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EUPHORIA AS A PERI-TRAUMATIC EMOTION IN PTSD – HOW POSITIVELY PERCEIVED EMOTIONS CAN AFFECT THE MAINTENANCE OF THE DISORDER: A CASE REPORT

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INTRODUCTION

Post Traumatic Stress Disorder (PTSD) is a psychiatric disorder that can occur after witnessing or experiencing life-threatening or otherwise deeply disturbing events, such as serious injuries or sexual violence. For a long time, PTSD has been classified as an anxiety disorder; other feelings such as guilt have not been in focus. In the DSM-V (American Psychiatric Association 2013), the placement of PTSD has been shifted from within the category of anxiety disorders to a new category of traumatic and stressor-related disorders (Zoellner et al. 2013). New symptoms regarding alterations in cognitions such as persistent negative beliefs and expectations about oneself or the world and persistent distorted blame of self or others for causing the traumatic event or for resulting consequences have been added to the criteria. With regard to persisting trauma-related emotions, we can separate them into two categories: peri-traumatic and post-traumatic reactions (Boos 2005). Peri-traumatic are the emotions that occur during the event and are constantly reexperienced after the event, such as fear. Emotions that occur only after the event, due to the changes in the belief-system of the patient, for example feeling guilty when he thinks of himself as responsible for the course of events are called post-traumatic.

In the following case-report, we describe for the first time the phenomenon that not only negatively but also positively regarded peri-traumatic emotions can occur, and how they can contribute to the maintenance of post-traumatic symptoms.

CASE REPORT

A 40-year-old woman was referred to our centre by her employer's liability insurance company for psychotherapeutical treatment of PTSD. She worked as a deputy shop manager in a supermarket and experienced two armed robberies during which she was threatened with a gun, beaten and choked by the offenders.

After the second traumatic event, she suffered from anxiety when confronted with trauma-associated stimuli, intrusive memories, flashbacks, nightmares, hypervigiliance, problems in concentration, avoidant behaviour towards trauma-related thoughts and external reminders, dissociative symptoms and suicidal thoughts. She could not remember the full course of events and described feeling numb and not being secure about the fact that she had survived the attack. She met PTSD criteria outlined in the DSM-V (American Psychiatric Association 2013).

To understand her biographic background, it is important to know that as a child, the patient suffered from life-threatening and painful somatic diseases such as leukaemia and chronic pyelonephritis resulting in long hospital stays. As a young child she had a near-death experience, which she connects to feeling warm, peaceful and comfortable. Near-death experiences are often-described phenomena that are commonly assumed to be the product of increased brain-activity during cardiac arrest (Borjina et al. 2013).

During both robberies, the patient was confronted with situations in which she felt helpless, powerless and frightened. In the light of her long history of clinical treatments, it seems obvious that she knows these emotions from her childhood. Regarding the robberies, the patient describes a situation in which the offender tells her that he "will now shoot" her. He points the gun at her chest and pulls the trigger, which results in a clicking sound. In this moment, the patient thinks she has been shot. She describes remembering the near death-experience from her childhood and being flooded by feelings of euphoria and relief.

Subsequently, she suffers from continuing suicidal thoughts and a yearning for death, which she connects to being relieved from her symptoms. The patient believes her perceptions and emotions during the near-death experience to be an insight into life after death. Therefore, she connects death to being warm, comfortable and secure. These beliefs contribute to the maintenance of PTSD symptoms, as she is not willing to tolerate negative emotions, consequently not reducing her avoidance behaviour. Maintaining suicide as an exit strategy prevents her from forming a positive life perspective, thus undermining the motivation to change her behaviour and endure feelings such as fear or helplessness.

DISCUSSION

To fully understand the patient's suicidal thoughts, we must take into account her emotional reactions during the events, as well as the explanatory model she formed about them.

During the robbery, she suffered from somatic pain as well as from psychological distress. She felt frightened, humiliated, helpless and desperate. When threatened with being shot, she remembered the feelings she had as a child when her heart stopped beating and was suddenly flooded with euphoria.

It is not an uncommon phenomenon that euphoria occurs in potentially dangerous situations. However, most often people actively create these situations, so-called sensation seeking, which is "a trait defined by the seeking of varied, novel, complex, and intense sensations and experiences, and the willingness to take physical, social, legal, and financial risks for the sake of such experience" (Zuckerman 1994). Sensation seeking itself is not pathological, but we do find it in clinical populations such as patients suffering from attention deficit hyperactivity disorder (ADHD) who try to create a suitable level of arousal (Geissler et al. 2014) or patients with borderline personality disorder who regulate their emotional tension by displaying high-risk or parasuicidal behaviour (Bandelow 2010). In this case, the patient was not seeking a thrill, but was confronted with a potentially life-threatening situation against her will. In her opinion, the feeling of euphoria when threatened with death was an indication that she would have been better off dead, instead of having to deal with the emotional consequences of the robberies. Reports of positively perceived emotions and sensations that occur during traumatic events are quasi non-existent in the public discourse and often missed even in experts' literature. The taboo that comes with feelings of guilt, shame and thoughts about being abnormal or disturbed, or being perceived as such by others, often results in patients keeping quiet about these experiences. Therapists will find this phenomenon, for example, with victims of sexual abuse who experience physical sexual excitation. If not asked about it directly, patients very likely do not talk about this aspect.

As described above, positively perceived feelings can also occur in traumatic situations that are not sexually related and can have a severe effect on their processing.

CONCLUSIONS

This case shows that during traumatic events, perceptions and emotions with positive connotations can occur. Patients should be asked about these aspects sensibly and carefully, as they can contribute to the maintenance of symptoms, such as feelings of guilt, shame, or in this case, suicidal tendencies. If not taken into account, these can easily lead to stagnation in the therapeutical process and impair the therapeutical outcome with the risk of chronification of the disorder.

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