**Book Crisis Intervention Strategies**

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**Introduction to posttraumatic stress disorder (PTSD).**

Part II’s discussion of the more common types of cri- ses that you, as a mental health worker or consumer of mental health care, are likely to encounter opens with posttraumatic stress disorder (PTSD). The reason for beginning here is that many other crises reviewed in this book may be rooted in PTSD. For ex- ample, suicide (Chu, 1999; Kramer et al., 1994) and substance abuse (Ouimette, Read, & Brown, 2005; Read, Bollinger, & Sharansky, 2003) may be the end products of attempting to cope with trauma. In contrast, rape, sexual abuse, battering, loss, physical violence, hostage situations, and large-scale natural and human-made disasters may precipitate the dis- order (Ackerman et al., 1998; Bigot & Ferrand, 1998; Darves-Bornoz et al., 1998; Davis et al., 2003; Elklit & Brink, 2004; King et al., 2003; Lang et al., 2004; Melhem et al., 2004; North, 2004; Pivar & Field, 2004). Going one-on-one with PTSD is tough enough, but to make matters worse, lots of times PTSD turns into a gang war with a host of other comorbid (occurring along with it) problems that make it even harder to deal with as individuals bounce in and out of trans- crisis (Masino & Norman, 2015). Finally, PTSD-like symptoms may appear in the very people who attempt to alleviate the mental and physical suffering of peo- ple in crisis (Figley, 2002; Halpern & Tramontin, 2007; Pearlman & Saakvitne, 1995) and have become known as compassion fatigue (Figley, 2002) and vicar- ious traumatization (Pearlman & Saakvitne, 1995). We know this is a long chapter and you might need to take a nap or a snack break to get through it. Try as we might to prune it down, we felt that “all this stuff” was critical to giving you the background for understanding not only what PTSD is about, but what occurs in treating the other crisis and transcri- sis topics in this book. What we knew about PTSD in the first edition of this book in 1987 and what we know about it now—particularly the neurobiology and just how complex that is in manifesting the various traumatic responses that occur in humans— is like the difference between writing with a goose quill, inkwell, and papyrus scroll and word process- ing with an Apple Thunderbolt, OSX Lion operating system, and high-speed printer/scanner/fax. So bear with us! If you nail this chapter down, the other chapters will make a whole lot more sense as to how “all this stuff” goes together. In summary, PTSD has moved from the psychological backwaters of the Vietnam War to now being so central to treatment issues in mental health that there is the National Center for PTSD (http://www.ptsd.va.gov) and the National Child Traumatic Stress Network (NCTSN) [www.nctsn.org](http://www.nctsn.org).

**Background**

Psychic trauma is a process initiated by an event that confronts an individual with an acute, overwhelming threat (Freud, 1917/1963). When the event occurs, the inner agency of the mind loses its ability to control the disorganizing effects of the experience, and disequilibrium occurs. The trauma tears up the individual’s psychological anchors, which are fixed in a secure sense of what has been in the past and what should be in the present (Erikson, 1968). When a traumatic event occurs that represents noth- ing like the person’s experience of past events, and the individual’s mind is unable to effectively answer basic questions of how and why it occurred and what it means, a crisis ensues. The traumatic wake of a crisis event typically includes immediate and vivid reexperi- encing, hyperarousal, and avoidance reactions, which are all common to PTSD. The event propels the indi- vidual into a traumatic state that lasts as long as the mind needs to reorganize, classify, and make sense of the traumatic event. Then, and only then, does psy- chic equilibrium return (Furst, 1978).

The typical kinds of responses that occur imme- diately after the crisis may give rise to what are called **peritraumatic** (around, or like, trauma) symptoms. These are common responses as the mind attempts to reorganize itself and cope with a horrific event. For many people, these responses will slowly disappear af- ter a few days. Most people are amazingly resilient in the aftermath of a traumatic crisis and quickly return to mental and physical homeostasis, but if the symp- toms continue for a minimum of 2 days and a max- imum of 4 weeks and occur within 1 month of the traumatic event, then those time frames will meet the criteria of **acute stress disorder (ASD)** (American Psychiatric Association, 2013). Acute stress disorder diagnostic criteria are similar to the criteria for PTSD, which you will soon meet, except that the diagnosis can only be given in the first month after a traumatic event. ASD is somewhat different than PTSD be- cause **dissociative symptoms** such as memory loss, a sense of detachment from the world, belief that things and people are unreal, a blurred sense of iden- tity, and a general disconnect from reality are present (International Society for the Study of Trauma and Dissociation, 2015). As we will see, it is important to tackle ASD symptoms immediately and head on, be- cause they tend to be valid predictors for “catching” PTSD. Percentage rates for ASD vary a great deal de- pending on trauma type from vehicle accidents that range in the teens, to victims of robbery in the twen- ties, and to rape which skyrockets to the nineties (Gibson, 2015).

If the person can effectively integrate the trauma into conscious awareness and organize it as a part of the past (as unpleasant as the event may be), then homeostasis returns, the problem is coped with, and the individual continues to travel life’s rocky road. If the event is not effectively integrated and is sub- merged from awareness, then the probability is high that the initiating stressor will continue to assail the person and become chronic PTSD. It may also dis- appear from conscious awareness and reemerge in a variety of symptomatic forms months or years after the event. When such crisis events are caused by the reemergence of the original unresolved stressor, they fall into the category of delayed PTSD (American Psy- chiatric Association, 2013).

PTSD is a newborn compared with the other crises we will examine, at least in regard to achieving official designation. In 1980, PTSD found its way int the third edition of the American Psychiatric Associa- tion’s (1980) *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* as a classifiable and valid mental disorder. However, the antecedents of what has been designated as PTSD first came to the attention of the medical establishment in the late 19th and early 20th centuries.

Two events serve as benchmarks in the history of PTSD. First, with the advent of rail transportation and subsequent train wrecks, physicians and early psychiatrists began to encounter in accident survivor’s trauma with no identifiable physical basis. Railway accident survivors of this type became so numerous that a medical term, **railway spine**, became an accepted diagnosis. In psychological parlance, the synonymous term **compensation neurosis** came into use for invalidism suffered and compensated by insurers as a result of such accidents (Trimble, 1985, pp. 7–10).

Concomitantly, Sigmund Freud formulated the concept of **hysterical neurosis** to describe trauma cases of young Victorian women with whom he was working. He documented symptoms of warded-off ideas, denial, repression, emotional avoidance, com- pulsive repetition of trauma-related behavior, and recurrent attacks of trauma-related emotional sen- sations (Breuer & Freud, 1895/1955). However, what Freud found and reported on the pervasive childhood sexual abuse of these women as the traumatic root of their hysteria was anathema to a puritanical Victo- rian society, and he was forced to disavow and then reject his findings (Herman, 1997, pp. 13–17).

Second, the advent of modern warfare in World Wars I and II, with powerful artillery and aerial bom- bardment, generated terms such as shell shock and **combat fatigue t**o explain the condition of trauma- tized soldiers who had no apparent physical wounds. As early as the American Civil War, soldiers were di- agnosed with **neurasathenia,** a state of mental and physical exhaustion. This malady was also termed **“soldier’s heart”** because of the belief that nerves at the base of the heart were somehow affected by com- bat. The term **nostalgia**, a 19th-century military term coined by physicians for combat soldiers with extreme homesickness, would be seen as combat- induced PTSD in current terms. The thought was that soldiers became nostalgic for home and thus started to manifest a variety of physical symptoms that would relieve them from combat and allow them to go home (Kinzie & Goetz, 1996). Various hypothe- ses such as the foregoing were proposed to account for such strange maladies (Trimble, 1985, p. 8), but Freud (1919/1959) believed that the term **war neurosis** more aptly characterized what was an emotional disorder that had nothing to do with the prevailing medical notion of neurology-based **shell shock**, the idea that concussion from the massive shelling common in World War I injured the brain’s neurological systems. The U.S. Medical Service Corps came to recognize combat fatigue (being on the front line too long) in World War II and the Korean War as a treatable psy- chological disturbance. The treatment approach was that combat fatigue was invariably acute and that treatment was best conducted as quickly and as close to the battle lines as possible. The idea was to facilitate a quick return to active duty. The prevailing thought was that time heals all wounds and that little concern needed to be given to long-term effects of traumatic stress. Such has not been the case (Archibald et al., 1962). Indeed, a notable proponent of establishing the Vietnam Veterans Centers, Arthur Blank, ruefully commented that when he was an army psychiatrist in Vietnam, he believed there would be no long-term dif- ficulties for veterans (MacPherson, 1984, p. 237).

Although PTSD can and does occur in response to the entire range of natural and human-made catas- trophes, it was the Vietnam War that clearly brought PTSD to the awareness of both the human services professions and the public. Through a combination of events and circumstances unparalleled in the military history of the United States, veterans who returned from that conflict began to develop a variety of men- tal health problems that had little basis for analysis and treatment in the prevailing psychological litera- ture. This combination of events and circumstances had insidious and long-term consequences that were not readily apparent either to the individuals affected or to human services professionals who attempted to treat them. Misdiagnosed, mistreated, and misunder- stood, military service personnel became known to a variety of social services agencies that included the police, mental health facilities, and unemployment offices (MacPherson, 1984, pp. 207–330, 651–690).

As the war continued to grind on, more and more veterans started having psychological problems. Re- buffed by the Veterans Administration, these veterans formed self-help groups to try to come to terms with their psychological issues. These “rap” groups rapidly coalesced and became a political force that pushed the federal government to come to grips with their problems. One major result of their lobbying efforts was the establishment of the Vietnam Veterans Centers, where alienated veterans could seek help for a variety of readjustment problems. An informal network of mental health professionals became interested in the veterans and started to classify their symptoms and compare them to the work Kardiner (1941) had done on war neurosis. Their review of clinical records led them to generate 27 of the most common symptoms of the Vietnam veterans’ “traumatic neurosis” (van der Kolk, Weisaeth, & van der Hart, 1996, p. 61). Interestingly, many of the physical or somatic complaints resemble those of a large retrospective archival study on the medical records of American Civil War Union veterans (Pizarro, Silver, & Prause, 2006)!

At the same time, researchers in the growing women’s movement were looking at psychological problems after domestic violence, rape, and child abuse. What they were finding in the individuals who had suffered from these civilian assaults closely paralleled the problems that Vietnam veterans were experiencing. Their research rediscovered what Freud had found 80 years before and had dismissed: that victims of physical and sexual assault suffered long-term effects of the psychological trauma (Herman, 1997, p. 32). These different research avenues culminated in combining the “Vietnam veterans syndrome,” the “rape trauma syndrome,” the “abused child syndrome,” and the “battered woman syndrome” into one diagnostic category—posttraumatic stress disorder—in the third edition of the American Psychiatric Association’s Diagnostic and Statistical Manual in 1980 (van der Kolk, Weisaeth, & van der Hart, 1996, p. 61).

Although the Vietnam War may be no more to you than a reference in a high school history book, the wall memorial in Washington, DC, or your “crazy old Uncle Harold” who continues to wear combat fatigues and a headband with a ponytail, the war’s effects are a crucial history lesson in mental health provision (or the lack thereof) that any aspiring mental health worker should learn. For that reason, the psychological lessons learned from the Vietnam War continue to play a major role in the discussion of PTSD in the eighth edition of this book. It should be clearly under- stood that, even 50 years after the fact, the events that caused the trauma in many of these approximately 1 million veterans who suffered and suffer from PTSD are as alive for them today as they were then (Price, 2011). What is perhaps even more ominous in regard to the Vietnam veterans is their “graying.” Mounting evidence indicates that World War II and Korean War veterans have manifested delayed onset or worsening of posttraumatic complaints as they have grown older.

Aging, with its subsequent loss of social supports through death, increased health problems, declining physical and mental capabilities, and economic hard- ship, appears to put older veterans at increased risk (Aarts & Op den Velde, 1996, pp. 359–374; Hamilton & Workman, 1998). Thus, it would appear that as this population ages, the mental health professions are a long way from being done with the legacy of Vietnam.

Perhaps even more ominous, the current wars in Iraq and Afghanistan have eerily similar parallels to Vietnam. There are no front lines, the enemy fades into the population, everyone in the theater of operations is essentially in combat. As a result, vigilance must be constant, 24/7, throughout one’s entire rotation. Degree of combat exposure has been found to be one of the major predictors of PTSD (Miller et al., 2008; Smith et al., 2008), and anybody that goes into the “sandboxes” as they now called can expect just that.

There are two major differences in these conflicts. So far there is general public support for the troops, whereas in Vietnam there was not. A support group is critical in any crisis, and this is particularly true of troops in an increasingly unpopular war. Lack of support and outright hatred of returning troops was a major contributing factor for PTSD in Vietnam veterans. However, while the armed forces in the current conflicts are all volunteers and not 18-year-old draftees, there are a tremendous number of reserve units in combat action, and there are also huge differences in the number of women involved in direct combat action. The question then becomes what the use of reservists and women in combat portends for the on- set of PTSD. Preliminary results regarding mental health problems in veterans returning from Iraq and Afghanistan have ranged from 19% to 44% of the samples examined (Hoge, Auchterlonie, & Milliken, 2006; Lapierre, Schweigler, & LaBauve, 2007).