

Post traumatic stress disorder psychology essay



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1. Introduction

This essay will look at Post-traumatic stress disorder; Specific reference will be made to the Diagnosis, Epidemiology, Treatment, Stress- Diathesis Model and PTSD on other disorders.

According to Grohol (2010) he stated that Post-traumatic- Stress disorder also known as PTSD forms part of anxiety disorder, being a weakening condition follows a horrifying, and traumatic event. The point after the event usually leads a person to recall the horrifying event of memory and can start becoming emotionally frozen with those they were once close too. A traumatic experience can be anything from mugging, attacks, witnessing an event that can be scarring, rape, natural disasters etc... different people experience different events more traumatizing then others therefore it is hard to pin point exactly what specific event are traumatizing, as some children may experience a divorce as a traumatic event.

2. Diagnosis

According to the National institution for mental health (NIMH) (2009) they looked at the signs and symptoms of PTSD and stated that it should always be a good starting point when looking at the possibility of someone having PTSD. NIMH (2009) stated that there are three specific seen as the main symptoms: ' Re-experiencing symptoms', ' Avoidance symptoms' and ' hyper arousal symptoms'. The Re-experiencing symptoms are stuff such as scary thought, nightmares and recurrences. Carlson and Ruzek (2010) stated that some of the symptoms could be getting upset, flashbacks of the ordeal, Bad dreams, Getting upset when reminded, Anxiety or fear build up, Anger or

aggressive, problem controlling emotions, issues thinking clearly . She went on saying that physical responses also noticed such has, unable to fall asleep, become shaky or sweaty, heavy breathing, always being on the lookout, not eating and heavy heart rate. Avoidance symptoms are depression, demotivated, emotionless, disconnected etc... and lastly hyper arousal is tension and troubles sleeping. Re-experiencing the event can cause issues in one's everyday life, avoidance can cause personal drifting from family and friends and hyper arousal makes a person become disinterested therefore their occupation starts paying the prices. Can (2006) looked at different aspects of avoidance in PTSD: Avoiding conversations, Trouble recalling parts of ordeal, Emotionless, Becomes affectionless, Find reality unreal, Feeling constantly weird, Feeling physically numb, Not feeling pain or other sensations and Losing interest in actives they once enjoyed. Simple material like this can provide a therapist with a clear base of diagnosis, therefore then looking further into the disorder by looking at the DSM-IV-TR.

The national center for PTSD (2007) stated that the American Psychiatric Association in 2000 reviewed the PTSD diagnostic criteria in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) and made some brush ups. According to the DSM-IV-TR there are six criteria that a practitioner needs to focuses on when diagnosing someone with PTSD. According to the DSM-IV (2000):

Criteria A: stressor

The individual experienced traumatic events in which both are present: 1) Experienced, witnessed, or confronted with an event or events that involve threatened death or serious injury. 2) The person's reaction occupied complex fear, helplessness, or horror. In children: expressed by disorganized behavior.

Criterion B: intrusive recollection

The disturbing incident is insistently being re-experienced in at least one (or more) of the following ways: 1) Persistent and unpleasant recollections of the event, including images, thoughts, or perceptions. In children: recurring play themes connecting to event. 2) Recurrent dreams of the event. In children: nightmare without conscious awareness of content. 3) Behaving or feeling that event will be repeated e. g., flashes, illusions, memories induced due to intoxication etc...in children: trauma-specific reenactment may occur. 4) Powerful psychological distress at exposure (internal or external cues) that signify or look like an aspect of the event. 5) physiological reactivity upon exposure to number 4.

Criterion C: avoidant/numbing

Constant abstention of stimuli linked with the trauma, Three (or more) of the following should be present: 1) Attempts to avoid recalling or speaking about the trauma. 2) They keep away from behaviors, residences, or individuals that can bring about the reappearing of the trauma. 3) Cannot remember a significant part about the event. 4) Reduced interest in certain activities. 5) Sense of disconnection or alienation from people. 6) Loss of affection 7) feels the future shall be a nightmare.

Criterion D: hyper-arousal

Constant stimulation that occurs that was not present before the trauma, at least two (or more) of the following should be noticed: 1) Trouble sleeping. 2) Irregular anger moods. 3) Lack of awareness. 4) Being constantly tense. 5) Overstressed frighten reaction.

Criterion E: duration

If symptoms in B, C, and D are longer than one month.

Criterion F: functional significance

If the event causes impairment in social, work and other significant function for a person.

Stipulate if:

Acute: if period of symptoms is less than three months.

Chronic: if length of symptoms is three months or longer.

Therefore for a person to be diagnosed they need to have the symptoms above present for at least a month or longer after the traumatic incident has occurred. The reason for these specific criteria is so that a mental disorder can be diagnosed correctly instead of their being a normal unhappy period so to say that causes general stress levels, which last for a week or so that could resemble PTSD but in actuality it is not.

Griez et al (2001) said that there are 6 specific varieties of PTSD that the diagnosis root can follow: 1) Borderline personality disorder, 2) Behavioral

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hyperactivity, 3) Dissociative disorders, 4) Somatoform, 5) Post-traumatic personality change or disorder and lastly the commonly know one 6) Post-traumatic stress disorder.

Can (2006) said that there are common secondary and associated posttraumatic symptoms. Secondary symptoms: are issues that develop because of the re-experiencing and avoidance symptoms of PTSD. For example, one is avoiding communication about event therefore cutting family off and becoming a loner instead. Associated symptoms: Do not come straight from being frozen with fear; they happen because of other things that were going on at the time of the trauma. For example, a person who is mentally traumatized in a car accident might have physically gotten hurt and cannot do the things they use to therefore becoming or developing depression. Can (2006) listed some of the secondary or associated trauma symptoms: Depression, Aggression, Despair, hopelessness, shame, guilt, self-blame, interpersonal issues, detachment, loss of interest, identity issues, lower self-esteem, eating irregularity, alcohol and drug abuse etc...

3. Epidemiology

According to Barlow and Durand (2009) briefly stated that epidemiology is a researching process examining the disturbance, prevalence (number of people exhibiting the specific disorder) and disadvantages of having a specific disorder in the population.

Gradus (2011) went on looking at the prevalence in connection with PTSD. To further expand on what prevalence is, it is the study of a percentage of people in a population that have a specific disorder at a specific period,

therefore indicating the current cause of the disorder. This looks at a person age, gender, how long the disorder shall last, when the disorder will change etc... Looking at prevalence in PTSD Gradus (2011) said that no exact studies looked evaluated the prevalence among children; instead, it looked at the children that have a low threshold for developing the disorder. Schnurr, Friedman and Bernardy (2002) went on giving statistical prevalence's for the different genders. They said that males are 10 percent more likely than females to experience a traumatic event, for every 20 percent of females that are more likely to develop post-traumatic stress disorder only 8 percent of males are likely to develop it. They continued saying that females are four times more liable in developing PTSD than males, also when it comes to races those that are non-white according to Schnurr et al (2002) are at higher risk of obtaining PTSD as oppose to white. Lastly they mentioned that younger and little educated people also get PTSD quicker because they did not have the correct social support needed after experiencing a dramatic event.

Griez et al. (2001) said that Epidemiology of PTSD can also be describes by three specific aspects, one being the Demographics and Risk Factors, secondly the Comorbidity and lastly Natural Course of PTSD:

The demographic and risk factors they stated as showing how widows and ladies that have gotten divorced show a high variability to getting PTSD. They are few characteristics that effect PTSD and can be the cause due to demographic and the easier risk factor, stressor and exposure (re-experiencing the event), Gender (Females usually more weaker to PTSD), Age (Younger are at more risk), Developmental (if experienced in childhood

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usually becomes chronic), psychiatric history (other disorders such as depression) , family characteristics (whether it runs in the family) and cultural factors (Specific culture group and religion and their view on PTSD can cause the internal and external expression). What Griez et al. (2001) picked up about Comorbidity is that 88.3 percent of males and 79 percent of females who have a present disorder and then exposed to a traumatic event can evidently develop lifetime PTSD. Lastly what Griez (2001) and his fellow colleagues mention was Natural course; they briefly mentioned that more than one-third of individuals with a pilot incident of PTSD neglected to improve even after many years, hence becoming chronic. Griez et al (2001) went on explaining that a study was done to back up the statement that the increase of PTSD is starting to become lifelong. An analysis of 61 Vietnam combat veterans with PTSD disclosed that onset of symptoms typically occurred at the time of acquaintance to combat trauma in Vietnam and enhanced rapidly during the first few years after the war, Symptoms increased therefore becoming chronic.

4. Treatment

Bennett (2003) closely looked at various treatment options for those suffering from PTSD. He stated that one way to prevent PTSD is by ' psychological debriefing'. A psychological debriefing a typical therapeutic session, which is one-on-one with the client, this is best straight after the traumatic experience has occurred. By going for therapy straight after an event, it better helps the client cope with their build up emotions and therefore express and manage it in a suitable way that shall not cause future impairment or emotional numbness. According to Griez, Faravelli, Nutt and

Zohar (2001) they showed that a study was conducted on victims of confirmed child abuse and neglect were evaluated and matched with a group of paralleled non-abused and non-neglected children and followed into adulthood. Victims of child abuse (sexual and physical) and neglect were found to be at a more critical threat of developing PTSD. This concluded how important therapy can be after a traumatic incident.

Bennett (2003) went on looking at three alternative treatment options, namely 'exposure technique', 'Eye movement desensitization and reprocessing (EMDR)' and 'Pharmacological interventions'. Exposure techniques are re-exposing an individual to that memory of the event and all the emotions and feeling connected to that event. This should be done in a control and safe environment for the client and CBT (cognitive- behavioral therapy) can be useful and relaxation techniques such as meditation or deep breathing. Shapiro discovered EMDR in 1990 by accident, Shapiro (1995) stated that one occasion when she was having a stroll in the woods her troubling thought began slowly vanishing, and when she had extracted the memories, again it was not as distressing as pervious occasions. She concluded that this happened because of her spontaneous eye movement that was moving rapidly back and forward and the up diagonally. Bennett (2003) went on explaining the EMDR treatment which is having an individual recall the central trauma with a negative though in mind, then the client should find strengthening emotions to comeback the negative emotion. While this occurs the counsellor tell them to trace his/her finger moving back and forth, each minute the finger speed increases, usually occurs in 24 movements then the client need to stop and let go. The process is repeated

until progress is seen of a weakening of the stress level toward the specific event. The last treatment option Bennett (2003) looked at was Pharmacological interventions, which in short is prescribing various types of medication to the client; the most popular form of drug that is given is antidepressant.

Smith and Segal (2011) added two other types of treatment roots that one could follow namely ' Trauma-focused cognitive-behavioral therapy' and ' Family therapy'. ' Trauma-focused cognitive-behavioral therapy' is CBT (Cognitive-behavioral therapy) for patients with PTSD and trauma includes wisely and slowly " exposing" oneself to mental, emotional, and conditions that recap the trauma. This is effective because it helps tame the irrational thinking and bring back that rational thought and showing the person there is in fact life after this event to look forward to. ' Family therapy', Smith and Segal (2011) said that seeing as PTSD effects not only the person experiencing it but also has an impact on the persons immediate family/surrounding this therapist journey should be considered. This aids family in gaining knowledge into the persons feeling and let them walk in those with PTSD shoes, there is also room for providing better interpersonal communication between the members of the family, forming a stronger support system for the client who has been exposed to that life changing event.

Smith and Segal (2011) said that it's important for a person with PTSD to implement self-help regulations in their life such as, avoiding alcohol, seeking out help, educated oneself about disorder and look at the

advantages and disadvantages and aiming at converting those disadvantages to help benefit oneself.

The Therapeutic databases involve relaxation, useful in the case of high levels of emotional arousal, avoided Situations or imaginings related to the trauma, and cognitive therapy. As stipulated by Griez et al (2001) six approaches have been intended: 1. Systematic desensitization - showing the dreaded agitations under relaxed environment. 2. Exposure in imagination- adjusting the patient to the repelled stimulus, by decreasing irregular reactivity and avoidance. 3. Stress management enforcing ways to help maintain anxiety levels and keep relaxed. 4. Cognitive therapy- similar to stress management and helping them deal internally. 5. Eye Movement Desensitization and Reprocessing (EMDR)- which was discussed above. 6. Debriefing- Also discussed above about seeking out therapy in the early stages of when the event was experienced.

When it comes to treating children, the task becomes a little different, van As and Naidoo (2006) said that when a child has become traumatized its important for not just the child to seek out counselling but also the primary care-giver mainly because it helps the care-give implement specific steps to help the child cope. The care-giver should enforce a safe environment, be supportive and gain better knowledge about how the child is feeling and how to react to that. The child on the other hand should be able to recall the story in a safe environment apart from their house, ensuring the child that they are not the cause of whatever has happened to them, as children love blaming themselves and just having a supportive figure through this rough

time. They went on saying that the best root of treatment is in fact therapy, whether it is long term or short term.

According to NIMH (2009) there are three main medication roots: 1.

Benzodiazepines: for relaxing and sleep, negative: memory issues or become addicted medication. 2. Antipsychotics. For Control reaction, Negative: weight gain higher risk of getting heart disease and diabetes. 3.

Antidepressants: Feel less tense or upset. Can (2006) said that there three basic line of medication, first line, second line and third line, she jotted down a list of medication that falls under each line for example: First-line Fluoxetine, paroxetine, sertraline etc... Second-line Fluvoxamine, mirtazapine, risperidone, olanzapine etc... Third-line Amitriptyline, imipramine, escitalopram Adjunctive: carbamazepine, gabapentin, valproate, clonidine, etc...

Cole (n. d.) concurred that using CBT and EMBR is one of the effective roots of treating PTSD; he specifically looked at three people in his center called The York stress and trauma center (YSTC) that personally underwent therapy in those two areas and have concluded that it was a great success. He looked at the cases of Emma, Steve and Trevor. Emma was a married mother of two, at 49 years of age she had a full time position that expected her to drive a lot. June last year she was in a terrible car accident, she managed to make it out safely. Since this event has occurred she has been utterly afraid of driving or being driven. She began having nightmares and became anxious when she had to be in a car, after 6 months has passed she finally sought out therapy. Steve on the other hand was a Royal Marine sergeant, while serving out his duty; he was blown up by a mortar. 20 years had passed yet

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he still experienced minor post trauma symptoms. He developed severe PTSD when yet again he was blown up by a mortar in one of his training program. Lastly, Trevor as a child was sexually abused by a family relative, he was able to marry but his childhood trauma returned when they decided they wanted to start a family. What concerned him most was that the childhood event would destroy his relationship with his family or cripple him in starting a loving one. Cole and the York stress and trauma center (YSTC) Implemented CBT and EMDR into the therapeutic process and they saw results, within 6 sessions they where able to help Emma get rid of her fear of driving, Steve and Trevor took little more time to help overcome their trauma but in the end they did. Steve began duty again and Trevor started a family without the fear of his childhood experience.

5. PTSD on other disorders and Diathesis- Stress Model

Friedman and Schustack (2009) explained that the Diathesis- Stress model is a predisposition, usually seen as heredity, of the body to a specific disease or disorder. They went on saying that this bring in the debate of the Nurture/ nature, they are not too sure whether the predisposition comes from a persons inheritance or their up bring. Barlow and Durand (2009) added to the explanation of the model saying that people inherit tendencies to express specific traits or behaviors under particular stressful conditions.

Schnurr et al. (2002) said that researcher and therapist quarreled that the DSM-IV criteria does not fully portray sufficiently the symptoms that people with that traumatic background experience. They said that there are mutual ones such as ' Complex PTSD' or ' Disorder of extreme stress' (DES) that could also be part of PTSD.

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Vals (2005) said that when it comes to PTSD there could be many other disorders that have similar appearance such as acute stress disorder, Adjustment Disorder, Depersonalization Disorder, Dissociative Identity Disorder (DID), Panic Disorder and Generalized Anxiety Disorder (GAD).

Acute stress disorder: is an anxiety disorder that matures within one month after a harsh traumatic event. Adjustment Disorder: is an abnormal reaction to a life stressor e. g. Divorce. Depersonalization Disorder: is where a person scrutinizes his or her own physical actions or cognitive processes.

Dissociative Identity Disorder (DID): is serious and chronic and may lead to disability and incapacity, seen to have a high suicide rate. Panic Disorder: makes the person trust that they are either seriously ill or going to die. This can become serious they can develop Agoraphobia (fear and avoidance of situations). Generalized Anxiety Disorder (GAD): constant worry and anxiety about your well-being, employment, wealth or personal life, last usually atleast six months. Yager (2007) when on concurring Vals statement and agreed that people with PTSD are vulnerable in getting more disorder on top of that. Meaning that it suggest that the great majority of individuals with PTSD intersect criteria for at least one other psychiatric disorder.

Wenar and Kerig (2000) looked at the comorbidity of PTSD and said that usually four different aspects have common conditions of PTSD; the common four are drugs, alcohol, panic and depression. Drug, alcohol and PTSD are similar in the sense of the symptoms, those who are abusing alcohol and drugs can been seen to have a behavior change, starts leading to severe health problems, become withdraw, have work and family problems and start loosing their interpersonal skill, all similar trait of PTSD. When it comes

to depression and PTSD they are similar mainly because a person with depression sees their selves as hopeless, they loose interest and focus, they become emotionless and usually suffer with insomnia. Panic and PTSD are similar in the sense that Panic disorder the individually usually finds it hard to catch their breath, they become shaken and sweaty and irritable easily and start avoiding places in an attempt to avoid a panic attack.

Griez (2001) jotted down percentages of areas that can effect PTSD and the percentages are as followed: " Affective disorders (almost 50% of cases for major depression, 20% for dysthymia), other Anxiety disorders (16% GAD, 9% panic disorder, 30% specific phobia, 28% social phobia, 19% agoraphobia, Substance use disorders (52% alcohol and 34% drugs in men, 28% alcohol and 27% drugs in women) and Conduct disorder (43% in men and 15% in women) and Somatisation (the exact percentage unknown)(Griez et al., 2001, p. 18)."

6. Conclusion

PTSD is becoming a big disorder in the 21st century due to the increase of crime, natural disasters, bombing etc... The currency is increasing each day and people do not have the money to seek out immediate therapy after a traumatic event has occurred and what has been discussed on the top is that instant therapy shall help intervention for the persons to not develop PTSD. With that said self-help is also important and avoiding alcohol and drug abuse can also prevent this disorder from developing, having a good support system enforced and always remembering that life doesn't end after something traumatic, it just makes one wiser in life.

This essay has looked at Post-traumatic stress disorder; Specific reference was made to the Diagnosis, Epidemiology, Treatment, Stress- Diathesis Model and PTSD on other disorders.