allow you to be traumatized. This doesn't help heal the survivor any faster.
- Boundary issues: Don't let their difficulties run or ruin your life.
- Could have victims write the details rather than saying them to the helper.
- Helpers need to have a religious, spiritual, or philosophical basis that allows for meaning in suffering and a way to order the universe. They also need to have social support if they need to talk.
- Don't be bashful about using professional help when necessary.

What do therapists do? Treatment focuses on the client's symptoms:

1. Intrusive reliving

Give the message: “It’s okay to remember. It won’t likely happen again. I can remember without having to get stuck feeling it all over again for ever.” Use a journal to capture the thoughts so you don’t have to keep thinking them over and over. Learn to identify and label triggers and to manage flashbacks.

2. Avoidance reactions (numbing, alcohol or substance abuse, self-mutilation, sexual acting out, eating disorders)

There are also positive feelings in life in addition to “numb” or “bad.” Let’s increase the awareness of those positive feelings. I can learn to self-soothe, cope with unwanted feelings. I can bear feeling some things. Label feelings and deal with them differently (anger—time out or expression; fear—relaxation and self-soothing; sadness—cry and express). Mental rehearsal of coping strategies, role playing, effective problem solving, decision making, goal setting. Get control with planning, not obsessions. Teach emotional tolerance: the ability to bear negative affect. Learned from successfully dealing with surmountable obstacles (“This is tough, and I will survive.”)

3. Autonomic hyper arousal-physiological panic symptoms

Relaxation and imagery methods to teach self-calming; exercise.

4. Irrational beliefs which continue to misshape the world (The world is threatening—unnecessary guilt, self-esteem issues, trust, meaning, faith. Why didn’t God stop this?) Cognitive therapy methods to change troublesome thoughts (put things in perspective, arrive at a more comprehensive view of the world)

Group treatment: Reduces sense of isolation, helps foster belief that others can understand them, provides social support, validates and normalizes. Confirms the reality of the experience. Can share coping strategies. Counteracts self-blame, promotes self-esteem. Promotes empowerment and can decrease dependency. Practice attachment and intimacy, share grief and loss. Can help with assigning meaning to the event and changing irrational beliefs.

Managing Flashbacks

Don’t panic. Treat it like a seizure. Keep the survivor safe and let the event end on its own, which is usually in a few minutes.

You could identify yourself in a calm, clear voice and say: “That happened a long time ago. No one will hurt you now. You are safe now. I want you to come back here now and be with me. What time is it? What day is it? What is the date? Where are we? What’s my name? What’s your name?”

Web Sites for PTSD

<http://www.mentalhealth.com/> megasite for all disorders

<http://www.cmhc.com/> mental health net

<http://mhsource.com/> megasite

<http://www.ncptsd.org/> National Center for PTSD

<http://www.trauma-pages.com> David Baldwin’s Trauma Information Pages

<http://www.cs.utk.edu/~bartley/saInfoPage.html> Sexual Assault Information Page

<http://www.rossinst.com/> Ross Institute for Psychological Trauma

Mending a Psyche

November 11, 2001

By Susan Dominus

Early in the morning on September 18, a woman waited anxiously in a small counseling center at the Port Authority's Journal Square branch, her head in her lap, her arms crossing her chest. Catching sight of her, a therapist assumed the woman was a stranger, one of the hundreds of Port Authority employees who had shown up for one-on-one help since they'd fled tower one on September 11. But when the woman looked up, the therapist was shocked. "Our eyes locked," she said. "I recognized her and she recognized me." The patient—I'll call her by her middle name, Elizabeth—was a coworker she knew well, a nurse in her 50s from the Port Authority Medical Department. Elizabeth had always seemed invincible, the sort of person who inspired bravery in her patients. Now she was hunched over in distress, trembling. "To see her, of all people, that way—it reinforced for me the magnitude of the event," the therapist said.

Crying but trying to stay composed, Elizabeth was thinking about the "missing" posters she'd passed in the lobby, which included dozens of Port Authority policemen whom she knew from her work. As soon as they saw each other, Elizabeth broke down, sobbing wildly. She says she felt a rush of profound relief—after a week of panic and grief, someone might finally help her—but she also felt keenly her loss of control. "You know me," she choked out. "You know I'm a strong person. But this was too much for me." The two embraced, and Elizabeth shook in her friend's arms. "I feel so afraid," she told her. "I feel scared all the time." She was afraid of taking the elevator by herself to the second floor. She was afraid in her own home, sitting quietly with her husband.

The therapist asked Elizabeth if she wanted to see someone else, someone she didn't know, but Elizabeth shook her head no: she'd prefer to see someone who knew her well—someone who wouldn't underestimate the person she'd been before.

For Elizabeth, the Port Authority's close-knit culture made her feel more comfortable about seeking help. But for other employees, that closeness threatens their confidence in confidentiality. It's for their sense of security that I have been asked to abbreviate the therapist's name to Dr. F.

Dr. F. showed Elizabeth how to breathe slowly, then, speaking gently, went through some of the symptoms Elizabeth might be having. She might have lost her appetite, have trouble sleeping, have trouble concentrating. She might feel nervous, anxious, guilty, frustrated, or sad. These feelings, Dr. F. assured her, were both predictable and temporary. As she explained these basic ideas, Dr. F. recalls, "I could see immediately a lightness about her that hadn't been there before." The simple assurance that those symptoms were normal eliminated one of Elizabeth's chief fears. "Elizabeth literally said to me, 'Thank you—I feel so much better now that I know I'm not losing my mind,'" she says.

Finally, as Elizabeth tried to tell her therapist which of those emotions she'd been feeling and why, she tumbled into the story of what had happened on September 11. Lapsing in and out of tears, Elizabeth told her how the building had swayed when the plane struck, how she and her colleagues had charged down 62 flights of stairs. Barely stopping to search for the details her memory hadn't yet recovered—at what point had she taken off her shoes?—she forged ahead: and then, and then, and then. She told Dr. F. she'd been safely out of tower one for only a few minutes before she found herself engulfed by blackness, felled by the force of debris flying through the air. She crawled on the ground, inhaling dirt she'd be spitting out for days to come. Someone else who was crawling nearby reached out for help, inadvertently grabbing Elizabeth's neck and nearly choking her.

But more than the physical distress, what Elizabeth needed urgently to convey to the therapist was the deep sense of solitude she felt as she groped blindly on the ground. "In your mind you're totally alone," she said. "Like you were in the world by yourself, and no one could help you."

No sooner had two men dragged her to safety, she recalled, than the second tower fell, forcing her to flee again. While describing her sense of isolation, she'd seemed almost sobered by awe; but she dissolved into tears again as she remembered her sense of wild confusion and terror. The panic of the moment blurred with panic about her future, what her life would look like even if she survived. Overwhelmed by the memory, she reverted, sobbing, to the state that Dr. F. found her in. Slowly, slowly, her head sank all the way down to her knees. She swayed from side to side and seemed to want to disappear into the folds of her curled-up body. But this time she was reliving the terror of that memory in the presence of someone she describes as "warm, but professional." "It's important for her to feel that terror, but in a safe place," explains Dr. F. "She sees that I'm going through it with her, but that I'm not terrified, that I'm not running away."

Elizabeth left Dr. F.'s office only an hour after she arrived, but in that short time she'd gained a profound sense of relief: she felt calmer, looser, as though she were starting to separate the strands in a choking tangle of emotions. "I felt like I was coming back to reality a little bit," she says. Elizabeth also left with strict instructions to turn off the TV news and return to the routines of her life. "It's such a simple thing," Elizabeth says, "but maybe because she was a doctor, I did what she said." In the days after her session, Elizabeth started cleaning the house from attic to basement, gritting her teeth as she headed down into its darkness. And then that Thursday she ate a meal for the first time: lasagna her husband made "Two big helpings" she says, as if still amazed.

Before her session, Elizabeth had been feeling numb, detached from the people she loved most and unable to sleep—symptoms that frequently usher in the longer-term problem of post-traumatic stress syndrome. After her session, she found her four adult daughters could make her laugh again. She felt fatigued enough to sleep for the first time, if not through the night, for a few hours at least. And she started talking about, and remembering, more specific details of what had occurred that day. She wasn't ready to commit to ongoing therapy, but she had new respect for its power. "If I hadn't talked to her, I would have let the fear overtake me," she says now. "I would have been home crying, at home all the time, scared to do anything. And it just would not have been me."

A few days after that session, Elizabeth felt strong enough to drive herself to church. “I’ve always been religious, since I was a child,” she says, and a Southern accent slips momentarily into her speech. But minutes after the service ended, she felt an unexpected hollowness. “It’s hard to explain,” she says. “I just felt real alone, real sad.” The fear was also creeping back. She remembered being told that there was a crisis center in a nearby hospital, and that’s where she drove. Within 15 minutes, she was escorted to a therapist’s office. A young woman with a kind manner and cornrowed hairdo listened attentively as Elizabeth talked about the question that had been weighing on her, one she hadn’t raised in Dr. F.’s office: Why had she been spared?

She had been haunted by a memory from September 11: As she was making her way down the stairwell of World Trade Center One, she passed a Port Authority cop she knew—a young man with two sons—who was on his way up. He said, “Just keep going, Elizabeth; you’re going to be Okay.” She waved at him: a single sweet flap of her hand. Days later, she’d see his face among the missing posters.

“Why me?” she asked the therapist, “My kids are grown. I don’t need to be here.” That feeling of guilt would not have been easy to admit in church, where she had testified gratefully to her miraculous salvation amid cries from her fellow congregants: praise the Lord; he was there with you. Nor could she convey it to her family—to them there was no question as to whether they still needed her. But in the privacy of a stranger’s office, she was able to express her self-doubt. Elizabeth says the young woman assured her that for whatever his reason, the Lord meant for her to be there.

Did the therapist really talk about the Almighty? When pressed, Elizabeth conceded that the counsel had been more general, but that’s what I understood her to mean,” she says. Therapy augmented her spiritual foundations; at other times, church would augment what she gained in therapy. Elizabeth was by now a true believer in both.

Finally, after four weeks of delaying and postponing, Elizabeth returned to work, at her new office in the Port Authority’s Technical Center. Her first week back was hard—the building was three stories high, which was two too many—but she was quickly busy dispensing flu shots, giving physicals, and playfully bossing around old colleagues. (“That felt real good,” she tells me, laughing, and it’s a loud, contagious laugh, a laugh from before.) But a week or so later she was incapacitated again. A friend came upon her hyperventilating in the hallway and ushered her directly to the office of another longtime colleague, Dr. D.

That therapist has also been newly relocated at the Tech Center, and her office is a low-ceilinged, small white cube. But the minute she entered it, Elizabeth felt a rare calm. A still, serious woman, Dr. D. speaks with a voice that is naturally low in tone and volume; talking to her, you’re inclined to match her soothing cadence. Once Elizabeth regained her composure, she explained what had set her off: for the first time since the 11th, she’d seen a medical assistant with whom she’d made the descent. The assistant had hurt her back and was unable to walk on her own, so she’d leaned her weight on Elizabeth and a friend, who slowly helped her down all those flights. The day they reunited, the medical assistant was still hysterical with fear. “It was like when I hugged her, she transferred her fear into me,” Elizabeth tried to explain.

Dr. D. had been on the stairs as well, and she knew that the medical assistant had been screaming in terror as they made the descent. “Seeing her today, sounding and feeling the way she did the day of the attack, feeling her body close to yours—it’s a trigger,” she told Elizabeth. “She’s put you right back where you were on the stairs.” Until then, Elizabeth hadn’t focused on the panic her colleague had exhibited that day or the effort it took to avoid its contagion, but now she remembered it vividly. “It made me feel better to understand that this feeling hadn’t come on out of the blue,” Elizabeth says. “I felt like I wouldn’t go to pieces the next time I saw that person again.”

But the fact that her therapist had firsthand experience of what Elizabeth had been through brought up another issue for her, one she raised in a follow-up session a few days later. “What about you?” she asked. If what Elizabeth was feeling was normal, then why was Dr. D. sitting there so calmly, as if she’d never felt a moment’s disruption? “I tried to be up front about it and use my own experience rather than ignore it,” the therapist explains. “I told her that I would be feeling exactly the way that she does, except that I have the training to already know the coping mechanisms that I’m trying to pass on to her.”

The discrepancy between them played on Elizabeth’s mind, but the conversation was a victory of sorts. Her previous sessions had entailed psychological triage, as the therapists taught Elizabeth crude but effective tools just to keep her from falling apart. Now she and Dr. D. had moved past the survival mechanisms to a more nuanced approach, circling around Elizabeth’s relationship to therapy itself.

In that same session, Elizabeth talked about her reluctance to continue on with a regular schedule of therapy. She’d said weeks earlier that she would start but had put it off, claiming she was too busy; in truth, she felt more comfortable with a scattershot approach rather than with burdening one person with her problems. “Even though I believe in it, it’s still hard for me to accept that I need it,” she said. “Won’t people say, ‘Elizabeth? In therapy?’” Dr. D. explained to her that that feeling—the sense that she’d let someone down by asking for help—was getting in the way of her recovery. “It’s a little sad to admit I need this, but it’s a little empowering,” Elizabeth says, a day or two after that session. “Now I think you cannot get better on your own. I’m sure even Dr. D. is talking to someone.”

Elizabeth has resigned herself to the understanding that she can’t will the flashbacks away, and that it might take months, or years, before she feels fully restored. Since that meeting, Dr. D. and Elizabeth have agreed to meet for regular sessions, in which she’d be receiving one of the most effective treatments for trauma, cognitive behavioral therapy. Specifically, her therapist will use a technique known as desensitization, in which Elizabeth will construct a hierarchy of the triggers that alarm her, from least terrifying to most. In the first session, Dr. D. will walk Elizabeth through some relaxation techniques—deep breathing, muscle relaxation—while she conjures a vision of the least anxiety-producing stimuli. Elizabeth now has a terror of tall buildings; the lowest item on her list might merely be “walking toward the building.” Once she can think about that calmly, the two will carefully talk through the next one, and then the next, returning to a “safe image” if it gets to be overwhelming. The process can take months. Eventually, some therapists build up to actual exposure to whatever it is that most terrifies the

patient. Some therapists have expressed hope that some part of the wreckage at the towers will remain in place: it's that important that their patients overcome their fear.

"I don't think I'll ever fly again," Elizabeth says. "But then again, who knows? Look how far I've come." The pride in her voice as she talks about her recovery is evident. "I can drive," she says. "I can go grocery shopping alone if I have to. Even just staying in my home alone, now I can do it—a little bit. I'm still leery, but if I have to stay alone, I can."

Her family has been spending a lot of time together, grateful for her survival, grateful for her returning peace of mind, a recovery they weren't sure they could hope for early on. Her daughter says she's relieved to see her mother getting back into all her routines—having dinner alone with her husband at the diner where they go every Thursday, cooking huge meals on Sundays. There's just one ritual she is surprised her mother hasn't resumed, her daughter says, "and I can't understand it. My mom's stopped playing the lottery. Ever since I was a little kid, my mom always played the 'Pick-It'; I've never known her not to. And the other day I asked her if she wanted me to put some numbers down for her, and she just said, 'I don't play the "Pick-It" anymore.'"

I ask Elizabeth why that is. She thinks for a minute, then answers. "I feel lucky to be alive."

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