
# The secondary behaviours of PTSD.

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**Abstract**

*Post Traumatic Stress Disorder (PTSD) has become a commonly used term in mental health with a significant amount of research being conducted on its effects. However little is understood about the secondary symptoms of PTSD on individuals and their families and communities. This article claims that it is these secondary symptoms that are the critical core factors derived from interactions between the primary symptoms and social contexts that generate the problematic we label as PTSD. The family is frequently the environment in which this problematic is both intergenerationally transmitted, and normalised. This paper presents an argument for the inclusion of secondary symptoms in diagnosis, management and treatment of PTSD in family contexts that have intergenerational consequences. It is not intended to provide any answers to this conundrum of quandaries. Rather, this paper intends to ignite conversation and question.*

There is a vast amount of research on PTSD from a clinical and medical perspective. The identification and treatment of this pathology has been extensively researched and discussed from the paradigms of neuroanatomy, genetics, psychology and sociology. There is not much the medical model does not know about PTSD. Its descriptive symptomology is well documented and evidence for effectiveness of treatment is well established. However, little is understood about the wide range of subsequent (or secondary) behaviours that result from social interactions of the primary behaviours. These secondary behaviours not only contribute to severity of the condition, but may often be their underlying cause. This article argues that mental and community health professionals must include the impact of these secondary behaviours in the treatment and management plan of a client and their family.

The primary guide to the diagnosis and treatment of PTSD is currently the DSM-IV-TR and is widely utilised by mental and community health professionals (American Psychiatric Association, 2000). While the DSM-IV-TR broadly defines the primary behaviours of this condition (such as hypervigilance, exaggerated startle response and sleep disturbances) it provides little description of what these qualities *look like* when they are behaved out in social contexts. This is a critical oversight for is this contextually-relevant social-feedback information that contributes to the generation of social problematic behaviours in people with PTSD and its related conditions. These social feedback mechanisms give rise to the secondary behaviours of PTSD, which drive its primary behaviours.

When examining secondary behaviours that manifest as contextualised social consequences of primary behaviours, it is first essential to understand what the primary behaviours are as they are used to diagnose the condition. Thus we ask, what is PTSD?

**What is PTSD?**

The acronym PTSD describes a group of socially problematic behaviours that are manifested by an individual following any significant traumatic event. The most recent version of the DSM describes PTSD as a condition that manifests as a result of a direct or indirect exposure to an actual or perceived serious threat to one's safety and survival and is usually accompanied at the time by intense fear, helplessness or horror (American Psychiatric Association, 2000; Rosenman, 2002). Clayton (2004) continues to state that PTSD specifically relates to the loss of any or all elements of control for the individual while exposed to this threat.

**What causes PTSD?**

PTSD is classed as an event-related condition, meaning its symptomology can be directly related to a single life-threatening event, real or perceived (American Psychiatric Association, 1994). Clayton (2004) points out that this definition specifically relates to the loss of any or all elements of control for the individual while exposed to this threat. Control is thus a central presence in families impacted by this condition and is expanded significantly further in a landmark Australian study by O'Brien (2012). Due to the demilitarising of PTSD the qualifying characteristics for this condition has expanded over time to account for similar symptoms reported in


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the civilian population. Events which can manifest with symptoms of PTSD include: Holocaust (Hantman & Solomon, 2007), armed robberies (MacDonald, Colotla, Flamer, & Karlinsky, 2003), sexual assault(Australian Institute of Criminology, 1999), terrorism (Fetter, 2005), workplace harassment (Willness, Steel, & Lee, 2007), automotive accidents (Matthews, 2005), and war (H. Johnson & Thompson, 2008).

**Symptoms of PTSD**

To qualify for a diagnosis of PTSD, the person must have been exposed to a significant psychologically traumatic event and expresses specific symptoms. The individual's initial response to that event must involve intense fear, helplessness or horror, disorganised or agitated behaviour and their disturbance must have been present for at least a month(American Psychiatric Association, 2000). PTSD is labeled acute if it has existed for less than three months and is labeled as chronic if it persists for greater than three months (American Psychiatric Association, 2000).

Typical symptoms include:

- hypervigilance,
- flashbacks,
- hallucinations,
- nightmares and
- emotional numbing (Yehuda, Golier, Halligan, & Harvey, 2004).
- Additional symptoms can include
- memory impairment,
- irritability,
- sleep disturbances,
- distress,
- hallucinations and
- avoidance (Ewing, 2005)
- as well as intense distress when exposed to personal or environmental cues that resemble the original traumatic event (National Centre for PTSD, 2007).

Children frequently present different symptoms to adults, with common age-appropriate behaviours demonstrated, including acting younger than their age (such as thumb-sucking), excessive worrying about dying at an early age, and reliving the trauma through play and/or art (American Academy of Child and Adolescent Psychiatry, 1999).These varying symptoms of PTSD complicate the diagnosis which is dependent on the symptoms produced.

**PTSD throughout history.**

Although it is a relatively recent inclusion into the realm of mental health disorders, it is not a new phenomenon as it has plagued humans for centuries and historically been linked with military service. Some of the earliest known records of this condition originated from the Egyptian and Roman doctors who treated their soldiers after natural disasters and battles (Birmes et al., 2010; McMaster, 2008; Trimble, 1985). Some historians claim variants of PTSD were documented in early biblical texts that describe the suffering and loss of the early Israelites (Birnbaum, 2008). A variety of names has been applied to PTSD throughout clinical history associated with military and war service including 'Post Combat Disorder', 'Soldiers' Heart', 'Shell Shock', 'War Neuroses', 'Combat Fatigue', 'Combat Stress Reaction', and most recently 'Gulf War Syndrome' (Beall, 1997; National Centre for Postraumatic Stress Disorder, 2003; National Centre for Posttraumatic Stress Disorder, 2003a).The American Veterans' Administration created a diagnostic guideline after the end of World War II in recognition of the collective effects of all wars on all soldiers, which in turn prompted the American Psychiatric Association to develop its own: the Diagnostic and Statistical Manual for Mental Disorders, (what we now know as the DSM) (Andreasen, 2004). The third edition of the DSM-III formally identified and labelled PTSD as an anxiety disorder (Lasiuk & Hegadoren, 2006) and was extended it to non-military experiences.

Of significant importance to this paper is the inclusion in the latest version of the DSM –V that PTSD may be heritable in the first generation offspring of sufferers (American Psychiatric Association, 2006). The DSM notes that first and second generation offspring can inherit the same psychiatric condition as their parents, forcing the DSM-IV-TR to mention heritability in several diagnoses including PTSD. However, the leading diagnostic guide for mental and community health professionals fails to describe *how* the symptoms are intergenerationally transmitted.

**Intergenerational transmission of PTSD**

To understand how a condition, which is based on a specific set of behavioural responses, can be transferred to


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subsequent generations, we must first review what the medical model currently knows about its heritiability. Research suggests that the major contributors to the heritability of PTSD are genetic factors (Kendler & Greenspan, 2006; Moffitt, Caspi, & Rutter, 2006; O'Brien, 2004, 2007; Schiffman, 2003): environmental factors, including parenting styles (Barry, Dunlap, Cotten, Lochman, & Wells, 2005; Chase-Lansdale, Wakschlag, & Brooks-Gunn, 1995; Tan-Roldan, 2005; Welberg & Seckl, 2001; Westerink & Giarratano, 1999; Yehuda, Halligan, & Bierer, 2001; Yehuda, Halligan, & Grossman, 2001): personality (Gallagher, 1996; A. Johnson, Vernon, Harris, & Jang, 2004); society (Kessler, 2000; Richerson & Boyd, 2005; Vincent, 2005; Young, 1995) and socio-economic status (Jayakody & Stauffer, 2000; Lupien et al., 2005; Peach, 2005; Porter, Lawson, & Bigler, 2005; Wildes, 2005; World Health Organisation, 2001). These studies further support the wide range of conditions genetically related to PTSD that are becoming increasingly apparent in our young primary-school-aged people (O'Brien, 2007).

The diagnostic criteria for PTSD have significantly assisted many people gain a sense of *why* they are behaving in socially unacceptable manners. However these criteria formalise that person's difference/, deviance, abnormality, disability and/or impairment effectively coercing them into a category that is not inclusive of qualities considered "normal". Thus people who accept (or are labeled with) these symptoms struggle with establishing and maintaining an understanding and identity of normality: They typically accept that they are "not normal" (O'Brien, 2012). This struggle with normality is driven by a conflict between the primary behaviours that define PTSD, and the secondary behaviours that are the consequences of social interplay of the primary behaviours. The next section of this paper contrasts the two.

**Primary behaviours**

Bawden (1945) made an early proposal of the broad descriptions of primary and secondary behaviours by claiming that primary behaviours were those that we share with lower animals and that secondary behaviours were those that characterise humanity. In alignment with Bawden's description, primary behaviours are a person's immediate action responses to environmental stimuli. They are the obvious behaviours and are frequently the only ones studied and treated. They form the diagnostic criteria for the condition and hence the range of mental health policies and treatment approaches (Greene, 2000) promoted in many Western societies and would therefore be the accepted identifiers of the condition that are recognised by practitioners and general society to label individuals and develop treatment plans.

Bawden (1945) further states that primary behaviours are reflexive, instinctive and autonomic responses and urges that are fundamental to survival. This is highly relevant in the case of PTSD as these four letters succinctly and collectively give meaning to a wide range of socially and personally dysfunctional, yet autonomic, reflexive and instinctive responses to a significant stressful and life-threatening event. Yet primary behaviours go further than merely identifying a condition based on a collection of symptomatic behaviours: They have a duality of responsibility in the role of diagnosis. They are the reference points for the development of understanding of both the condition *and* the person's position in it. They serve as the source of interpretation for the myriad of associated events and lived experiences that, as part of a highly complex process, serve to develop a sense of normality and security for the individual, and their family (O'Brien, 2012). This is illustrated in figure #1.

Figure #1

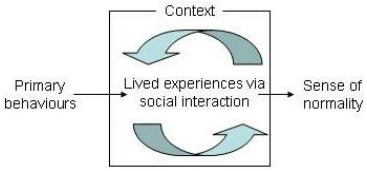


Figure #1 illustrates a critical section of a larger process that leads to functional or dysfunctional responses to secondary behaviours. (This larger process is illustrated later in the paper in Figure #2).

Bawden (1945) continues to describe secondary behaviours as intentional by-products of biological and social evolution that humans have fabricated to create their unique views of their world. This paper extends Bawden's assertions by further insisting that the acculturation and appropriation of those primary behaviours


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give rise to secondary behaviours, through social and cultural pressures and processes in the specific case of the heritable aspects of PTSD.

**Secondary behaviours**

The definition and description of the primary behaviours (as symptoms) have changed over time, as society has changed. This suggests PTSD is a social condition, not just an individual one, indicating there are neglected or hidden social influences involved and not just simply the primary behaviours that have been the focus of study for decades. These neglected and hidden influences constitute the secondary behaviours of PTSD that not only arise because of the social interaction of the primary behaviours, but influence their emergence as well. Thus they run full-circle. The problems associated with this raise the issue of the neglect of secondary behaviours as a significant contributing factor to the problems associated with the identification, treatment and management of PTSD. This is even more prevalent for those who possess genetic predispositions to PTSD symptoms, yet escape its diagnosis (and the benefits and privileges of such a diagnosis – such as explanation, understanding, identity and solidarity).

Secondary behaviours have so far escaped the attention of the medical model and the singularity of the diagnostic system. Much of the literature available does not specifically identify nor define secondary behaviours as a contextually relevant, active entity in the formation and perpetuation of PTSD or the normality that people and families struggle to achieve and maintain.

This is concerning since this paper asserts that secondary behaviours are important in understanding the formation and perpetuation of a sense of normality (Davis, 1995; Misztal, 2001) and identity (Ekeland & Berger, 2006; Inder et al., 2008), for it is both of these that reinforce the primary behaviours and give meaning to them (Adkins, Smith, Barnett, & Grant, 2007; Greene, 2000) as they are at the core of the response. This builds on Bawden's (1945) description of secondary behaviours in that it applies a progressive affect determined by the social and cultural environment.

**Guilt and Shame**

There is scant literature on the existence and influence of secondary behaviours, particularly relating to PTSD. Of the handful available, Kletter, Weems and Carrion (2009) clearly identify guilt as a transgenerational consequence to violence that is experienced in childhood, where the child commonly accepts blame for the situation. This qualifies guilt as a secondary behaviour. They further state that guilt is present in most cases of PTSD from a very early age, but varies in intensity with maturity and stage of development. In earlier works guilt was identified as being a key factor in manipulating identity development and influencing the emergence of adult pathologies (Berman, Weems, & Stickle, 2006) such as depression, anxiety and antisocial behaviours. Without realising they were describing the process behind the formation of secondary behaviours, Richerson and Boyd (2005: pg 59) state, "People's choices change their environment, and these changes lead to different choices".

In an Australian landmark study on the lived experiences of children of Vietnam Veterans, O'Brien (2012) examines the interactive articulations of children of Vietnam Veterans as they describe growing up under the influence of PTSD in a military family. O'Brien's study clearly identifies both guilt and shame as significant secondary qualities that give rise to much of the primary behaviours that drive the qualities of PTSD down from one generation to the next. In this study, O'Brien (2012) separates guilt from shame using the contexts expressed by his participants ensuring the definitions remain faithful to their experiences. Guilt is inferred as an internalized response to failure in stoicism (I failed to live up to my own expectations), while shame is the externalized response. (I failed to live up to family expectations – impact of my failure on my family). O'Brien further demonstrates in this study that children raised in military families see emotional weakness as a failure to live up to the cultural expectancies they were raised under, and this makes emotions difficult to express, accept and understand as they progress through adolescence and adulthood, and, importantly, into parenthood where they attempt to forge


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emotional sensitivities with their own children.

Heckhausen and Schulz, (1995) developed a theory of life-span development that examines the existence and influence of primary and secondary controls in the way a person changes their world to suit their needs. Heckhausen and Schulz assert that primary controls are actions which the individual directs outwards on the environment and secondary controls are those directed inwards and are primarily cognitive. They claim that secondary controls are predominantly used by the individual during middle childhood and early adolescence when they are undergoing many cognitive and social challenges. They further assert that the person devises and implements secondary controls in response to the failure of their primary controls and tentatively suggest that they lead back to primary control. This provides a simplistic picture of resilience and coping. The findings of O'Brien (2012) support these assertions.

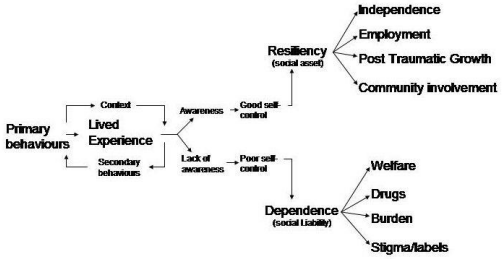
It important to note that Heckhausen and Schulz, (1995) specifically discuss life stages as critical to the emergence of secondary behaviours and controls. In the case of children growing up in families impacted by PTSD, adolescence was a time of realising they are different from other children who are not raised in military families (O'Brien, 2012). This challenged the identity and social position they had fought to establish throughout their childhood and early adolescence. These are the fundamental building blocks that form the disparity of social experiences which children raised in military families use to formulate their sense of "I am not normal".

The work of Heckhausen and Schulz (1995) and O'Brien (2012) is symbolic of the dominant attitude towards PTSD that ignores the situation or context in which the person with PTSD qualities exists and interacts that gives rise to both the secondary behaviours.

**Secondary behaviours as products of context**

Thus secondary behaviours are the products of primary behaviours in social context: they are the consequences of social interactions between a person or family with the qualities of PTSD and the contexts in which those interactions occur. This impacts on the development of a sense of normality. This relationship is illustrated in figure #2.

Figure #2: Interaction dynamic and outcomes of secondary behaviours in context.




As figure #2 depicts, the products of the dynamic interplay between primary behaviours, social contexts and secondary behaviours can produce qualities of resilience or dependence, based on the normative family processes developed by the family and/or person. The person interprets the feedback from their peers regarding their behaviours and adapts or reinforces these behaviours accordingly. These in turn become favourable or unfavourable character traits.

The critical factor that determines whether that feedback coerces dysfunctional or functional behaviours depends on the level of awareness the person and family has regarding the cause and management of those character traits. This awareness is the fundamental quality that drives the normative processes managed by the family. However, the family must gain that awareness from somewhere, and typically, this will be the mental health and community support professional. This is the critical role of that professional, and the point at which they make, or break families struggling with the intergenerational impacts of significant trauma. Thus it is vital to the survival of that family and its individual members that the professional is not ignorant of secondary behaviours and the impacts they have on development and maintenance of normality.

**Normality is contextually relevant**

Not all contexts produce problematic behaviours. A person with PTSD in a crowded shopping centre, for example, may experience substantial difficulties, yet, in that same physical location after closing time, their behaviours are no longer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problematic. The person remains constant. Their PTSD is constant. The shopping centre is constant. What is *not* constant is the context. The critical factor is the crowd. Two factors inherent with "crowds" are the critical contexts that manifest the problematic behaviours. These are movement and noise. Both are considered fundamental elements of perceived threat to a person on heightened state of awareness.

Secondary behaviours follow suit. Just as the problematic aspects of primary behaviours to PTSD are context-specific, so too are their secondary behaviours, which in turn, lead to a fundamental sense of normality. Thus PTSD becomes not a question of *what* it is, but *when* and *where*, and this is what drives secondary behaviour formation and normality development.

This neglect of context in the understanding of PTSD emerges as significant issues for individuals and families as they struggle to build and maintain a sense of what is, and is not, normal. A sense of normality is critical for healthy identity and social development. This sense is centrally underpinned by the secondary behaviours that inform and respond to the social contexts in which they manifest.

The following table presents some of the typical contexts in which PTSD interacts to produce secondary behaviours with intergenerational consequences.

**Table #1:** Contexts leading to secondary behaviours

| | |
|---|---|
| Walking on eggshells | Wide range of insecurities. |
| Unjustified punishment or outburst | Mistrust in others and systems.<br>Retaliation against authority figures. |
| Emotional absence in parent | Emotional mismanagement in adolescence and beyond.<br>Lack of emotional guidance.<br>Lack of effective parenting skills. |
| Mum as buffer | High levels of responsibility expected in mothers – leads to guilt when own parenting fails. |
| Rare moments of emotional connection | High value placed on positives. Very protective of personal space possessions and family. |

The critical, neglected point illustrated in this table is that these complications are heavily influenced by the contexts in which these symptoms manifest, perpetuate and are judged by others. A behaviour is only problematic if it is deemed a problem by the majority. In other words, if all people had qualities of PTSD to some level, then the associative and descriptive behaviours would not be problematic. This is demonstrated in countries where significant trauma is a common daily occurrence, such as Syria, Libia, Afghanistan, Iraq, Bosnia and other areas of civil unrest. To illustrate this point from a physical perspective, if everyone in a community lived in wheelchairs, then the physical environment would be very different, making access for people walking at 5-7 feet tall difficult or impossible.The mundane, vital function of simply going to the toilet, for example, would be a difficult exercise for someone not in a wheelchair as toilets would be very different in form and function to what we understand today.

Normal behaviour and ability is established by the dominant majority. Thus, with the growing pandemic of people and families impacted by trauma, the lens of normality is shifting, and it is the secondary behaviours that are informing this paradigm shift.

**Secondary behaviours and development of a sense of normality.**

The paucity of research on secondary behaviours and fundamental contributors to socially problematic behaviours attributable to PTSD symptoms is concerning. A recent study of normality in children of Australian Vietnam veterans demonstrated that normality is a highly elusive construct due to the influence of PTSD and dysfunctional family mechanisms to mitigate or "normalise" the behaviours attributable to PTSD (O'Brien, 2012).

"Normal" is a reactionary concept constructed by and through social interaction. It is a sense of social positioning one attains through comparisons of ritualised acceptable attributes (appearance, language and behaviour). However it is the family that generates the majority of this normality for it is here the person acquires much of their physical and behavioural characteristics.


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When the front door is closed, the majority of behaviours/ routines/rituals that would be abnormal in the broader community become normal. They become expected, typical and consistent. They form the person's establishment of their sense of normality and thus their identity. (This is not confused with *right* or *wrong*. While for many children of Vietnam veterans in O'Brien's study (2012) a nightly drunken beating from their Veteran father was a "normal" part of family life, it does not make it right). The person's sense of normality is challenged when they leave the family home and interact with wider society. The secondary behaviours they develop in response to contextual feedback of their primary behaviours conflict with those generated within their family contexts, and thus contradict healthy identity development.

Secondary behaviours must be studied to acquire a complete picture of the issue, yet have thus far been mostly ignored. Again, the DSM-IV-TR makes no mention of secondary behaviours, neither in broad, nor concise description. This is evidence of a short-circuit in the feedback loop: a lack of insight from data collected on the lived experience of PTSD and the impact of treatment. It begs to ask what influence secondary behaviours have on the development and establishment of a sense of normality and understanding in relation to PTSD, its multigenerational impacts and, perhaps, mental conditions in general.

**Typical secondary behaviours of PTSD.**

Based on recent research conducted by O'Brien (2012) secondary behaviours attributed to growing up in an family environment influenced by PTSD and its secondary behaviours includes;

- Feelings of alienation.
- Needed control of immediate environment.
- Developing awareness of issues in mid-late adolescence.
- Compensatory behaviours and parenting techniques.
- Critical for lack of discipline in self and others.
- Fearful of rejection.
- Social anxiety/avoidance.
- Place high value on small positives.
- Felt displaced in social environments.
- Stress and battle seen as a normal way of life.
- Difficulty expressing or managing emotions, especially those relating to
- stress.
- Disruptive levels of guilt.
- Self-doubt and mistrust in others.
- Poor self concept, feelings of failure and low self-esteem.
- Fatigue, frustration, loss of hope and lack of belief in a future.
- Anxious, fearful and socially withdrawn.
- Overwhelmed, may shut down and appear not to care.
- Self-aggrandizement --attempting to "look good".
- Inability to manage change, particularly rapid change.

Plus those related to a variety of emotion-management issues such as:

- ADHD, Autism-Spectrum-Disorders and depression and anxiety conditions.
- Destabilization of identity.
- Several "unexplained" illnesses.
- Mistrust of medical system due to inability to adequately explain these illnesses.
- Deeper issues evident at home.
- "Rescuer" persona
- Rigid, resistant and argumentative.
- Highly determined or dogmatic.
- Difficulties obtaining and maintaining employment.
- Compensatory behaviours.
- Very high levels of self-discipline, structure and routine.
- Philosophical approach to life.
- Resilience.
- Effective management.

These are the culturally and contextually specific qualities and criteria that mental and community health practitioners must be aware of, and searching for when providing therapeutic services to clients identifying impacts of trauma. The very language used to express and portray their experiences and the sense they make of them varies in cultural context to mainstream cases, and this further varies between military and non-military communities (O'Brien, 2012). Failure to do this may result in a deepening of the emerging stigma between these clients and the mental health field resulting in higher incidents of suicide, antisocial behaviours and mental health issues.


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## Conclusion

This paper has attempted to present an argument for the inclusion of secondary behaviours of PTSD in its diagnosis, description and treatment plan for individuals and families. It has presented the existence of the consequential effects of social interactions of the primary behaviours of PTSD and the impact they have on the development and maintenance of a sense of normality and identity for people with PTSD as a significant influence in their daily lives. The neglect of secondary behaviours in the diagnostic and descriptive criteria for a person's PTSD may substantially contribute to the problematic itself.

It is often the role of the family to mitigate and ameliorate the detrimental impacts of PTSD in one or more family members. When the front door is closed, the environment for the PTSD-affected family can be normalised and understood. When they leave the home the environment lacks trust, stability, predictability and reliability, leading to social interaction problematics and the classification of PTSD symptoms.

It is therefore the purpose of mental and community health practitioners working with people and families experiencing the intergenerational impacts of PTSD to optimally stabilize the processes of the social feedback information system that drives the secondary behaviours of PTSD. By developing supportive programs and strategies to assist individuals and families to recognise, understand and optimise these secondary behaviours health professionals can substantially impede the intergenerational progression of this substantial problem. It is critical to note that this also applies to clients with physical disabilities, as PTSD is often a comorbid (associated) condition to their physical one.

The methods or processes that are used by families and their members to create, maintain and project normality, security and stability to subsequent generations is a field rich in research opportunity, yet significantly under-investigated. Therefore, the understanding of these everyday experiences for the children of PTSD sufferers is the gap in literature, practice and research. What is needed, then, is an updated, all-inclusive description *and* diagnosis of PTSD that includes the social contextual consequences of PTSD in Action.

Only then will the condition known as Post Traumatic Stress Disorder be recognised for both its dysfunctional and functional qualities.

Only then will mental and community health professionals be in a position to heal and turn the focus from "mental illness" to "mental health".

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**References:**

Adkins, B., Smith, D., Barnett, K., & Grant, E. (2007). Public space as 'context' in assistive information and communication technologies for people with cognitive impairment. *Information, Communication and Society, 9*(3), 355-372.

American Academy of Child and Adolescent Psychiatry. (1999). *Facts for families: Post Traumatic Stress Disorder (PTSD)*. Retrieved 15 September, 2010, from http://aacap.org/page.ww?name=Posttraumatic+Stress+Disorder+(PTSD)&section=Facts+for+Families

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4 ed.): Washington DC: Author.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual for Mental Disorders* (IV - Text Revision ed.). New York: American Psychiatric, Association.

Andreasen, N. (2004). Acute and Delayed Posttraumatic Stress Disorders: A History and Some Issues. *American Journal of Psychiatry, 161*, 1321-1323.

Australian Institute of Criminology. (1999). *Violence in the Workplace* (No. 22). Canberra: Australian Institute of Criminology.

Barry, T., Dunlap, S., Cotten, S., Lochman, J., & Wells, K. (2005). The influence of maternal stress and distress on disruptive behavior problems in boys. *Journal of the American Academy of Child and Adolescent Psychiatry., 44*(3), 265-273.

Bawden, H. (1945). Primary and secondary behavior. *Psychological Review, 52*(3), 150-161.

Beall, L. (1997). Post-traumatic Stress Disorder: a bibliographic essay. *Choice, 34*(6), 917-930.

Berman, S., Weems, C., & Stickle, T. (2006). Existential anxiety in adolescents: Prevalence, structure, and association with psychological symptoms and identity development. *Journal of Youth & Adolescence., 35*, 303-310.

Birmes, P., Bui, E., Klein, R., Billard, J., Schmitt, L., Allenou, C., et al. (2010). Psychotraumatology in antiquity. *Stress & Health, 26*(1), 21-31.

Birnbaum, A. (2008). Collective trauma and post-traumatic symptoms in the biblical narrative of ancient Israel *Mental Health, Religion & Culture, 11*(5), 533-546.

Chase-Lansdale, P. L., Wakschlag, L. S., & Brooks-Gunn, J. (1995). A psychological perspective on the development of caring in children and youth: the role of the family. *Journal of Adolescence, 18*(5), 515-556.

Clayton, P. (2004). PTSD, Acute Stress Disorder, and DSM-V. *American Journal of Psychiatry, 161*(3), 584-.

Davis, L. (1995). *Enforcing Normalcy: Disability, deafness and the body.* London: Verso.

Ekeland, T., & Berger, R. (2006). The negotiation of identity among people with mental illness in rural communities. *Community Mental Health Journal, 42*(3), 225-232.

Ewing, J. (2005, July 26 2005). *What is PTSD?* Paper presented at the Healthy Connections Seminar, Caloundra Returned and Services Leagues, Caloundra, Queensland, Australia.

Fetter, J. (2005). Psychosocial response to mass casualty terrorism: guidelines for physicians. *Primary Care Companion Journal of Clinical Psychiatry., 7*(2), 49-52.

Gallagher, W. (1996). *ID : How Heredity and Experience Make You Who You Are Book.* N.Y.: Random House.

Greene, K. (2000). Elliott Sober and David Sloan Wilson, Unto others: The evolution and psychology of unselfish behavior. *Public Choice, 103*, 383-386.


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Hantman, S., & Solomon, Z. (2007). Recurrent trauma: Holocaust survivors cope with aging and cancer. *Psychiatric Epidemiology, 42*, 396-402.

Heckhausen, J., & Schulz, R. (1995). A life-span theory of control. *Psychological Review, 102*(2), 284-304.

Inder, M., Crowe, M., Moore, S., Luty, S., Carter, J., & Joyce, P. (2008). "I actually don't know who I am": The impact of bipolar disorder on the development of Self. *Psychiatry., 71*(2), 123-133.

Jayakody, R., & Stauffer, D. (2000). Mental Health Problems Among Single Mothers: Implications for Work and Welfare Reform. *Journal of Social Issues, 56*(4), 617-634.

Johnson, A., Vernon, P., Harris, J., & Jang, K. (2004). A behavior genetic investigation of the relationship between leadership and personality. *Twin Research, 7*, 27-32.

Johnson, H., & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review *Clinical Psychology Review, 28*(1), 36-47.

Kendler, K., & Greenspan, R. (2006). The Nature of Genetic Influences on Behavior: Lessons From "Simpler" Organisms. *American Journal of Psychiatry, 163*(10), 1683-1694.

Kessler, R. (2000). Posttraumatic Stress Disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry., 61*(Supplementary 5), 4-12.

Kletter, H., Weems, C., & Carrion, V. (2009). Guilt and Posttraumatic Stress Symptoms in Child Victims of Interpersonal Violence. *Clinical Child Psychology and Psychiatry 14*(1), 71-83.

Lasiuk, G., & Hegadoren, R. (2006). Posttraumatic Stress Disorder Part II: Development of the construct within the North American Psychiatric Taxonomy. *Perspectives in Psychiatric Care, 42*(2), 72-81.

Lupien, S., Fiocco, A., Wan, N., Maheu, F., Lord, C., Schramek, T., et al. (2005). Stress hormones and human memory function across the lifespan. *Psychoneuroendocrinology, 30*(3), 225-242.

MacDonald, H., Colotla, V., Flamer, S., & Karlinsky, H. (2003). Posttraumatic Stress Disorder (PTSD) in the Workplace: A Descriptive Study of Workers Experiencing PTSD Resulting from Work Injury. *Journal of Occupational Rehabilitation, 13*(2), 63-77.

Matthews, L. (2005). Work potential of road accident survivors with post-traumatic stress disorder. *Behaviour Research and Therapy., 43*(4), 457-483.

McMaster, H. (2008). Ancient lessons for today's soldiers. *Survival, 50*(4), 177-190.

Misztal, B. (2001). Normality and trust in Goffman's theory of interaction order. *Sociological Theory, 19*(3), 312-324.

Moffitt, T., Caspi, A., & Rutter, M. (2006). Measured Gene-Environment Interactions in Psychopathology. Concepts, Research Strategies, and Implications for Research, Intervention, and Public Understanding of Genetics. *Perspectives on Psychological Science, 1*(1), 5-27.

National Centre for Postraumatic Stress Disorder. (2003). *PTSD in children and Adolescents: A National Centre for Posttraumatic Stress Disorder Factsheet.* Retrieved July 28, 2006, from http://www.ncptsd.org/facts/specific/fs_children.html

National Centre for Posttraumatic Stress Disorder. (2003a). *What is posttraumatic stress disorder? A National Centre for Posttraumatic Stress Disorder Factsheet.* Retrieved January 14th, 2006, from http://www.ncptsd.org/facts/general/fs_what_is_ptsd.html

National Centre for PTSD. (2007). *DSM-IV-TR criteria for PTSD*. Retrieved 10 October, 2010, from http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp

O'Brien, K. (2004). *The intergenerational transference of Post-Traumatic Stress Disorder amongst children and grandchildren of Vietnam veterans in Australia: An argument for a genetic origin. Review of current literature.* Paper presented at the Proceedings


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Social Change in the 21st Century Conference;, Centre for Social Change Research; Queensland University of Technology, Brisbane, Queensland, Australia.

O'Brien, K. (2007). *Capturing the experience of disability in Queensland primary schools: the case of PTSD.* Unpublished Honours, Queensland University of Technology, Brisbane.

O'Brien, K. (2012). *The lived experience of Post Traumatic Stress Disorder for children of Vietnam veterans in Australia* (Doctoral Dissertation). Brisbane, Queensland, Australia: Queensland University of Technology.

Peach, H. (2005). Further support for the families of Australia's war veterans requires a broad research strategy. *The Medical Journal of Australia, 183*(3), 147-150.

Porter, C., Lawson, J., & Bigler, E. (2005). Neurobehavioral sequelae of child sexual abuse. *Child Neuropsychology, 11*(2), 203-220.

Richerson, P., & Boyd, R. (2005). *Not by genes alone: how culture transformed human evolution.* Chicago, USA.: University of Chicago.

Rosenman, S. (2002). Trauma and posttraumatic stress disorder in Australia: findings in the population sample of the Australian National Survey of Mental Health and Wellbeing. *Australia and New Zealand Journal of Psychiatry., 36*(4), 515-520.

Schiffman, L. (2003). Hadassah Doctors Link Gene Mutation with PTSD. *The Jewish Post of New York.*

Tan-Roldan, A. (2005). *Care and Nurture of Very Young Children In Marginalized Communities of Contemporary Philippines: A Framework for Intervention Programs.* Paper presented at the International Conference Childhoods, University of Oslo, Norway.

Trimble, M. (1985). Post-traumatic Stress Disorder: History of a Concept. In C. Figley (Ed.), *Trauma and its Wake, Volume 1: The Study and Treatment of Post-Traumatic Stress Disorder* (pp. 5-14). Bristol, USA: Brunner/Mazel.

Vincent, J. (2005). Understanding generations: political economy and culture in an ageing society. *British Journal of Sociology, 56*(4), 579-599.

Welberg, L., & Seckl, J. (2001). Prenatal Stress, Glucocorticoids and the Programming of the Brain. *Journal of Neuroendocrinology, 13*(2), 113-128.

Westerink, J., & Giarratano, L. (1999). The impact of posttraumatic stress disorder on partners and children of Australian Vietnam veterans. *Australian and New Zealand Journal of Psychiatry, 33*(6), 841-847.

Wildes, M. (2005). *The Legacy of the Vietnam War.*, from http://www.onlineopinion.com.au/view.asp?article=155

Willness, C., Steel, P., & Lee, K. (2007). A meta-analysis of the antecedents and consequences of workplace sexual harassment. *Personnel Psychology, 60*(1), 127-162.

World Health Organisation. (2001). *Chapter 2: Burden of Mental and Behavioural Disorders*. Retrieved September 28, 2006, from http://www.who.int/whr/2001/chapter2/en/index7.html

Yehuda, R., Golier, J., Halligan, S., & Harvey, P. (2004). Learning and memory in Holocaust survivors with posttraumatic stress disorder. *Biological Psychiatry., 55*(3), 291-295.

Yehuda, R., Halligan, S., & Bierer, L. (2001). Relationship of parental trauma exposure and PTSD to PTSD, depressive and anxiety disorders in offspring. *Journal of Psychiatric Research., 35*(5), 261-270.

Yehuda, R., Halligan, S., & Grossman, R. (2001). Childhood trauma and risk for PTSD: Relationship to intergenerational effects of trauma, parental PTSD, and cortisol excretion. *Development and Psychopathology., 13*, 733-753.


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Reproduced by Families After Trauma Permission under license 2012.

Young, A. (1995). *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder.* London: Princeton University Press.


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Reproduced by Families After Trauma Permission under license 2012.