Post traumatic stress disorder:todays best treatments research paper sample

Family, Children

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Post Traumatic Stress Disorder (PTSD) is a severe anxiety disorder that can develop in anyone after exposure to an event that results in psychological trauma. Although there has been much focus in recent years on PTSD experienced by soldiers returning home from war, the disorder is not limited to that group of people. In fact, PTSD can occur in a variety of situations and to just about anyone, including abused children, sexual assault and rape victims, people who have experienced natural disasters, people who have experienced a car crash, and many other traumatic situations. In order for people with PTSD to receive adequate treatment, they must receive the correct diagnosis because PTSD is not a simple anxiety disorder. People with PTSD may experience nightmares, flashbacks, avoidance of places or things that remind them of the traumatic incident, feelings of guilt and sadness, sleeping difficulties, outbursts of anger, and thoughts of self-harm or of harming others (“ Post Traumatic” 3). In order for people to receive the best possible treatment for PTSD, first the disorder and its symptoms must be understood. Once that is established, physicians, psychologists, the community, and patients can work together to find the best methods of treatment for PTSD. There are

Treatments for Children with PTSD

Although all children experience anxiety to some degree, for children with PTSD, this anxiety reaches another level. PTSD is more difficult to diagnose in children because it relies, in part, on children's self-reporting which may not be entirely reliable because their communication skills may be lacking or absent (Cohen 1). Additionally, children with PTSD may display different symptoms than adults. For example, school aged children may begin to refuse to play with their friends, to go places, complain of physical problems such as stomach and headaches, lose the ability to talk, reenact the trauma in their play, or begin to behave like a much younger child (" Post Traumatic" 3, " PTSD in"). Older children and teenagers may display symptoms that are much more similar to those that adults display, although teenagers with PTSD are more likely to act impulsively or aggressively than their younger counterparts (" PTSD in"). According to the National Center for PTSD, out of all of the children who experience trauma, up to 43% of girls and boys develop p PTSD, with girls having a slightly higher incidence than boys (" PTSD in"). The best treatment options for children with PTSD vary according to the child's age, depending on whether the child is preschool aged, school aged, or adolescent.

There are two best treatment models that are considered preferred for the preschool aged child. The first is Child-Parent Psychotherapy (CPP), and the second is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen 2). These therapies both address the challenge of assessing PTSD in infants and toddlers as well as the children's dependence on parents. Research on these types of therapies includes children who have experienced domestic violence

or sexual abuse, and the therapies involve non-perpetrating parents. CPP works because it “ uses the relationship between the child and parent to address the child’s trauma symptoms”, while TF-CBT works because there is an active focus on improving parenting skills and creating healthier child-parent interaction (Cohen 1). CPP was shown to be significantly better than case management alone, while TF-CBT was shown to be superior to Non-Directive Supportive Therapy (Cohen 2). Play therapy is another option for preschool-aged children with PTSD, if the child cannot deal with the trauma directly as the other forms of therapy require (“ Treatment of.

For school-aged children, TF-CBT was shown to be the most effective method of treating PTSD; again, TF-CBT was most effective when parents were also included, something that therapists often do not do (Cohen 2). Additional studies concerning other types of therapies such as Eye Movement Desensitization Reprocessing (EMDR) and psychological debriefing have found some advocates, especially in Europe, but not enough testing has been completed on these methods to see if they are truly effective for school-aged children or not (Cohen 2). In addition, Psychological First Aid (PFA) is a treatment method that can be used for children who experience violence in their homes; PFA is similar to TF-CBT, although it focuses more on giving children support, comfort, teaching children problem solving methods, and “ letting children know their reactions are normal” (“ Treatment of”).

Adolescents, although more reliable in self-reporting symptoms, vary quite a bit in what the best way is to treat PTSD. One study of war-traumatized adolescents in Uganda discovered that Interpersonal Psychotherapy, a form of group therapy, was not effective for boys but was effective for girls (Cohen

3). TF-CBT in conjunction with antidepressants was also studied, but concerns about the safety of antidepressant medication for children does not make this an ideal choice for adolescent PTSD treatment. For adolescents, TF-CBT or PFA therapies alone are the usual and best methods for treating their PTSD (“ Treatment of”). A promising treatment currently being researched is Trauma and Grief Components Therapy and group and family intervention. Unfortunately, studies concerning adolescents and PTSD suffer from small sample sizes or simply a lack of overall research and there is no consensus on the best treatment for PTSD for adolescents.

Treatments for Adults with PTSD

Treatment for PTSD in adults differs than treatment for children because in most cases, adults are not wholly dependent on another person for their care. In addition to the disruptive symptoms of PTSD, the disorder is often comorbid with other disorders, the most common being depression, anxiety, and substance abuse; comorbid means that people experience more than one illness at the same time (Brady, Killeen, Brewerton, and Licerini 22).

Figure 1 The Depressed Thinking Cycle (Denman 245).

Figure 1 illustrates the depressed thinking cycle. Because people with PTSD often have other psychiatric disorders such as depression, the other disorders sometimes altogether mask a diagnosis of PTSD. Considering the types of symptoms that PTSD sufferers typically demonstrate, such as nightmares, sleeping difficulties, and social withdrawal, it is easy to see how a clinician may misdiagnose a patient who may be unwilling or unable to talk about the trauma experienced. In addition, this diagram of the depressed

thinking trap illustrates the difficulty a person experiencing both PTSD and depression can experience that may make it more difficult to either ask for or accept help and treatment.

People often wonder why when two people have been through the same traumatic experience, such as a wartime situation, one gets PTSD while the other does not. According to the National Institute of Mental Health (NIMH), there are both risk factors and resilience factors that play a part in determining why some people get PTSD and some do not. Risk factors making it more likely a person will get PTSD include things such as experiencing traumas and dangerous events, a history of mental illness, feeling helplessness, horror, or extreme fear, having no or little social support after the trauma, and others (“ Why do” 2013). Resilience factors that make it less likely a person will get PTSD include seeking and finding support from others including friends and family, positive feelings about “ one’s own actions in the face of danger,” and others (“ Why do” 2013). What this information demonstrates is that PTSD is a disorder created by a complex combination of events and individual experiences past and present. What this means is that while some treatments may work for some people, they may not work for others; therefore, a variety of good treatment methods need to be available depending on the situation of a person diagnosed with PTSD.

In the “ Treatment” section of Krippner, Davies, and Pitchford’s Biographies of Disease, Post-traumatic stress disorder, the authors discus Freud’s thoughts relating to psychology and trauma. “ When the subconscious is exposed to traumatic stress the id becomes empowered, allowing one’s

biological drives to overpower the logical guidance system of the ego. The superego then overrides rational thought and begins to impose its own Agenda regarding the trauma” (Krippner, Davies, and Pichford 105). In other words, when trauma occurs, a person may not always be aware of why he or she is behaving in an illogical, uncontrolled, and detrimental manner because the actions are spurred by the subconscious. From the Freudian perspective, this offers a reason why psychoanalysis or “ talk therapy” can work to help people recover from trauma. According to Freud’s theory, PTSD can result when a person is overwhelmed by an experience and is unable to understand the resulting feelings. With therapy, a people with PTSD can learn to understand why they are compelled to act on a thought or project certain behaviors. A therapist can help the PTSD-sufferer understand her maladaptive behavior by defining it with concrete terms, to deal with feelings of inadequacy, and to eliminate undesirable traits and behaviors ((Krippner, Davies, and Pichford 107). Although the popularity of Freud’s theories has passed for most psychiatrists and psychologists today, many of the methods that Freud pioneered such as talk therapy are still actively used to treat a variety of psychological disorders, including PTSD. Talk therapy alone is not as effective as when it is combined with other forms of therapies, but it can be an essential part of treating PTSD.

According to the United States Department of Veterans Affairs National Center for PTSD, two types of cognitive behavioral therapy (CBT) are most effective in treating PTSD. These include Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) therapy (“ Treatment of” 2007). One typical symptom a person suffering from PTSD experiences is guilt or the feeling

that the person was somehow to blame for the traumatic event that occurred. CPT is designed so that with the aid of a therapist, the patient can “ learn to replace [upsetting] thoughts with more accurate and less distressing thoughts” (“ Treatment of” 2007). PE therapy is different in that the patient repeatedly talks about the trauma with a therapist in order to gain control over feelings and thoughts that occur concerning the trauma (“ Treatment of” 2007). Although it is not stated explicitly, it could be considered that people may find that receiving both CPT and PE therapies would be very effective as combination therapies. Another treatment for PTSD that has garnered more support over the past decade is Eye Movement Desensitization and Reprocessing (EMDR). During EMDR therapy, the therapist asks a patient to focus on the trauma or anxiety-causing situation; as the patient focuses on the trauma, the patient follows “ the therapist’s back-and-forth finger movements with their eyes, much like a person in an old Hollywood movie following a hypnotist’s swinging pocket watch” (Lilienfeld and Arkowitz 2008). Lilienfeld and Arkowitz are making light of and oversimplifying what research has shown to be a very effective treatment for trauma patients. In fact, there are eight stages to EMDR, including history and treatment planning, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation (Shapiro, F. and Forrest, M. S.). . Patients are not simply ordered to think about their trauma and follow a finger, but their reactions are measured in detail throughout each stage. For example, during the installation phase, the Validity of Cognition (VOC) scale is used to assess how well a patient is adapting to the positive view or truth of the situation (Shapiro, F. and Forrest, M. S.). EMDR provides a unique

therapeutic benefit for PTSD patients because it helps patients form a more reflexive, automatic response to negative feelings and beliefs surrounding the traumatic event, replacing them with new and more positive internal associations (Shapiro). Shapiro describes EMDR as a possible superior therapy to CBT or PE because it does not require the PTSD patient to give detailed descriptions of the trauma. This may be especially valuable in treating combat veterans with PTSD because “ the veteran can be effectively treated even if he or she chooses not to discuss the event for any reason, including that it is classified information” (Shapiro).

In addition to individual therapies like CBT and EMDR, group and family therapy is also recommended by the National Center for PTSD as effective treatments for the disorder (“ Treatment of”). Group therapy can be especially valuable in assisting PTSD patients in understanding and dealing with symptoms, problems, and in building strategies to deal with the trauma they have experienced. An example is a therapeutic group for survivors of rape; according to Dr. Rebecca Campbell, “ Because many feminist therapists focus on self-blame following rape, group therapy is often a preferred treatment choice as a group setting can break down post-rape isolation, promote sharing of experiences, and develop supportive relationships.” Group therapy can help trauma survivors with PTSD understand that in some ways, their reactions are normal, to learn that they are not alone, and to see the various ways others are experiencing success in treatment (Campbell). The same is true for survivors of other traumatic experiences who have PTSD. Family therapy is also a valuable treatment for PTSD because most often, it affects not only the trauma survivor, but the

entire family (“ Treatment of”). During family therapy, with the assistance of a trained mediator such as a psychologist, each member of the family can discuss their fears and concerns, as well as develop strategies to help each other during recovery (“ Treatment of”).

For adults, CBT alone may not be enough to deal with PTSD. When CBT alone is not enough, medication such as SSRI antidepressants like Zoloft can be very beneficial in conjunction with CBT (“ Treatment of” 2007, “ Post-Traumatic” 2012). Medication can assist in treatment of PTSD because “ PTSD can be conceptualized as dysregulation of the naturally occurring stress hormones in the body and increased sensitivity of the stress and anxiety circuits in the brain” (Jeffreys 2009). In other words, a person with PTSD may find that the “ fight or flight” or adrenaline response is over-reactive. Symptoms include tremors, increased heart rate, rapid breathing, and sweating as a result of this constant hyperarousal (Jeffreys 2009). Medication assists in re-regulating the chemicals in the brain and body responsible for hyperactive stress hormones in people with PTSD. Medication is considered to be effective if it assists in dealing with the three main PTSD symptom clusters, which are hyperarousal, avoidance, and re-experiencing (Jeffreys 2009). Although medication is an ideal form of treatment in conjunction with CBT or other therapies, there are some situations in which it may not be desirable. For instance, pregnant patients or patients with substance abuse problems may not be able to take medications safely (Jeffreys 2009).

Another medicinal treatment option to treat PTSD that is being explored by Dr. Eugene Lipov of the Advanced Pain Centers in Hoffman Estates, Illinois, is

the injection of stellate ganglion nerve block. Although a relatively small amount of PTSD patients have been treated with stellate ganglion nerve block, after only one block, “ On average, these individuals experienced a 41% decrease in the severity of the disorder” (Vlessides). Although the mechanisim by which stellate ganglion nerve block works is highly technical, in basic terms it halts the production of excess norepinephrine, leading to a decrease in the excessive stress response PTSD patients experience (Vlessides). Similar to epidurals given to pregnant women during labor, the injection takes about 15 minutes in administration, and patients can experience relief in as little as 30 minutes (Crees). The biggest risk with this therapy for PTSD patients appears to be that it is expensive and may not work at all; in addition, some patients experience “ temporary seizures and other events linked to the central nervous system” though no fatalaties have been reported (Vlessides). Although this treatment for PTSD has shown to be effective, because of the expense, government agencies and other funding sources for research have been reluctant to provide resources for research (Vlessides). However, Dr. Lipov is very persistent in continuing research that may provide a “ cure” for PTSD.

People suffering from PTSD may also seek out “ complementary and alternative medicine” (CAM) treatment for their disorder in addition to traditional Western medical therapies (Strauss and Lang 1). According to Strauss and Lang, “ complementary” treatment is defined as treatment which is used in addition to standard PTSD treatments, while “ alternative” treatment is defined as treatments used instead of standard PTSD treatments (1). There are five categories of CAM, including natural products

such as herbal supplements, mind-body medicine such as acupuncture or yoga, manipulative and body-based practices such as massage, other alternative practices such as movement or energy therapies, and whole medicine systems such as Ayurvedic or Chinese medicine (Strauss and Lang 1). Strauss and Lang report that almost 40% of PTSD patients say they use CAM to deal with their mental and emotional problems (1-2). Unfortunately, the effectiveness of CAM in treating PTSD suffers from a lack of empirical research; Strauss and Lang write that " the most basic question " Can it work?" for PTSD has not yet been answered" (2). However, because some of the techniques of traditional PTSD treatments and CAM overlap, Strauss and Lang describe acupuncture, relaxation, and meditation as three likely effective treatments for PTSD (2). Because of the lack of research, Strauss and Lang recommend these types of treatment options not as a replacement for traditional treatment, but ones to be used in conjunction with better-researched traditional treatments for PTSD. In other words, it is not that there is no value in alternative treatments and they may be very valuable for some PTSD sufferers, but until there is more research into the five categories of CAM, PTSD patients should approach them with caution and as a supplement to other treatments.

PTSD is a complex disorder that affects people in a variety of ways, and as a result there is no one-size-fits-all best treatment option. As research has demonstrated, treatment options for children and adults with PTSD are very different. While a particular treatment option may work very well for one patient, it may not work at all for a different patient. Additionally, it may be that a combination of two or more treatment options are optimal for some

people with PTSD. The positive thing is that research continues on the current options as well as many new treatments. In other words, today's best treatments may yet be eclipsed by even better options, offering the hope so badly needed by people suffering from PTSD.

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