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Libido and PTSD

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A B S T R A C T

The most frequent PTSD treatment is group therapy. Experiences gained from this kind of work warn us of big difficulties, especially if psychotherapist is an analytically oriented person. He has to do with non-presence of insight. These groups are dominated by projection and catharsis, which is often a source of secondary traumas. However, patients are fond of these group sessions. In the dynamics of such group sessions, what can be recognized is the tendency towards repression of the actual problems a PTSD patient has in his family, at work and in social relations. One of these problems, marked for the intensity of repression and negation, is the problem of libido. Weakness of potency and other libidinous problems are often the source of family problems as well as auto-aggressive acts. Libidinous problems are a taboo topic and the task of a psychodynamically oriented psychotherapeutist is to point out at this problem. Psychotherapeutic process changes its dynamics while directing verbalization to the problem of libido. Apart from readiness for solving the problem, patients with PTSD diagnosis show an interest in the members of their family being involved into psychotherapy. A special dynamics is being developed while solving the libidinous problems of the widows whose husbands were killed in war.

Introduction

Posttraumatic stress disturbance (PTSD) is a distress[1,2]. This is a response to a trauma. What we talk here about is the emotional incapability to solve the closeness of death[3–6]. Prevalence of PTSD in USA is 5% of the total population. The intensity of trauma is the initial diagnostic factor for a PTSD diagnosis. There are tests which differentiate war veterans' PTSD (as a consequence of war traumas) from the stress caused by »ordinary stressors«. »Ordinary stressors« presume an adaptable reaction[7]. However, a stressful response is more dependent on the patient's personality than on the intensity of the trauma. Every trauma is, in fact, secondary[9–15]. Traumatic childhood experiences and too morbid a development of

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a personality are responsible for the occurrence of PTSD[16]. There are three basic groups of PTSD symptoms: intrusive recollections, avoidant/numbing symptoms and hyperarousal symptoms[17]. PTSD is classified as an anxiety disorder. PTSD can become a chronic psychiatric disorder that can persist for decades and sometimes for a lifetime. High rates of co-morbidity (major affective disorders, dysthymia, alcohol or substance disorders, anxiety disorders or personality disorders) complicate the treatment[18]. 82.5% of our respondents, apart from the mentioned symptoms, have shown impotence[19–21]. Since we talk primarily of younger persons, this symptom is becoming a serious obstacle to a harmonious family life, socialization and self-esteem. Reactions to impotence create a multitude of various symptoms, among which we should stress depression and inclination to suicide[22].

How does PTSD influence the outbreak of sexual disturbance? PTSD is not only a psychological change[23,24]. Physiological changes of distress are known as well, especially when it is about hormonal functions. Neuroendocrine abnormalities have been detected in the noradrenergic, hypothalamic-pituitary-adrenocortical and endogenous opinoid systems. Fear and anxiety have an inhibitory effect on testosterone levels, but high testosterone levels are actually associated with aggressive behaviour. Testosterone levels may be affected by PTSD because high levels are related to »impulsivity, disinhibitory sensation seeking, and persistence«.

Discussion

For our psychodynamic orientation in understanding of libidinous disturbances, the level of testosterone is not important. What is libido? Libido is a dynamic manifestation of sexual instinct in psychical life[26]. Libido is, therefore, mental and not physical energy. It is the source of sexuality and pleasure. Freud seems to have identified libido with Eros[27,28]. Eros is the bearer of life elan, as opposed to death, Thanatos. On the other hand, the closeness of death is, when we talk about PTSD, mentioned as the cause of its occurrence. Thanatos has energetically conquered the PTSD patient on expense of Eros. Libido is energy directed to objects; when the object is ego itself, we may talk about narcissism. One's inability to direct one's libido towards objects is being manifested as impotence as well. Impotence is regarded to be inability to accomplish a sexual intercourse in less than 20% attempts. Thus, we cannot talk about impotence if one fifth of sexual attempts are successful. Impotence related to PTSD stems from the basic symptoms related to intrapsychic processes and attitudes towards surrounding. A person with PTSD feels on guard, distrustful of others, avoids being touched, and if touched unexpectedly, has a strong startling response. With such a symptom, sexual contact is impossible. A person with PTSD is sad or depressed, loses interest in significant activities in his life, and his range of emotions is rather restricted. Erotic desire is indisputably one of the basic life activities.

Conclusions

The most successful interventions are those implemented immediately after a war zone trauma. This is often referred to as critical incident stress debriefing. It is clear that the best outcomes are obtained when the trauma survivor receives critical incident stress debriefing within hours or a day of exposure. The results with chronic PTSD patients are often less successful. PTSD is refractory to current available treatments.

For many affected patients with chronic PTSD a number of treatment options

are available (often offered in combination) such as psychodynamic psychotherapy, behavioural therapy and pharmacotherapy. Wolberg recommends hypnosis and narcohypnosis in treatment of PTSD.

Libidinous problems often lead to familial disagreement and divorce. Sometimes a new partner regains the lost potency. Our experiences show that 15% of impotences disappear soon. The rest of them, a bigger number, lasts for years and forms the majority of secondary traumas.

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SAŽETAK

Najčešći oblik liječenja PTSDa je grupna terapija. Iskustva iz takvoga rada upozoravaju na velike poteškoće pogotovo ako je psihoterapeut analitički orijentirana oso-

ba. On se mora zadovoljiti s nenazočnošću uvida. U takvim grupama dominiraju projekcija i katarza što je nerijetko izvor sekundarnih trauma. Bolesnici, ipak rado dolaze na grupne seanse. U dinamici takvih grupnih seansi prepoznaje se tendencija potiskivanja aktualnih problema koje bolesnik s dijagnozom PTSD ima u obitelji, na radnom mjestu i u društvenim odnosima. Među tim problemima ističe se, po intenzitetu potiskivanja i negiranja, problem libida. Slabost potencije, ali i drugi libidni problemi, nerijetko su izvor obiteljskih problema kao i autoagresivnih postupaka. Libidne poteškoće predstavljaju tabuiranu temu i zadaća psihodinamski orijentiranog psihoterapeuta jest ukazati na taj problem. Psihoterapijski proces mijenja svoju dinamiku pri usmjerenju verbalizacije na problem libida. Osim spremnosti za rješavanjem toga problema, bolesnici s PTSD dijagnozom pokazuju interes za uključenjem u psihoterapiju i članove njihove obitelji. Posebna se dinamika razvija pri riješavanju libidnih problema udovica poginulih u ratnim okolnostima.