

"The most valuable, user-friendly manual on PTSD I have ever seen. Must reading for victims, their families, and their therapists."

—George S. Everly, Jr., Ph.D., executive editor,
International Journal of Emergency Mental Health

The Post- Traumatic Stress Disorder SOURCEBOOK

A GUIDE
TO
HEALING,
RECOVERY,
AND
GROWTH



Glenn R. Schiraldi, Ph.D.

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ALSO BY GLENN R. SCHIRALDI:

Conquer Anxiety, Worry and Nervous Fatigue: A Guide to Greater Peace

Building Self-Esteem: A 125-Day Program

Facts to Relax By: A Guide to Relaxation and Stress Reduction

Hope and Help for Depression: A Practical Guide

Stress Management Strategies

The Post-Traumatic Stress Disorder Sourcebook

A Guide to Healing, Recovery, and Growth

Glenn R. Schiraldi, Ph.D.

The Post-Traumatic Stress Disorder Sourcebook is intended solely for educational and informational purposes and not as medical advice. Please consult a medical or mental health professional if you have any questions about your health.

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In recent years, so much has been learned about post-traumatic stress disorder (PTSD). No one compiles a synthesis such as this one without relying on the cumulative efforts of many brilliant theorists, researchers, and clinicians who have advanced our understanding of PTSD and its treatment. I am grateful to dissociation pioneers Drs. Pierre Janet, Richard P Kluft, Frank W Putnam, and Richard J. Loewenstein. I am thankful to Drs. Bessel van der Kolk for his insights regarding the brain and trauma, George S. Everly, Jr., Charles R. Figley, Edna B. Foa, Judith L. Herman, Mardi Horowitz, Donald Meichenbaum, James W. Pennebaker, Beverly Raphael, Francine Shapiro, John P. Wilson, and many others who have so diligently labored to further our knowledge.

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Finally, I am exceedingly grateful to the survivors of trauma in all walks of life who have battled to overcome their symptoms, and by their courage inspired us all.

Portions of this book have been adapted from some of my previous works: *Conquer Anxiety, Worry and Nervous Fatigue: A Guide to Greater Peace*; *Building Self-Esteem: A 125-Day Program*; *Facts to Relax By: A Guide to Relaxation and Stress Reduction*; *Hope and Help for Depression: A Practical Guide*; and *Stress Management Strategies*.

The book provides information on the most promising treatment approaches for post-traumatic stress disorder. It will likely inform you and help you make wise decisions regarding your healing, recovery, and growth. However, this book is not a substitute for treatment by a qualified mental health professional, when such help is needed.

Pace yourself when reading this book so as not to become overwhelmed. The treatment approaches described herein can be very effective if properly timed, paced, and applied within the context of a sound working relationship with a skilled mental health professional. Conversely, some approaches (sometimes even certain symptom management approaches), when applied too early, too fast, or alone, might actually increase symptoms. A skilled therapist can help ensure that issues of pacing and safety are attended to, while helping to provide perspective amidst the complexities of recovery. If in doubt, discuss any questions you have with a mental health professional specializing in post-traumatic stress disorder before attempting any approach described herein.

Finally, research regarding the treatment of PTSD is in its early stages. As yet no one treatment approach has been shown to be superior to any other for all people. Thus, it is important that survivors and clinicians be informed about the range of treatment options so that they can make the best decisions possible about the treatment or combination of treatment approaches.

INTRODUCTION

We are never prepared for what we expect.

-James A. Michener, Caravans

A firefighter cradles a lifeless little girl. Seven months later he leaves his beloved profession because of post-traumatic stress disorder (PTSD). In a dimly-lit campus parking lot, a bright coed is assaulted. Three weeks later she drops out of college. PTSD has claimed yet another victim.

Life doesn't prepare us for trauma. Following exposure to traumatic events, millions of people develop PTSD, or lesser forms of this condition with symptoms ranging from nightmares to headaches, flashbacks, withdrawing from people, profound sadness, anxiety, anger, guilt, fatigue, pessimism, sexual problems, and emotional numbing. Unless proper treatment is found, many, perhaps most, of these people will secretly and needlessly battle distressing symptoms for life.

The good news, however, is that PTSD can be treated successfully. With the right treatment, victims can begin to heal and return to the journey of joyful living. This book is written for all victims of trauma. You will find it useful if you are a survivor of rape, abuse of any kind, domestic violence, war, crime, natural disasters, industrial disasters, accidents, terrorism, and

other traumatic events. It will also be helpful to those whose work exposes them to trauma. Such professions include police officers, fire fighters, rescue and disaster workers, military service personnel, emergency medical service workers, paramedics, physicians, and nurses. The book will help you understand the changes that traumatic events cause in people, the process of recovery, and the full range of treatment options. In addition, this book will be of great use to concerned friends, family, and health professionals who associate with survivors of traumatic events.

If you are a survivor, the book will involve you in your own healing and help you to take control of your recovery process. It will also help you to recognize your limitations, determine if help is needed, and find the right help. Once you understand the promising range of treatment options available, you will be better able to choose the best ones for you and benefit from their use. Should you decide to seek the services of a mental health professional, this book will be a valuable resource to you both.

In one sense, PTSD is described by great emotional upheaval and the shattering of the soul. From another view, however, PTSD is also the story of courage, determination, resilience, and the ultimate triumph of the human spirit. Today there is much cause for hope. People with PTSD can be helped. We now know many ways to lessen the great suffering caused by traumatic events, to help victims deal more comfortably with lingering or recurrent symptoms, and to help them move beyond the trauma. It seems that these words apply especially to this book:

Pain is a great teacher. Yet the greatest teacher imparts little wisdom if the student has not eyes to see and ears to hear. I write this so that we may benefit from our suffering and triumph over our pain . . . and in the process become better, stronger, warmer, more compassionate, deeper, happier human beings realizing that the ultimate value of pain reduction is not comfort, but growth.¹

The goal of this book, then, is to help you move beyond survival, toward the realm of living well. Because you are certainly more than a survivor . . . and much more than just a victim.

The book is organized as follows:

Part I explains all about PTSD. You'll understand that the symptoms you are experiencing make sense, and that you are not going crazy. You'll understand anxiety, dissociation, memory networks, and triggers. And you'll get answers to commonly asked questions.

Part II explains that healing, recovery, and growth are possible. You'll

understand the principles of treatment and healing, and the broad types of treatment approaches that are available.

Part III prepares you for healing and recovery. You'll be guided to establish physical and emotional safety, and to take care of important needs.

In Part IV you will learn how to manage troubling symptoms of PTSD so that you can be more comfortable and progress more successfully and confidently in treatment.

Part V explains the broad range of treatment options that are available to you. Chapters 19 to 22 explain important basic principles and skills for neutralizing traumatic memories, including changing commonly held negative and guilt-promoting thoughts. You'll learn how confiding traumatic wounds begins the healing process. Promising newer therapeutic approaches are described in chapters 23 to 27. These are applied under the direction of a therapist; however, you'll know what to ask for and will tend to be more comfortable with these approaches once you've read about them. Chapters 28 to 39 describe other important approaches to healing. Some approaches, such as those in chapters 29, 33, and 38 are applied under the direction of a therapist. Other chapters will be useful to discuss in a therapeutic setting and/or to try as homework under a therapist's direction. The reminder is constant: read for understanding there is power in being informed. If there is any doubt about what to apply or when, discuss your questions with a trauma specialist before attempting anything in this book.

Part VI will help you move beyond PTSD and grow despite your experience with trauma. We'll explore positive aspects of living including intimacy, sexuality, meaning and purpose, spiritual and religious satisfaction, happiness, pleasure, and humor. And finally, you'll be shown how to plan for setbacks and cope with them confidently.

Finally, a range of appendices will direct you to additional important information, including a very comprehensive resource list. Read this book with hope, for indeed there is good reason to hope. Remain committed to your well-being and to the enjoyment of life, and you will become a more valuable resource to others and to yourself.

PART I

ABOUT PTSD

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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.

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.

Table 1.1

POTENTIALLY TRAUMATIC EVENTS/STRESSORS

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

- Abuse
- Combat, civil war, resistance fighting
- 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) Σ
- 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

- siveness 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.**

- C. Avoidance.** Persistent avoidance of stimuli associated with the trauma and numbing of general respon-

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

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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 blood¹²
- elevated heart rate (either resting or in response to stress)
- elevated blood pressure
- hyperventilation (i.e., expelling CO₂ 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, how-

ever, 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.

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