PTSD Misconceptions, Trauma Rituals, and PTSD Induction

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Abstract

Despite the fact that there are many faces to PTSD (Kilbourne & Kilbourne, 2012), and that women are the largest group of individuals impacted by violence and PTSD in the USA, many misconceptions continue to surround the conceptualization, diagnosis, and treatment of PTSD. Perhaps the single foremost misconception involving PTSD is that combat PTSD is the face of PTSD, and that there are certain aspects of combat PTSD which distinguishes it inexorably from any other type of PTSD. However, the presence of common factors across all types of PTSD makes a strong case for conceptualizing PTSD and other trauma disorders in terms of Trauma Spectrum Disorders (e.g., TSDs) analogous to Autistic Spectrum Disorders. It is argued that the natural occurrence or induction of trauma disorders is a good place to start to identify the common dimensions of TSDs and 8 criterion conditions of TSDs are identified. Additionally, Trauma Spectrum Disorder Enhancement laws were proposed to curb the institutionalized and run-away assault on women and children in contemporary American society.

Key Words: PTSD, Trauma rituals, induction, trauma spectrum, PTSD enhancement laws
1. Introduction

During the past 15 years, the United States has been involved in several simultaneous wars (e.g., Iraq, Afghanistan, the war on terror, etc.) that have had a profound impact on contemporary American society and the global community, economically, socially, politically, and morally. Some believe these wars have drawn into sharp relief post World War II U.S. policy on international relations and have raised serious questions about U.S. overreliance on military solutions in general and war in particular to deal with complex geopolitical problems and crises. Any knee-jerk reaction to these wars, whether in support or in opposition, probably misses the complexities of the issues at hand, how fast the world is changing, and how difficult the cost benefit calculus truly is.

One unexpected consequence of the American wars in Iraq and Afghanistan has been the recognition that some of the costs to war, especially to combatants, do not walk away quietly into the night. To the contrary, “the tail” of some war related consequences to combatants may be very long and difficult to fully calculate in dollars and cents, let alone in psychological, emotional, moral, and spiritual terms. Combat PTSD (Posttraumatic Stress Disorder) is such a consequence. The costs of Combat PTSD (e.g., economic, financial, political, social, medical, psychological, and spiritual) may not be fully calculable and may have already surpassed the billion-dollar mark in contemporary American society.

In many respects, Combat PTSD has become the face of PTSD and an “American Hero’s Disease” (Kilbourne & Kilbourne, 2012), which, unfortunately, creates the false belief that there is something unique and daunting about Combat PTSD which distinguishes it conceptually and scientifically from other types of PTSD. That erroneous belief may impede our scientific and medical understanding of trauma disorders in general and PTSD in particular, and which may, in turn, lessen our ability to effectively treat PTSD. There are in fact many faces to PTSD (e.g., woman, children, first responders, disaster victims, work and traffic accident victims, military combatants, displaced persons, etc.) in contemporary American society (Kilbourne & Kilbourne, 2012), and women and children are far more likely than military combatants to be victims of PTSD (Hamblen & Barnett, 2010; NCS-R, 2005; Schnurr, Friedman, & Bernardy, 2002; Schoenstadt, 2009; Tolin & Foa, 2006). The disproportionate impact of PTSD on women and children is a chronic and irascible societal problem in American society, and tends to dwarf in numbers the incidence of Combat PTSD.

The present paper contends that the current DSM-5 definition of PTSD: 1) captures more women and children as victims of PTSD in contemporary American society than combat and noncombat military personnel combined, 2) cannot empirically distinguish between the different victims of PTSD in contemporary American society, 3) is in fact based on a coding
artifact in field trial data (i.e., error of method), and 4) is more likely a cultural bound American reaction to trauma than a universal reaction to trauma.

Alternatively, the present paper proffers, on empirical, statistical, and conceptual grounds, that trauma reactions, both within and between cultures, are better understood on a spectrum, and, therefore, similar to autistic spectrum disorders or the spectrum of light (i.e., the range of wave lengths of electromagnetic radiation that are eyes are sensitive to), the conceptualization of TSDs is introduced to emphasize the common features (i.e., quantitative and qualitative) of all trauma reactions. The present paper also discusses our rapidly advancing knowledge regarding TSDs and the need for contemporary trauma researchers and practitioners to acknowledge the reality of trauma spectrum induction, either unintentionally by virtue of neglect and discrimination (e.g., assault, rape, child abuse, foster care, etc.) or by virtue of intent (e.g., kidnappings, hostage-taking, and/or terrorist acts). Education and clinical treatment may not be enough to curb the wave of trauma associated with both unintentional and intentional trauma induction in contemporary American society. Trauma enhancement laws, analogous to gang enhancement laws, are proposed to help curb the wave of trauma associated crimes occurring in contemporary American society.

2. PTSD and the Facts

First, there are more civilian women and children victims of PTSD than combat and non-combat military personnel combined in contemporary American society. Using both the NCS-R (2005) and the U.S. Census Bureau data (2015), which are the best available estimates for the general population, one can generate a reasonable extrapolation indicating that approximately 16 million woman have or had PTSD sometime during their lifetime. Similarly, when combining the Comorbidity Survey Replication – Adolescent Supplement (Merikangas et al., 2010) and the Forum on Child and Family Statistics (n.d.) it is also a reasonable extrapolation that there are about 7.4 million juveniles that suffer from PTSD. Regarding the occurrence of Combat PTSD amongst those deployed since 2001, Tanielan et al. (2010) concluded that perhaps 300,000 service members indicated PTSD and major depression. To summarize, then, there are good estimates that there are approximately 16 million women and 7.4 million juveniles (23.4 million total) with PTSD compared to only 300,000 service members with PTSD. Taken together, the combination of media (sensationalism), war in general, politics, and being a war fatigued nation suggests that the media and ideology have significantly influenced the definition of PTSD and have transformed it into more of a socio-political concept than a medical/scientific concept.

Second, there is virtually no extant empirical and scientific data, medical, psychiatric, psychological, neurological, sociological, anthropological, etc., that can reliably distinguish the different victims of PTSD (e.g., women, children, men, young, old, black, white, Latino,
military personnel [combat versus noncombat], first responders [firefighters, emergency workers, police, ambulance drivers, and medics], disaster victims [flood, tornado, fire, war], and displaced individuals [refugees, immigrants, foster care, emergency care/CPS], and, therefore, type of victim cannot be used as the basis for a meaningful typology of PTSD disorders or trauma disorders.

Third, Kilbourne, Kilbourne, and Goodman (in press) have pointed out that the absence of any systematic statistical analyses of the actual diagnostic structure of any of the Diagnostic and Statistical Manuals of Mental Disorders seriously limits confidence in diagnostic validity and interrater reliability. Kilbourne et al (in press) identified a Common Symptom Requirement Dichotomy in the DSM-5 (i.e., Number of Not Mandatory Symptoms versus Number of Mandatory Symptoms) and found that Symptom Requirement Dichotomy statistically differentiated: 1) the 5 distinct DSM-5 Trauma-and Stressor-Related Disorders (i.e., Reactive Attachment Disorder [RAD], Disinhibited Social Engagement Disorder [DSED], Posttraumatic Stress Disorder [PTSD], Acute Stress Disorder [ASD], and Adjustment Disorder [AD] (Pearson Chi Square = 13.752, p = .008; Yate’s Chi Square = 9.198, p = .056; Cramer’s V = .425, p < .01); 2) theCollapsed Adult Disorders (i.e., Medical versus Psychosocial) (Pearson Chi Square = 4.71, p = .029; Yate’s Chi Square = 3.93, p = .0474; Fisher Exact Probability Test [2-tailed] = .0376) reported in the DSM-5 Adult Field Trials (Regier et al., 2013); and 3) the Child Disorders (Pearson Chi Square = 24.44, p = .0002; Yate’s Chi Square = 19.48, p = .002; Cramer’s V = .58, p < .01) reported in the DSM-5 Child Field Trials (Regier et al., 2013). Additionally, Kilbourne et al (in press) found that the reported Kappa Reliability Coefficients in the DSM-5 Field Trials for both Adult and Child Disorders (Regier et al, 2013) were a quadratic function of the Number of Not Mandatory symptoms (all Adult $R^2$’s ≥ .245 and all Child $R^2$’s ≥ .142) listed in the DSM-5 for each of the targeted diagnostic categories. The number of Not Mandatory Symptoms and Regression Coefficients in the quadratic regression equations (Adult and Child Disorders) predicted Kappa Reliability Coefficients (all p’s ≥ .33, ranging from .33 to .56). These findings provided incontrovertible evidence that the Kappa interrater reliability coefficients in the DSM-5 Field Trials were confounded with systematic measurement error (i.e., error in method).

Fourth, a review of anthropological data, history, and literature indicates that trauma tends to be reported across all human cultures in various ways, does not fit into one single dimension disorder, and may in fact be associated with either positive and/or negative effects (Can, 2013; Lester, 2013).
3. Trauma Spectrum Disorder

A spectrum is generally a good way to describe phenomena that occur within a range of values and when particular phenomena do not differ categorically from one another but do differ in a matter of degrees. In the physical world, humans perceive light as a function of the range of wavelengths of electromagnetic radiation. More recently, the American Psychiatric Association has collapsed the various types of autistic disorders into Autistic Spectrum Disorder because the various types of autism do not distinguish themselves from one another on neurological grounds and tend to share certain common dimensions or features that differ primarily in degree, not substance. The re-conceptualization of autism on a spectrum may ultimately transform the diagnosis and treatment of autism, and it may, in turn, foreshadow a major re-conceptualization of all mental disorders, especially those mental disorders with a known or suspected biological component (i.e., genetic, biological, medical, etc.). Collapsing PTSD and the other Trauma-Related Disorders (i.e., RAD, DSED, and ASD) into a single disorder, Trauma Spectrum Disorder, makes a lot of sense conceptually, empirically, and pragmatically since these disorders cannot be distinguished from one another on neurological grounds and since they share many of the same common dimensions or features. Re-conceptualizing PTSD as part of a TSD also makes sense in light of the current method bias inherent in DSM-5 psychiatric diagnoses (Kilbourne & Kilbourne, 2011; Kilbourne, Kilbourne, and Goodman, in press) and given the absence of any convincing empirical evidence that PTSD is a cross-cultural phenomenon and not a unique American psychiatric diagnosis. In sum, then, there is sufficient evidence to justify collapsing the Trauma Related Disorders in the DSM-5 into a single disorder, Trauma Spectrum Disorder (TSDs). However, the common dimensions or features of TSDs are an empirical question and should not be a knee-jerk regurgitation of DSM-5 criteria which are culturally bound, do not reflect representative samples of trauma victims in American culture, and which have not been found to indicate inter-rater reliability independent of coding error.

4. Trauma Spectrum Induction

While the common dimensions of TSDs are an empirical question which invite a major research undertaking, a good starting point for understanding the natural occurrence of trauma disorders is to begin with a sound conceptual analysis of any prototypic or most common trauma reaction in a given culture. That conceptual analysis does not become the standard for a discipline. Rather that conceptual analysis is employed to generate hypotheses that can be tested both within and between cultures. Thus, the natural occurrence or natural induction of trauma disorders is a good place to start conceptually to identify the common dimensions of TSDs.
When we think of trauma spectrum induction we are likely to conjure up images of Dr. Frankenstein and the Frankenstein monster. We are also likely to trigger associations and images of psychologists and psychiatrists in their laboratories manipulating experimental subjects (Zimbardo and Milgram), testing experimental drugs (Szalavitz, 2016), even using brainwashing and water boarding to manipulate the will of coerced individuals or extracting confessions from prisoners and hostages (Encyclopedia Britannica, 2016; Schein, 1961). However, such negative imagery, associations, and stereotypes could not be further from the truth. What we are interested in here is the scientific analysis of the psychosocial and physical conditions which are associated with the induction, consolidation, and sustainment of psychological trauma across individuals, groups, and cultures. From a stochastic perspective (Kilbourne, Kilbourne, Goodman, 2014; Kilbourne, Kilbourne, Goodman, & Harned, 2016; Kilbourne, Kilbourne, Goodman, & Harned, in press), we are interested in ascertaining the probabilities of trauma unfolding in a given individual across time, situation and culture. A scientific analysis of the conditions associated with trauma induction, including the vulnerabilities of particular individuals, that will help practitioners better understand TSDs across a wide array of conditions and help practitioners provide better treatments to those impacted by trauma. It will also help other professionals, laypersons, and advocates to coordinate their efforts to prevent those social and economic arrangements and conditions in society which, intentionally or unintentionally, increase the likelihood (the probabilities) of trauma disorders to develop in particular individuals within a particular societal and/or cultural context.

Rather than conceptualizing the induction of TSDs as an event or process that begins in a laboratory and is systematically manipulated and measured, it is important to shift our thinking from the scientific laboratory to the real world where trauma reactions and presumably TSDs occur on a fairly regular basis. Systematic patterns of trauma induction regularly occur within contemporary American society, especially in relation to women and children (the largest two groups impacted by trauma and PTSD), and invariably involve the violation of their basic human and civil rights, unlike first responders and military combatants. Woman and children are unknowing victims of trauma inducing acts whereas first responders and combatants are knowing casualties of trauma inducing acts. While the sudden unexpected violation of self and/or physical integrity tends to characterize all traumatic psychological reactions, whether women, children, first responders, disaster victims, and/or combatants, what is unique about women and children is that the unexpected violation of self and/or physical integrity usually involves the violation of their basic rights as human beings. Those who violate their basic human rights are generally aware of what they are doing and they do so willfully and intentionally. So, at least with women and children, the induction of TSDs appears willfully inflicted upon them by perpetrators who hope the trauma
will in fact help them achieve their goals and subjugate their victims. It is conceptually the same as using torture or waterboarding to elicit forced confessions in captives and prisoners of war. In many respects, then, what happens to women and children in contemporary American society when their basic human rights are violated serves as the prototype for understanding the necessary and sufficient conditions for inducing TSDs.

The following are conceptually distinct criteria or conditions that have been identified in clinical case studies of PTSD or what we are now referring to as TSDs:

1. The individual experiences a profound and unexpected violation of self and/or physical integrity.
2. The individual finds themselves in a life situation where escape is difficult to impossible, at least temporarily (physically or psychologically), and experiences feelings of helplessness.
3. The individual experiences intense negative arousal and intense negative affect.
4. The individual attempts to avoid thoughts, feelings, memories, and situations that remind them of the trauma inducing event.
5. The individual reports detailed memories of some aspect of the trauma inducing event, as if it happened yesterday.
6. The individual develops a trauma self or self-alert system (beliefs, emotional reactions, perceptions, stories, rituals, and re-enactments) which alerts and protects them from danger.
7. The individual incorporates new information, stimuli, and situations (i.e., a gradient and generalization) into their trauma self or self-alert system.
8. The individual’s self/physical integrity threshold is lowered and they become more vulnerable to subsequent traumatic reactions.

5. Trauma Enhancement Laws

In the state of California, section 186.20 of the Penal Code is cited as the “California Street Terrorism Enforcement and Preventions Act” (Penal Code, n.d.). Section 186.21 guarantees that it is the right of every person: regardless of race, color, creed, religion, national origin, gender, gender identity, gender expression, age, sexual orientation, or handicap, to be secure and protected from fear, intimidation, and physical harm caused by the activities of violent groups and individuals (Penal Code, n.d.).

The aforementioned introduces an area in which forensic psychologists can help the public; that is by legislating, enacting, and supporting laws that function to deter individuals who might consider committing certain crimes associated with severe psychological trauma and PTSD or what we are now referring to as Trauma Spectrum Disorder (TSD). The issue of PTSD and the court is not a new one. PTSD has been used to affirm worker’s
compensation cases as well as in an attempt to establish the insanity defense. However, currently, there is not yet a law in place that addresses culpability when wittingly or unwittingly inducing PTSD or what we are now referring to as TSDs.

Beatings, torture, rape, molest, and/or threats of death can be contrived or executed to induce trauma and PTSD. Unscrupulous individuals, professional or layperson, may induce and perpetuate PTSD in the following ways: 1) stage repeated traumatic life threatening events (real or imaginary), 2) use psychological techniques (e.g., EMDR or CBT) to activate traumatic memories and induce dissociation, 3) reinforce PTSD symptoms (e.g., hyper-vigilance, disturbed sleep [e.g., accentuate the volley of involuntary mental flashbacks that may occur during trauma onset], explosive anger, or foreshortened future, etc.), 4) explain trauma experience as a doorway to the real self or real world to justify extreme action (e.g., abandon family, blame self, untoward sex acts, or sacrifice oneself to a higher cause), 5) collect detailed trauma histories and manipulate associations and traumatic memories, and 6) withhold, delay and/or deny appropriate psychological and medical treatment.

It follows from the above that education and treatment may not be sufficient to stem the tide of violent assaults against women and children and may require trauma enhancement laws, which would be analogous to gang enhancement laws (section 186.22 of the California Penal Code) (Gangs187.com, 2012; Shouse California Law Group, 2016). Such laws increase sentencing for gang affiliated violence, crimes, and felonies committed for the benefit of, at the direction of, or in association with any criminal street gang with the intent to promote, or further assist in any criminal conduct by gang members (Couzens & Bigelow, 2015; Harris, 1999; LegalMatch, 2012; Pennypacker & Bennett, 2015; Shouse California Law Group, 2016; U.S. Department of Justice, 2009; Wallin & Klarich a Law Corporation, 2015). PTSD or TSD enhancement laws would be additional felony offenses attached to certain crimes (e.g., rape, molest, hostage taking, assaulting a firefighter or police officer) that would increase sentencing, whether or not the offender was aware that psychological trauma, PTSD, or TSD was a likely result of their offense. Implementing a PTSD or TSD enhancement law would in fact fall in line with the purpose of preexisting enhancement laws: 1) deterrence, and 2) extending punishments that help keep criminals in prison and away from the public.

A PTSD or TSD enhancement law would also comply with the Federal “three Strikes” statute because many crimes that result in psychological trauma (i.e., attempted murder, interpersonal violence, sexual offenses) are included in this statute (Carbon, n.d.; Couzens & Bigelow, 2015; Pennypacker & Bennett, 2015; Shouse California Law Group, 2015; U.S. Department of Justice, 1995; U.S. Department of Justice, 2009; Yoshino, 2008). Under this statute, the defendant is mandated to life imprisonment if he or she is convicted in Federal Court of a “serious violent felony” (e.g., murder, manslaughter, sex offenses, kidnapping, robbery, and any other offenses punishable by ten years or more which include elements of
force or by its nature involves significant risk of force) and has two or more convictions in state or Federal Courts, where at least one is a “serious violent felony.”

Such PTSD or TSD enhancement laws would be a practical deterrent and one which would hopefully help to reverse the near epidemic of physical and sexual assaults upon women and children in contemporary American society. TSD enhancement laws would certainly increase the consequences to terrorists, foreign and domestic, who conspire to subvert democratic institutions and democratic governments, and they might also reduce violent and sexual crimes in prisons.

Many laws fall in line with the “State side” or “Federal side” when it comes down to evidence being used to charge and eventually sentence an individual. State side versus Federal side becomes relevant to proposed PTSD or TSD enhancement laws because State side and Federal side address where the crime can be charged, depending on the amount of available evidence. This could prove beneficial, for example, if an adequate amount of evidence does not exist to fully charge an individual on the Federal side, but there is enough evidence that supports a State side charge independent of a subsequent Federal side charge (or vice versa). With the aforementioned in mind, it would therefore be plausible that an individual who is charged with inducing PTSD will receive a two-pronged charge where aspects of the crime explicitly meet State side criteria (i.e., implicitly not Federal side criteria) and other aspects of the crime will meet Federal side criteria (i.e., implicitly not state side criteria).

Developing and implementing laws that prosecute those who wittingly or unwittingly induce PTSD or TSD serves two primary functions, protecting the victims (predominately women and children) and targeting adult sexual exploiters of children and other adults for punishment, not the victim and especially not children. Charging an individual with an additional PTSD or TSD enhancement will thus introduce the victim to resources that were not previously available (e.g., monetary compensation that will be used towards psychotherapy, necessary medication follow-ups, co-occurring rehabilitation facilities if necessary, paying for support groups, etc.).

In part, this proposition introduces the Eight Amendment which prohibits cruel and unusual punishment and helps regulate the severity of sentencing so that the sentence is not disproportionate to the present crime committed (LegalMatch, 2012). This becomes important when dealing with the possibility of a TSD enhancement law because one of the criteria is simply a perceived threat to self or others which sits in contrast to the Eighth Amendment in that an enhancement sentence can be perceived as excessive if a prior crime does not include actual or threatened violence.
6. Conclusion

The present paper discussed some basic misconceptions associated with PTSD and reviewed evidence indicating that the current DSM-5 definition of PTSD: 1) captures more women and juveniles as victims of PTSD in contemporary American society than combat and noncombat military personnel combined, 2) cannot empirically distinguish between the different victims of PTSD in contemporary American society, 3) is in fact based on a coding artifact in field trial data (i.e., error of method), and 4) is more likely a culturally bound American reaction to trauma than a universal reaction to trauma. The present paper also introduced the idea of Trauma Spectrum Disorders (TSDs) to supplant and replace the DSM-5 diagnosis of PTSD, analogous to Autistic Spectrum Disorders in the DSM-5, since trauma disorders cannot be neuro-psychologically or neuro-biologically distinguished from one another, and share multiple common dimensions that vary in degree and not in kind. A conceptual analysis of Trauma Spectrum Induction was proffered as a starting point for identifying the basic conditions associated with the onset, occurrence and persistence of trauma disorders and in order to facilitate empirical research on TSDs both within and between cultures. Lastly, Trauma Spectrum Disorder Enhancement laws were proposed to curb the institutionalized and run-away assault on women and children in contemporary American society.

While the present paper broke significant ground in re-conceptualizing some of our basic assumptions regarding the nature, occurrence, types, and diagnosis of PTSD, the present paper clearly limits itself to individual and group PTSD or what was re-conceptualized as Trauma Spectrum Disorders. There is virtually no discussion of cultural trauma or national trauma. The “Vietnam War” or the “Resistance War Against America” lasted for twenty years (1954 to 1975). The death toll was staggering (Rummel, n.d.): 1) 533,000 North Vietnam, Viet Cong, military and civilian war dead; 2) 1,450,000 Vietnam, Cambodia, and Laos war dead; and 3) 58,220 American war dead. (These figures are by some estimates low.) The trauma American soldiers brought home with them is still being treated in VA Centers across the USA. The trauma that military and civilian participants live with on a daily basis in Vietnam, Cambodia, and Laos is probably incalculable. Perhaps the real costs of trauma, PTSD, or Trauma Spectrum Disorders, whatever you want to call it, is not the costs to the individual but to the larger collectivity, the culture, the nation, the species. Maybe the “tail” of these costs goes on for hundreds of years.
References


