Life threatening situations and how to overcome them: ptsd symptoms and treatment...

Health & Medicine, Mental Health

Post-traumatic stress disorder (PTSD) is a psychiatric health condition that occasionally develops in people after they experience a life-threatening or alarming situation. PTSD was formerly known as ‘ shell shock’ or ‘ combat stress’ and the diagnoses was limited to those who had developed the disorder from experiences in the military such as involvement in explosions or fire-fights. However it is now recognised that PTSD can develop in anyone who has been in a life-threatening or alarming situation with modern statistics demonstrating how common the disorder actually is, affecting one in five fire-fighters, one in three teenage crash victims, half of female rape victims, and two out of three prisoners of war (Kenny, 2013).

All people will experience traumatic events at points in their life and with the discovered likelihood of PTSD being discovered, it is now more important to design and designate treatments for counsellors and psychotherapists to utilise in treating their clients.

Every sufferer of PTSD will be affected in a unique way due to the many different symptoms and types of symptom. There are various different treatments available that can be provided depending on the sufferer and how the disorder affects them. Causes of PTSD other than military combat include being the victim of a violent crime such as robbery, involvement in motor vehicle accidents or sometimes even unexpected loud noises (Cohen 2013). PTSD can also occur during adulthood when people recover repressed memories from hugely unpleasant experiences that occurred during childhood such as sexual abuse or being witness to extreme violence.

When people survive traumatic and shocking events such as terrorist attacks or natural disaster then generally all survivors will be negatively psychologically affected for a short period of time, for example people might develop depression if they acquired injuries or lost family. However many are soon able to naturally return to their normal mental state.

However, sometimes peoples stress reactions remain triggered and become worse over time. These people have the potential to develop PTSD, where sufferers possess constant feelings of distress, fear, hopelessness and anxiety, with many also suffering from prolonged depression.

There are three types of symptoms that people experience once they develop PTSD and they will vary from person to person. The initial symptom type is re-experiencing the trauma. This involves reliving the experience via nightmares, flashbacks, intrusive images or thoughts, recurring emotional and physical sensations such as sweating, shaking nausea and becoming upset or angry when confronted with a reminder of the experience. The next symptom type is hyperarousal. This is when the body’s survival mechanisms activate unnecessarily in normal life over minor incidents as opposed to life-threatening situations. This will make it difficult for sufferers to relax, as they are easily startled and it is difficult for them to calm down. Hyperarousal symptoms include an inability to concentrate or relax, problems sleeping, and intense random feelings of panic. The third symptom type of PTSD is avoidance. This is when PTSD sufferers will actively try to evade reminders of their experience by avoiding communication with people involved in the experience with them and places such as where the experience happened or

that reminds them of the experience. People with this symptom dislike discussing their traumatic experience and try to keep themselves and their minds busy, attempting to deal with their traumatic memories and feelings by endeavouring to elude feeling anything at all. This emotional numbing negatively affects their ability to communicate with other people. Symptoms of avoidance are feelings of isolation and loneliness, an inability to express affection or warmth, and in some cases sufferers develop an attachment to alcohol in order to avoid memories or a disinterest in hobbies and other interests that they use to enjoy.

“ Symptoms of post-traumatic stress disorder can be hard to manage. They can affect all aspects of life including health, well-being and relationships. Many sufferers will develop physical ailments as a result of the constant stress. These include headaches, dizziness, chest pains, diarrhoea and stomach aches. It is also common for symptoms of other mental health issues such as depression, phobias, and anxiety to emerge.” (Daniels, 2008)

PTSD impairs the sufferer’s ability to function socially and if untreated can cause marital problems, divorces and relationship problems within their family or confrontations and inability to connect with their friends. It is important to treat PTSD early to help reduce long-term symptoms and the damage in sufferer’s lives that PTSD can cause. Due to the complex nature of the human mind and the vast library of psychological disorders that have been recognised, it was not always easy to diagnose or spot PTSD. However modern healthcare and training has reached a level where PTSD is now

easier to diagnose due to a criteria of symptoms and physical and mental conditions that sometimes accompany the disorder.

“ PTSD is marked by clear biological changes such as shortness of breath, dizziness and excessive sweating and nausea as well as psychological symptoms. People with PTSD often may develop additional disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health.” (PTSD, 2007)

Once PTSD has been diagnosed then treatment can commence. Available treatment includes medication such as antidepressants along with several types of psychotherapy and counselling depending on the severity and symptoms displayed.

Cognitive-behavioural therapy (CBT) is a widely used form of therapy that is often used in treating PTSD. CBT is most commonly used for treating anxiety and depression but it can be applied to treating other mental health conditions such as obsessive-compulsive disorder, phobias, insomnia, alcohol dependence and PTSD. This therapy can also be used alongside treatment for physical health problems.

“ CBT is sometimes used to treat people with long-term health conditions, such as irritable bowel syndrome (IBS) and chronic fatigue syndrome (CFS). CBT cannot cure the physical symptoms of these health conditions, but it can help people cope better with their symptoms.” (NHS choices, 2014)

This form of therapy differentiates from other forms of talk therapy by focusing specifically on the client’s current problems as opposed to issues from their past and generally helps them deal with their problems directly by breaking them down into smaller parts. This therapy is based on the concept that our thoughts, actions and feelings are interconnected. Most sessions of therapy using CBT is applied in sessions once a weekly or once every two weeks, with each client receiving around 5 and 20 sessions lasting between thirty minutes to an hour.

The way that CBT is used to treat PTSD will vary by case but the therapy will generally look to change irrational thoughts that the client has and dismiss negative feelings that they associate with their traumatic experience. CBT is widely used in the treatment of PTSD there exists evidence to CBTs effectiveness in treating depression, which is a common symptom of PTSD. A well known trial of CBT had 469 adults with depression that had not responded to 6 months of antidepressants be split into two groups, one continuing to only receive prescribed antidepressants whilst the other group would receive both, antidepressants and CBT.

“ The study found that people who received CBT in addition to antidepressants, rather than continuing to receive antidepressants alone, had around a three-fold increased chance of responding to treatment and having a reduction in their depression symptoms over the following 12 months. This provides further evidence on the effectiveness of CBT to treat depression, particularly in those who have not responded to antidepressants alone”. (NHS choices, 2015)

There are several forms of CBT that can be applied to treating PTSD. Stress Inoculation Training (SIT) is a form of CBT normally used in treating clients suffering from high levels of stress and aims to change the clients thinking patterns about their lives and about themselves. Counsellors using SIT will try to help the client alter their emotional responses and behaviour before the clients stress levels become too elevated. SIT is a three-stage treatment. The first stage of SIT is ‘ conceptualisation’. In this stage the counsellor assists their clients in identifying what stresses them, how they respond and what the outcome of their response is. The second stage of SIT is ‘ skill acquisition and rehearsal’. In this stage the counsellor assists their client in developing and practising positive coping statements that they can use in stressful situations. Clients also learn techniques such as relaxation and how to develop a realistic appraisal of situations. In the third stage called ‘ application and follow-thorough’ the client applies the skills learned to more difficult situations whilst receiving support from the counsellor when needed (Mills, 2008).

Rational emotive behavioural therapy (REBT) is another form of CBT used in treating PTSD. REBT is a comprehensive form of psychotherapy developed by Albert Ellis in the 1950s. This therapy helps clients alter irrational beliefs and is based on the premise that when we become upset, it is not the events taking place in our lives that upset us, but the beliefs that we hold that leave us to become depressed, angry, or enraged and this therapy focuses on solving behavioural and emotional issues in clients and helping clients enable themselves to lead fulfilling and positive lives. Ellis advocated that his

clients were blaming external events for their emotional issues, stating that the way they interpreted these occurrences was the catalyst in their emotional distress.

“ To explain this process, Ellis developed what he referred to as the ABC Model:

1. Activating Event: Something happens in the environment around you.
2. Beliefs: You hold a belief about the event or situation.
3. Consequence: You have an emotional response to your belief.”

Like other forms of therapy, REBT does not have a single approach to treating clients. When applying REBT to treating PTSD the counsellor will assist the client behaviourally, emotionally, and cognitively to help them learn to control their hyperarousal and anxiety. Once their client has adapted techniques needed to control their stress reactions, they will work with the counsellor to develop more functional responses to combat the re-experiencing of the trauma and their avoidance.

Exposure therapy is additional form of CBT that is commonly used by counsellors to treat anxiety disorders such as generalised anxiety disorder and phobias. This theoretically based technique exposes the patient to the feared context without danger in order to assist them in facing and gaining control of the distress that this experience makes them feel. When counsellors use this technique they must be careful not to re-traumatise their client.

“ Exposing someone to their fears or prior traumas without the client first learning the accompanying coping techniques — such as relaxation or

imagery exercises — can result in a person simply being re-traumatized by the event or fear.” (Grohl, 2013)

A longer and more intense form of Exposure therapy that is commonly used is Prolonged Exposure therapy (PE). This form is evidenced based for treating PTSD demonstrated in this case study conducted by Eftekhari.

“ This evaluation included 1931 veterans treated by 804 clinicians participating in the Department of Veterans Affairs (VA) PE Training Program. After completing a 4-day experiential PE training workshop, clinicians implemented PE (while receiving consultation) with a minimum of 2 veteran patients who had a primary diagnosis of PTSD.

MAIN OUTCOMES AND MEASURES:

Changes in PTSD and depression symptoms were assessed with the PTSD Checklist and the Beck Depression Inventory II, measured at baseline and at the final treatment session. Multiple and single imputation were used to estimate the posttest scores of patients who left treatment before completing 8 sessions. Demographic predictors of treatment dropout were also examined.

RESULTS:

Intent-to-treat analyses indicate that PE is effective in reducing symptoms of both PTSD (pre-post d = 0. 87) and depression (pre-post d = 0. 66), with effect sizes comparable to those reported in previous efficacy trials. The proportion of patients screening positive for PTSD on the PTSD Checklist decreased from 87. 6% to 46. 2%.”

In PE clients are repeatedly engaged in activities or actions that they no longer partake in due to the experience that caused their PTSD. Over time this will reduce the distressful feelings of fear and anxiety and clients will learn and accept that what they avoid in life is not dangerously and they will also learn to cope when distressed. Sometimes counsellors will use a technique in PE called imaginal exposure.

“ Imaginal exposure involves repeatedly revisiting the traumatic experience in memory describing the event aloud in detail. The narrative is recorded and the client listens to the recording between sessions to maximize therapeutic value. Revisiting the event in this way promotes processing of the trauma memory by activating the thoughts and emotions associated with the trauma in a safe context. Imaginal exposure also helps the client realize he or she can cope with the distress associated with the memory.”

PE is applied to treating PTSD in three, sometimes four main steps.

The first step in PE as in many forms of therapy is education, where the client learns about the treatment they’re going to receive. In this case they would learn about the therapy and possible more about PTSD in itself, such as about trauma reactions, and the symptoms. This helps the client understand the purpose and objective of this treatment.

The next step is breathing. In this step clients learn several breathing skills such as breathing retraining, which helps them, learn to relax. This is a necessary step in many forms of treatment for PTSD as when people become panicked or anxious their breathing is often altered. Thus learning how they

can control their breathing provides them with ways to help manage abrupt distress.

Real world practice (Also known as vivo exposure) is the next and sometimes final step in Exposure therapy. For PTSD treatment the client will approach locations or situations they do not present a rational threat, yet they have been avoiding due to its relation to their traumatic experience. For example, a man who has developed PTSD after being involved in a collision and is avoiding being near motor vehicles and driving. During treatment he would gradually go through steps of entering a car, remaining in the car, switching on the engine and maybe driving very small distances, building up his confidence at his own pace. This exposure will help the clients trauma related distress gradually lessen over a period of time and allows them to therefore gain more control over their life.

Talking through the trauma is a step not always necessary in PE but is sometimes used when clients have mostly recovered from their PTSD to a point where they can function in their normal life yet still display minor symptoms of re-experiencing the trauma such as flashbacks or nightmares. During this step in PTSD treatment the counsellor uses imaginal exposure and talk with the clients about how they can gain more control over their thought patterns and emotions. During this step the clients learn that do not need to fear their memories. This is often very challenging for clients as it involves thinking about these stressful memories deliberately. However over time they tend to feel better as they learn to make sense of what happened and will possess few negative feelings about the experience.

Out of the three forms of CBT mentioned PE is considered the most effective in the treatment of PTSD. However, the forms mentioned and other forms of CBT and therapy should still be considered all depending on the client and severity of their PTSD.

“ Exposure therapy, SIT, and cognitive therapy are the most widely accepted CBT treatments of PTSD and controlled research studies and case reports provide strong empirical evidence for the efficacy of these techniques. While clinical studies also demonstrate the efficacy of EMDR, the unconventional aspects of the treatment still raise questions about the technique. The technique was devised by Dr F. Shapiro and the protocols and discussion of the treatment are recorded in Shapiro (1999, 2001, 2002).” (Perelman School of Medicine, 2014)

PE is one of the most popular choices of therapy for many counsellors in treating PTSD and other mental health issues such as phobias. However, Cognitive-Processing-Therapy (CPT) is a form of CBT that was developed in 1992 in an attempt to create a create a form of therapy specific to treating PTSD in it’s entirety, although focus from it’s development and case studies were mainly centred on treating PTSD in female victims of sexual assault. CPT is evidence based with several case studies conducted by Resick and Schnicke demonstrated how PTSD can be treated using CPT.

“ In addition to a series of case study reports that indicated the therapy to be promising, Resick and Schnicke (1992) reported on CPT presented in a group-therapy format as compared with a naturally occurring wait-list

condition. This 12-session therapy appeared to be effective for both PTSD and depressive symptoms in a first report in which 19 women treated with CPT were compared with 20 wait-list women. At 3- and 6-month follow-ups, none of the treated women met the criteria for PTSD" (Resick & Schnicke, 1992).

CPT isn't only used for treatment of PTSD developed from sexual assault however. This form of therapy can be applied to treating PTSD from alternative circumstances that have left the sufferer with a distorted view on the world, distorted and negative view on their life and PTSD suffers who feel unable to make sense of their trauma and are having trouble focusing on other aspects of their life. CPT helps the client handle their distressing thoughts and gain a better understanding of their trauma, learn why they are unable to recover fully and learn how their view on the world has changed due to their traumatic event. PCT happens in four main steps.

The first step is Learning About the Therapy and PTSD symptoms. The therapy begins with the client learning how PTSD is affecting them and what symptoms they have (Some clients symptoms only include flashbacks and nightmares, whilst others suffer purely from hyperarousal) and how the therapy will help them. During this step the client is able to ask all their questions and decide if they will continue with CPT. The counsellor will tell them about other forms of therapy such as forms of CBT if the client expresses doubt.

The next step is Becoming Aware of Thoughts and Feelings. Here CPT will focus on assisting the client in developing a greater awareness of their thoughts and feelings, as it is human nature to revaluate negative experiences and make sense of why they occurred. During this step clients learn how to pay attention to their thoughts about the traumatic experience and how it made them feel. Next they are asked to step back and process how their trauma is affecting them now. This allows them to reflect on how they feel about their trauma in a different way than they were able to before. This step can be carried out either by talking with the counsellor directly or writing how they feel on paper.

The next step is Learning Skills. This step is done with the assistance of worksheets. After the first three steps have been successful and the client has developed a greater awareness of their thoughts and feelings then they are taught skills that they can use to question their thoughts. This step allows the client to choose how they want to feel about the event that caused them to develop PTSD.

The last step is Understanding Changes in Beliefs. The simple nature of PTSD is that sufferers have difficulty understanding how they are suppose to live in the world after trauma, with many suffers developing depression as well as their PTSD symptoms. This step aims at treating the depression found in many PTSD sufferers as well as PTSD. In this step clients learn more about common changes in beliefs about oneself and the world that can happen after experiencing traumatic events. Their ideas on humanistic qualities trust, self-esteem, other people, safety, control and more are all eligible to

be greatly altered after a traumatic experience and CPT allows them to talk about each of these beliefs and develop a better balance between the beliefs they had on humanistic qualities before they developed PTSD and now.

CPT was developed with the intention of being used specifically as a therapy that could be applied to treating female victims of sexual assault, a very common cause of PTSD. However its effectiveness has lead to it being tried in testing PTSD derived from other causes such as from military experience. These trials produced very high success rates and many countries such as the UK and US have taught CPT treatment to counsellors that specify in treating war veterans who suffer from PTSD and depression.

All forms of CBT have their place in the treatment of PTSD, mainly dependant on the client, what symptoms they have, the cause of their PTSD and how badly it affects them. Clients suffering purely from hyperarousal could benefit very well from SIT, as it targets their symptoms directly and therefore they will recover faster, making this therapy the most efficient. Clients who suffer only from mild avoidance symptoms could benefit well from REBT for likewise reasons. However most PTSD suffers will exhibit a combination of symptoms and symptom types making either Prolonged Exposure therapy or CPT the best option. However, both forms of therapy have strengths and weaknesses. When using PE there is a greater risk of re-traumatising the client due to this therapy directly exposing them to what triggers their PTSD or what they’re avoiding. However this therapeutic form can be applied to clients who display all symptom types of PTSD on all levels from most traumatic experiences. CPT was specifically designed for the treatment of

PTSD and is very successful in the treatment of sexual assault victims and veterans with the disorder, as demonstrated in the case studies conducted by Resick & Schnicke and has a much lesser risk of re-truamatising the client, making it the perfect option for cases where PE would be inapplicable. However CPT is more limited in the treatment it can provide and is not as practical as PE, with the client learning more about skills they can utilise to manage their PTSD as opposed to the direct confrontation experienced in PE.

The success in treatment for those who experienced sexual assault or military violence could possibly result from these victim types suffering PTSD from more personal events, as being directly attacked by another person with intention to kill or harm will affect people to a much deeper level due to the personal nature of it and will distort their perception of the world to a greater extent than PTSD caused by accidents or natural disaster. PTSD caused by sexual assault is considered by some to be a form of PTSD in its own. (PTSD, 2007).

Since CPT works with the client in a more personal way than exposure therapy, counsellors should consider using CPT over other forms of CBT when counselling suffers with severe symptoms that developed the disorder from experiences such as assault or war. Nevertheless, in order to treat each client as an individual, their symptoms, traumatic event, and emotional stability must be taken into account when deciding treatment, in order to treat their PTSD as efficiently and effectively as possible and clients should have all appropriate options made known to them and have a role in

deciding what treatment they receive as they will possess the best knowledge on how their disorder is affecting them.

The best treatment for this disorder could be investigated using several different methods of research. These methods include interviews with patients and case studies. During an interview, patients who have received CBT could be questioned on how they feel the therapy benefited them. This method allows the patient to directly state how they are feeling post-treatment allowing an accurate perception of the method of CBTs efficiency. Benefits of using the interview method include it being a straightforward process with minimal time and labour required and can therefore be asked of many other patients who have had the same therapy, producing scientific and reliable results. However this method also relies on information provided by patients who may not know exactly how the therapeutic process works. The only element of this method that could be considered unethical would be that for many who have or have had PTSD find the disorder discomforting to talk about.

Using the case study method, a patient suffering from PTSD could be investigated prior to and after treatment to observe how the therapy affected their disorder. This method allows experts to directly observe the patients before and after treatment and use their expertise to analyse how well the therapy works. However this method of research requires more resources than the interview method and takes longer and is a more difficult process to repeat, therefore not producing as large a variety of results. To be ethically considerate using this approach the researchers would have to

ensure their investigation does not affect the patients therapy, that they receive the patients consent prior to research and that the patient is not named if they do not want to be.

If I were to do this Independent Research Project again then I would carry it our very similar to how I have here with a few minor changes. For one I would try to make the explanations on the forms of CBT briefer and more relevant to PTSD so I could therefore include more forms of CBT and more relevant information. Additionally I could also mention and talk about other forms of therapy that can be used to treat PTSD and possibly compare them to CBT. An example of this include the Psychodynamic approach which can aid those who developed PTSD from repressed childhood memories. However I am contented with my IRP and my final submission.