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# Posttraumatic Stress Disorder

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**Posttraumatic Stress Disorder.** Posttraumatic stress disorder (PTSD) is a psychological disorder precipitated by exposure to a traumatic event or a series of events. This event is usually experienced by an individual. However, PTSD can also develop as a result of observing or hearing of a traumatic event occurring in someone else's life (such as a relative or a close friend). PTSD was introduced as a disorder in 1980 in the *DSM-III*. The *DSM-III-R*'s condition for diagnosis was the experiencing of a traumatic event that was "outside the range of usual human experience." However, in *DSM-IV*, the focus is not so much on the nature of the event as it is on the individual's response to the event and his or her vulnerability to developing the characteristic symptoms.

**Clinical Picture.** Individuals with PTSD experience three categories of symptoms—intrusive recollections, avoidant-numbing symptoms, and hyperarousal. Reexperiencing the trauma through intrusive recollections such as flashbacks and nightmares, in which the individual involuntarily feels or acts as though the events were recurring, are considered the hallmark symptoms of PTSD (Calhoun & Resick, 1993). The nightmares are usually replications of the traumatic event, whereas flashbacks are evidenced by extreme physiological and emotional arousal in which the individual feels immobilized and becomes unaware of his or her surroundings. The intrusive recollections are triggered by specific events that resemble or symbolize some aspect of the trauma: an anniversary, the sound of a gunshot, weather conditions, a particular scent, clothing, or location. For instance, a woman who

was raped in an elevator would breathe quickly and begin to sweat upon entering one.

Individuals also tend to avoid stimuli related to the trauma. Conscious efforts are made to avoid feelings, thoughts, and activities related to the traumatic events. Individuals also resist talking about the trauma because it brings up recollections of the events. The numbing behavior is usually evident through a lessened response to the outside world that occurs soon after the traumatic experience. Individuals no longer enjoy some of the activities they were previously interested in and maintain distance from others. They have difficulties labeling their feelings or trusting others, and they often feel that the future is meaningless. Individuals may also experience problems recalling important aspects of the event because of their tendency to avoid the anxiety aroused by memories of the events. For some individuals, dissociation may occur; they become amnesic about the feelings and memories of the trauma. They also feel anger toward those who were responsible for the events, ashamed of their feelings of helplessness, and guilty about what they did or failed to do. These feelings of anger, avoidance, guilt, and shame may cause them to feel isolated and demoralized (American Psychiatric Association, 1994; Long, 1996; Tomb, 1994).

These individuals also become easily startled or physically aroused, responses that were not present prior to the trauma. They experience symptoms of anxiety as evidenced by difficulties falling or staying asleep because of the nightmares they repeatedly experience. Individuals also tend to be hyper-vigilant about their environment. For instance, rape victims continually scan their environment watching for potential rapists. Other symptoms include irritable feelings, uncontrollable anger, and problems with concentrating and finishing tasks.

The symptoms usually take a different form with children. They experience nightmares about monsters rather than traumatic events. They reenact the events in compulsive play and daydreams and often complain of headaches and stomachaches. They also regress to more infantlike behaviors and forget toilet training. Separation anxiety, fear of strangers, and school phobias are not uncommon. Defiant, passive, or clinging behaviors also occur (American Psychiatric Association, 1994; Long, 1996; Tomb, 1994).

**Etiology.** Disagreement exists concerning the relationship between particular predispositions and the probability of developing PTSD. However, the likelihood that a stressor will produce PTSD is greater if the stress is sudden, severe, unexpected, prolonged, repetitive, life-threatening, humiliating, isolating, causes physical damage, and destroys one's community and social support system. Individuals seem to have a higher risk of developing PTSD if they have a previous psychiatric disorder, a family history of psychiatric illness, a personality style such as introversion, personality disorders, a history of

trauma, inadequate coping skills, poor stress tolerance, and insufficient social supports (Tomb, 1994).

**Diagnostic Criteria.** In order to make a diagnosis of PTSD, the *DSM-IV* criteria require that the individual be exposed to or have a history of exposure to a "traumatic event" or events that involve actual or threatened death or serious injury or a threat to physical integrity. These events include military combat, natural or manmade disasters, accidents, violent assaults (sexual abuse, rape, kidnapping, torture), and diagnosis with a terminal disease. The immediate response to these events is fear, helplessness, or horror. Witnessing the events or learning about them occurring with family members or close friends rather than directly experiencing them is also included in the criteria. Other symptoms include persistent reexperiencing of the traumatic event, avoidance of stimuli that are related to the events and feelings of numbness, and increased arousal. These symptoms must occur for more than one month and cause severe impairment in social, occupational, and other areas of functioning. The diagnosis is "acute" when the symptoms have occurred for less than three months, "chronic" when the symptoms persist for three months or longer, and "with delayed onset" when the symptoms begin six months after the occurrence of the trauma. If the symptoms of anxiety occur within one month after being exposed to the traumatic event, the diagnosis is acute stress disorder (American Psychiatric Association, 1994).

**Treatment.** Treatment should occur immediately after the traumatic event occurs or as soon as possible after its occurrence. Three significant goals of therapy are to establish a safe, trusting environment so that the individual can talk about traumatic material; to explore traumatic material in sufficient depth so that the individual can gradually integrate intrusive recollections with avoidant symptoms; and to assist the individual in disconnecting from the trauma and working on reestablishment of relationships with family and friends (Friedman, 1996; Herman, 1992). The therapist's genuineness, warmth, and empathy aid the patient in this process by his or her confidence about the treatment and ability to understand the significance of the trauma. Various approaches to treatment are common. The psychodynamic approach focuses on altering destructive attributions and reinterpreting the experience and involves gradual confrontation of the patient's feeling of shame, helplessness, and vulnerability. The behavioral approach emphasizes how the patient can cope with present symptoms and problems through exposure, rather than uncovering the story of the trauma (Tomb, 1994). Eye Movement Desensitization and Reprocessing (EMDR), a relatively new and controversial treatment that uses rapid rhythmic eye movements, shows some promise (Shapiro, 1989). Many trauma victims also find group treatment helpful (Tomb, 1994).

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See TRAUMA; STRESS.