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Post-traumatic stress disorder is a modern name given to a disease with a long history. One of the first clinical papers describing the malady was from Jacob DaCosta in 1871 that described soldiers with what he termed an “irritable heart” (Kaplan, 2007, p. 613). The disease is often marked by autonomic dysfunction and cardiac symptoms. Because of these symptoms, following the American Civil War, physicians termed it “soldier’s heart.” As the Freudian school of psychoanalysis grew in stature the disease became “traumatic neurosis.” Following the First World War, the condition was referred to as shell shock and was attributed to traumatic brain injuries. After the horrors of the Second World War the literature referred to it by yet another name: operational fatigue. It was only after the Vietnam War that the name posttraumatic stress disorder was coined, and so far the name has stuck (Kaplan, 2007, p. 613).

Posttraumatic stress disorder (PTSD) is caused by traumatic events that manifest themselves in the typical symptoms of fear, a feeling of helplessness, reliving the traumatic event, and efforts to avoid reminders of the event. Diagnosis can be made when symptoms last more than one month and the symptoms affect either the work or family life of the patient. Common stressors that may cause symptoms of PTSD are war, torture, natural catastrophes, assault, rape, and accidents. People with PTSD continue to relive the traumatic event in dreams and in thoughts. They undergo a numbing and a heightened sense of arousal while they are determined to avoid the topic (Kaplan, 2007, p. 612).

It is estimated that in the general population approximately 8% of people will acquire PTSD, while another 5-15% will have a less severe symptoms.

Among high risk groups there may be a much higher prevalence. For instance, Vietnam veterans have a disease rate of approximately 30%. Women are twice as likely to be diagnosed with PTSD, but the etiology is usually different for men and women. Male trauma is usually associated with military conflict, whereas female trauma is most commonly associated with assault and sexual violence. Socially withdrawn individuals are more likely to suffer the effects of the disease, but the most important risk factor is the length, severity, and exposure to the trauma. There is a genetic component to the disease as well, since people with a close relative suffering depression seem to be at higher risk for PTSD (Kaplan, 2007, p. 613).

PTSD has a very high rate of comorbidity and approximately 2/3 of patients have other psychiatric disorders. Some of the more commonly associated syndromes are depression, drug abuse, anxiety, and bipolar disorder (Kaplan, 2007, p. 613). In a study of veterans returning from Afghanistan and Iraq, Maguen, et al., found a very high correlation of PTSD with irritable bowel syndrome (2013). The study was exceptionally large at 603, 221 veterans. It was a retrospective, cross sectional analysis of the existing medical records of the VA Roster, a database of Iraq and Afghanistan veterans. They concluded that men with PTSD had twice the risk of the general population for all gastrointestinal diseases, including gastro-esophageal reflux, dyspepsia, or irritable bowel disease, however, irritable bowel and PTSD in male veterans was strongly linked, whereas the other gastrointestinal disturbances were equally linked to PTSD as they were to depression and anxiety based diseases (Maguen, et al., 2013).

In veterans, comorbid alcohol use disorders and PTSD are increasingly

common problem (Carter, et al., 2011). More than forty percent of the PTSD population meet the criteria for diagnosis with an alcohol abuse disorder which indicates a strong correlation between alcohol use and trauma. In comparison to the civilian population, the military population had significantly higher levels of alcohol use disorders (Carter, et al., 2011). Alcohol abuse and PTSD reciprocally influence the course and chronicity of the other and lead to poor outcomes. It has been hypothesized that alcohol abuse may be a form of self-medication, however alcohol withdrawal has been shown to exacerbate PTSD symptoms and reinforces the cycle of substance abuse and symptomology of PTSD. Interestingly, in response to negative emotions, veterans were more likely to endorse a craving for alcohol, suggesting a strong link to the self-medication theory (Carter, et al., 2011). Another position is that alcohol use disorders and PTSD share common etiological factors, namely, a lack of awareness and understanding of emotions, and an inability to control behavior when experiencing emotional distress (Carter, et al., 2011).

The etiology of PTSD revolves around a stressor, a prime causative factor. But, it is important to note that not everyone who experiences the event will end with PTSD. A stressor is a necessary but not sufficient event for the occurrence of disease. The reaction to the event must encompass fear and horror. Furthermore, it is important to consider the context of the trauma both to the individual and society. Most people, in the face of trauma, will not succumb to PTSD. However, events that may seem negligible to some may trigger PTSD in others. Childhood traumas, personality disorders, poor socialization, family history of psychiatric illness, and excessive alcohol

intake have all been linked to the possibility of acquiring the disease (Kaplan, 2007, p. 613). In a large retrospective study performed by Koola, et al., in 2013, it was found the veterans suffering form PTSD reported a high rate of childhood physical and sexual abuse. Indeed, patients with PTSD were more likely to report this abuse than patients suffering from another psychiatric illness. Indeed, early life stressors were a common link between all the psychiatric patients in the veterans hospital (Koola, et al., 2013).

Different schools of psychological thought view the syndrome differently. Psychodynamic theories view the disease as reawakening childhood psychological issues. Cognitive behavioral models view the problem as a deficit of individual rationalization. Furthermore the behaviorists see the disease as having two phases, the initial trauma producing a conditioned fear response and a second instrumental learning phase where the conditioned response occurs absent the offending stimuli. There is also a school of thought that views the disease as stemming from a biological basis. Several neurotransmitters have been suspected of involvement, including norepinephrine, dopamine, endogenous opioids, benzodiazepine receptors and the hypothalamus-pituitary-adrenal axis (Kaplan, 2007, p. 614).

The diagnostic criteria of PTSD are long, but not particularly complicated. As can be seen in table 1, the main points of the criteria are as follows: a traumatic event, persistent re-experience of the traumatic event, avoidance of stimuli associated with the event, persistent arousal, and that the disturbance lasts longer than one month and causes clinically significant disturbances. Cases of the disease that last longer than one month but less

than three are termed acute, and the disease is considered chronic if symptoms persist for longer than three months. If symptoms begin six months after the triggering traumatic event, it is considered to be delayed onset.

The main clinical features of PTSD are the re-experiencing of the traumatic event, patterns of avoidance, emotional numbing, and constant hyperarousal. Mental status examinations may indicate deep seeded feelings of guilt and humiliation. There may be

Furthermore, patients may prove to be aggressive and exhibit poor impulse control. Cognitive testing will often reveal an impaired memory and poor attention span (Kaplan, 2007, p. 615). In a study performed by Insana, et al., in 2013, they found that veterans exposed to combat related stress and had subsequently been diagnosed with PTSD had considerably worse sleep quality than control samples. The correlation was so great that using the scores of the Pittsburgh Sleep Quality Index Addendum for PTSD (PSQI-A) they were able to identify which patients were the PTSD patients with a predictive value of 93%. Higher PSQI-A scores correlated with more pronounced symptoms of PTSD and the authors make an argument that the PSQI-A questionnaire should be used as part of the clinical evaluation of PTSD (Insana, et al., 2013).

Treatment of PTSD is generally multi-pronged, encompassing both pharmacological and psychotherapeutic interventions. The main prong of the approach should be psychotherapy where the patient is encouraged to talk about the trauma, given support, and taught coping mechanisms. Sedatives and hypnotics may also aid the psychotherapeutic approach (Kaplan, 2007,

p. 620).

In sum, PTSD and its symptomology of re-experiencing the trauma, avoidance of discussions and memories of the events, and the hyper-vigilance that comes with it represents the ongoing costs traumatic events. These symptoms have consequences that are much larger than just the individual, as it effects employment, family relations, and social attachments that have formed throughout their entire lives.. PTSD is particularly aggravated when humans as opposed to an act of God cause the stressors.

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