

POST-TRAUMATIC STRESS DISORDER (PTSD) AND MORAL INJURY: A BRIEF OVERVIEW

WILLIAM C. GIBSON, PH.D.

Definition of PTSD

Post-traumatic stress disorder (PTSD) may arise when a person experiences a traumatic event such as death, threatened death, serious injury, or actual or threatened sexual violence. This can involve direct exposure to one or more of these events, witnessing such an event, or hearing about someone close to them experiencing such an event. PTSD can also arise when professionals and others experience repeated indirect exposure to traumatic events (vicarious trauma) or in others, especially family members, who hear about the first-hand trauma experiences of others (secondary trauma).

This definition applies primarily to *simple trauma*, or exposure to one circumscribed traumatic event. By contrast, *complex trauma* may arise from exposure over time to prolonged, repeated trauma, such as physical or sexual abuse, neglect, or violence. The symptom pictures resulting from simple and complex trauma differ somewhat.

We can think of response to trauma as falling along a continuum, from an acute stress reaction that resolves without the person developing long-term PTSD, to the classic presentation of simple PTSD from one exposure to trauma, to complex PTSD from prolonged and/or repeated exposure to trauma. If the event is severe enough, nearly everyone will have symptoms related to PTSD, at least for a brief period of time.

Some statistics about trauma and its aftermath

- At least 15% of Americans report being molested, raped, physically attacked, or involved in combat
- Men are physically assaulted more often, while women are more often sexually assaulted
- The most common causes of trauma in men are experiencing combat and witnessing death or serious injury; the most common causes of trauma for women are rape and assault
- Men tend to be more often attacked by strangers, while women are attacked more often by someone they know
- People experiencing “intentional trauma” (rape, assault, combat) are at greater risk for developing prolonged PTSD than those experiencing “unintentional trauma” (being in an accident, witnessing violence or a natural disaster)
- Women are at twice the risk of developing PTSD compared with men
- Half of all victims of physical violence are under 25
- 29% of all forcible rapes occur before age 11
- In adolescents age 12-17, about 8% have been victims of serious sexual assault, about 17% have been victims of serious physical assault, and about 40% have witnessed serious violence

- Persons with histories of severe child maltreatment showed a 4 to 12 times greater risk for developing alcoholism, depression, drug abuse, and suicide attempts; are 2 to 4 times more at risk for such conditions as smoking, having a high number of sexual partners, and developing an STD; are at about one-and-a-half times greater risk for physical inactivity and obesity; and face a one-and-a-half to three times greater risk for a long list of physical illnesses

What happens during and after a traumatic or stressful event?

When we experience a stressful or traumatic event, our brains and bodies go through a series of natural reactions.

Physiological response

The brain secretes stress-responsive substances that alter the functioning of the brainstem, the limbic system, and the frontal lobes. The brainstem and limbic system serve to mobilize the body to respond (fight, flight, or freeze), while the frontal lobes and other cortical areas evaluate the situation and determine the best response. For most people, after the stressful event is over, they are able to return to physiological homeostasis. But for those who develop persistent PTSD symptoms, the experience of the traumatic event(s) is so overwhelming that it alters how they physically respond to trauma. In such individuals, the “threat-assessment” area of our brain, the limbic system, which is designed to adapt to the experience of threat, may become hypersensitive after a trauma to the point where even minor triggers or non-related events may give rise to a physical stress response

Psychological response (See Table 1)

Most of us grow up with a set of beliefs about ourselves, other people, and the world. We tend to believe that we’re basically good people, so we won’t harm other people and they won’t harm us; we believe that others are basically good as well; and we believe that the world is a fairly benign place where, most likely, nothing bad will happen to us. Furthermore, we tend to believe that good things happen to good people and bad things happen to bad people, often referred to as the “just world hypothesis.” Exposure to one or more traumatic events can at the very least cause us to question these beliefs, and at worst completely destroy them, leaving us with no clear anchor or orienting point in the world and often resulting in the development of a distorted view of ourselves, others, and/or the world. Trauma also distorts our sense of time; the past and present no longer have firm boundaries, but the past can intrude into the present at any time in unpredictable and distressing ways. In addition, because traumatic memories have such powerful sensory components, they do not fall into a narrative (story) structure, but feel fragmented, and thus more frightening and disorienting. This all may lead the person with PTSD symptoms to avoid people, places, and things that might trigger one of these intrusions; and this, in turn, can lead to more general withdrawal and avoidance, self-medication with alcohol or drugs to regulate emotions, and trouble concentrating and focusing on the present, as well as other symptoms described below.

Simple trauma

Experience of a single, discrete traumatic event often results in feelings of fear, terror, and helplessness. In addition, people may experience one or some combination of other responses, such as numbness, withdrawal, confusion, and shock. All of these may set the stage for later PTSD symptoms. While the presence or absence of any of these responses does not necessarily predict whether the person will

develop PTSD, people who take a more active, problem-solving approach to the traumatic event are less likely to develop PTSD, while those who dissociate are more likely to develop PTSD. Likewise, people with a prior history of exposure to trauma or any emotional disorder, those with a history of substance abuse, those with a family history of anxiety, people who were separated from their parents at an early age, and those without social support tend to be at greater risk for developing PTSD.

After a traumatic event, most people will still experience some strong response. Intrusive images and sensations will trigger strong emotions and thoughts, which in turn give rise to alterations in arousal and reactivity (irritability, hypervigilance). In most cases, the person experiences the emotions that arise in response to triggers without avoidance, and their fear response fades naturally over time. By contrast, people who develop PTSD seem to be more likely to experience more avoidance in response to the strong negative experiences associated with trauma, and thus have less chance to deal actively with the thoughts and feelings that arise. The cycle of triggers—thoughts/ feelings—arousal never becomes uncoupled, but instead tends to recur. On average, by one year post-trauma, between 17 and 20% of people still meet the diagnostic criteria for PTSD. Several things affect the time and trajectory of this recovery, including genetic factors, personality factors, prior and subsequent exposure to trauma, and the type of trauma experienced (intentional or unintentional).

Complex trauma

Those exposed to repeated trauma over time may present with some or all of the typical PTSD symptoms. In addition, they may show persistent personality changes, including persistent distortions of their ability to relate to others and in their sense of identity; excessive dependence; difficulty planning; and difficulty with decision-making, sometimes to the point of paralysis. Other common symptoms include helplessness, fear, anxiety, self-hatred, shame, distrust, aggression against self and others, fatigue, sleep and eating problems, and physical complaints. Those suffering from complex PTSD may also be more likely to continue to dissociate in response to real or perceived threats. Even if those who experience repeated or persistent trauma don't meet the criteria for PTSD, they may still experience subclinical PTSD, depression, anxiety, or other diagnosable problems.

Those exposed to persistent and/or repeated trauma are at greater risk for repeated harm, both self-inflicted and from others. Individuals with post-traumatic stress from both simple and complex trauma may also develop an "emotion-focused" style of coping where their goal is to alter their distressed emotional state rather than attempt to change the circumstances that give rise to that state. This coping style is largely responsible for the high rate of substance abuse among those who experience PTSD. Between 25 and 50% of people seeking treatment for substance abuse meet the criteria for a co-morbid diagnosis of PTSD.

MORAL INJURY

There are two main ways of defining moral injury:

- Betrayal of what is morally correct by someone in a position of authority in a high-stakes situation (Jonathan Shay)
- Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations (Brett Litz and colleagues)

While these two definitions differ somewhat, they share the common core of injury to one's conscience arising from exposure to a morally transgressive situation. Moral injury can result from acts on a personal/individual, group, or organizational level. It is not a psychological disorder, but rather is a natural human response to an abnormal event. Moral injury may co-occur with PTSD or may exist on its own. Those suffering from moral injury may demonstrate PTSD-like symptoms (nightmares, intrusive memories/images, avoidance, emotional numbing). Other symptoms may be more prevalent, however, including shame, guilt, anxiety, depression, self-sabotaging, and self-destructive behaviors. In addition to these primarily psychological symptoms, those suffering from PTSD, moral injury, or both may also experience despair, a loss of meaning, and loss of religion/spirituality. (See Figure 1)

WORKING WITH PTSD AND MORAL INJURY

The literature divides approaches to working with those who have experienced trauma into two categories – *trauma-specific* and *trauma-informed*.

Trauma-specific care involves using one or more therapies or techniques designed specifically to directly treat PTSD symptoms. Examples of trauma-specific therapies are cognitive processing therapy (CPT) and prolonged exposure (PE). Both of these approaches are based on cognitive-behavioral models and focus on reducing avoidance of distressing emotions, teaching tools and techniques to help the person cope with these distressing feelings and symptoms when they arise, and systematically examining, challenging, and changing distorted beliefs the person has about him- or herself and the traumatic event. These approaches are used primarily to treat simple PTSD, although some of the tools and techniques can also be used when working with those with a history of complex trauma.

The concept of *trauma-informed care* arose in the early 2000s as people began to realize the prevalence of exposure to trauma. In contrast to trauma-specific approaches that target symptoms, a trauma-informed approach offers a more general approach to and framework for working with those who have experienced both simple and complex trauma. A trauma-informed approach is particularly useful when non-specialists or non-clinicians are working with those who have experienced complex trauma and who may or may not meet the formal diagnostic criteria for PTSD.

The following are generally agreed-upon principles of a trauma-informed approach:

- Acknowledge the high prevalence of exposure to trauma in both childhood and adulthood and the effects this exposure has on people's development and coping strategies
- Recognize the signs of trauma: Take a good trauma history, learn to spot trauma symptoms, and pay close attention to people who are members of groups that are at potentially greater risk for

exposure to both past and current trauma (women, children, homeless, those with substance abuse issues, those with serious and/or chronic mental illness, those from violent neighborhoods, those from disadvantaged circumstances)

- Be sensitive to the possibility of re-traumatization and work to avoid it: Re-traumatization can occur in several ways – through intrusive or insensitive procedures; through the insensitive exercise of power or control; through aggressive or confrontational techniques; or through an implicit or explicit message that the person should avoid talking about his or her trauma, which may re-create a situation where the person was told to keep quiet about abuse, or may suggest that the person is exaggerating his or her abuse, or may make things worse by talking about it
- Create a setting where all involved feel physically and psychologically safe
- Be trustworthy and transparent when working with those who have experienced trauma
- Foster collaborative relationships
- Encourage reconnection through peer and supportive relationships
- Provide empowerment, voice, and choice
- Be mindful of the roles cultural, gender, and historical issues play in the experience of trauma and individual and organizational responses to those who have experienced trauma

In addition to these general guidelines for taking a trauma-informed approach, here are some specific guidelines for therapists and counselors who work with those who have experienced trauma:

- A safe, trustworthy, empathetic, healing relationship is key
- Pay special attention to the role of remembrance, grief, and mourning in therapy
- Foster reconnection with oneself through letting go of distorted aspects of the self that developed in response to trauma and acknowledgement of and expression of desires and initiative. Help the person connect feelings to language, help them find language for their experience (create a narrative), help them find or create a different sense of meaning related to the event, and support them in seeking out experiences that contradict their previous experiences and beliefs related to the traumatic event(s)
- Foster reconnection with others through developing trusting and intimate relationships and telling one's story as appropriate and to the extent the person feels comfortable. This may involve becoming part of a formal or informal group. In some cases, the person may develop a sense of mission to engage with the world in a larger way pertaining to his or her trauma.

While there is no parallel literature on “moral-injury informed care,” many, or even most, of the principles of trauma informed care apply to working with those with moral injury:

- Realize the frequency and extent of moral injury
- Learn to take a good moral injury history; this may be more subtle and harder to tease out than trauma
- Be careful to avoid re-injury through inadvertent judgment or shaming
- Forgiveness of self and others is key, but be careful not to offer or suggest forgiveness too quickly
- Be willing to carefully explore the person’s religious, spiritual, and moral history, as these form the context in which the moral injury occurred
- Be mindful of the potential roles of ritual and symbol to foster healing, reconnection, and restoration to a sense of community

For all who work extensively with those who have experienced trauma and those who suffer from moral injury, two things are of crucial importance:

- Don’t ever hesitate to consult or refer
- Make sure to have a good support system available for yourself (supervision, peer supervision, personal therapy, friends, religious/spiritual support, healthy self-care)

“The reason for evil in the world is that people are not able to tell their stories.” ~ Carl Jung

“All sorrows can be borne if you put them in a story, or tell a story about them.” ~ Isak Dinesen

RESOURCES

BOOKS

Brock, Rita Nakashima & Lettini, Gabriella (2012). *Soul repair: Recovering from moral injury after war*. Boston: Beacon Press.

Herman, Judith (1997). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.

Janoff-Bulman, Ronnie (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Klay, Phil (2014). *Redeployment*. New York: Penguin Books.

Lifton, Robert Jay (1973). *Home from the war: Learning from Vietnam veterans*. New York: Other Press.

McClelland, Mac (2015). *Irritable hearts: A PTSD love story*. New York: Flatiron Books.

Morris, David J. (2015). *The evil hours: A biography of Post-Traumatic Stress Disorder*. New York: Houghton Mifflin Harcourt.

Shay, Jonathan (1995). *Achilles in Vietnam: Combat trauma and the undoing of character*. New York: Simon and Schuster.

Shay, Jonathan (2002). *Odysseus in America: Combat trauma and the trials of homecoming*. New York: Scribner.

Sherman, Nancy (2015). *Afterwar: Healing the moral wounds of our soldiers*. New York: Oxford University Press.

Sherman, Nancy (2011). *The untold war: Inside the hearts, minds, and souls of our soldiers*. New York. W W. Norton & Company.

Tick, Edward (2005). *War and the soul: Healing our nation's veterans from post-traumatic stress disorder*. Wheaton, IL: Quest Books.

Tick, Edward (2014). *Warrior's return: Restoring the soul after war*. Boulder, CO: Sounds True.

Van Der Kolk, Bessel (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. NY: Viking.

HELPFUL WEBSITES

PTSD

National Center for PTSD: www.ptsd.va.gov

Wellness resources for the military community: www.afterdeployment.org

Shared experiences for veterans: www.maketheconnection.ne

National Institute of Mental Health PTSD page: www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml

The Trauma-Informed Care Project: traumainformedcareproject.org

National Center for Trauma-Informed Care: www.samhsa.gov/ntic

Moral Injury

Soul Repair Center: brite.edu/academics/programs/soul-repair/

VA PTSD website article on moral injury: www.ptsd.va.gov/professional/newsletters/research-quarterly/v23n1.pdf

MOVIES

The Best Years of our Lives (1946)

Born on the Fourth of July (1989)

Brothers (2009)

Coming Home (1978)

The Deerhunter (1978)

The Fisher King (1991) – non-combat PTSD

Gran Torino (2008)

In the Valley of Elah (2008)

Jackknife (1989)

Missing in America (2005)

The Prince of Tides (1991) – adult effects of childhood trauma

The War at Home (1996)

OTHER RESOURCES (YouTube videos)

Jonathan Shay on moral injury www.youtube.com/watch?v=XBkCg6_ISpQ

Rita Brock on soul repair www.youtube.com/watch?v=rIVYpRM8xtc

TABLE 1: PTSD SYMPTOMS

PTSD symptoms are divided into four clusters:

RE-EXPERIENCING SYMPTOMS

- Flashbacks—A dissociative reaction that is a kind of virtual reality reliving of the traumatic event(s)
- Intrusive thoughts and memories related to the trauma(s).
- Nightmares

AROUSAL SYMPTOMS

- Hypervigilance—The need to be always watchful or on guard
- Hyperarousal—Reacting or startling very easily, as well as having trouble falling asleep or staying asleep
- Irritability or anger
- Problems with concentration
- Reckless or self-destructive behaviors, risk-taking, substance abuse

CHANGES IN MOOD AND THINKING

- Depression/sadness
- Guilt
- Shame
- Fear
- Self-blame and blaming others
- Feeling alienated and cut off from other people and/or the world around you
- Loss of interest in previously enjoyable activities
- Difficulty experiencing positive emotions, emotional numbing
- Negative beliefs about oneself, others, and/or the world
- Trouble remembering parts of the traumatic experience(s)

AVOIDANCE OF REMINDERS OF THE EVENTS

- Avoiding people, places, and events that remind the person of the trauma(s), and avoiding thinking about or having feelings about the trauma(s)

FIGURE 1: The Relationship Between PTSD and Moral Injury

