CHAPTER 9

THE TRAUMATIZED PATIENT

Trauma is common in everyday life. It can take many forms, from the unexpected loss of a loved one to a serious motor vehicle accident, the diagnosis of a life-threatening illness, or being the victim of an assault. Popular attention has focused on the aftermath of severe trauma such as civilian disasters, industrial explosions, natural catastrophes, terrorist attacks, life-threatening combat situations, rape, and childhood sexual abuse.

For most people the immediate reaction to experiencing acute trauma is helplessness, horror, fear, or anger. Nearly all people have an immediate acute stress response disorder at some time in their lives but recover rapidly. Posttraumatic stress disorder (PTSD) also may occur after many types of traumatic events. However, only a small percentage will go on to develop persistent PTSD.

Clinical descriptions of what would come to be called PTSD have existed for centuries. Classic examples include accounts of the psychological consequences of frightening combat situations. Some soldiers who engaged in the murderous trench warfare of World War I, in which combatants were slaughtered in droves, developed dissociative flashbacks of terrifying combat experiences when they were no longer at the front line. These were combined with recurrent nightmares in which the life-threatening experience would be repeated over and over again. This disorder incapacitated the soldier and was labeled war neurosis or shell shock. The same phenomenon was seen during World War II, the Korean War, and the Vietnam conflict and has been found to be universal in combat situations. During these latter three conflicts, psychiatrists were moved to locations close to the front lines rather than remaining in base hospitals in the United States. One motive for this change was the knowledge that acute and immediate psychological intervention had a
better chance of returning the serviceman to active duty.

The experience of trauma was important to Freud's early theories of the cause of neurosis. He postulated that trauma occurring in childhood, especially sexual abuse, led to the repression of memories of these experiences and their later expression in symbolic form in the neuroses. Treatment was initially conceptualized as cathartic or abreactive, in which the "toxic" traumatic memories would be brought to consciousness and discharged. When this treatment model foundered in the clinical situation—the patient was often not "cured" by the recovery of so-called repressed memories whose veracity was often questionable—Freud's theory of what was necessary for therapeutic progress and the forces arrayed against it underwent radical change. Issues of resistance, defense, fantasy, transference, the therapeutic relationship, and so on came to the forefront in his theory of therapeutic action and replaced the earlier abreactive model.

Kardiner's studies of World War I veterans established early criteria for what would later be called PTSD. He noted the constriction of affect and social withdrawal that occurred in traumatized servicemen who developed a chronic disorder.

Zetzel examined cases of war neurosis during World War II. She observed that both the experience of anxiety and the capacity to tolerate anxiety prior to the traumatic event and the onset of the war neurosis had good prognostic significance. She repudiated Fairbairn's assertion that war neurosis was due to separation anxiety in unduly dependent men. Zetzel concluded that external events, no matter how overwhelming, precipitate war neurosis only when they connect with specific unconscious conflicts.

In the 1970s, Horowitz delineated the relationship between trauma and its impact on the individual's psychological functioning. He noted that some severely traumatized individuals alternated between denial of the event and repeated reexperiences of the trauma through dissociative flashbacks in waking life and recurrent terrifying nightmares that recapitulated the traumatic event.

Andreasen's studies of burn patients led to the establishment of PTSD in the official DSM-III nomenclature in 1980. She observed that burn patients universally experienced an acute stress disorder subsequent to their injuries. Some went on to develop persistent PTSD. The diagnosis of acute stress disorder was added to DSM-IV in 1994 to distinguish individuals with PTSD-like symptoms that lasted less than a month from those who experienced milder or more transient symptoms following trauma. Ursano and colleagues examined the rates of acute and chronic PTSD in the victims of serious motor vehicle accidents.
Rates of PTSD were high. Female victims had an increased risk of acute but not chronic PTSD. The presence of an Axis II disorder increased the risk of chronic but not acute PTSD. Chronic trauma in the form of physical or sexual abuse in childhood is thought to be an important factor in the development of borderline personality disorder, suggesting to some that the condition is, at times, a kind of posttraumatic personality disorder. (For a further explication, see Chapter 10, “The Borderline Patient.”)

Finally, psychodynamic thinking emphasizes the personal meaning of the trauma for the individual and the fantasies that form around it as an intervening step between trauma and response. The high percentage of people who do not develop persistent PTSD after even severe trauma suggests that this intervening step and the predisposing psychological factors may be more important to the prognosis than the trauma itself.

**PSYCHOPATHOLOGY**

PTSD can be thought of as a disorder of memory (Table 9–1). Most experiences, pleasurable or painful, fade over time. The patient with PTSD remains bound to the past traumatic experience, which has not diminished in memory with the passage of time. In ordinary life, certain stimuli may arouse past memories with extraordinary intensity. Proust’s classic description of tasting a madeleine soaked in tea as an adult and how this sensation evoked vivid, almost hallucinatory, memories of childhood is an example. The PTSD patient is trapped in the memory of the past traumatic experience, which can be easily and vividly reawakened by seemingly innocuous stimuli. As some have suggested, for the PTSD patient the traumatic experience is not normally integrated and the memory of it dominates his consciousness.

**Comorbidities**

PTSD is classified with the anxiety disorders. As noted in Chapter 8, “The Anxiety Disorder Patient,” there is considerable overlap in the taxonomy of the anxiety disorders. One disorder may shade into another. The common factor is probably a constitutionally based low capacity for tolerating anxiety. Because most people do not develop PTSD even when subjected to serious trauma, predisposing factors are important. PTSD patients are more likely to have had a previous depressive episode, panic disorder, or other anxiety disorder than are other patients. The presence of an Axis II personality disorder (particularly bor-
TABLE 9-1. DSM-IV-TR diagnostic criteria for posttraumatic stress disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror.  
       Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.  
       Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   (2) recurrent distressing dreams of the event.  
       Note: In children, there may be frightening dreams without recognizable content.
   (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).  
       Note: In young children, trauma-specific reenactment may occur.
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect (e.g., unable to have loving feelings)
   (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)
TABLE 9-1. DSM-IV-TR diagnostic criteria for posttraumatic stress disorder (continued)

| D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following: |
| (1) difficulty falling or staying asleep |
| (2) irritability or outbursts of anger |
| (3) difficulty concentrating |
| (4) hypervigilance |
| (5) exaggerated startle response |
| E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month. |
| F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. |

Specify if:
- Acute: if duration of symptoms is less than 3 months
- Chronic: if duration of symptoms is 3 months or more

Specify if:
- With delayed onset: if onset of symptoms is at least 6 months after the stressor


derline{derline}) or a history of traumatic experiences in childhood is also predictive for chronic PTSD following trauma. The presence of major depression also makes the patient more vulnerable to PTSD following trauma. Reciprocally, the development of PTSD increases the risk for major depression. Some researchers have suggested that comorbid PTSD and depression following trauma can best be thought of as a single general traumatic stress construct.

**MANAGEMENT OF THE INTERVIEW**

The traumatized patient often fears reexperiencing the trauma if he talks about it in the clinical situation. The interviewer should be sensitive to this and acknowledge that talking about recent traumatic events can be highly distressing. The patient will be reassured if the clinician says at the outset, “How much you want to talk about what has happened to you is up to you. We can explore this at your pace.” One aspect of suffering trauma is the patient’s feeling of loss of control, and such
an intervention by the interviewer mitigates this experience in the clinical situation. It says, “You are in charge of your experience. I am here to help you figure out ways to alleviate your symptoms.”

The importance of not causing an iatrogenic “retraumatization” in the interview is highlighted by the common experience of rape victims feeling they have been “raped again” by medical evaluations or by legal authorities aggressively investigating the crime.

To avoid retraumatization, the clinician can shift the interview into an examination of the patient’s life, history, social supports, and so on. An empathic interest in the patient as person, not victim, can be highly therapeutic. There is simultaneously another agenda: What are the patient’s psychological strengths and weaknesses? What is the meaning of this trauma in terms of his history? Which unconscious fantasies have been aroused? How does he deal with his own aggression and activity versus passivity? The clinician might say, “You have been through a horrendous event that remains with you. I want to get to know you as a person separate from this horror. That will help us understand better the persistence of this event in your mental life. Knowing about your abilities and strengths will give us a framework to build on and potentially reduce the constant intrusion of the memory of this trauma into your mind.” A clinician interested in the patient’s life and conflicts will elicit predisposing factors that are important to the development of either the acute or chronic disorder and its resolution. Horrible events occur to innocent people and should be acknowledged as such, but there is an intervening psychological step—a type of intrapsychic assimilation and its resonance with previous history and mental life before PTSD develops.

An emergency department resident physician was stabbed by a patient high on methamphetamine while the doctor was attempting to examine him. The doctor received a superficial cut to his arm before the patient was restrained. The lesion required suturing, which took place in the same department. The resident found when he attempted to return to work a few days later that he became overwhelmed with anxiety and was unable to function. He was referred for psychological help and began the interview by railing against the inadequate security in the emergency department. “How did that drug addict get in concealing a knife? They don’t even have metal detectors.” His fury at the authorities escalated. “They expect me to go back taking regular call. I could have been killed, and all they care about is my working my regular shift.” He had experienced recurrent terrifying nightmares since the traumatic event. Their content was of being assaulted and endangered, and his sleep was constantly disrupted. He felt jittery and anxious all the time. His home situation had become difficult: “I can’t take care of the kids. I’m so on
The interviewer empathically acknowledged the terror that the assault from a drug-crazed patient had aroused. "You could have been killed. It was a terrifying event. It seems that your anger at this dangerous patient is now directed at the hospital." It emerged during the course of the interview that his wife was becoming increasingly critical of his all-consuming professional commitments prior to the traumatic event. She had complained that he was not involved enough in the care of their young children and that when he was home, he was often exhausted and irritable. He had begun to fear for the stability of their marriage. "She's become a classic case of the busy doctor's wife—jealous of my marriage to my work."

The interviewer explored the patient's history of earlier traumatic events. When the patient was 15, his father had died suddenly of cardiac arrest. He was in school at the time. He recalled the dread he felt when he was summoned from the classroom and told that his father had had a heart attack. It was not until he was home that he was informed his father was dead. Their relationship had been difficult. His father was a hard-driving business executive who was often critical of the patient as a teenager. Simultaneously the patient's mother frequently complained to him of his father's absence from the home because of his "obsession with work." The patient reflected that his father's sudden death had had a lot to do with his own subsequent choice of career as an emergency department physician. "I bring people back from the grave, and until I became a mental wreck, I was good at it."

The experience of current trauma resonating with the early trauma of his father's sudden death and the connection between his mother's criticism of his father's preoccupation with work and his wife's criticism of his commitment to his professional life at the expense of the family were not interpreted by the interviewer. To have done so would have been to retraumatize the patient. These issues became the focus of later psychotherapeutic work once the patient was stabilized with a combination of medication and empathic listening. The patient's acute stress disorder resolved, and he was then able to engage in more deep-seated and productive exploration of his conflicts, rescue fantasies, and their relationship to his career and current marital discord.

A recently discharged military officer presented in an initial interview complaining of both flashbacks and recurrent terrifying nightmares whose content was that of a lethal firefight he had endured and survived while on patrol in Afghanistan. His tour of duty had consisted of patrols in a dangerous and unstable border area where the platoon under his command was engaged in flushing out remnants of the Taliban. Numerous skirmishes occurred during his time there, but the most
frightening was when his patrol found themselves surrounded in a mountain valley and subjected to continuous mortar fire that pinned them down. “It was horrible. We were sitting ducks in that valley. They were all above us, firing at us as if we were a quail shoot. My sergeant was my best buddy. He had his leg blown off from a mortar shell. I tried to put on a tourniquet. Shells were all around us. He bled to death. I can’t get the image of his dying face out of my mind. I loved the guy.” As commanding officer, he called in helicopter gunships, and he and the remainder of his platoon were safely evacuated. His flashbacks and nightmares began shortly thereafter. He became incapable of further military duty and received a medical discharge.

The interviewer inquired about his background. “It was tough growing up. We lived in the ghetto. My dad was an ugly drunk. He often attacked my mom. I remember trying to protect her from him.” When he was 15, his father was killed in a drunken brawl. The patient recalled feeling little grief, thinking his father deserved it. He remained deeply attached to his mother and felt she was her favorite. An accomplished student, he entered a college military academy, where he did well. While he was there, one of his brothers, who had become addicted to crack cocaine, was murdered during a drug deal. The patient felt considerable guilt about this, feeling that if he had not been away at school, he could have straightened out his brother and saved his life. The patient commented, “I feel I’ve been around violence and death all my life. The shoot-outs in the ghetto, my father, my brother getting into drugs. I thought I had escaped, but I didn’t. It all came back halfway around the world in the Hindu Kush.”

Ultimately, with a combination of psychotherapy and medication, the patient’s PTSD remitted. The psychotherapy focused on the oedipal and sibling guilt he had felt concerning the violent deaths of his father and brother. These losses, his conscious and unconscious sense of responsibility, and his evocation of murderous fantasies toward his father had been aroused by the death of the sergeant and had formed the nidus of his PTSD.

CONCLUSION

Both acute and chronic stress disorders are common. It is an error to dismiss the impact of trauma on the individual, but it is an equal error to accept the precipitating trauma as the full explanation for the appearance of PTSD. The interviewer should acknowledge the patient’s feelings concerning the frightening and overwhelming nature of the traumatic experience and then gently explore the issues of the patient’s life, history, and conflicts that predispose to PTSD.

In our current state of knowledge, the treatment of PTSD remains
controversial. Medication and cognitive-behavioral and supportive psychotherapies all have a part to play in the acute phase. Ongoing insight-oriented psychotherapy may be highly therapeutic in the long term. Some patients profit by exploring and sharing their painful memories, whereas others seal them off and avoid them. The skillful therapist is interested in, and respectful of, the patient’s preferred defensive style. The therapist is available to the patient but not intrusive or insistent in demanding the patient’s self-exposure. This relationship offers support through a healing process while avoiding retraumatization.