



# The Mulberry Report

Solutions For Life

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## **Post Traumatic Stress Disorder: The Diagnosis and Treatment** By Ralph Nichols, LCSW, Executive Director

Most likely there are very few of us who have not experienced a traumatic event in our lives; and, for some, this could have involved a series of traumas such as exposure to repeated abuse and neglect. There is a diagnosis that is applicable for people who are still confronting the residue of trauma exposure regardless of the intensity. Due to the persistence of a few mental health professionals (psychiatrists, psychologists and social workers) in the 1970's, the diagnosis of Post Traumatic Stress Disorder (PTSD) was finally accepted by the American Psychiatric Association in 1980.

Much of the clinical work that underscored the development of this diagnosis had focused on the trauma of combat experienced by many of our Vietnam veterans, even though evidence of combat trauma was noted with WW I and WW II veterans as well, but had been "labeled" as "combat fatigue" or "shell shock."

Since 1980, a great deal of clinical research has occurred specific to PTSD providing clinicians with a wealth of data to help in their work with trauma victims. Consequently, the original clinical indicators to support the presence of PTSD have expanded beyond combat stress, and can be the result of exposure to other traumatic experiences. These include abuse, neglect, aftermath of natural disasters, rape, crime, school shootings, and on-the-job traumas experienced by police and emergency personnel. Over the years, clinical data has enabled mental health clinicians to more accurately describe the roots of traumatic experiences rather than "labeling" the patient with depression, anxiety or some other behavioral disorder.

The symptoms can vary but often include intrusive thoughts about the event(s) such as nightmares, hyper-vigilance and startled responses. For example, an Iraq war veteran described being awakened by the loud sound of a garbage dumpster being unloaded outside his apartment window. He quickly found himself under his bed which often happened with the sound of incoming mortar shells at his base camp in Iraq.

Sometimes, clinical symptoms may not always provide us with a clear understanding of the impact of what actually may be related to a previous traumatic event. This can occur when an individual experiences a stressful trauma that resurfaces a reminder of a traumatic event that occurred years earlier, and, in which the individual may not yet connect the symptoms with a previous experience. Consequently, it is not unusual for some people to feel depressed, anxious, moody or agitated when the root of the issue may be a history of abuse and neglect, sexual molestation, combat, or growing up with an alcoholic parent or having experienced parental abandonment.

### **The Mulberry Report**

The Mulberry Report is a publication of Mulberry Center, Inc. for our patients and area companies served by our Employee Assistance Program (EAP).

If there is a topic that you'd like to see covered in a Mulberry Report issue, please contact Ralph Nichols, executive director, at [eap@mulberrycenter.org](mailto:eap@mulberrycenter.org) or 812-423-4700. Visit our website at [www.mulberrycenter.org](http://www.mulberrycenter.org).

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**“We are forever changed by what we see.”**

- Elie Weisel, author and Holocaust survivor.  
(Prescott, 1998)

## Sources

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Laura Prescott, founder and president of Sister Witness International, Inc., eloquently described her history of sexual abuse as a child and the outcome of not having a trained therapist help her work through the trauma. Some of her life experiences brought back the horrors of past episodes of domestic violence and sexual assault. As a former state hospital patient, Ms. Prescott was diagnosed as delusional, antagonistic, non-compliant and attention seeking. Her medical record, however, did not document her long-term sexual abuse by her grandfather that began when she was in elementary school. During one of her hospitalizations she recalled a need to express feelings but was not allowed to do so:

“...there was no place for my anger on inpatient units, that it would be too upsetting for the milieu; instead if I was too overwhelmed, I should take a pill to calm me down, to de-escalate, to mask the symptoms rather than to heal the tragic gaping wounds. However, the concern for the milieu didn't stop staff from publicly rushing me in the hallways while huge security guards bore down on my body.”

Ms. Prescott recalled that one of the male attendant's physical appearance reminded her of her sexually abusive grandfather. As she noted, “What I learned in these moments was to stop hoping for anything different. Each time I was restrained, I learned to drive the memories deeper into myself, to close and fragment a little bit more.” For Ms. Prescott, being placed in seclusion and restraints resurfaced a sense of powerlessness and hopeless despair that she had experienced each time her grandfather took control.

Police officers are often exposed to on-the-job traumas working death-causing auto accidents and apprehending criminal suspects in which the occurrence is life threatening. Sometimes, repeat occurrences can resurface previous occasions of “close calls” and recall of working horrendous auto accidents. For many people the very nature of our work can set the stage for traumatic experiences.

The objective in “working through the trauma” (as Ms. Prescott notes) is “to stand in the face of controversy and bear witness in order to become a survivor. To accomplish this, “we need to be challenged to go deeper and reassess where we have been and where we are going, to engage in a journey that moves us beyond what we see and hear on the surface in order to challenge the deepest recesses of our own fears.” Mulberry Center is here to help with the journey.

Mr. Nichols is a graduate of Indiana University School of Social Work with over 37 years of clinical experience in mental health. He is the Executive Director of Mulberry Center, Inc.