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TABLE OF CONTENTS

Cover: Stars in a landing zone about transporting a patient helped by a Community Volunteer Firefighter in a rural community is Saskatchewan

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TRAUMA, SOUL WOUNDS, AND PTSD

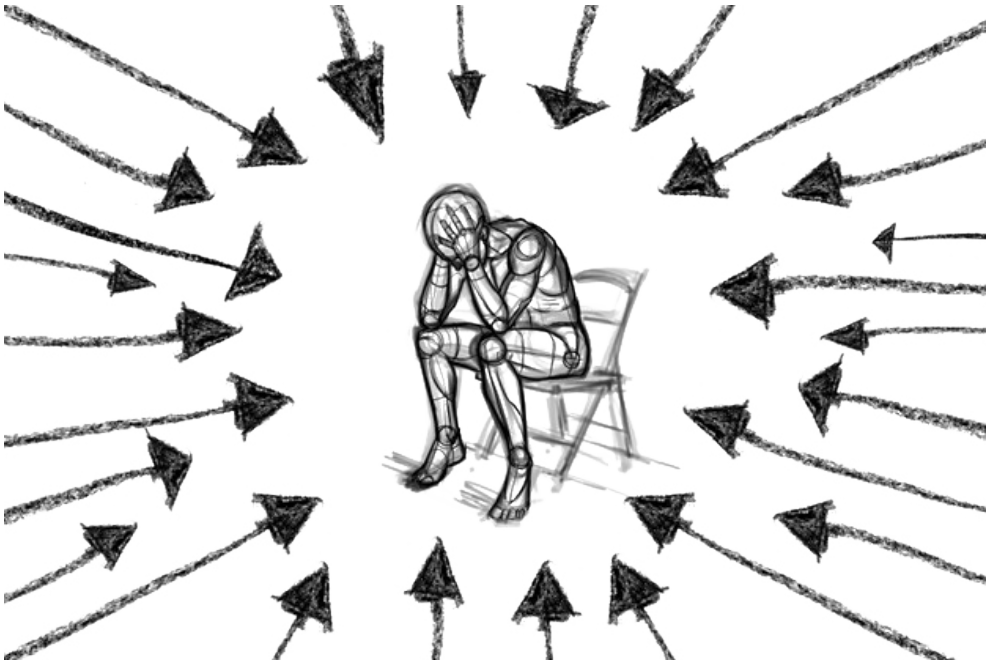
BY DAVID WOLFF

ABSTRACT

Trauma is defined as a wound of the psyche that affects an individual's identity; a soul wound. Soul wounds can cause natural physical and psychological responses and can progress to PTSD if they remain unchecked. The nature of trauma, PTSD, and the trauma-PTSD relationship are discussed. Different therapeutic interventions are offered. It appears that PTSD is a result of the individual's thoughts, beliefs, perceptions, and how they view the world that perpetuates a physical and psychological negative response, begging the question, can you train your mind to process thoughts that arise as a result of potentially traumatic events to prevent the onset of PTSD?

TRAUMA

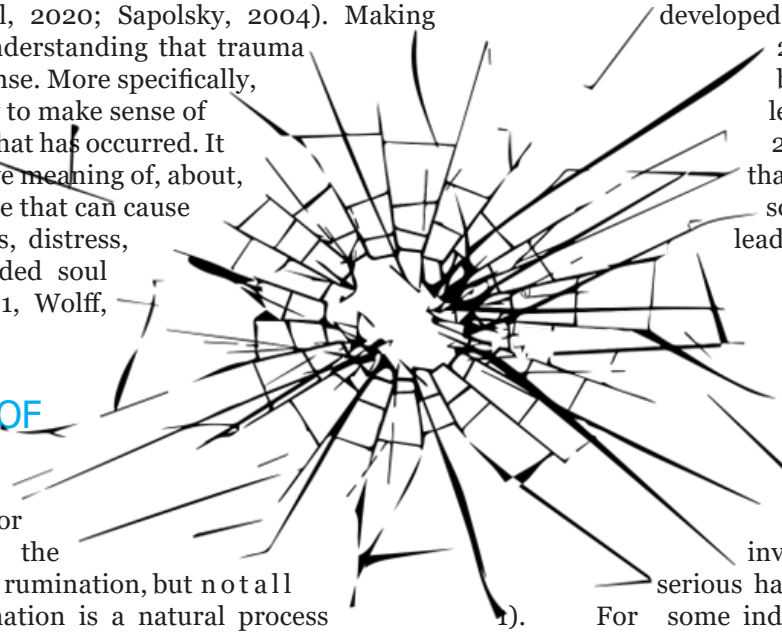
In the context of psychology, trauma is a term that is defined in many ways. According to the American Psychological Association (APA), (2022), trauma "is an emotional response to a terrible event like an accident, rape, or natural disaster" (para. 1). The Centre for Addiction and Mental Health (CAMH), (2022), defines trauma as "a term used to describe the challenging emotional consequences that living through a distressing event can have for an individual" (para. 1). Merriam-Webster (2022), defines trauma as "a disordered psychic or behavioural state resulting from severe mental or emotional stress or physical injury", but they also add "an agent, force, or mechanism that causes trauma" agreeing with Courtois et al. (2017) who suggests trauma is the event or experience. Levers (2012), suggests trauma is severe harm to the psyche. The psyche is a person's soul or personality; "the totality of elements forming the mind" (Merriam-Webster, 2022). Another term for psyche is 'identity', where meaning, functionality, sensitivity, and sociality intersect; something that is built from adolescence into adulthood (Illeris, 2016). Considering these wide-ranging definitions, trauma can be considered as; a wound of the psyche or identity of a person that causes a loss of trust, feelings of guilt, a sense of undeserving and of being fragile and damaged, a sense of violated worldviews, and the inability to derive meaning from experience (Knobloch et al. 2021; Levers, 2012), what Knobloch et al. call a 'soul wound'. This definition creates many questions. How is trauma caused? What is the connection between trauma and posttraumatic stress disorder (PTSD) if trauma is a soul wound? Why do some suffer trauma, and some do not when both experience the same potentially traumatizing event? And how do you recognize and overcome trauma? I will break down and attempt to answer these questions and offer discussion and conclusions that may inform future research.



NATURE AND CAUSES OF TRAUMA

The above looked at the definition of trauma; what trauma is, or theoretical knowledge about trauma, but how does one make sense of trauma? According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-V), (American Psychiatric Association [APA], 2013), the criterion for PTSD suggests trauma is caused by "Exposure to actual or threatened death, serious injury, or sexual violence" (p. 271). This is a good place to pause and reflect and ask yourself, does the DSM-V describe all of the potential causes of trauma to the psyche? A relatively new concept in the first responder world is moral injury. Like trauma, the definition of moral injury is one that appears to be elusive. Moral injury is described as being a perceived wrongdoing, a transgression of one's moral values. Transgressions can be caused by many sources, including first responder work and the associated events as described by the DSM-V. A potentially morally injurious event is one

that challenges an individual's values or core beliefs. It is important to note that moral injury is not synonymous with PTSD, although moral injury can progress to PTSD (Koenig et al, 2020); Rodrigues et al., 2022). But what is moral injury? It can be surmised from the literature that moral injury is akin to trauma to the psyche; a soul wound. And trauma can progress to PTSD (APA, 2013). The question remains, what is the origin of trauma? How do we move from an event to trauma? It is what individuals think, feel, and believe about the event that can lead to trauma (Brooks et al, 2020; Sapolsky, 2004). Making sense of trauma is understanding that trauma is all about making sense. More specifically, trauma is the inability to make sense of what is occurring or what has occurred. It is the inability to derive meaning of, about, or from, the experience that can cause disorienting dilemmas, distress, trauma, and a wounded soul (Knobloch et al. 2021, Wolff, 2020).



FORMATION OF TRAUMA

A factor that contributes to the formation of trauma is rumination, but not all rumination, as rumination is a natural process an individual uses to make sense of potentially trauma-causing events. Rumination is thinking about the event or experience in a repetitive manner, usually in the form of questioning one's own actions or inactions during the event or experience, such as, why did it happen? How could it have been prevented? This is different from intrusive thoughts, although rumination can be a result of intrusive thoughts. Rumination usually focuses on meanings, to make sense of the event or experience. It is an adaptive response, but it can also become a maladaptive response in the form of negative appraisals (Moulds et al., 2020). Positive rumination is similar to introspection and critical self-reflection. But hypervigilance, which can be caused by trauma experiences (discussed below), can interfere with an individual's ability to employ introspection and critical self-reflection (Briere & Scott, 2015). Additionally, such reflection is a skill that a large portion of the population is unable to practice (Keagan, 1997), and difficult to teach and learn (Wolff, 2020), partially explaining why some may experience trauma while others do not.

Like all wounds, psychological trauma can heal and result in growth. It is how we respond to that distress that determines if the event results in posttraumatic growth, becomes a soul wound, or PTSD. Growth can occur through how an individual processes a potentially trauma-causing event or experience. The experience needs to have been an event that challenged the individual's core beliefs and had sufficient impact to cause the individual to reassess themselves, ruminate in a critical way, and ultimately heal the trauma (Sayed et al., 2015). But there are some who do not experience any trauma at all. It can then be assumed that some have had life experiences where trauma has healed in the past or where there has been growth resulting in changed perceptions that provide the individual with a different lens or filter through which they view the world. For some, the individual could have cognitive characteristics that allow them to immediately process events in a critical way that prevents trauma, have developed other coping strategies (Wolff, 2020), or a strong spiritual belief system that offers some level of protection (Koenig et al, 2020), thus leaving the minority that suffers trauma; trauma, or a soul wound, that can potentially lead to PTSD.

TRAUMA TO PTSD

According to CAMH (2022), PTSD "is a natural emotional response to frightening or dangerous experiences that involve actual or threatened serious harm to oneself or others" (para. 1). For some individuals, the natural emotional response persists and causes significant distress and/or functional impairment, potentially meeting the symptom criteria for Acute Stress Disorder (ASD), or PTSD (Courtois et al., 2017). It is when the individual cannot process the event, and it starts to, and persists in, significant distress and/or functional impairment, where the natural response becomes dysfunctional and possibly leads to a disorder. According to Briere and Scott (2015), "Avoiding unwanted thoughts, feelings, and memories actually increases or sustains pain, symptoms, and distress—whereas directly experiencing and engaging pain ultimately reduces it" (p102), illustrating how rumination can exacerbate or improve an individual's wellbeing. Many individuals will have some reactions that remit spontaneously, and some individuals may not experience a reaction at all. For those who are resilient, they may have different perceptions about the event or severity of the event because of their life experience and coping skills, or higher levels of intelligence and education (Briere & Scott, 2015; Keagan, 1997, Lewis-Schroeder et al. 2018; Watson, 2019). For those who directly engage with the pain, there is often concrete rumination; critical self-reflection and critical reflection; an adaptive response and a resiliency factor (Wolff, 2020). Ultimately, it is a change of perspective of the event(s) as the event cannot be changed, and the transgression cannot be altered, but the core belief can be reflected on and transformed in a way that can heal the soul wound.

COMPLICATING FACTORS

This is where trauma and PTSD become messy. There are many barriers to coping, concrete rumination and critical self-reflection. In addition to contributing factors, such as the severity; duration; frequency of the event, and risk factors, such as; family history of psychiatric problems; history of childhood or previous trauma; and a lack of coping skills, social support, or access to mental health resources (Briere & Scott, 2015; Lewis-Schroeder et al. 2018; Watson, 2019), critical reflection is difficult for many (Keagan, 1997) and difficult to put into practice if in a hypervigilant state (Briere & Scott, 2015). Additionally, there have been many associations of PTSD to other mental health disorders and comorbidities (Russell & Lightman, 2019; Sapolsky, 2004). According to APA (2013), "Individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder (e.g., depressive, bipolar, anxiety, or substance use disorders)" (p. 280). Individuals who have been diagnosed with PTSD also have a sixfold increase in suicidality (Sayed et al., 2015). Although many people may present with any number of other disorders, the root cause may be trauma or a soul wound, and the primary concern is PTSD (Levers, 2012) and therefore become the focus of the treatment modalities.

OVERVIEW OF RECOMMENDED TREATMENT MODALITIES

According to CAMH (2022b), there are multiple therapies and interventions used in the treatment of PTSD but there is no clear evidence if one is superior to another. Each therapy focuses on a particular psychotherapy, and one may be more suited for a specific individual depending on their stability, the severity of the trauma, and their ability to tolerate intense evoked emotions. The types of treatments fall into two categories; past-focused, where therapy works with traumatic memories; and present-focused, where therapy works with skills deficits and coping resources. There are some therapists who use components from both types, but what is important is to recognise what factors contribute to an individual's improvement. The four most popular therapies for PTSD include Cognitive Behavior Therapy (CBT), with or without Cognitive Processing Therapy (CPT), Eye Movement Desensitization Reprocessing (EMDR), Dialectical Behavior Therapy (DBT), and Prolonged Exposure Therapy (PET). There are also alternative therapies gaining ground such as the use of psychedelics in therapy, and peer-led group psychoeducation. Each one is highlighted below:

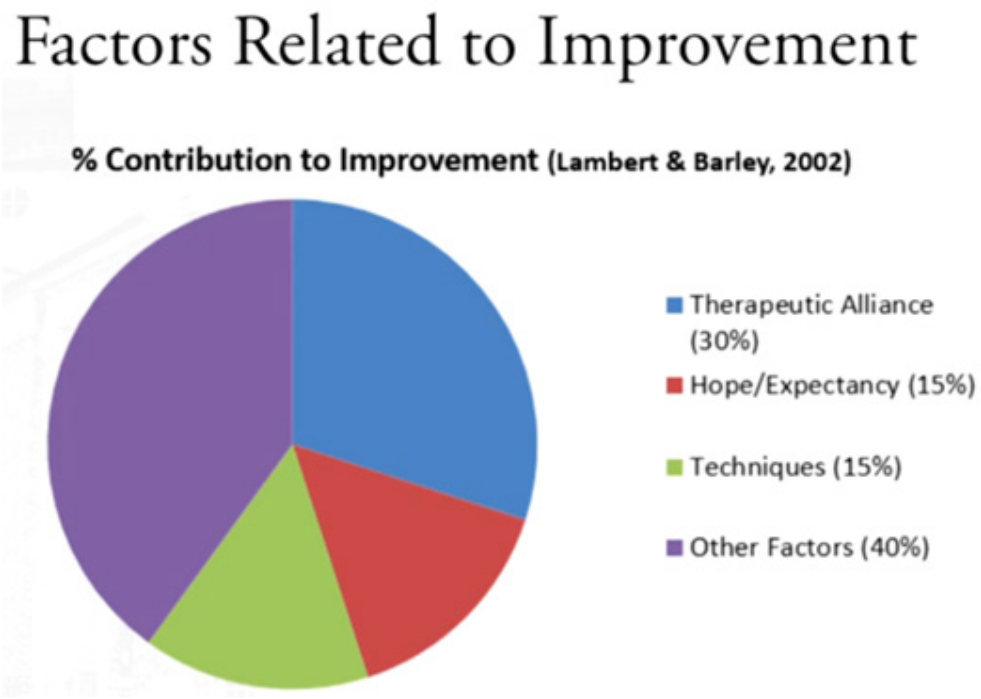
- CBT is predominantly present-focused. CBT strategies include education; cognitive processing (CPT), which can be past-focused; and cognitive restructuring and imaginal desensitization (Kress et al., 2021; Lewis-Schroeder et al. 2018). CBT targets the thoughts that patients have regarding their traumatic events, along with the effects of the trauma in the present, to help the patient understand that the thoughts that are often automatic and trigger their behaviours and emotions. CBT helps the patient identify and process these thoughts and, subsequently, their emotions (Ventura, 2012).

- EMDR, which is past-focused, integrates; imaginal flooding (evoking

memory of the event); cognition (recognizing and replacing thoughts); relaxation (intentional breathing exercises); and guided eye movements (Kress et al., 2021; Lewis-Schroeder et al. 2018). As in CBT, the patient thinks or talks about their memories, except in EMDR, this is done while focusing on therapist-guided eye movements or hand taps. The patient recalls their past experiences in an effort to desensitise and reprocess their thoughts. The eye movements aid in regulating the associated emotions while reprocessing the thoughts (Ventura, 2012).

- DBT, which is present-focused, helps the patient develop; dialectical thinking skills, a balance between acceptance of situations and experiences, change, and what cannot be changed; emotion regulation, an awareness of emotions and how they affect behaviour and the opposite of desired functioning; mindfulness, a balancing of the opposing rational and emotional minds; distress tolerance, self-soothing activities and distraction skills/cognitive strategies; and interpersonal effectiveness, learning to establish and maintain positive relationships (Kress et al., 2021; Lewis-Schroeder et al. 2018). DBT Helps the patient learn how to regulate their emotions before reprocessing their experiences by severing the triggers from their learned emotional responses, challenging, and changing thinking patterns (Ventura, 2012).

- PET is past-focused. PET strategies include psychoeducation; imaginal exposure to traumatic memories; in vivo exposure to safe but feared stimuli; self-assessment of anxiety using subjective units of distress (SUDS); and processing (reframing) of trauma memories (Kress et al., 2021; Lewis-Schroeder et al. 2018). PET helps the patient face and gain control of their fears. The process gradually confronts their traumas one piece at a time by repeatedly talking about each piece of the event until the patient becomes desensitized and regains control over their emotions. Some techniques may use flooding, where multiple memories may be recalled to process feelings of being overwhelmed (Ventura, 2012).



- Psychedelics are usually used in conjunction with various past-focused therapies and target dysregulated neurotransmitter systems to heighten insightfulness and introspection, diminish fear and hyperarousal, provide a sense of increased connection to self/others/universe/divine/nature, and strengthen therapeutic alliance allowing for meaningful engagement in psychotherapy. Psychedelics are still Schedule 1 Drugs, and such therapy is highly experimental (Averill & Abdallah, 2022).

- Peer-led psychoeducational groups. One such group is called REBOOT. REBOOT offers three programs, each one with a specialized focus: Combat, First Responders, and Lay people. The educational programs structure the material according to people's readiness for change and the stages of behaviour modification, targeting each stage of the Trans-theoretical model of health behaviour change. Observational learning, positive role modelling, and intrinsic and extrinsic reinforcement (social-cognitive theory) are used to cultivate people's sense of purpose, reframe human suffering as an opportunity to build resilience, and involve them in activities meaningful to them to bolster their wellbeing (Knobloch & Owens, 2021; Knobloch et al. 2021). The uniqueness of REBOOT is, that it involves families, includes unstructured time for fellowship, applies Christian principles, teachings, and scriptures to redefine human suffering as a mechanism for growth, and deals with soul wounds that contribute to self-destructive behaviour. The program is based on faith, and although Christian-based, REBOOT is open to all.

When reviewing the different therapeutic options, an important consideration is how much each component of the therapeutic modality contributes to an individual's improvement. Teaching, providing, and practicing coping skills and prevention strategies can contribute up to 40% toward an individual's improvement. Another 15% of improvement can simply be attributed to the patient's own expectations (expectation of improvement) or hope (a personal belief system). Therapeutic alliance (relationship with therapist) accounts for 30%; (Lambert & Barley, 2002). Together,

faith, hope, and active coping can contribute more than 55% towards patient improvement in therapy, has been associated with posttraumatic growth, and can be instrumental in the meaning-making process (Brooks et al., 2019; Wolff, 2020). When you add 30% for therapeutic alliance (relationship with therapist) and consider that the balance of therapeutic technique is only 15% (Lambert & Barley, 2002), a unique perspective on an individual's choice of prevention (because, ultimately, prevention is intervention) can be taken. What are the main contributors towards improvement, and which modality can provide that for you?

CONCLUSION

Trauma is an injury to the psyche; a soul wound, a wound that can affect the identity of a person. Trauma is caused by an extreme event or multiple events that trigger a natural physical and psychological response, and if unresolved, can overwhelm an individual's capacity to cope. For most, symptoms will resolve over time, but for some, this state can result in the development of PTSD where the symptoms cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (APA, 2013). Many individuals who suffer from PTSD will also have at least one comorbid disorder, such as depressive, bipolar, anxiety, or substance use disorders, where the trauma is the root cause, thus complicating recovery. There are several therapies used to assist individuals in overcoming trauma through processing their trauma-causing thoughts and beliefs, learning skills to identify triggering beliefs and how to cope, or a combination of both. There are novel therapies, such as the use of psychedelics in therapy, that blur the lines between the science of dysregulation of neurotransmitters and the divine, and peer-led faith-based courses and support groups, each with various levels of success. It appears that PTSD is a result of the individual's thoughts, beliefs, perceptions, and how they view the world, which perpetuates a physical and psychological negative response. This begs the question, can you train your mind to process thoughts that arise as a result of potentially traumatic events to prevent the onset of PTSD, and if a soul wound, what role do faith, hope, spirituality, and a belief in God have to play in such resiliency? Future research is needed to identify how such a belief system can prevent the onset of PTSD when potentially traumatic events are experienced.

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ABOUT THE AUTHOR

David Wolff began his paramedic career in 1986 and has a wide range of experience in the public and private sectors, including direct provision of care, teaching, and management at all levels, becoming a Certified Municipal Manager (CMM III, EMS Executive) prior to returning to school in 2017.

David completed a Bachelor's Degree in Clinical Practice at Charles Sturt University in 2009 (part-time), a Master's Degree of Adult Education at St. Francis Xavier University, NS (2017-2020), where he focused on the study of reflective practice as a PTSD resiliency tool, and also concurrently completed the First Responder's PTSD Prevention and Recovery Certificate at SFU, BC (2018-2020). David is currently enrolled in the Doctor of Education (Ed.D.) in Community Care and Counseling: Traumatology Cognate, at Liberty University, VA, USA, where his focus is on personal worldviews and their relationship with resilient identities.

David is a fellow of the McNally Project, a Research Appraiser in the Prehospital Evidence Base Practice program at Dalhousie University, a member of CIPSRT's Academic, Researcher, and Clinician Network (ARC Network), and Chair of the Ontario Paramedic Association's (OPA) Paramedic Wellness Committee.