Responding to Violence and Trauma

My history – worked for about 16-17 years as a Biblical Counselor. Ran a transitional home for mothers and their children for 5 years, ran a residential treatment center for girls for 6 ½ years, and have been volunteer counseling for 5 years

I love Jesus. He is my identity.

I never set out to be a counselor. I never was interested in counseling traumatized women. I especially never intended to study psychological manuals and treatment plans to help girls who were unfit to function in society. I have come to this place kind of accidentally by just trying to serve the next need.

So to help you know how to listen to this session here are some things about the way I think that will help you to know me well enough to decide how to process this sessions data:

- I trust some of the secular psychological diagnosis. They're great at organizing data.
- Don't trust psycho treatment plans, necessarily. They don't believe that problems this big can be resolved. They don't believe in healing or restoration.
- I use secular Psychology diagnostic material to understand, but I really try to use a lot of discernment and wisdom when considering worldly wisdom and interventions.
- My observation from years of social service interactions confirm the secular Psychological diagnostic material. If I trusted only my observations my understandings might be incomplete, b/c my observations are limited to my limited experiences and the field in which I worked.
- I saw the majority of what is described in this lecture in one situation or another over my years of professional work.
- I continue to see what is described in this lecture in some of my voluntarily biblical counseling just through my church outside of the residential setting. If I did not have the previous experience, education, and intervention knowledge I would be really really overwhelmed with my once weekly for an hour counseling session.

I love Jesus and I love biblical counseling.

- But I'm not such a strict biblical counselor that I believe that the only wisdom there is, is found in scriptures.
- I believe all wisdom should be compared to the scriptures and only what matches up with it should be believed and acted upon.
- But there is a lot of wisdom and knowledge available and a lot of people are passionate about research and intervention in hurting people's lives.
- I pray for sensitivity to the Holy Spirit, for the ability to not be affected by my emotions when working with hard counseling situations, and for the capacity to not become self-guided in my interventions.

My experience is mostly with adult women working through Complex PTSD

I choose to believe the best about the different secular theorists even when I disagree with their conclusions or interactions. I also choose to believe the best about the different Christian or biblical counselors who may have already tried to help my clients.

- I will not agree with all of them.
- I will not agree with many of them.
- I will do my best to not judge or criticize or slander or accuse the motives of any of them.
- If I believe that the theorists involved really care about their clients and are doing their best to help them be successful, I will be careful to treat both the theorists and their clients with love and respect.
- They were doing their best to understand and treat complex problems, often without the aid of a biblical viewpoint, a savior, or the Holy Spirit. That helps me treat them gently.

Note on Notes: A blank column has been provided for you to jot down notes throughout the lecture similar to what you would do while you're counseling someone and gathering data.

- In situations like trauma we are often tempted to think "How could I possibly help someone who has been hurt or damaged so significantly?"
- It feels as if their situation is more complex than you can handle.

This first session is going to focus mostly on organizing the mental, emotional, physical, and relational data that is prevalent in the life of someone affected by trauma and extreme stressors. Sessions two and three will focus more on how to help someone spiritually as they resolve those mental, emotional, physical, and relational stressors.

However, woven through this first session you are going to hear **clue words** or **phrases** that will help indicate themes you might want to explore biblically that will prep you to teach and disciple those who might be suffering through trauma.

- Obviously, with a real person in a real counseling case you would need to personalize that help to present biblical solutions to a real situation.
- But I want to encourage you to be listening for themes that you recognize from Scripture no matter how a secular person would organize these volumes of mental, emotional, physical, and relational data.

I would encourage you to use the Brainstorming Notes Column to write down any words that you hear that would indicate a pattern that you would then be able to use to organize how you are going to plan to help this counselee from a biblical perspective. I will do some of this with the power point, but I encourage you to try to identify common biblical themes as I teach this first session.

For example:

I'm about to begin this session by sharing some definitions to frequently used words. When you hear those definitions, jot down the biblical themes you see or questions you'd want to explore later.

I. Definitions:

A. Violence – the use of physical **force** so as to injure, abuse, damage, or destroy; intense, turbulent, or furious and often destructive action or force[1]

B. Trauma – an **injury** such as a wound; a disordered psychic or behavioral state resulting from severe mental or emotional stress or physical injury; an emotional upset; Trauma is the Greek word for "wound." The psychological reaction to an emotional trauma is called Posttraumatic Stress Disorder.

II. A Short History of Trauma and Mental Health:

A. Symptoms of trauma-related mental health issues have been recorded since the days of the ancient Greeks.[2]

B. During the World Wars PTSD was known as "Shell shock" and "combat neurosis."[3]

C. A diagnosis regarding trauma related mental health issues was included in the 1952 DSM-I as "gross stress reaction."[4]

D. "Posttraumatic stress disorder" came into use in the 1970's following military action in the Vietnam War.[5]

E. PTSD was officially recognized by the American Psychiatric Association in 1980.[6]

F. DSM-III diagnoses and descriptions were influenced by the experiences of the soldiers in the Vietnam War (railway spine, stress syndrome, nostalgia, soldier's heart, shell shock, battle fatigue, combat stress reaction, traumatic war neurosis).

G. Complex PTSD was first described in 1992 and is not yet adopted by the American Psychiatric Association's Diagnostic and Statistical Manual.[7] The International Classification of Diseases (ICD), maintained by the World Health Organization has included CPTSD in the 11th edition.[8]

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[1] https://www.merriam-webster.com/dictionary/violence

[2] *Handbook of Integrative Clinical Psychology, Psychiatry, and Behavioral Medicine Perspectives, Practices, and Research*. New York: Springer Pub. Co. p. 353. ISBN 9780826110954.

[3] Herman J (2015). *Trauma and Recovery: The Aftermath of Violence—From Domestic Abuse to Political Terror*. Basic Books. p. 9. ISBN 9780465098736.

[4] Andreasen NC (October 2010). "Posttraumatic stress disorder: a history and a critique". *Annals of the New York Academy of Sciences*. **1208** (Psychiatric and Neurologic Aspects of War): 67–71. doi:10.1111/j.1749-6632.2010.05699.x. PMID 20955327.

[5] *Clinical child psychiatry* (3. ed.). Chichester, West Sussex, UK: John Wiley & Sons. p. Chapter 15. ISBN 9781119967705.

[6] "Finalizing PTSD in DSM-5: getting here from there and where to go next". *Journal of Traumatic Stress*. **26** (5): 548–56. doi:10.1002/jts.21840. PMID 24151001.

[7] Judith L. Herman (30 May 1997). *Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror*. Basic Books. ISBN 978-0-465-08730-3. Retrieved 29 October 2012.

[8] https://cptsd.com/

III. Prevalence of Trauma Related Mental Health Problems:

A. Most who experience a traumatic event will not develop PTSD.[9] They will:

- experience the trauma,
- think through it,
- come to healthy conclusions, and
- allow the difficult event to be integrated into their life story without life-altering complications.

B. For those that struggle to resolve traumatic events, **symptoms of Acute Stress Reaction or Acute Stress Disorder may begin immediately.**

C. If those symptoms persist longer than one month, Posttraumatic Stress Disorder may be diagnosed. PTSD generally begin within 3 months about the inciting traumatic event, but sometimes delays for years.[10]

D. Worldwide statistics:

In the United States:

- More than **60**% of men and women will experience one traumatic event in their life.[11]
- About **3.5%** of adults have PTSD in a given year.
- **Adults - 6.8%**[12] **- 9%** of adults will develop it at some point in their life.[13]
  - Of that total:
    - Men **– 3.6%**
    - Women – **9.7%** (more than twice as likely to develop PTSD as men)[14]
  - Men are more likely to experience a traumatic event, but women are more likely for their traumatic event to result in troublesome mental health or emotionally troubled symptoms. It is more common in women

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[9] Bisson JI, Cosgrove S, Lewis C, Robert NP (November 2015). "Post-traumatic stress disorder". *BMJ*. **351**: h6161. doi:10.1136/bmj.h6161. PMC 4663500. PMID 26611143.
[10] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing. pp. 271–280. ISBN 978-0-89042-555-8.
[11] Olszewski TM, Varrasse JF (June 2005). "The neurobiology of PTSD: implications for nurses". *Journal of Psychosocial Nursing and Mental Health Services*. **43** (6): 40–7. PMID 16018133.
[12] Olszewski TM, Varrasse JF (June 2005). "The neurobiology of PTSD: implications for nurses". *Journal of Psychosocial Nursing and Mental Health Services*. **43** (6): 40–7. PMID 16018133.
[13] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing. pp. 271–280. ISBN 978-0-89042-555-8.
[14] Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB (December 1995). "Posttraumatic stress disorder in the National Comorbidity Survey". *Archives of General Psychiatry*. **52** (12): 1048–60. doi:10.1001/archpsyc.1995.03950240066012. PMID 7492257.

than men[15] which makes sense because women are more likely to experience interpersonal violence and sexual assault. [16]

- **Children** – Children are less likely to develop PTSD after trauma, especially if they are under 10 years of age. [17]
    - Active PTSD is diagnosed in only **1%** of children in a non-war torn and developed country, but their symptoms may continue for decades in the absence of therapy.[18]
    - **16%** of children exposed to a traumatic event in childhood eventually develop PTSD.[19]

In the rest of the world

- Between 0.5% and 1%[20]
- Higher rates during armed conflict[21]

E. Those experiencing **interpersonal** trauma are more likely to develop PTSD (rape, child abuse) compared to someone experiencing **non-assault-based trauma** (accident, natural disaster).[22]

F. Those most at risk to develop PTSD or some trauma related diagnosis include the following:

- Most common type of event leading to development of PTSD worldwide…**Someone who experiences an unexpected death of a loved one** –

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[15] "Post-Traumatic Stress Disorder". *National Institute of Mental Health*. February 2016. Archived from the original on 9 March 2016. Retrieved 10 March 2016.

[16] *National Collaborating Centre for Mental Health (UK) (2005). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. NICE Clinical Guidelines, No. 26. National Institute for Health and Clinical Excellence: Guidance. Gaskell (Royal College of Psychiatrists). ISBN 9781904671251. Archivedfrom the original on 2017-09-08. Lay summary – Pubmed Health (plain English).*

[1717] *National Collaborating Centre for Mental Health (UK) (2005). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. NICE Clinical Guidelines, No. 26. National Institute for Health and Clinical Excellence: Guidance. Gaskell (Royal College of Psychiatrists). ISBN 9781904671251. Archived from the original on 2017-09-08. Lay summary – Pubmed Health (plain English).*

[18] *National Collaborating Centre for Mental Health (UK) (2005). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. NICE Clinical Guidelines, No. 26. National Institute for Health and Clinical Excellence: Guidance. Gaskell (Royal College of Psychiatrists). ISBN 9781904671251. Archived from the original on 2017-09-08. Lay summary – Pubmed Health (plain English).*

[19] Alisic E, Zalta AK, van Wesel F, Larsen SE, Hafstad GS, Hassanpour K, Smid GE (2014). "Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis". *The British Journal of Psychiatry*. **204** (5): 335–40. doi:10.1192/bjp.bp.113.131227. PMID 24785767.

[20] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing. pp. 271–280. ISBN 978-0-89042-555-8.

[21] Bisson JI, Cosgrove S, Lewis C, Robert NP (November 2015). "Post-traumatic stress disorder". *BMJ*. **351**: h6161. doi:10.1136/bmj.h6161. PMC 4663500. PMID 26611143.

[22] Zoladz PR, Diamond DM (June 2013). "Current status on behavioral and biological markers of PTSD: a search for clarity in a conflicting literature". *Neuroscience and Biobehavioral Reviews*. **37** (5): 860–95. doi:10.1016/j.neubiorev.2013.03.024. PMID 23567521.

        - 5.2% risk of developing PTSD after learning of the unexpected death of a loved one[23]
        - because this is such a high percent this accounts for about 20% of PTSD cases worldwide.[24]
    - Victims of **violent crime**
    - Victims of **natural disasters**
    - Persons employed in occupations that expose them to **violence** (soldiers/police)
    - Persons employed in occupations that expose them to **disasters** (emergency service personal/firefighters) [25]
    - **Combat** military personnel (78% of people exposed to combat will not develop PTSD; and of the 25% of military personnel who do experience PTSD, its appearance is usually delayed[26])
    - Victims of inter-partner violence
        - **Domestic Violence**
        - Domestic Violence while pregnant
        - **Sexual assault** or rape:
            - About 50% of those who are raped will develop PTSD[27]
            - especially when the victim was confined or restrained
            - if the victim believed they would be killed
            - if the victim was very young or very old
            - if the rapist was an acquaintance
            - if the victim was not believed or blamed[28]
    - Those who experience life-threatening **illness** or who have children experiencing life-threatening illnesses – cancer, heart attack, stroke. 22% of cancer survivors may have life-long PTSD symptoms.
    - Women with **pregnancy** related trauma –

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[23] Atwoli L, Stein DJ, King A, Petukhova M, Aguilar-Gaxiola S, Alonso J, Bromet EJ, de Girolamo G, Demyttenaere K, Florescu S, Maria Haro J, Karam EG, Kawakami N, Lee S, Lepine JP, Navarro-Mateu F, O'Neill S, Pennell BE, Piazza M, Posada-Villa J, Sampson NA, Ten Have M, Zaslavsky AM, Kessler RC (April 2017). "Posttraumatic stress disorder associated with unexpected death of a loved one: Cross-national findings from the world mental health surveys". *Depression and Anxiety*. **34** (4): 315–326. doi:10.1002/da.22579. PMC 5661943. PMID 27921352.

[24] Kessler RC, Aguilar-Gaxiola S, Alonso J, Benjet C, Bromet EJ, Cardoso G, Degenhardt L, de Girolamo G, Dinolova RV, Ferry F, Florescu S, Gureje O, Haro JM, Huang Y, Karam EG, Kawakami N, Lee S, Lepine JP, Levinson D, Navarro-Mateu F, Pennell BE, Piazza M, Posada-Villa J, Scott KM, Stein DJ, Ten Have M, Torres Y, Viana MC, Petukhova MV, Sampson NA, Zaslavsky AM, Koenen KC (2017-10-27). "Trauma and PTSD in the WHO World Mental Health Surveys". *European Journal of Psychotraumatology*. **8** (sup5): 1353383. doi:10.1080/20008198.2017.1353383. PMC 5632781. PMID 29075426.

[25] Fullerton CS, Ursano RJ, Wang L (August 2004). "Acute stress disorder, posttraumatic stress disorder, and depression in disaster or rescue workers". *The American Journal of Psychiatry*. **161** (8): 1370–6. CiteSeerX 10.1.1.600.4486. doi:10.1176/appi.ajp.161.8.1370. PMID 15285961.

[26] Shalev A, Liberzon I, Marmar C (June 2017). "Post-Traumatic Stress Disorder". *The New England Journal of Medicine*. **376** (25): 2459–2469. doi:10.1056/NEJMra1612499. PMID 28636846.

[27] Bisson JI, Cosgrove S, Lewis C, Robert NP (November 2015). "Post-traumatic stress disorder". *BMJ*. **351**: h6161. doi:10.1136/bmj.h6161. PMC 4663500. PMID 26611143.

[28] Mason F, Lodrick Z (February 2013). "Psychological consequences of sexual assault". *Best Practice & Research. Clinical Obstetrics & Gynaecology*. **27** (1): 27–37. doi:10.1016/j.bpobgyn.2012.08.015. PMID 23182852.

        - Childbirth in general – 24-30% prevalence at 6 weeks, 13.6% prevalence at 6 months[29]
        - miscarriage[30],
        - subsequent miscarriages[31],
        - difficult childbirths[32],
        - emergency conditions at childbirth[33],
        - childbirth involving the death of the infant[34]
    - Concentration camp survivors
    - Refugee Populations (range is from 4%-86%. Displaced persons are much more likely to be affected[35])

IV. The Typical Development of Trauma into Acute Stress Disorder or Posttraumatic Stress Disorder:

A. A person <u>experiences</u> or witnesses a traumatic event:

- The event causes the victim/witness to **experience extreme, disturbing, or unexpected <u>fear, stress, pain</u>**[36]
- The event involves or threatens serious **<u>injury</u>**, **perceived serious injury**, or **death** to themselves or someone else. [37]

B. Person avoids trauma-related **<u>thoughts</u>** and **<u>emotions</u>**.

C. Person avoids **<u>discussion</u>** of the traumatic event.

D. Person may have **<u>amnesia</u>** of the event.

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[29] *Montmasson H, Bertrand P, Perrotin F, El-Hage W (October 2012). "[Predictors of postpartum post-traumatic stress disorder in primiparous mothers]". Journal de Gynecologie, Obstetrique et Biologie de la Reproduction. **41** (6): 553–60. doi:10.1016/j.jgyn.2012.04.010. PMID 22622194.*

[30] Daugirdaitė V, van den Akker O, Purewal S (2015). "Posttraumatic stress and posttraumatic stress disorder after termination of pregnancy and reproductive loss: a systematic review". *Journal of Pregnancy*. **2015**: 1–14. doi:10.1155/2015/646345. PMC 4334933. PMID 25734016.

[31] Daugirdaitė V, van den Akker O, Purewal S (2015). "Posttraumatic stress and posttraumatic stress disorder after termination of pregnancy and reproductive loss: a systematic review". *Journal of Pregnancy*. **2015**: 1–14. doi:10.1155/2015/646345. PMC 4334933. PMID 25734016.

[32] Olde E, van der Hart O, Kleber R, van Son M (January 2006). "Posttraumatic stress following childbirth: a review". *Clinical Psychology Review*. **26**(1): 1–16. doi:10.1016/j.cpr.2005.07.002. PMID 16176853.

[33] Martin, Colin (2012). *Perinatal Mental Health : a Clinical Guide*. Cumbria England: M & K Pub. p. 26. ISBN 9781907830495.

[34] Christiansen DM (February 2017). "Posttraumatic stress disorder in parents following infant death: A systematic review". *Clinical Psychology Review*. **51**: 60–74. doi:10.1016/j.cpr.2016.10.007. PMID 27838460.

[35] Hollifield M, Warner TD, Lian N, Krakow B, Jenkins JH, Kesler J, Stevenson J, Westermeyer J (August 2002). "Measuring trauma and health status in refugees: a critical review". *JAMA*. **288** (5): 611–21. doi:10.1001/jama.288.5.611. PMID 12150673.

[36] Ben-Ezra, Menachem; Essar, Nir; Saar, Ronen (2006). "Gender differences and acute stress reactions among rescue personnel 36 to 48 hours after exposure to traumatic event". *Traumatology*. **12** (2): 139–42. doi:10.1177/1534765606294557.

[37] Ben-Ezra, Menachem; Essar, Nir; Saar, Ronen (2006). "Gender differences and acute stress reactions among rescue personnel 36 to 48 hours after exposure to traumatic event". *Traumatology*. **12** (2): 139–42. doi:10.1177/1534765606294557.

E. The event is **relived** by the person through:

- Intrusive, recurrent **recollections**
- Dissociative episodes of **reliving** the trauma (flashbacks)
- **Nightmares**

F. Distressing symptoms of **less than** one month are characterized as Acute Stress Disorder[38]

G. If distressing symptoms persists to a degree that dysfunction in normal life is experienced for **longer than one month** they are eligible for a Posttraumatic Stress Disorder (PTSD) diagnosis.

H. The proximity to, duration, and severity of the trauma all affect the individual's response to it.

I. **Interpersonal trauma** will cause more problems than impersonal trauma.[39]

J. Exceptions:

- **Development of PTSD in a child** also depends upon the childhood trauma, how chronic it was, and the familial stressors involved or surrounding the trauma.[40] Attachment problems may result. [41] DSM has special diagnostic criteria when working with children under the age of 6.

- **Development of CPTSD** - Prolonged abuse, especially when it was **repetitively** perpetrated against children by **caregivers** during multiple childhood and adolescent developmental stages, or abuse that included a degree of **captivity**, enslavement, or inability to escape, as well as a destruction or distortion of personal **identity** and involving significant **emotional** dysregulation may qualify for a diagnosis of Complex PTSD.[42]

    - The title **Developmental Trauma Disorder** (DTD) has also been suggested since the stage of development affects and is affected by the trauma that is being **chronically** experienced. [43] This cluster of symptoms were often observed in cases of prolonged abuse, especially when it was perpetrated

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[38] *American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders: DSM-IV. Washington, DC: American Psychiatric Association.* ISBN 978-0-89042-061-4.[page needed]; on-line.

[39] *Janoff-Bulman, R. (1992). Shattered Assumptions: Toward a New Psychology of Trauma. New York: Free Press.*[page needed]

[40] Koenen KC, Moffitt TE, Poulton R, Martin J, Caspi A (February 2007). "Early childhood factors associated with the development of post-traumatic stress disorder: results from a longitudinal birth cohort". *Psychological Medicine*. **37** (2): 181–92. doi:10.1017/S0033291706009019. PMC 2254221. PMID 17052377.

[41] aor N, Wolmer L, Mayes LC, Golomb A, Silverberg DS, Weizman R, Cohen DJ (May 1996). "Israeli preschoolers under Scud missile attacks. A developmental perspective on risk-modifying factors". *Archives of General Psychiatry*. **53** (5): 416–23. doi:10.1001/archpsyc.1996.01830050052008. PMID 8624185.

[42] Courtois, C. A. (2004). "Complex Trauma, Complex Reactions: Assessment and Treatment"(PDF). *Psychotherapy: Theory, Research, Practice, Training*. **41** (4): 412–425. CiteSeerX 10.1.1.600.157. doi:10.1037/0033-3204.41.4.412.

[43] Ford; Grasso; Greene; Levine; Spinazzola; Van Der Kolk (August 2013). "Clinical Significance of a Proposed Developmental Trauma Disorder Diagnosis: Results of an International Survey of Clinicians". *Journal of Clinical Psychiatry*. **74** (8): 841–9. doi:10.4088/JCP.12m08030. PMID 24021504.

against children by caregivers during multiple childhood and adolescent developmental stages.[44]

V. Defining Different Trauma Related Diagnoses: Not necessary for you to diagnose people you counsel properly, but seeing the differences in these diagnoses will help you as you organize data.

A. **Acute Stress Reaction / Acute Stress Disorder:**[45]

- Sometimes called "**Shock**" (not the circulatory condition of shock/hypoperfusion)
- It is a psychological condition occurring following a **terrifying** or **traumatic** event, witnessing a traumatic event that induced **a strong emotional response** within the person.
- May develop into PTSD if the stress is not managed properly.
- Thought of as the "**acute**" phase of PTSD.
    - Symptoms last one month or less
    - Symptoms that last more than one month are diagnosed as PTSD
- Characterized by: [46]
    - The person was exposed to: death, threatened death, actual or threatened serious physical injury, or actual or threatened sexual violence, as follows:
        - Direct **exposure**
        - **Witnessing**, in person
        - Indirectly, by learning that a close **relative** or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
        - Repeated or extreme indirect **exposure** to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies or pictures.
    - Inclusion of any of the following symptoms:
        - **Intrusion Symptom Cluster:**
            - Recurring and distressing dreams
            - Flashbacks – reliving memories of the traumatic event
            - Memories related to the event
            - Intense psychological distress or somatic reactions to internal and external traumatic cues
        - **Avoidance symptoms:** generalized hyper-avoidance of reminders of the event or similar traumatic experiences

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[44] Courtois, C. A. (2004). "Complex Trauma, Complex Reactions: Assessment and Treatment"(PDF). *Psychotherapy: Theory, Research, Practice, Training*. **41** (4): 412–425. CiteSeerX 10.1.1.600.157. doi:10.1037/0033-3204.41.4.412.

[45] Reynaud, Emmanuelle; Guedj, Eric; Trousselard, Marion; El Khoury-Malhame, Myriam; Zendjidjian, Xavier; Fakra, Eric; Souville, Marc; Nazarian, Bruno; Blin, Olivier; Canini, Frédéric; Khalfa, Stephanie (2015). "Acute stress disorder modifies cerebral activity of amygdala and prefrontal cortex". *Cognitive Neuroscience*. **6** (1): 39–43. doi:10.1080/17588928.2014.996212. PMID 25599382.

[46] American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5 ed.)*. Arlington, VA: American Psychiatric Publishing.

- **Mood symptoms:** persistent inability to experience positive emotions such as happiness, loving feelings, or satisfaction
- **Arousal symptoms:** sleep disturbances, hypervigilance, difficulties concentrating, easy to startle, irritability/anger/aggression
- **Dissociative symptoms –**
    - numbing and detachment from emotional reactions,
    - physical detachment (seeing oneself from another perspective),
    - decreased awareness of one's surroundings,
    - perception that the environment is dreamlike,
    - dissociative amnesia (inability to recall critical aspects of the event)

B. **Posttraumatic Stress Disorder** – usually one major trauma with distressing symptoms lasting more than one month

- Used to be classified as an **anxiety** disorder.
- Was recently reclassified as a "**Trauma** and **Stressor** related Disorder" in the DSM-5[47]
- The person was exposed to: death, threatened death, actual or threatened serious physical injury, or actual or threatened sexual violence, as follows: [48]
    - Direct exposure
    - Witnessing, in person
    - Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
    - Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies or pictures.
- Diagnosis involves four symptom clusters[49]:
    - **Intrusion Symptoms** (Re-Experiencing) - 1+ for diagnosis
        - Recurrent, involuntary and intrusive recollections or memories
        - Traumatic nightmares
        - Dissociative reactions (flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness
        - Intense or prolonged distress after exposure to traumatic reminders
        - Marked physiological reactivity after exposure to trauma-related stimuli
    - **Persistent effortful avoidance of distressing trauma-related stimuli after the event** – 1+ for diagnosis
        - Trauma-related thoughts or feelings

[47] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing. pp. 271–280. ISBN 978-0-89042-555-8.
[48] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
[49] https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd

        - Trauma-related external reminders (people, places, conversations, activities, objects or situations)
    - **Negative Alterations in cognition and mood that began or worsened after the traumatic event** – 2+ for diagnosis
        - Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs)
        - Persistent (& often distorted) negative beliefs and expectations about oneself or the world (e.g. "I am bad," "the world is completely dangerous")
        - Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences
        - Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame)
        - Markedly diminished interest in (pre-traumatic) significant activities
        - Feeling alienated from others (e.g. detachment or estrangement)
        - Constricted affect: persistent inability to experience positive emotions
    - **Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event** - 2+ needed for diagnosis
        - Irritable or aggressive behavior
        - Self-destructive or reckless behavior
        - Hypervigilance
        - Exaggerated startle response
        - Problems in concentration
        - Sleep disturbance
    - Persistence of symptoms for more than one month
    - Significant symptom-related distress or functional impairment
    - Not due to medication, substance or illness

C. Complex Post-Traumatic Stress Disorder –It includes all symptoms of PTSD but also includes additional symptoms:

- **Repetitious incidents of trauma** - Develops as a result of layers of interpersonal trauma rather than a single traumatic impersonal event.[50]
- **Caregiver involvement** – Trauma is especially dangerous to children when it comes at the hands of the child's primary caregiver.[51] As a result of this early childhood interpersonal trauma, it often results in problems with appropriate attachment in the relationship with the abuser as well as the relationships with all/most other human beings.[52]

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[50] Herman JL (1997). *Trauma and Recovery* (2nd ed.). New York: Basic Books. pp. 119–122. ISBN 978-0-465-08730-3.

[51] Ford; Grasso; Greene; Levine; Spinazzola; Van Der Kolk (August 2013). "Clinical Significance of a Proposed Developmental Trauma Disorder Diagnosis: Results of an International Survey of Clinicians". *Journal of Clinical Psychiatry*. **74** (8): 841–9. doi:10.4088/JCP.12m08030. PMID 24021504.

[52] *Schechter, D. S.; Coates, S. W.; Kaminer, T.; Coots, T.; Zeanah, C. H.; Davies, M.; Schonfeld, I. S.; Marshall, R. D.; Liebowitz, M. R.; Trabka, K. A.; McCaw, J. E.; Myers, M. M. (2008). "Distorted Maternal Mental Representations and Atypical Behavior in a Clinical Sample of Violence-Exposed Mothers and Their Toddlers". Journal of Trauma & Dissociation. **9**(2): 123–147. doi:10.1080/15299730802045666. PMC 2577290. PMID 18985165.*, pp. 123-149

- **Distorts a person's core identity and involves significant emotional dysregulation**[53]
    - there is a loss of a sense of safety, trust, and self-worth
    - there is a loss of a sense of self, coherence, or what it means to be human
    - trauma often is characterized by subjective events like betrayal, defeat, or shame[54]
    - Most CPTSD victims demonstrate lasting personality disturbances with huge revictimization risks. [55]
- **Captivity or entrapment:**
    - Leads to feelings of terror, worthlessness, helplessness, and deformation of one's identity and sense of self[56]
    - Victim has little or no chance of **escape**:
        - chronic sexual, psychological, or physical abuse and neglect
        - chronic intimate partner violence
        - victims of kidnapping or hostage situations
        - indentured servitude
        - victims of slavery or human trafficking
        - sweatshop workers
        - prisoners of war
        - concentration camp survivors
        - residential school survivors
        - defectors of cults or cult-like organization[57]

VI. Special Note about the life-encompassing results of CPTSD - The repetitious nature of these repetitious interpersonal traumas with comorbid enslavement, destruction of sense of self, and emotional dysregulation result in symptoms that are more complex than simple PTSD[5859]:

A. Symptoms:

- Attachment – problems with relationships boundaries, lack of trust, social isolation, difficulty perceiving and responding to other's emotional states

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[53] Brewin, Chris R.; Cloitre, Marylène; Hyland, Philip; Shevlin, Mark; Maercker, Andreas; Bryant, Richard A.; Humayun, Asma; Jones, Lynne M.; Kagee, Ashraf; Rousseau, Cécile; Somasundaram, Daya; Suzuki, Yuriko; Wessely, Simon; Van Ommeren, Mark; Reed, Geoffrey M. (2017-12-01). "A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD". *Clinical Psychology Review*. **58**: 1–15. doi:10.1016/j.cpr.2017.09.001. ISSN 0272-7358. PMID 29029837.

[54] van der Kolk (2005). "Developmental trauma disorder" (PDF). Psychiatric Annals. pp. 401–408. Retrieved 14 November 2013.

[55] Ide, N.; Paez, A. (2000). "Complex PTSD: A review of current issues". *International Journal of Emergency Mental Health*. **2** (1): 43–49. PMID 11232103.

[56] Lewis Herman, Judith (1992). *Trauma and Recovery*. Basic Books.

[57] Stein, Jacob Y.; Wilmot, Dayna V.; Solomon, Zahava (2016), "Does one size fit all? Nosological, clinical, and scientific implications of variations in ptsd criterion A", *Journal of Anxiety Disorders*, **43**: 106–117, doi:10.1016/j.janxdis.2016.07.001, PMID 27449856

[58] van der Kolk (2005). "Developmental trauma disorder" (PDF). Psychiatric Annals. pp. 401–408. Retrieved 14 November 2013.

[59] Cook, A.; Blaustein, M.; Spinazzola, J.; Van Der Kolk, B. (2005). "Complex trauma in children and adolescents". *Psychiatric Annals*. **35** (5): 390–398. Retrieved 2008-03-29.

- Biology – sensory-motor development dysfunction, sensory-integration difficulties, somatization, increased medical problems

- Affect or emotional regulation – poor affect regulation, difficulty identifying and expressing emotions and internal states, and difficulties communicating needs, wants, or wishes

- Dissociation – amnesia, depersonalization, discrete states of consciousness with discrete memories, affect, and functioning, and impaired memory for state-based events

- Behavior Control – problems with impulse control, aggression, pathological self-soothing, and sleep problems

- Cognition – difficult regulating attention, problems with a variety of executive functions like planning, judgement, initiation, use of material, and self-monitoring, difficulty processing new information, difficulty focusing and completing tasks, poor object constancy, problems with "cause and effect" thinking, language development problems such as a gap between receptive and expressive communication abilities

- Self-Concept – fragmented and disconnected autobiographical narrative, disturbed body image, low self-esteem, excessive shame, and negative internal working models of self

B. Behaviors - You are likely to see an immense list of behaviors that you'll have to sort through in counseling:[60][61]

- Inability to regulate emotions – persistent dysphoria, chronic suicidal ideation and preoccupation, self-injury, explosive or extremely inhibited anger, compulsive or extremely inhibited sexuality (possibly alternating between the two)

- **Variations of consciousness** – amnesia or improved recall of the traumatic events, episodes of dissociation, depersonalization/derealization, reliving experiences

- **Changes in self-perception** – sense of helplessness or paralysis of initiative, shame, guilt, and self-blame, sense of defilement or stigma, sense of being completely different from other human beings (specialness, utter aloneness, belief that no other person can understand, feeling of nonhuman identity)

- **Varied changes in perception of the perpetrators**, such a preoccupation with the relationship with the perpetrator (preoccupation with revenge possible), an unrealistic attribution of total power of the perpetrator, idealization or paradoxical gratitude, sense of a special or supernatural relationship with a perpetrator, acceptance of perpetrator's belief system or rationalizations

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[60] Judith L. Herman (30 May 1997). *Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror*. Basic Books. ISBN 978-0-465-08730-3. Retrieved 29 October 2012

[61] "Complex PTSD". *www.ptsd.va.gov (National Center for PTSD)*. United States Department of Veterans Affairs. 2007.

- **Alterations in relations with others,** such as isolation and withdrawal, disruption in intimate relationships, repeated search for a rescuer, persistent distrust, and repeated failures of self-protection

- **Changes in systems of meaning**, such as a loss of sustaining faith and a sense of hopelessness and despair

C. Special notes about attachment:

Attachment Issues: Early experiences with caregivers gradually give rise to a system of thoughts, memories, beliefs, expectations, emotions, and behaviors about the self and others. This internal working model of social relationships affects future interactions with self and others.[62]

- Complex PTSD may progress to a diagnosis like **Reactive Attachment Disorder(RAD)**, which is grossly disturbed internal working models of relationships that may lead to interpersonal and behavioral difficulties in later life.[63]
  - Criteria for RAD include: [64]
    - markedly disturbed and developmentally inappropriate social relatedness in most contexts (child avoids or doesn't respond to care when offered by caregivers or is indiscriminately affectionate with strangers)
    - disturbance is not accounted for by a developmental delay
    - onset before 5 years of age
    - history of significant neglect
    - implicit lack of identifiable, preferred attachment figure
    - Additional criteria include:
      - Abuse – psychological or physical in addition to neglect
      - Associated emotional disturbances
      - Poor social interaction with peers, aggression toward self and others, misery, growth failure
- Variants of Attachment In Children:
  - **Secure attachment** – a child feels that they can rely on their caregivers to attend to their needs of proximity, emotional support, and protection. Child explores freely while caregiver is present, engages with strangers, is visibly upset when the caregiver departs, and is generally happy to see caregiver return. Child is certain caregiver will be responsive to their needs and communication. Parents who consistently respond to their child's needs will generally create securely attached children within temperamental differences.[65]

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[62] Mercer, J (2006). *Understanding Attachment: Parenting, child care, and emotional development*. Westport, CT: Praeger Publishers. pp. 39–40. ISBN 0275982173. LCCN 2005019272. OCLC 61115448.
[63] O'Connor TG, Zeanah CH (2003). "Attachment disorders: assessment strategies and treatment approaches". *Attach Hum Dev*. **5** (3): 223–44. doi:10.1080/1461730310001593974. PMID 12944216.
[64] *Diagnostic and Statistical Manual of Mental Disorders: Text Revision*. American Psychiatric Association. 2000. p. 943. ISBN 978-0-89042-025-6.
[65] Schacter, D.L. et al. (2009). Psychology, Second Edition. New York: Worth Publishers. pp.441

- **Anxious – <u>ambivalent</u> attachment** – separation anxiety and does not feel reassured that the caregiver will return. The child explores little, is wary of strangers even when the parent is present. When the caregiver departs the child is highly stressed and is generally ambivalent when the caregiver returns.[66] Child responds unpredictably and displays anger or helplessness toward the caregiver upon reunion with caregiver. This is a conditional strategy for maintaining control of the situation with the caregiver. [67][68]
- **Anxious – <u>avoidant</u> attachment** – child avoids parents – shows little emotion when caregiver departs or returns, child does not explore much regardless of who is there[69][70]
- **<u>Disorganized</u> attachment** – lack of attachment behavior – child exhibits abnormal behaviors in attempts to control their own crying or emotional distress; child displays overt signs of fear, contradictory behaviors or affects occurring simultaneously or sequentially; stereotypic, asymmetric, misdirected, or jerky movements; freezing and apparent dissociation.[71] Evidence suggests that the attachment system has been flooded with some emotion like fear or anger and detachment is their way of protecting themselves in the face of frightening or unfathomable parenting.[72]

- Variants of Attachment as Seen in Adults:
  - **<u>Securely</u> Attached** – adults tend to have positive views of themselves, their partners, and their relationships. They feel comfortable with intimacy and independence, balancing the two.
  - **<u>Anxious</u> – <u>Preoccupied</u>** – seek high levels of intimacy, approval, and responsiveness from partners, becoming overly dependent. They are less trusting, have less positive views about themselves, and their partners, and may have high levels of emotional expressiveness, worry, and impulsiveness in relationships
  - **<u>Dismissive – avoidant</u>** – adults desire high levels of independence, often appearing to avoid attachment altogether. They view themselves as self-sufficient, invulnerable to attachment feelings, and not needing close

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[66] Ainsworth, M.D.S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the strange situation. Hillsdale, NJ: Earlbaum.

[67] Solomon, J.; George, C.; De Jong, A. (1995). "Children classified as controlling at age six: Evidence of disorganized representational strategies and aggression at home and at school". *Development and Psychopathology*. **7**: 447–447. doi:10.1017/s0954579400006623.

[68] Crittenden, P. (1999) 'Danger and development: the organization of self-protective strategies' in Atypical Attachment in Infancy and Early Childhood Among Children at Developmental Risk ed. Joan I. Vondra & Douglas Barnett, Oxford: Blackwell pp. 145–171

[69] Ainsworth, M. D.; Bell, S. M. (1970). "Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation". *Child Development*. **41** (1): 49–67. doi:10.2307/1127388. PMID 5490680.

[70] Sroufe, A.; Waters, E. (1977). "Attachment as an Organizational Construct". *Child Development*. **48** (4): 1184–1199. doi:10.1111/j.1467-8624.1977.tb03922.x.

[71] Karlen Lyons-Ruth, Jean-Francois Bureau, M. Ann Easterbrooks, Ingrid Obsuth, Kate Hennighausen & Lauriane Vulliez-Coady (2013) Parsing the construct of maternal insensitivity: distinct longitudinal pathways associated with early maternal withdrawal, Attachment & Human Development, 15:5–6, 562–582

[72] Sroufe, A. Egeland, B., Carlson, E. & Collins, W.A. (2005) The Development of the person: the Minnesota study of risk and adaptation from birth to adulthood, NY: Guilford Press, p.245

relationships. They suppress their feelings, dealing with conflict by distancing themselves with partners of whom they often have a poor opinion. This might present like someone who engages in low psychological intimacy (one-night stands, sexual problems within marriage from little enjoyment in intimacy).

- **Fearful – avoidant** – adults have mixed feelings about close relationships, both desiring and feeling uncomfortable with emotional closeness. They mistrust their partners and view themselves as unworthy. Tend to seek less intimacy, suppressing their feelings[73][74][75][76]

VII. Complicating factors:

A. **88%** of men and **79%** of women with lifetime PTSD have at least one **co-morbid psychiatric** disorder

- Major Depressive Disorder – 48% men; 49% women[77]

B. A person with PTSD is at higher risk for **suicide** and intentional **self-harm**. [78]

C**. Drug and alcohol abuse** commonly co-occur with PTSD.[79] This will definitely complicate the recovery process. Sometimes when treating a drug or alcohol dependency you may uncover an underlying mental health concern involving trauma that the person has been self-medicating through the abuse of substances.

Percentages of individuals who experience alcohol abuse or dependence do so because of co-morbid PTSD.

- 51.0% of men
- 27.9% of women[80]

D. Those with certain neurological/biological conditions may be more predisposed to develop PTSD. [81]

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[73] Hazan C, Shaver PR (March 1987). "Romantic love conceptualized as an attachment process". *Journal of Personality and Social Psychology*. **52** (3): 511–24. doi:10.1037/0022-3514.52.3.511. PMID 3572722.
[74] Hazan C, Shaver PR (1990). "Love and work: An attachment theoretical perspective". *Journal of Personality and Social Psychology*. **59** (2): 270–80. doi:10.1037/0022-3514.59.2.270.
[75] Hazan C, Shaver PR (1994). "Attachment as an organizational framework for research on close relationships". *Psychological Inquiry*. **5**: 1–22. doi:10.1207/s15327965pli0501_1.
[76] Bartholomew K, Horowitz LM (August 1991). "Attachment styles among young adults: a test of a four-category model". *Journal of Personality and Social Psychology*. **61** (2): 226–44. doi:10.1037/0022-3514.61.2.226. PMID 1920064.
[77] Sher L (August 2010). "Neurobiology of suicidal behavior in post-traumatic stress disorder". *Expert Review of Neurotherapeutics*. **10** (8): 1233–5. doi:10.1586/ern.10.114. PMID 20662745.
[78] Bisson JI, Cosgrove S, Lewis C, Robert NP (November 2015). "Post-traumatic stress disorder". *BMJ*. **351**: h6161. doi:10.1136/bmj.h6161. PMC 4663500. PMID 26611143.
[79] Maxmen JS, Ward NG (2002). *Psychotropic drugs: fast facts* (3rd ed.). New York: W. W. Norton. p. 348. ISBN 978-0-393-70301-6.
[80] Sher L (August 2010). "Neurobiology of suicidal behavior in post-traumatic stress disorder". *Expert Review of Neurotherapeutics*. **10** (8): 1233–5. doi:10.1586/ern.10.114. PMID 20662745.
[81] Yamasue H, Kasai K, Iwanami A, Ohtani T, Yamada H, Abe O, Kuroki N, Fukuda R, Tochigi M, Furukawa S, Sadamatsu M, Sasaki T, Aoki S, Ohtomo K, Asukai N, Kato N (July 2003). "Voxel-based analysis of MRI

E. Problems resulting from dealing with trauma are **subjective**, are sometimes overreported (especially when trying to get disability), or are often underreported because of stigma, pride, or fear of how they will affect relationships or employment. [82]

F. With **complex** PTSD treatment problems will be complicated by grossly inappropriate interpersonal skills, fundamentally flawed sense of self, gross trust issues, insecure attachment.

VIII. Common Secular Therapeutic Interventions and Treatment Strategies for Victims of Trauma[83] It is helpful to know about secular treatment philosophies because in most cases biblical counseling will not be the first stop at help for a person who is traumatized. It would be helpful to know what other kinds of treatment and therapies they have received. It will help you understand and be sensitive to what they have been exposed to. Reminds me of the lady with the issue of blood that had tried for 12 years to have her issue of blood treated and was now penniless as a result and still affected. The power of Jesus was the only hope she had for recovery.

- Secular therapists treat for money.
    - Therapeutic interventions follow the money
    - Therapeutic interventions dry up when the money does
- Biblical counselors treat for free

(Note: PDF of Research on all Secular Treatment Plans is available by email jocewally@gmail.com)

A. **Basics about Treatment:**

- **Diagnosis** is necessary for secular treatment. Insurance companies will not pay for treatment unless a diagnosis is recognized in the DSM V. These labels often begin an inappropriate cycle of victimization and excusing self from dealing with the issues. Counselees often don't understand the diagnosis was simply necessary for their therapist to be paid for treatment.
- **Insurance** often predicts treatment:
    - Insurance companies will only pay for treatment plans that are **empirically supported**, **evidence-based** and **reimbursable**. In order for a treatment plan to be accepted it requires years of professional review and scrutiny.
    - It also has to stand up to the possibility of client **litigation**, so in many cases treatment plans are promising to accomplish very little, very slowly, and very cautiously. There is always the threat that a client or a client's family will use the therapist's recommendations against the therapist if they become frustrated that the treatment plan was ineffective. There's a lot of pressure for therapists to perform, which causes them to be incredibly unattached and cautious.
    - Different healthcare or medical systems will have their own Clinical Practice Guidelines

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reveals anterior cingulate gray-matter volume reduction in posttraumatic stress disorder due to terrorism". *Proceedings of the National Academy of Sciences of the United States of America*. **100** (15): 9039–43. doi:10.1073/pnas.1530467100. PMC 166434. PMID 12853571.

[82] First MB (2013). *DSM-5® Handbook of Differential Diagnosis*. American Psychiatric Pub. p. 225. ISBN 9781585629985.

[83] https://www.webmd.com/mental-health/what-are-treatments-for-posttraumatic-stress-disorder#1

- Clinical Practice Guidelines will outline:[84]
  - Definition of "Traumatic Events"
  - Definitions of diagnoses
    - "Acute Stress Reaction"
    - "Acute Stress Disorder"
    - "Posttraumatic Stress Disorder"
  - Which version of the DSM they are utilizing
  - Epidemiology and Impact
  - Clinical Practice Guideline methods
  - Who the care is centered around
  - How decisions will be made
  - How to implement the Clinical Practice Guidelines

B. Trauma Based Secular Therapies for PTSD:

Special Note: You do not need to know about how to do these therapies in order to biblically counsel. However, many of your traumatized counselees will have already been exposed to these therapeutic interventions, so it is helpful to know about them. It helps to know what they have already been exposed to, as well as what their assumptions about treatment and healing might include. These therapeutic interventions include a lot of education/indoctrination. Knowing about these may help you to know what underlying meanings and beliefs about truth might need to be combated.

Special Note #2: Your student notes do not include a complete summary of each therapeutic intervention. I have left space for you to jot down anything that is interesting to you as I speak. I have a PDF of this research available to anyone who emails me and asks for it. I didn't want to make your student notes longer than necessary, but the research is available if a more complete description of these different therapies is interesting or helpful to you.

1. Generally "Trauma-focused psychotherapy" are the most highly recommended kind of treatment for PTSD.

- Trauma-focused psychotherapy means the treatment is focused on the memory of the traumatic event and its meaning to the individual person.
- The interventions will be focused around visualizing, talking, or thinking about the traumatic event.
- They may also include changing unhelpful beliefs about the trauma.[85]

2. There are three most highly recommended trauma-based therapies by the United States Veterans Affairs and Department of Defense are:

- **Prolonged Exposure Therapy (PE)** involves assisting trauma survivors to re-experience distressing trauma-related memories and reminders in order to facilitate habituation and successful emotional processing of the trauma memory. Most ET programs include

[84] https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf
[85] https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGPatientSummaryFinalRev0731172.pdf

both imaginal confrontation with the traumatic memories and real-life exposure to trauma reminders.
    - If you've been avoiding things that remind you of the traumatic event, PE will help you confront them.
    - Usually involves 8 to 15 sessions, usually 90 minutes each[86]
    - At the beginning, therapist will teach you breathing techniques to ease anxiety when you think about what happened.
    - Later, make a list of things you've been avoiding and learn how to face them, one by one.
    - Following sessions, recount the traumatic experience to your therapist, go home and listen to a recording of yourself.
    - Repeat homework over time to help ease your symptoms.
- **Cognitive Processing Therapy (CPT)[87]** a manualized therapy used by clinicians to help people recover from PTSD; Classifies PTSD as a disorder of non-recovery, in which sufferer's beliefs about the causes and consequences of traumatic events produce strong negative emotions, which prevent accurate processing of the traumatic memory and the emotions resulting from the events. By avoiding traumatic triggers their day-to-day functioning is limited. Helps patients appraise and correct "stuck points" and progress toward recovery.[88]
    - 12-week course of treatment, sessions are weekly for 60-90 minutes
    - Begins by talking about the traumatic event with therapist and how your thoughts about it affect your life
    - Write in detail about what happened
    - This process helps you examine how you think about your trauma and figure out new ways to live with it.
        - Examples:
            - If you've been blaming self for what happened, the therapist can help take into account all the things that were beyond your control and understand it wasn't really your fault.
- **Eye Movement Desensitization and Reprocessing (EMDR)**– theory proposes that eye movement can be used to facilitate emotional processing of memories, changing the persons' memory to attend to more adaptive information. The therapist initiates rapid eye movement while the person focuses on the memories, feelings or thoughts about a particular trauma.[89]
    - This involves thinking about the trauma more thank talking about the trauma. [90]
    - May not have to tell therapist about the experience.

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[86] https://www.webmd.com/mental-health/what-are-treatments-for-posttraumatic-stress-disorder#1
[87] https://www.webmd.com/mental-health/what-are-treatments-for-posttraumatic-stress-disorder#1
[88] *"Cognitive Processing Therapy (CPT)". American Psychological Association. Retrieved 4 October 2017.*
[89] Jeffries FW, Davis P (May 2013). "What is the role of eye movements in eye movement desensitization and reprocessing (EMDR) for post-traumatic stress disorder (PTSD)? a review". *Behavioural and Cognitive Psychotherapy*. **41** (3): 290–300. doi:10.1017/S1352465812000793. PMID 23102050.
[90] https://www.webmd.com/mental-health/what-are-treatments-for-posttraumatic-stress-disorder#1

- Concentrated on it while you watch or listen to something they're doing…moving a hand, flashing a light, or making a sound
- Goal is to think about something positive while you remember your trauma.
- 3 months of weekly sessions

C. **Therapy for Complex PTSD**[91] – involves less focusing on the actual events of trauma but more on the problems that cause functional impairment than the PTSD symptoms, such as emotional dysregulation, dissociation, and interpersonal problems.

- The following areas should be addressed:
  - **Safety**
  - Self-regulation
  - Self-reflective information **processing**
  - Traumatic experiences integration
  - **Relational** engagement
  - Positive affect enhancement
- Therapeutic strategies include:
  - Teaching adequate **coping** strategies and addressing safety concerns
  - Decreasing **avoidance** of traumatic stimuli and applying coping skills learned in phase one; Begin to challenge assumptions about the trauma and introduce alternative narratives about the trauma
  - Solidify what has already been learned and transfer these strategies to future stressful events
- Specific treatments recommended:
  - **Emotionally Focused Therapy** – 8-20 sessions, based on the approach that human emotions are connected to human needs, and therefore emotions have an innately adaptive potential that, if activated and worked through, can help people change problematic emotional states and interpersonal relationships.[92] Essentially this therapy is focused on learning how to process emotions.
  - **Internal Family Systems Therapy** – Combines systems thinking with the view that the mind is made up of relatively discrete subpersonalities each with its own viewpoint and qualities. IFS sees consciousness as composed of three types of subpersonalities or parts: managers, exiles, and firefighters and each part has its own perspective, interests, memories, and viewpoint. Core tenet of IFS is that every part has a positive intent for the person, even if its actions or effects are counterproductive or cause dysfunction.
  - **Sensorimotor Psychotherapy** – somatic psychotherapy that is "body-oriented talk therapy"; it blends theory and technique from cognitive, affective, and psychodynamic therapy with straight forward somatic interventions, such as helping clients to become aware of their bodies, to track their bodily sensations,

[91] Lawson, David (July 2017). "Treating Adults With Complex Trauma: An Evidence-Based Case Study". *Journal of Counseling and Development*. **95**: 288–298.

[92] Greenberg & Safran 1987; Safran & Greenberg 1991; Greenberg, Rice & Elliott 1993; Greenberg & Paivio 1997; Greenberg 2002a; Johnson 2004; Flanagan 2010

and to implement physical actions that promote empowerment and competency.[93]

- **Eye Movement Desensitization and Reprocessing Therapy (EMDR)** – a form of psychotherapy in which the person being treated is asked to recall distressing images while generating one type of bilateral sensory input, such as side-to-side eye movements or hand tapping. It is sometimes called pseudoscience but it included in several guidelines for treatment of PTSD[94]
- **Dialectical Behavior Therapy (DBT)** – evidence-based psychotherapy designed to help people suffering from borderline personality disorder and mood disorders who need to change patterns of behavior that are not helpful, such as self-harm, suicidal ideation, and substance abuse. [95] Works to help people increase their emotional and cognitive regulation by learning about the triggers that lead to reactive states and helps to assess which coping skills to apply in the sequence of events, thoughts, feelings, and behaviors to help avoid undesired reactions. Combines standard cognitive behavioral techniques for emotion regulation and reality-testing with concepts of distress tolerance, acceptance, and mindful awareness largely derived from Buddhist meditative practice.[96]
- **Cognitive Behavior Therapy** – psychosocial intervention that aims to improve mental health by challenging and changing unhelpful cognitive distortions (thoughts, beliefs, attitudes) and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. This is a mindfulness-based therapy that is "problem-focused" and "action oriented"[97]
- **Exposure Therapy** – used to treat anxiety disorders and involves exposing the target patient to the anxiety source or its context without the intention to cause any danger. This is thought to help them overcome their anxiety or distress.[98]
- **Psychodynamic Therapy** – a form of depth psychology whose primary focus is to reveal the unconscious content of a client's psyche in an effort to alleviate psychic tension. Usually once or twice per week. Principle theorists are Freud, Klein, Jung, etc.
- **Family Systems Therapy** – branch of therapy that works with families and couples in intimate relationships to nurture change and development. Views change in terms of systems of interaction between family members. Emphasizes family relationships as an important factor in psychological health.

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[93] Ogden, Pat (2015). *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment*. Norton. p. 14.
[94] Feske, Ulrike (1998). "Eye movement desensitization and reprocessing treatment for posttraumatic stress disorder". *Clinical Psychology: Science and Practice*. **5** (2): 171–181. doi:10.1111/j.1468-2850.1998.tb00142.x.
[95] "An Overview of Dialectical Behavior Therapy – Psych Central". 17 May 2016. Retrieved 2015-01-19.
[96] Linehan, M. M.; Armstrong, H. E.; Suarez, A.; Allmon, D.; Heard, H. L. (1991). "Cognitive-behavioral treatment of chronically parasuicidal borderline patients". *Archives of General Psychiatry*. **48** (12): 1060–64. doi:10.1001/archpsyc.1991.01810360024003.
[97] Schacter DL, Gilbert DT, Wegner DM (2010), *Psychology* (2nd ed.), New York: Worth Pub, p. 600
[98] Joseph, J.S.; Gray, M.J. (2008). "Exposure Therapy for Posttraumatic Stress Disorder". *Journal of Behavior Analysis of Offender and Victim: Treatment and Prevention*. **1** (4): 69–80. doi:10.1037/h0100457.

Key factor is that regardless of the origin of the problem including family in the solution benefits the client.[99]

- **Group Therapy** – form of psychotherapy in which one or more therapists treat a small group of clients together as a group. It involves processing as a group, providing support for each other, learning skills (like anger management, mindfulness, relaxation training, or social skills training), or receiving psychoeducation (problem-solving and communication skills, provides education and resources in an empathetic and supportive environment)[100]. Some group therapies include art therapy, dance therapy, and/or music therapy.

D. Additional non-trauma focused therapies sometimes used are as follows:

- **Artistic Expression Therapies:**
  - Art Therapy
  - Play Therapy
  - Exercise, Sport, or Physical Therapy
- **Brief Eclectic Psychotherapy (BEP)[101]**
  - Practice relaxation skills
  - Recall details of the traumatic memory
  - Reframe negative thoughts about the trauma,
  - Write a letter about the traumatic event
  - Hold a farewell ritual to leave the trauma in the past
- **Cognitive Behavioral Therapy (CBT)**–
  - Seeks to change the way a person feels and acts by changing the patterns of thinking or behavior or both, responsible for negative emotions.
  - CBT has been proven to be an effective treatment for PTSD and is considered the standard of care by the United States Department of Defense.[102]
  - In CBT, individuals learn to identify thoughts that make them feel afraid or upset and replace them with less distressing thoughts.
  - The goal is to understand how certain thoughts about events cause PTSD-related stress.
- **Interpersonal Psychotherapy (IPT)[103]**
  - Encourages the patient to regain control of mood and functioning
  - Helps the patient to understand that depression is a medical illness, rather than the patient's fault or personal defect.
  - Helps the patient understand that depression is a treatable condition.

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[99] Sholevar, G.P. (2003). Family Theory and Therapy. In Sholevar, G.P. & Schwoeri, L.D. *Textbook of Family and Couples Therapy: Clinical Applications.* Washington, DC: American Psychiatric Publishing Inc.[page needed]

[100] Vreeland, B. (2012). An Evidence-Based Practice of Psychoeducation for Schizophrenia: A Practical Intervention for Patients and Their Families. Psychiatric Times, 29(2), 34-40

[101] https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGPatientSummaryFinalRev0731172.pdf

[102] "Treatment of PTSD – PTSD: National Center for PTSD". U.S. Department of Veterans Affairs. May 26, 2016. Archived from the original on December 1, 2016.

[103] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414693/

    - This helps the patient define the problem and excuses the patient from self-blame
    - Helps to link the patient's mood and the disturbing life events that either trigger or follow the onset of a mood disorder. Links major life events with mood complications (death of a loved one, struggle about roles with significant other, life upheaval, geographic or career move, beginning or ending of marriage or other relationship, physical illness)
    - Focus is to resolve the disturbing life events, build social skills, and help him organize his/her life
    - As patient solves life problem, depressive symptoms should resolve as well
- **Military Programs** – Battlemind Program; Wounded Warrior Project; Warrior Care Network
- **Narrative Exposure Therapy (NET)**[104]
    - Developed for people who experienced trauma from ongoing war, conflict, or organized violence
    - Talk through stressful life events in order (from birth to the present day) in order to put them together into a story
- **Present Centered Therapy (PCT)**[105]
    - Non-trauma focused therapy for PTSD.
    - Focused on altering the present maladaptive relation patterns and behavior
    - Provides psycho-education regarding impact of trauma on patient's life
    - Teaches the use of problem-solving strategies that focus on current issues.
    - Does not use exposure or cognitive restructuring techniques.
- **Stress Inoculation Training**[106] **(SIT)**
    - Type of Cognitive Behavior Therapy.
    - Can by individual or group
    - Won't have to go into detail about what happened.
    - Focus is more on changing how you deal with the stress from the event.
    - Possible interventions include massage and breathing techniques or other ways to stop negative thoughts by relaxing your mind and body.
    - After about 3 months, you should have the skills to release the added stress from your life.
- **Written Narrative Exposure**[107]
    - Writing about the trauma during sessions following assignments from therapist
    - Writing is done alone
    - Briefly discusses any reactions to the writing assignments with the therapist at the end of the session

E. **Medication**

[104] https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGPatientSummaryFinalRev0731172.pdf
[105] https://www.div12.org/treatment/present-centered-therapy-for-post-traumatic-stress-disorder/
[106] https://www.webmd.com/mental-health/what-are-treatments-for-posttraumatic-stress-disorder#1
[107] https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGPatientSummaryFinalRev0731172.pdf

- Theory is that neurotransmitters work differently for each person and that affects how traumatized people process "**threats.**"
    - Easily triggered "fight or flight" response, causes patient to be jumpy or on-edge.
    - Constantly trying to shut down sensitive fight or flight could cause emotional coldness or feeling removed.
- Medication is thought to help the patient stop thinking about **reacting** to what happened, including nightmares and flashbacks.
    - Not thinking about those negative emotions could help have a more positive outlook on life and feel "normal."
- Doctors usually begin with drugs that affect the chemistry related to fear and anxiety, including serotonin or norepinephrine (SSRI's and SNRI's).
    - Approved by the FDA for treatment of PTSD:
        - **Paroxetine (Paxil)** – approved to treat PTSD by the FDA
        - **Sertraline (Zoloft)** – approved to treat PTSD by the FDA
    - Approved by the FDA for treatment of depression and anxiety:
        - **Fluoxetine (Prozac)**
        - **Venlafaxine (Effexor)**
    - Lesser Prescribed Medications –
        - **Nefazodone** [108] - used to treat depression, including major depressive disorder
        - **Imipramine** [109] - tricyclic antidepressant, used to treat depression
        - **Phenelzine** [110] - MAOI (monoamine oxidase inhibitor), treat depression that includes sadness, fear, anxiety or worry about physical health. Usually given after other Rxs have been tried without successful treatment of symptoms. Not for treating severe depression or bipolar disorder.
    - "Off label" medications (manufacturer didn't ask the FDA to review studies of the drug showing its effectiveness specifically for PTSD)
        - Antidepressants
        - MAOI's or Monoamine oxidase inhibitors
        - SGA's – Antipsychotics or second-generation antipsychotics
        - Beta-blockers
        - Benzodiazepines – may worsen outcomes [111][112]
        - Symptom Specific Medications –
            - Prazosin (Minipress) for insomnia or nightmares

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[108] https://www.drugs.com/mtm/nefazodone.html

[109] https://www.drugs.com/search.php?searchterm=Imipramine&a=1&m=imipri

[110] https://www.drugs.com/mtm/phenelzine.html

[111] Guina J, Rossetter SR, DeRHODES BJ, Nahhas RW, Welton RS (July 2015). "Benzodiazepines for PTSD: A Systematic Review and Meta-Analysis". *Journal of Psychiatric Practice*. **21** (4): 281–303. doi:10.1097/pra.0000000000000091. PMID 26164054.

[112] Hoskins M, Pearce J, Bethell A, Dankova L, Barbui C, Tol WA, van Ommeren M, de Jong J, Seedat S, Chen H, Bisson JI (February 2015). "Pharmacotherapy for post-traumatic stress disorder: systematic review and meta-analysis". *The British Journal of Psychiatry*. **206** (2): 93–100. doi:10.1192/bjp.bp.114.148551. PMID 25644881. Some drugs have a small positive impact on PTSD symptoms

- A patient will usually will end up on a **combination** of drugs depending on the specific symptoms being experienced.
    - Treatment will also depend upon medication side effects
    - Treatment is impacted by whether anxiety, depression, bipolar disorder, or substance abuse problems also exist.
- Patients will spend a significant amount of time getting the **dosages** and combination regulated.
    - Regular tests (liver tests) may be required.
- Medications won't get rid of symptoms, but they'll make them less intense or more manageable.

F. Common elements to secular therapeutic interventions:

- Distress is centered an inability to **handle** difficulty mentally and emotionally.
- To resolve that difficulty, you must:
    - **Expose** yourself to the traumatic thing that what happened – re-visit the traumatic event when you've been unwilling to do that previously
    - **Think** about and process what happened
    - Form a correct and truthful **conclusion** about what happened
    - **Respond** to what happened in a healthy way
    - Learn how to relax your **physical body** and monitor/correct yourself in constructive ways

Things to think about if there is time:

The Statistics:

- More than **60**% of men and women will experience one traumatic event in their life.[113]
- About **3.5%** of adults have PTSD in a given year.
- **Adults - 6.8%[114] - 9%** of adults will develop it at some point in their life.[115]
    - Of that total:
        - Men **– 3.6%**
        - Women – **9.7%** (more than twice as likely to develop PTSD as men)[116]
    - Men are more likely to experience a traumatic event, but women are more likely for their traumatic event to result in troublesome mental

[113] Olszewski TM, Varrasse JF (June 2005). "The neurobiology of PTSD: implications for nurses". *Journal of Psychosocial Nursing and Mental Health Services*. **43** (6): 40–7. PMID 16018133.
[114] Olszewski TM, Varrasse JF (June 2005). "The neurobiology of PTSD: implications for nurses". *Journal of Psychosocial Nursing and Mental Health Services*. **43** (6): 40–7. PMID 16018133.
[115] American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing. pp. 271–280. ISBN 978-0-89042-555-8.
[116] Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB (December 1995). "Posttraumatic stress disorder in the National Comorbidity Survey". *Archives of General Psychiatry*. **52** (12): 1048–60. doi:10.1001/archpsyc.1995.03950240066012. PMID 7492257.

health or emotionally troubled symptoms. It is more common in women than men[117] which makes sense because women are more likely to experience interpersonal violence and sexual assault. [118]

- **Children** – Children are less likely to develop PTSD after trauma, especially if they are under 10 years of age. [119]
    - Active PTSD is diagnosed in only **1%** of children in a non-war torn and developed country, but their symptoms may continue for decades in the absence of therapy.[120]
    - **16%** of children exposed to a traumatic event in childhood eventually develop PTSD.[121]

Assumptions:

The majority of the individuals in your congregation or church have been affected by trauma.

3.5% of the people in your church will be affected each year. If you have a congregation of 100, 3 to 4 people each year will be experiencing life-alteringly difficult circumstances.

10% of the women who experience life-alternigly difficult circumstances will struggle to resolve those issues positively.

Most children who have a trauma will not at the time have difficulty, but at least 16% will develop problems when they look back on their life as an adult and try to process it.

The most common reason world-wide that someone negatively processes trauma is upon experiencing the unexpected loss of a close loved one.

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[117] "Post-Traumatic Stress Disorder". *National Institute of Mental Health*. February 2016. Archived from the original on 9 March 2016. Retrieved 10 March 2016.

[118] *National Collaborating Centre for Mental Health (UK) (2005). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. NICE Clinical Guidelines, No. 26. National Institute for Health and Clinical Excellence: Guidance. Gaskell (Royal College of Psychiatrists). ISBN 9781904671251. Archivedfrom the original on 2017-09-08. Lay summary – Pubmed Health (plain English).*

[119][119] *National Collaborating Centre for Mental Health (UK) (2005). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. NICE Clinical Guidelines, No. 26. National Institute for Health and Clinical Excellence: Guidance. Gaskell (Royal College of Psychiatrists). ISBN 9781904671251. Archived from the original on 2017-09-08. Lay summary – Pubmed Health (plain English).*

[120] *National Collaborating Centre for Mental Health (UK) (2005). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. NICE Clinical Guidelines, No. 26. National Institute for Health and Clinical Excellence: Guidance. Gaskell (Royal College of Psychiatrists). ISBN 9781904671251. Archived from the original on 2017-09-08. Lay summary – Pubmed Health (plain English).*

[121] Alisic E, Zalta AK, van Wesel F, Larsen SE, Hafstad GS, Hassanpour K, Smid GE (2014). "Rates of post-traumatic stress disorder in trauma-exposed children and adolescents: meta-analysis". *The British Journal of Psychiatry*. **204** (5): 335–40. doi:10.1192/bjp.bp.113.131227. PMID 24785767.

When something violent or extremely scary happens where death has to be faced happens people are likely to process it negatively.

Nearly 30% of women who give birth will struggle with an unexpected emergency or difficult childbirth experience that is traumatizing for them.

It makes you think….

If such a high number of individuals are facing difficulty or have the risk of negatively processing life-difficulty, we should be planning for how we should intervene as a church.

We shouldn't be thrown off by it when it happens.

We should be expecting the members of our church to have life-difficulty, to possibly process it negatively, and to be ready to be spiritual friends who can be present and available at the time of difficult to help them think about it biblically.