

**THE TRUTH
ABOUT
TRAUMA**

SHELLY BEACH & WANDA SANCHEZ

TABLE OF CONTENTS

ABOUT THE AUTHORS	3
CHAPTER 1: WHAT IS TRAUMA?	6
CHAPTER 3: WHY DOESN'T TRAUMA	16
AFFECT EVERYONE THE SAME WAY?	16
CHAPTER 4: HOW DO PEOPLE WITH PTSD FEEL	21
CHAPTER 5: FAITH IN THE HEALING	25
CHAPTER 6: WHY SHOULD YOU CARE, AND HOW CAN YOU HELP?	29
RESOURCES	33
POSTTRAUMATIC STRESS DISORDER DSM-IV™ DIAGNOSIS & CRITERIA	34
CONTENT ASSISTANCE	42
PHOTO CREDITS	42

About the Authors



Shelly Beach is an award-winning author of eight books and ghost writer/co-writer of numerous other titles. She has written with a Mayo Clinic physician, Pulitzer Prize finalist, New York Times best-selling authors, as well as noted Christian leaders. Her work has also appeared in a wide variety of secular and religious periodicals. Shelly was also one

of three writers for Zondervan's *NIV Stewardship Study Bible* and served as managing editor for Zondervan's *Hope in the Mourning Bible* for those who are grieving.

Shelly is a national speaker with Advanced Writers and Speakers, as well as *Daughters of Dignity* prison ministry, delivering a message of hope to thousands of women each year. She speaks at conferences, retreats, as well as to counselors, therapists, and social workers. As the Christian faith expert for Caring.com, she writes to an audience of approximately two million readers.

Shelly is the co-founder of the Cedar Falls Christian Writers' Workshop in Cedar Falls, Iowa, and the Breathe Writer's Conference in Grand Rapids, Michigan. She holds an M.R. E. from Grand Rapids Theological Seminary and serves as an adjunct professor at Cornerstone University. Shelly also freelances as an editor for publishing houses and provides writing consulting services.

She is a member of the Christian Authors' Network, Advanced Writers and Speakers Association, and American Christian Fiction Writers.

Wanda Sanchez is the executive producer of one of the nation's longest running talk shows, which broadcasts in San Francisco—a prime U.S. market. An industry professional who has produced television as well as radio, she has

more than twenty-five years' experience in media production, marketing, and publicity. Her clients have appeared on *Larry King*, *Oprah*, as well as *Good Morning America* and top cable and network news shows. Wanda is a regular contributor to *Family Labs*, an online magazine. Wanda's writing has also been published in *Worldnet Daily*. She is the Grand Rapids mental health columnist for *Examiner.com*, writing to an audience of approximately 20 million readers each month. As a media personality, Wanda is followed by five thousand fans on Facebook and more than 1,500 fans on Twitter.

Wanda experienced extensive physical and emotional trauma at the hands of family members and strangers, trauma that profoundly influenced the course of her life. At the age of forty-eight, she reached a point of despair and agreed to enter an intensive trauma treatment program as a last resort. When the treatment program ended just ten days later, her life had radically changed. Today she blogs and speaks about hope for recovery from post traumatic stress disorder to women and mental health professionals across the nation.

Shelly and Wanda are also co-authors of the forthcoming book *Love Letters from the Edge: Meditations for Those Struggling with Brokenness, Trauma, and the Pain of Life* (Kregel Publications 2014).



Chapter 1: What is Trauma?

When I was nineteen-year-old college student when my happy-go-lucky *Wheel-of-Fortune* life suddenly turned into an episode of *Criminal Minds*.

I'd come home from a date on a sultry June night and prepared to settle into bed. Mom and Dad were sleeping in the bedroom across the hall, and my older brother was working second shift.

Moments after I flipped off my headboard lamp, the most wanted rapist in a three-state area slit the screen of our kitchen window and crawled into our home. He carefully cut our telephone and electrical lines, then entered my bedroom, where he pressed a metal object to my head in the darkness, threatened to kill me if I made any noise, and assaulted me in my bed.

For years I lived with the aftermath of the terror I experienced that night: nightmares, fear, insomnia, and an inability to focus and to study. For a time I dropped out of college. And after my marriage and the birth of my first child, I struggled with unnamed depression.

Although I didn't know it at the time, I was struggling with the symptoms of post traumatic stress disorder. And I didn't know what to do or where to turn to get help.

What is trauma?

What do people mean when they use the word "trauma"? The Substance Abuse and Mental Health Services Administration defines trauma in the following way:

*Individual trauma results from an event, series of events, or set of circumstances **that are experienced by an individual as physically or emotionally harmful or threatening** and that **have lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being**. Events and circumstances may include the actual or extreme threat of physical or psychological harm or the withholding of material or relational resources essential to healthy development. These events and circumstances may occur as a single occurrence or repeatedly over time. The individual's experience of these events or circumstances helps to determine whether it is a traumatic event. (<http://1.usa.gov/YNghba>)*

A simpler definition is that **trauma occurs when any event overwhelms the brain's ability to cope.**

A comprehensive definition with accompanying criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, can be found in the Resource section of this publication on page 34.

What happens when we experience trauma?

During the normal day-to-day routine of life, the left and right sides of the brain work together to process information and produce the sequences that give our memories a beginning, middle, and end. The brain then "files" these

events in a systematized manner so that we can process them, access them, and use them to make meaning.

But during traumatic events, the right side of the brain that controls sequencing and putting things in a beginning-middle-and-end order shuts down, and experiences are processed primarily by the left side. Because of this, experiences can become encoded or “trapped” in the left side of the brain, and the person continues to experience past events as if they are still happening.

People who suffer from post traumatic stress disorder (PTSD) often experience repeating thought and have difficulty escaping from patterns of thinking that keep them “trapped” in the patterns of behavior. Sights, sounds, and smells can “trigger” thinking patterns and behavioral responses.

For the person with PTSD, **flashbacks** are distinctively different from memories. A person experiencing a flashback literally re-experiences a past event in the present -- with all the sensations, smells, visual images, and related emotions that became locked away and encoded in their brain during their traumatic event. Unfortunately for some people, traumatic experiences happened repeatedly -- as with repeated sexual, verbal, or physical abuse -- and those multiple experiences become tangled and “unfiled” experiences that are “stuck” in the left side of their brains. Those memories become blocked and replay in seemingly endless patterns and cycles in the minds of those who have experienced trauma. They cannot simply decide to stop thinking about those things or disengage from the symptoms that result from PTSD. Trauma therapy helps individuals address the biology of the brain and re-file experiences in their proper place so that they can be sequenced appropriately and the person who experienced the trauma can be free to address their symptoms.

Who is most likely to suffer from PTSD?

Many people mistakenly think the term “trauma” applies only to those who’ve experienced military conflict. But, to the contrary, millions of Americans suffer with the effects of trauma, called post-traumatic stress disorder, or PTSD.

According to the Sidran Institute and other sources

- **70% of adults** in the U.S. have experienced some kind of traumatic event at least once in their lives. That’s 223.4 million people.

- An estimated **8% of Americans have PTSD at any given time.**
- Among people who experience severe trauma, **60-80% will develop PTSD.**
- An estimated **1 out of 10 women develop PTSD during their lifetime.** (www.healmyptsd.org)
- Nearly **25% of women** newly diagnosed with breast cancer will go on to develop PTSD. (<http://bit.ly/XWXXOk>)
- According to PsycCentral, **one in five spinal cord patients** will develop PTSD. (<http://bit.ly/VenkHL>)
- The New York Times Reports that increasing numbers of caregivers are struggling with PTSD. (<http://nyti.ms/14vQl6z>)

Who does trauma impact?

People who struggle with the symptoms of trauma are everywhere. They are every age, every color, every race, and from every socio-economic background. They sit beside us in the workplace, in our classrooms, at our family reunions, in our churches, and in any environment where we are with people.

And often the symptoms of trauma have taken hold of our lives or the lives of people we love, and we have never made the “connection” to the cause. We may have struggled with symptoms for years—fears, depression, addictions, hyper vigilance, obsessive-compulsive behaviors or other cycles of thinking and acting—and never addressed the trauma with an appropriate approach.

Unfortunately, people who have suffered with trauma often struggle to find safe places to talk about their feelings.

- **At home:** PTSD sufferers may feel shame because it feels difficult or impossible to break free from cycles of thinking and patterns of behavior. The symptoms of PTSD often include addiction and self-abusive behaviors, which compounds guilt and shame.
- **At work:** PTSD sufferers often feel they must hide their struggles or risk their jobs.
- **Among friends:** PTSD sufferers often feel shame and guilt, choosing to “hide in plain sight” or isolate.

- **At church:** Because people with PTSD find themselves “stuck,” they often feel enormous guilt at church. Faith is supposed to provide the answers to life’s problems, and some Christians infer that if we have not been healed, it is because we have not applied enough faith.

The impact of trauma in our world is becoming an increasing priority. In an effort to provide the most effective care possible, many medical communities are turning to trauma-based delivery systems. New evidence regarding links to trauma in almost every facet of life is being made every day. With the growing number of military officer returning home with PTSD, we are beginning to recognize the individual, family, and cultural impact of this growing problem.

So why this book?

Unfortunately, many people who’ve experienced trauma don’t understand its effect on their lives and have struggled with the symptoms of post traumatic stress disorder for years.

And too often family members and friends underestimate the power of trauma or don’t recognize it as a powerful enemy that can sometimes threaten the very life of their loved ones.

This book has been written as a beginning resource—a starting point—for those who wish to learn about post traumatic stress disorder. It is written by two women who have learned about PTSD from their personal experience and the experience of their loved ones. We are **not** trained clinicians, although we do collaborate with traumatologists frequently in our work as consultants with PTSDPerspectives (PTSDPerspectives.org).

We have a special heart for the thousands of women we speak to in prisons, churches, clinical settings, through media outlets, as well as the professionals who work with traumatized, abused, and hurting people across our nation. Our goal is to elevate awareness of PTSD and to point people to hope and healing.

We hope this book and the additional resources offered through PTSDPerspectives.org and our developing resources, products, and ministries help you in your journey toward healing.



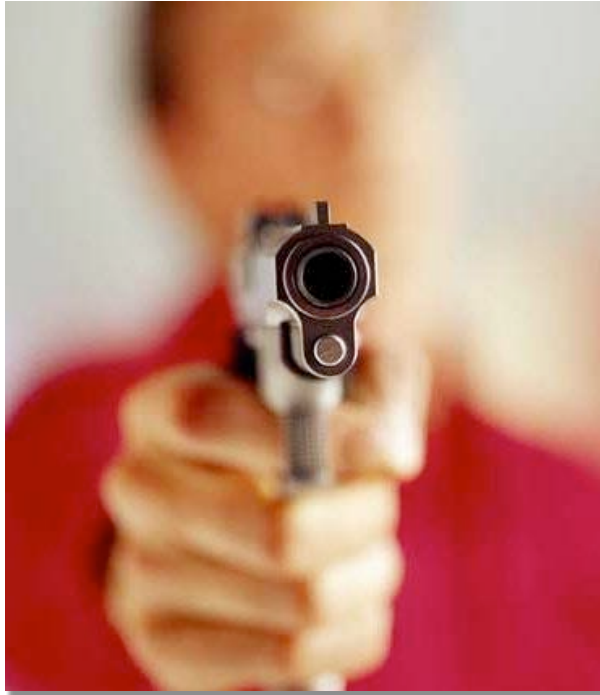
Chapter 2: What Kinds of Experiences Produce Post Traumatic Stress Disorder?

When most people think about post traumatic stress disorder, they typically think about soldiers returning from war. In fact, a newly released report states that since 9/11, nearly 30 percent of the 834,463 Iraq and Afghanistan War veterans treated at Veteran's Administration (V.A.) hospitals and clinics have been diagnosed with PTSD. (<http://thebea.st/QzbDc3>)

The V.A. is investing renewed efforts in research and funding to find effective treatments for soldiers returning from war and offers numerous programs for returning vets. (<http://1.usa.gov/nH444h>)

New medical research is also finding evidence for trauma relating to spinal cord surgery, cardiac care, cancer care, early childhood medical trauma, childbirth, and other areas of medical care.

What kinds of experiences produce post traumatic stress disorder?



The answer is, far more kinds of life experiences than most people typically associate with PTSD. And the reason for the prevalence of PTSD is simple.

A person experiences trauma when they believe their life or the life of someone else is at risk. The symptoms of PTSD can be triggered by a one-time event or by experiences that take place over a long period of time. Any experience that causes a person to believe his or her life is in danger or the life of someone else is in danger can overwhelm the brain

and cause trauma, even if that person is an infant. And the effects of the trauma can linger for years, growing more difficult to mask and manage as time goes on. Some of those types of experiences include

- Being in an accident or witnessing an accident
- Difficult birth experience, for either the mother or the child
- Miscarriage
- Separation at birth or adoption
- Medical trauma in adulthood, childhood, or at birth
 - heart attack
 - cancer
 - spinal surgery
 - pre-verbal childhood medical trauma
 - “locked in” experiences of coma
- Severe bullying
- Death of a loved one

- Being the victim of violence or witnessing violence
- Military experience
- Experiences in law enforcement
- Natural disasters

Evidence shows that when children experience trauma, treatment is most effective when it is provided early.

The most important thing we can do for those who have experienced trauma is to help them find a voice to articulate their pain and point them to those who understand the biology and chemistry of healing, while providing critical spiritual and emotional support.

What kinds of symptoms does PTSD produce?

Many television shows today feature people who are plagued by the symptoms of trauma: *Hoarders*, *Celebrity Rehab*, *Teen Trouble*, *Scared Straight*, *The Biggest Loser*. Unfortunately, many of the people featured on these shows can trace their symptoms back to a root cause of trauma.

However, producers of the show address the *symptoms* of the trauma (hoarding, drug addiction, alcoholism, eating disorders, food addiction, etc.), rather than the trauma itself. These individuals seldom see long-term results and often slip back into recurring patterns of behavior. (<http://bit.ly/MfXtym>)

Trauma can cause a number of physical effects.

Short-term effects can include

- Hyper-vigilance
- Sleeplessness or disturbed sleep patterns
- Restlessness
- Generalized anxiety
- Inability to relax
- Shallow breathing
- Fatigue
- An exaggerated startle response to triggering events, sudden noises and/or unexpected touch

Other symptoms can include headaches, backaches, TMJ, skin complaints such as itching or rashes and unintentional weight loss.

In the weeks following a traumatic experience, the body often remains on alert and reacts to triggers as if they are life-threatening warnings.

If chronic post-traumatic stress disorder develops (CPTSD) survivors can experience

- chronic fatigue syndrome
- irritable bowel syndrome
- fibromyalgia
- interstitial cystitis
- myofacial, lower back and pelvic pain
- other chronic illnesses

These symptoms can develop in adults, teenagers, children, and even babies. Traumatologist Margaret Vasquez at Freedom's Calling Trauma Institute (www.freedomscalling.org) successfully treats children as young as two years old at her clinic, as does the team at Intensive Trauma Therapy in Morgantown, West Virginia (www.traumatherapy.us).

What do the emotional symptoms of PTSD look like?

Trauma can also cause emotional effects, such as

- obsessive-compulsive disorder
- depression
- anxiety disorders
- suicidal urges
- addictions
- urges to self-mutilate
- flashbacks
- nightmares
- panic attacks
- debilitating insecurities
- a sense of inferiority
- guilt

Most often, people with PTSD do not link their symptoms to the root of their trauma and struggle for years in isolation and silence.

What about spiritual effects?

Tragically, trauma can also often cause spiritual effects. Many people live with ongoing pain, fear, and crippling doubt that robs them of the freedom to fully experience a life of faith, hope, and love.

Unfortunately, the spiritual effects of trauma are not often recognized or talked about among the family and friends of trauma survivors, especially in churches. This often leaves already wounded survivors with a tremendous

sense of guilt, shame, and abandonment. However, the symptoms of trauma -- shame, lack of trust, difficulty forgiving, receiving love, and seeing themselves of value -- are treatable and are best resolved when patients are treated for trauma itself, not simply the symptoms of trauma.

Many PTSD sufferers often feel that they are often the one truly unfixable person in the world. But the good news that PTSD is treatable.

There is HOPE.

And that hope can begin today.



Chapter 3: Why Doesn't Trauma Affect Everyone the Same Way?

Like me, several of my close friends also experienced the devastating trauma of sexual abuse. One friend's abuse began in very early childhood and continued at the hands of multiple perpetrators over many years. For a different friend, abuse began at the hands of a family member when she was a toddler and continued over five to seven years. She can't really remember for sure. My sexual abuse came at the hands of a stranger and was a one-time violent attack.

Although each of us developed the symptoms that follow trauma, we processed our abuse and recovery differently. All of us developed triggers associated with sights, sounds, smells, and visual objects, but we responded to those triggers with different degrees of intensity over different durations of time. Some of us developed eating disorders and obsessive-compulsive thoughts, and others did not. Some of us struggled with addictions and self-

abuse, and others did not. Some fought with depression and a preoccupation with suicide, and some did not.

So why did we process our traumatic experiences so differently? Why did some of us heal more quickly than others, and why did some of us develop more significant symptoms of PTSD?

Why do some people process trauma differently than others?

The simple truth is that the same trauma can happen to three different people at the same time and that each person will process the experience differently. For instance, a train could derail, causing the death of a passenger and severe injury to several others. Among the survivors, some might develop short-term PTSD, some severe PTSD with symptoms that remain for decades, while others respond with minimal symptoms while exhibiting great resilience.

But why?

A number of key factors influence the way a person processes a traumatic experience:

1. Things about the person's life before the trauma: their ability to cope with stress and their overall mental health, previous exposure to trauma, family instability,
2. Things about the person's life in response to the trauma: event's meaning to the victim (stranger -vs- family member) their support system from family and friends and their ability to obtain professional help immediately following the trauma,



3. Things about the circumstances of the trauma: age at which the trauma occurred, the duration of time over which the trauma occurred (a single event -vs- multiple events; duration of time of the event itself), sense of ongoing threat, lack of control, whether or not multiple types of traumas occurred in the life of the person (natural disasters, sexual abuse, domestic violence, separation at birth, etc.)

In the case of my good friends and me, each of our abuse situations was different. I was sexually attacked one time by a stranger. My friend “Diane” was abused over a period of about seven years by a trusted family member—her father. A third close friend, “Brenda,” was abused by multiple molesters—both trusted family members and strangers—over more than twelve years. She also experienced other forms of trauma, including domestic violence and natural disaster. While I developed short-term symptoms of PTSD, “Brenda” developed a severe and chronic form of PTSD and struggled for more than forty years before she found effective treatment.

What forms does PTSD take?

According to Harvard Health Publications, post-traumatic stress disorder (PTSD) has three forms:

1. acute, in which symptoms last one to three months after the trauma
2. chronic, in which the symptoms last three months or more
3. delayed onset, in which at least six months pass between the traumatic event and the start of symptoms.

No matter what level of PTSD your loved one may experience, they will typically experience one or many of the following symptoms:

- flashbacks and nightmares
- avoidance and numbing out
- being “on guard”
- depression and fixation on suicide
- self-abuse
- panic attacks
- addictive behaviors
- obsessive-compulsive behaviors
- physical symptoms, like headaches, diarrhea, muscle aches and pains, palpitations

Life for the PTSD sufferer can feel like a seemingly endless struggle with symptoms, with no way out.

So what can help a trauma survivor process their experiences and move forward?

- Effective PTSD therapy from a professional who understands the biological and emotional elements of trauma. Trauma produces chemical and biological responses in the brain that control the manner in which we process information. Trauma therapy addresses those issues so that people can then more effectively address distorted thinking patterns and symptoms.

- An optimistic attitude and the willingness to move forward. Those who find healing are typically people who are willing to do the next hard thing in spite of how they may feel. Trauma therapy often requires confronting lies with truth and moving toward the big picture.

- Resilience, or the ability to find purpose in pain. Those who have experienced trauma are often people who have been ravaged by life and hurt in brutal ways. Helen Keller said, "Character cannot be developed in ease and quiet. Only through experience of trial and suffering can the soul be strengthened, ambition inspired, and success achieved." Resilience is an inner quality that many of us bring to trauma before it occurs. But we can also build resilience as we journey through our experience:

- Build quality personal relationships. Refuse to isolate.
- Be optimistic.
- Practice effective communication (honesty, openness, assertiveness).
- Become an active problem solver. Learn about PTSD and effective treatments, then create a plan.
- Cultivate self-confidence and a sense of humor.
- Respect others.
- Practice generosity and gratitude.

(<http://bit.ly/14SD1Ln>)

- Motivation to deal with the trauma. People who hope to heal from PTSD must find their own motivation to invest in the process of moving forward. Trauma therapy requires hard work emotionally and spiritually. While hope may be borrowed, motivation cannot.

- Hope. Most people who live with PTSD are doubtful that they can be helped. The illness itself creates defeating and damning cycles of self-talk and behavior. But hope can be borrowed from a friend. Not many years ago,

after struggling with PTSD for more than forty years, Wanda Sanchez was certain she couldn't face another day. A friend told her that she would carry Wanda's hope until she found the strength to carry it for others. Today, after successful trauma treatment, Wanda speaks to thousands of people about hope for healing from PTSD each year.

If you're reading this book, you may be the voice of hope to a friend or

loved one. Have you been called to carry their hope until they can carry it for someone else? The eBook you are reading is the first in a series of HopeBucket Publications co-authored by Wanda Sanchez.

Does healing come to all trauma survivors on the same timeline? No. If that survivor is you, be patient with yourself, and look for friends and advocates who can come beside you in your journey. And if you know a trauma survivor, don't impose YOUR timeline of expectations upon them. Those who hurt need advocates, encouragers, listeners, mentors, and prayer partners.

But above all, they need time, compassion, an environment of safety, and **hope.**

Chapter 4: How Do People with PTSD Feel

Those who live through trauma experience a wide range of emotions. But because of the biological reactions that occur in the brain, certain responses are common to many trauma victims.



- **A sense of being trapped.** Chemical reactions occur in the brain during trauma that literally lock experiences in the memory. PTSD makes people relive their trauma over and over again, including the sights, smells, conversations, and emotional and physical pain. Just one whiff of a smell, sight of an object, or song on a nearby iPod can throw someone into a flashback.
- **Numb, distant, and detached from the world around them.** People with PTSD often describe their feelings as “empty” and “dark,” and although they feel numb, they feel pain. These feelings are usually attached to the person’s struggle to relate to people around them. Surprisingly, people with PTSD often try to hide their true feelings because of shame and guilt.
- **The need to wear a “mask.”** People with PTSD frequently cover up their struggles and true feelings with an outer façade. For instance, for soldiers and abuse victims, the coping mechanisms that protected them while living in threatening conditions, such as a startle response, hyper vigilance, and aggression, must now be masked and are disruptive to life.
- **Shame and guilt.** People with PTSD often feel shame and guilt over their inability to break free from their cycle of feelings and behaviors. And, unfortunately, people who don’t understand PTSD often place unrealistic expectations on the hurting, knowingly or unknowingly expressing the idea that the victim should “just get over it,” “be better by now,” or “move on.”

One of the most effective ways to help people understand how people with PTSD feel is to peek into the world of an abuse survivor.

A young woman living in the Southwest was the victim of a sexual assault in her early twenties. Ten years after her experience, she describes her feelings and her life in these words (used with permission):

Talking seems pointless. Life seems pointless. I have to wear a smile, laugh, pretend to be positive, and lie every hour of the day. I tell people I’m feeling fine. They wouldn’t understand the darkness.

Sadness is always there, but it’s more than that.

It’s misery, but I have to act like I’m fine. It makes my family mad because they can’t fix me.

Why can’t I let go of this? I feel so jealous of women who are the way I want to be: carefree, full of faith, happy, loving life! It’s hard to control

myself when I'm at work or shopping or in public or at home. When someone or something startles me, I flip out. My husband scolds me. I keep telling him I don't do this on purpose. I don't realize I do it.

So often I think about harming myself and wanting to die. I think about what my life would have been like if ... If someone hugs me and touches my stomach, I feel like they're suffocating me. My husband can't touch my stomach. My seatbelt can't touch my stomach. I freak out if a doctor comes near my stomach.



I don't know what it's like to be me, and I hate it. Every day, I wear shame on my face, whether I try to hide it, disguise it, or try to make it feel better. The older I get, the harder it becomes to wear the mask. I used to attend church and pray, but I've stopped. I feel embarrassed in front of God. I hardly ever go any more. People try to make me feel guilty, but they don't have a clue that most days I'm just trying to stay alive.

How do you cope with wanting to apologize every day for how disgusting you are? How do you cope with memories that play over and over

in your brain? How do you cope with wanting to kill yourself every day on the same day? How do you cope with nightmares? They seem so real you start to see them as reality. How do you cope with trying everything, and nothing helps? How do you cope with wanting to hurt yourself all the time?

The only thing that helps is shutting down. Throw yourself down the stairs. Drive off a bridge and into the lake. Fall in the bathtub. The thoughts are always there.

I can't bring myself to talk to anyone about how I really feel. I know I'll get in trouble if I do. It's not safe.

And it really won't help anyway. Nothing ever changes.

I hate how my past controls me. I hate that I've lost my faith. I hate that this abuse has robbed me of my future. I hate the rituals that now control my life. I hate how difficult it is to live each day. I hate that I want to hurt myself every day. I hate wearing a mask every day of my life. I hate having to lie to people about how I really feel. I hate feeling lonely, even with people around. I hate being a disappointment to myself and everyone else.

I hate how I hate myself.



Chapter 5: Faith in the Healing

Most people seek out a surgeon if they have cancer. They head to an emergency room if their appendix bursts. And they go to a dentist when they have a toothache.

But surprisingly, people are sometimes reluctant to seek out specialists who understand post-traumatic stress disorder, the biology of brain chemistry, and its effects. PTSD is caused by the body's physical response to crisis, much the same way a bruise is caused by a blow to the body.

Anyone who experiences trauma will experience symptoms of some kind. For some people, some or most of those symptoms will resolve within four weeks to two months of the trauma. For other people, symptoms may linger for several years. Some people are helped by talking through their trauma with supportive friends and family or with the help of a counselor. But for other people, symptoms will linger for months and even years, and more specific PTSD treatment is necessary. It's important to distinguish the symptoms that follow trauma (depression, self-harm behaviors, addictions, compulsive behaviors, isolation, etc.) with the trauma itself and to find treatment that deals the trauma, as well as the symptoms. The most effective treatments for PTSD address the trauma itself.

Why are people sometimes reluctant to seek help?

Many people associate a stigma with PTSD. PTSD can be a debilitating condition, often accompanied by a wide range of symptoms. People often experience problems at work, in their personal relationships, or at school. They may be struggling with anxiety disorders, depression, addictions, and depression and be unwilling to share those battles with others for fear of losing respect or even their job.

In one recent study, people cited the following reasons for not seeking treatment:

- 28% believe no one can help them.
- 28% believe their problem is something they should be able to cope with.
- 17% don't think their problem was significant enough to contact a doctor.
- 15% thought the problem would get better on its own.
- 13% were too embarrassed to discuss the problem with anyone.

- 10% were afraid of the consequences of seeking help (hospitalization, long-term treatment, etc.)

Within the military

- 61% strongly agreed with the idea that disclosing a psychological problem would negatively impact their military career.
- 43% stated that admitting a psychological problem would cause other people to not want to be around them.

(<http://ptsd.about.com/od/treatment/a/Stigma.htm>)

Does seeking trauma treatment mean someone doesn't trust God?

The issue of stigma associated with mental illness also exists within some faith circles. Unfortunately, people sometimes communicate a “Can’t you just get over it?” or “Isn’t trusting God enough?” attitude toward people who suffer trauma and choose to seek treatment through therapy, counseling, or other methods.

This attitude is overly simplistic. People who live with PTSD cannot choose to “move on” any more than someone with a thyroid condition or broken leg can choose to “move on” without addressing their medical issues. People who suffer with the after-effects of trauma will deal with varying degrees and manifestations of symptoms. It will be important for them to find treatments that are right for their needs and diagnoses.

As the Creator and Sustainer of the universe, God is the healer of all things. He has given good things to us as tools to accomplish that healing. If a woman chooses chemotherapy when she is diagnosed with cancer, she is choosing one of God’s tools, and He is still her ultimate healer.

If a rape victim seeks counseling or trauma therapy after her assault, she is choosing one of God’s tools, and He is still her ultimate healer.

Unfortunately, many people who experience trauma struggle to find effective treatment. Abuse often happens in childhood and in secret, and the symptoms of PTSD can be hidden in the dark places of the soul for years. Many people find it difficult to admit the hurt they’ve experienced. They’re ashamed

of the ways they act and of their seeming powerlessness to gain victory over their patterns of behavior and thinking.

Many people who experience trauma need the specific therapy approaches that reroute the “trapped” messages that have been encoded in only one side of their brain. Other people will find healing in other approaches. But individuals need to be encouraged to find the PTSD therapy that is most suited to their need. This often requires the skill of a therapist trained specifically for treatment of post-traumatic stress disorder.

More than anything, the wounded need to feel safe. They need to feel accepted. They need to feel a reason to hope. And they need to feel the love of God, the source of healing and hope, and the support of His people.

Unfortunately, church staff is often untrained in how to recognize trauma. But every congregation in the nation ministers to the walking wounded—in growing numbers.

- A typical church congregation of 200 people serves an average of 16 people with one level or another of PTSD. If that congregation is within an urban area with higher populations of traumatized people, that number rises to nearly 50.
- If this congregation is a larger church of 1,000 members in a rural or bedroom community, they will serve an average of 160 people who are experiencing a level of PTSD. If that church is within the inner city, that number rises to nearly 250.

The implications for how churches conduct ministry is enormous and is growing more crucial with every passing day.

In fact, it's crucial that we understand the impact of trauma in every sphere of culture today—in the workplace, in our schools, and especially in our families.

The question is not whether or not trauma will touch the life of someone we know and love some day. The question is *when* it will happen and how we will respond.



Chapter 6: Why Should You Care, and How Can You Help?

The simple truth is that trauma plays a dramatic role in modern life, in our families, churches, schools, and places of employment. Seventy percent of adults in the United States have experienced some kind of traumatic event in their life, and approximately 8% of the general population is struggling with post-traumatic stress disorder at some level.

Someone you know and care about has been touched by trauma.

The people who sit beside you at basketball games or in your church pew.

People you work with -- your fellow employees, or if you're an employer, the people you employ.

The people who live next door or around the corner.

Your child's teacher.

The nurse's aide in your parent's assisted living center.

Many of these people are struggling, and they don't know how to talk about the effort it takes to get through one more day. Many are dealing with the symptoms of PTSD and turning to the coping mechanisms that help them deal with the pain: cutting burning, substance abuse, obsessive behaviors.

Unfortunately, those coping mechanisms wear out and eventually stop working.

And when they do, many people turn to suicide.

Why should you and I care?

Everything Wanda and I do in life is motivated by our faith. We believe we're called to be hope carriers for others who have lost hope. That we're called to be light in a dark world. That we're called to bear burdens. And as believers in Jesus Christ, we're called to love others as we desire to be loved ourselves.

That can be tough in a world where people abuse others and where trauma is part of life.

So how do we do this?

- **By understanding.** By learning about trauma and PTSD, its causes, treatments, and effects. By understanding that those who struggle with PTSD often struggle with guilt and shame for the things done to them and for the coping mechanisms they turn to in order to survive the pain. They need compassion and understanding that flows from a genuine spirit of love.
- **By listening without judgment and easy answers.** Life is complicated and messy, and it's disingenuous to offer simplistic answers to every hurt in life. People who've experienced deep hurts need to know they can say life hurts, that they're afraid, and know they're safe to express their feelings without being judged, given timelines, or fearing their pain will be spiritualized.
- **By providing an environment of emotional safety.** In our churches, this means talking about mental health issues openly and honestly and offering resources for emotional and prayer support, as well as guidance to professional counseling and therapy. This does not in any way diminish or threaten the central role of the Bible.
- **By talking about the pain of life openly and in healthy ways.** People need to know that trauma is part of the broken world that Jesus came to save. They are not alone. They are not unfixable. Their symptoms make

sense. They make sense. They have a reason to hope. But they will never know these things until we begin to talk about difficult issues openly and honestly in our churches, communities, and families.

- **By being patient.** Don't expect everyone to heal in the same way. People with PTSD are on different timelines. The circumstances of their wounding have produced different factors for healing. Be patient. Don't impose your own limited perspective on their healing. Pray for them and with them. Direct them toward appropriate resources. Ask them what support looks like to them. And never quit loving them in ways they can see and feel, as God directs you.
- **By becoming knowledgeable about resources for the wounded, and pointing people to them.** Learn about local options for treatment, as well as the best options nationally. Various approaches exist for PTSD treatment:
 - EMDR: The term stands for Eye Movement Desensitization and Reprocessing. This treatment stimulates the information processing system that stores memories so that the memory can be absorbed into the proper timeline in the brain and become part of the past.
 - Cognitive behavior therapy: This therapy focuses on the concept that if we change the way we think and feel about our behavior, we will change our behavior.
 - Talk Therapy: Talk therapy is based on the assumption that talking about the trauma and applying insight, persuasion, and counseling, will help the individual overcome and heal from PTSD symptoms.
 - Instinctual Trauma Response Model: This is an intensive treatment that uses a variety of techniques to move memories into the appropriate timeline. Treatment using the ITR model takes only five to ten days of outpatient therapy that does not involve counseling, but rather, accessing the trauma in safe ways and giving the trauma story a beginning, middle, and end.

It's important for us as authors of this book to note that Wanda Sanchez underwent several of the above models of therapy, along with extensive spiritual intervention and biblical counseling, as well as treatment in numerous clinical settings over the course of more than forty years. She saw very limited results until she went to Intensive Trauma Therapy in Morgantown, West Virginia for nine days of outpatient treatment under the ITR model of therapy. In just days, a lifetime of nightmares, flashbacks, obsessions, and other symptoms vanished, and other aspects of Wanda's PTSD became manageable. We are strong advocates of the ITR model and Intensive

Trauma Therapy and Freedom's Calling Intensive Trauma Institute because we have seen these treatment centers produce results where other forms of therapy have failed.



We encourage you to learn more about PTSD and explore how you can help bring hope and healing to those around you, whether you are a medical professional, an educator, a child advocate, a parent, or someone who knows someone who has been wounded.

And if you are in need of more information for yourself, we encourage you to explore the resources we have made available at the back of this publication and check out www.PTSDPerspectives.org.

Resources

Dr. Beth Robinson, Lubbock, Texas
www.drbethrobinson.com

EMDR Institute
www.emdr.com

Freedom's Calling, Brunswick, GA
912.275.7307
www.freedom'scalling.org

Heal My PTSD
<http://healmyptsd.com>

Intensive Trauma Therapy, Morgantown, West Virginia
304.291.2912
www.traumatherapy.us

www.MusicfortheSoul.org

Tell Me What You See project for those struggling with eating disorders
<http://www.musicforthesoul.org/resources/tell-me-what-you-see/>

National Center for PTSD
<http://www.ptsd.va.gov>

PTSD Self-Assessment Test
<http://www.healthyplace.com/psychological-tests/ptsd-test/>

PTSD Perspectives
www.PTSDPerspectives.org

The Sidran Institute
<http://www.sidran.org>

Wedgwood Christian Services, Grand Rapids
www.wedgwood.org

Posttraumatic Stress Disorder DSM-IV™

Diagnosis & Criteria

309.81 Posttraumatic Stress Disorder

Diagnostic Features

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent re-experiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to,

observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase.

The traumatic event can be re-experienced in various ways. Commonly the person has recurrent and intrusive recollections of the event (Criterion B1) or recurrent distressing dreams during which the event is replayed (Criterion B2). In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment (Criterion B3). Intense psychological distress (Criterion B4) or physiological reactivity (Criterion B5) often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g. anniversaries of the traumatic event; cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for combat veterans of the South Pacific; entering any elevator for a woman who was raped in an elevator).

Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event (Criterion C1) and to avoid activities, situation, or people who arouse recollections of it (Criterion C2). This avoidance of reminders may include amnesia for an important aspect of the traumatic event (Criterion C3). Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. The individual may complain of having markedly diminished interest or participation in previously enjoyed activities (Criterion C4), of feeling detached or estranged from other people (Criterion C5), or of having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality) (Criterion C6). The individual may have a sense of a foreshortened future (e.g., not expecting to have a career, marriage, children, or a normal life span) (Criterion C7).

The individual has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived (Criterion D1), hyper vigilance (Criterion D4), and exaggerated startle response (Criterion D5). Some individuals report irritability or outbursts of anger (Criterion D2) or difficulty concentrating or completing tasks (Criterion D3).

Specifiers

The following specifiers may be used to specify onset and duration of the symptoms of Posttraumatic Stress Disorder:

Acute. This specifier should be used when the duration of symptoms is less than 3 months. **Chronic.** This specifier should be used when the symptoms last 3 months or longer. **With Delayed Onset.** This specifier indicates that at least 6 months have passed between the traumatic event and the onset of the symptoms.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Posttraumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Phobic avoidance of situations or activities that resemble or symbolize the original trauma may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs, hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.

There may be increased risk of Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Specific Phobia, Major Depressive Disorder, Somatization Disorder, and Substance-Related Disorders. It is not known to what extent these disorders precede or follow the onset of Posttraumatic Stress Disorder.

Associated laboratory findings. Increased arousal may be measured through studies of autonomic functioning (e.g., heart rate, electromyography, sweat gland activity).

Associated physical examination findings and general medical conditions. General medical conditions may occur as a consequence of the trauma (e.g., head injury, burns).

Specific Culture and Age Features

Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals.

In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may also be "omen formation" - that is, belief in an ability to foresee future untoward events. Children may also exhibit various physical symptoms such as stomachaches and headaches.

Prevalence

Community-based studies reveal a lifetime prevalence for Posttraumatic Stress Disorder ranging from 1% to 14%, with the variability related to methods of ascertainment and the population sampled. Studies of at-risk individuals (e.g., combat veterans, victims of volcanic eruptions or criminal violence) have yielded prevalence rates ranging from 3% to 58%.

Course

Posttraumatic Stress Disorder can occur at any age, including childhood. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear. Frequently, the disturbance initially meets criteria for Acute Stress Disorder (see p. 429) in the immediate aftermath of the trauma. The symptoms of the disorder and the relative predominance of re-experiencing, avoidance, and hyper arousal symptoms may vary over time. Duration of the symptoms varies, with complete recovery occurring within 3 months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma.

The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Posttraumatic Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

Differential Diagnosis

In Posttraumatic Stress Disorder, the stressor must be of an extreme (i.e., life-threatening) nature. In contrast, in **Adjustment Disorder**, the stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situations in which the response to an extreme stressor does not meet the criteria for Posttraumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to Posttraumatic Stress Disorder. **Symptoms of avoidance, numbing, and increased arousal that are present before exposure to the stressor** do not meet criteria for the diagnosis of Posttraumatic Stress Disorder and require consideration of other diagnoses (e.g., Brief Psychotic Disorder, Conversion Disorder, Major Depressive Disorder), these diagnoses should be given instead of, or in addition to, Posttraumatic Stress Disorder.

Acute Stress Disorder is distinguished from Posttraumatic Stress Disorder

because the symptom pattern in Acute Stress Disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist for more than 1 month and meet criteria for Posttraumatic Stress Disorder, the diagnosis is changed from Acute Stress Disorder to Posttraumatic Stress Disorder

In **Obsessive-Compulsive Disorder**, there are recurrent intrusive thoughts, but these are experienced as inappropriate and are not related to an experienced traumatic event. Flashbacks in Posttraumatic Stress Disorder must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in **Schizophrenia, other Psychotic Disorders, Mood Disorder With Psychotic Features, a delirium, Substance-Induced Disorders, and Psychotic Disorders Due to a General Medical Condition.**

Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role.

309.81 DSM-IV Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following have been 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 re-experienced 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 upon 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)

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) hyper vigilance (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one 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*

Content Assistance

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