Post-traumatic stress disorder essay sample

Abstract

Post-Traumatic stress disorder (PTSD) affects many different people in different ways. Along with post-traumatic stress disorder often comes a co-morbid aspect that patients see as coping mechanisms for the post-traumatic stress disorder that they know little about. Post-traumatic stress and alcohol/substance abuse addiction often find themselves closely related due to the vast amount of individuals who use alcohol or other substances to treat the symptoms of PTSD. When a patient takes on substance abuse, they no longer have one disorder to deal with, they have two. Patients and counselors alike have many different methods for trying to help those who have dual disorders. Each case is different and no case can be compared to any other. Post-traumatic stress disorder has a unique effect on every individual who has to endure it.

PTSD – An Introduction

” Post-traumatic Stress Disorder (PTSD) was first recognized by the American Psychiatric Association as a diagnosable condition in 1980” (Souza & Spates, 2008). The National Institute of Mental Health states that “ PTSD develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers” (National Institute of Mental Health, 2014). One common misconception that society has is that PTSD only affects those who have been in war. Though war veterans make up a big part of the individuals who have suffered from post-traumatic stress disorder, there are others who are affected as well.

The National Institute of Mental Health explains that PTSD " can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes" (National Institute of Mental Health, 2014). Post-traumatic stress disorder (PTSD) is a disorder is one of the longest lasting anxiety disorders. Along with that, PTSD affects many different people who could all be triggered by different events. Seedat (2013) states that " post-traumatic stress disorder (PTSD) is among the most prevalent anxiety disorders, both in terms of lifetime and 12-month prevalence rates documented in epidemiological studies worldwide". Seedat also states that " The National Comorbidity Survey Replication (NCS-R) study conducted in the USA, for example, found the lifetime prevalence of PTSD to be 6. 8% while the 12-month prevalence was 3. 5%" (Seedat, 2013).

This means that those who suffer from PTSD are almost twice as likely to have symptoms and signs throughout their lifetime as they are to have symptoms and signs for 12-months. Some countries such as South Africa have reported that their lifetime rate of PTSD is 2. 3%, but with that being said, they have also reported that " PTSD was among the anxiety disorders with the highest proportion of severe cases (36% of all individuals with PTSD were severely ill)" (Seedat, 2013). It has also been stated that " the subjective emotional experience of an individual in the aftermath of the trauma just also be taken into account (APA, 2000). There are three essential " clusters" of symptoms. Souza and Spates state that " the three clusters of

symptoms that classify PTSD are re-experiencing, avoidance and numbing, and hyperarousal.

Each of these symptom clusters is distinct and affects different areas of psychological functioning" (Souza & Spates, 2008). The first cluster of symptoms is re-experiencing. It " refers to the persistent emergence of thoughts and feelings associated with the traumatic event" (Souza & Spates, 2008). The second cluster is known as avoidance and numbing. In this cluster " both the persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness that was not characteristic of the individual prior to the trauma (American Psychiatric Association, 2000)" (Souza & Spates, 2008). The last cluster is hyperarousal. " This category refers to persistent symptoms of increased physiological arousal that were not present prior to exposure of the traumatic event" (Souza & Spates, 2008).

Seedat explains that " the disorder represents a pathological response to a traumatic event, characterized by symptoms of recurrent and intrusive distressing recollections of the event (e. g. nightmares, a sense of reliving the experience with illusions, hallucinations, or dissociative flashback episodes, intense psychological or physiological distress at exposure to cues that resemble the traumatic event)" (Seedat, 2013). Seedat also states that other symptoms could be such things as avoidance of stimuli associated with the trauma that you have experienced "(e. g. inability to recall important aspects of the trauma, loss of interest, estrangement from others)" (Seedat, 2013). Seedat mentions increased arousal as other PTSD symptom. This

could include “(sleep disturbances, irritability, difficult concentrating, hypervigilance, and exaggerated startle response)” (Seedat, 2013).

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) includes other symptoms that are characterized by cognition and mood of the individual. Seedat states that in order for an individual to be diagnosed with PTSD, symptoms must be present for more than 1 month” (Seedat, 2013). Though Seedat states that PTSD is an anxiety disorder, the DSM-V disagrees. The DSM-V classifies PTSD as a trauma- and stressor-related disorder rather than an anxiety disorder (American Psychiatric Association, 2014).

Some of the other risk factors that could increase an individual’s likelihood of PTSD would be “ severity of the traumatic exposure, history of past trauma or previous psychiatric disorder, female gender, experience of further stressful events, and lack of social support” (Seedat, 2013). Anthony Steele, writer and researcher for The Veteran Advisor states that “ included in the diagnoses of PTSD, the traumatic event must be unrelenting in at least one of the following (list not inclusive):

Nightmares of the event

Flashbacks

Repeated and hurtful recollections of the event

Fear when exposed to occurrences or situations similar to the traumatic event PTSD also involves constant problems with at least one of the following (not present before the traumatic event; list not inclusive):

Becoming angry for no apparent reason

Inability to think straight or keep your thoughts in order

Overreaction to sudden noises

Difficulty falling or staying asleep

Hypervigilance

PTSD can also involve avoiding things associated with the trauma as indicated by the following:

No interest in participating in social events

Few friends and a hard time getting close to immediate family

Feeling of no hope for the future

Avoiding activities, people, or places that will arouse recollections of the trauma

Making a conscious effort not to talk or think about the trauma

Not getting close to anyone or allowing anyone to get close to you" (Steele, 2010).

Along with the many different beliefs about the classification of PTSD come the many different ideas about where PTSD originates and who is more susceptible to the disorder. The National Institute of Mental Health states that PTSD symptoms such as fear memories may be created through an individual's genealogy (National Mental Health Institute, 2014). Research shows that there is a protein, Stathmin which is needed for individuals to make fear memories (National Mental Health Institute, 2014). The NMHI reports a study done on mice. They state that " mice that did not make stathmin were less likely than normal mice to ' freeze,' a natural, protective response to danger, after being exposed to a fearful experience.

They also showed less innate fear by exploring open spaces more willingly than normal mice" (National Mental Health Institute, 2014). With that being said, the signaling chemical gastrin-releasing peptide (GRP) is released by the brain during emotional events. " In mice, GRP seems to help control the fear response, and lack of GRP may lead to the creation of greater and more lasting memories of fear" (National Mental Health Institute, 2014). Another gene-based observation states that the 5-HTTLPR gene that controls serotonin levels (the brain chemical that regulates the mood) and appears to fuel the fear response (National Mental Health Institute, 2014). Post-traumatic stress disorder may have to do with not only genes, but specific areas of the brain.

The National Institute of Mental Health states " the amygdala, known for its role in emotion, learning, and memory…appears to be active in fear acquisition, or learning to fear an event (such as touching a hot stove), as well as in the early stages of fear extinction, or learning not to fear" (National Mental Health Institute, 2014). Additionally, " storing extinction memories and dampening the original fear response appears to involve the prefrontal cortex (PFC) area of the brain, involved in tasks such as decision-making, problem solving, and judgment" (National Mental Health Institute, 2014). Just like every aspect of PTSD, every case is different. There is no set protocol for those who are suffering from PTSD.

Other factors that may have an effect on the occurrence and severity of PTSD. The National Institute of Mental Health also states that other factors can include but are not limited to " environmental factors, such as childhood trauma, head injury, or a history of mental illness" (National Institute of

Mental Health, 2014). Other factors can include “ personality and cognitive factors, such as optimism and the tendency to view challenges in a positive or negative way, as well as social factors, such as the availability and use of social support” (National Institute of Mental Health, 2014). Though there are many symptoms and “ causes” for PTSD, what individuals chose as coping mechanisms while suffering from the disorder can be equally as harmful as the disorder itself. Substance Abuse

Those who suffer from Post-traumatic stress disorder of times choose their own coping mechanisms instead of those that are suggested for them. The coping mechanisms that patients choose are short term solutions for long term problems. Often times patients will choose drugs or alcohol in an attempt to silence the noise inside of them. Patients who suffer from PTSD often times have difficulty sleeping and have many triggers which do not allow them to live normal day to day lives.

Souza and Spates’ research shows that there are very few times when individuals with PTSD are not also plagued by other disorders such as alcoholism. It is stated that “ while PTSD itself is estimated to occur in 8% of the population, the prevalence rates increase dramatically in persons suffering from other mental disorders (Riggs, Volpicelli, Kalmanson, & Foa, 2003).” (Souza & Spates, 2008). Similarly, “ the National Comorbidity Survey (1995) estimates that over 8% of men and 79% of women who meet the criteria for chronic PTSD also meet the criteria for one or more additional psychiatric diagnoses (Kessler, Sonnega, Hughes, & Nelson, 1995)” (Souza & Spates, 2008).

Souza and Spates both believe that it is important for the client to better understand what addiction is and the definitions of use and abuse. The DSM-IV-TR (2000), states that a dependency on alcohol can be defined as “ a maladaptive pattern of substance use leading to clinically significant impairment or distress”. If the use of a substance leads to issues such as impairment or distress, then that dependency can be classified as addiction. Abuse is a terms that means “ there is no physical dependence on the chemical(s) in question at this time” (Doweiko, 2012, p 14).

The standard definition of substance abuse is that it is “ a patterned use of a substance in which the user consumes the substance in amounts or with methods neither approved nor supervised by medical professionals”” (http://en. wikipedia. org/wiki/Substance_abuse). Commonly abused substances include but are not limited to depressants, opioids, hallucinogens, inhalants, steroids, and some over-the-counter medications (Souza & Spates, 2008). It is stated that “ when working with a PTSD-SA population, there are several forms of substances which are more likely to be abused when compared to substance users that do not meet criteria for PTSD” (Souza & Spates, 2008). Souza and Spates state that “ this can occur in two different forms. The first refers to the PTSD symptom clusters of intrusion, arousal, numbing, and avoidance.

Self-medication through substances in order to relieve symptoms of PTSD can lead to abuse and dependence for the substance class whose function is associated with this type of symptom” (Souza & Spates, 2008). It is also stated that “ classes of substances that serve to exacerbate the symptoms of PTSD can be negatively reinforced by substance-intoxication-induced or

withdrawal-induced intensification (Stewart et al., 1999)" (Souza & Spates, 2008). Though substance abuse is often times thought of as alcohol dependency, that statement is a common misconception. Souza and Spates state that " estimates indicate that the prevalence rates of PTSD and cocaine dependence are high. Studies suggest that approximately 45% of cocaine-dependent individuals will meet criteria of PTSD… at some point in their lifetime" (Souza & Spates, 2008).

" In general, cocaine and opiate users report higher rates of exposure to traumatic events when compared to abusers of other groups of substances" (Souza & Spates, 2008). It was also found that " PTSD-SA individuals experience an increased likelihood for exposure to high-risk, trauma inducing environmental conditions than the general population (Kellogg & Triffleman, 1998). Souza and Spates speak of the " Pandora's Bo hypothesis throughout their research. They state that " the Pandora's Box hypothesis states that any attempts to address trauma related material in the incipient stages of substance dependence treatment would severely interfere with treatment effectiveness.

Encouraging the individual to recall trauma material is believed to result in an influx of negative thoughts and emotions with which the individual is not equipped to cope at this stage of therapy" (Souza & Spates, 2008). Additionally, " proponents of this theory believe that the individual will be incapable of maintaining abstinence from substances and would either resume or intensify their drug behaviors (Hien, Cohen, Miele, Litt & Capstick, 2004).

Betsey Bates states that “ an estimated half of returning veterans and a third of civilians with PTSD have co-occurring substance abuse, and up to 42% of people in treatment for addictions have a current diagnosis of PTSD” (Bates, 2010). Bates’ research shows that there are many programs that do not treat PTSD and substance abuse simultaneously. This may be for many different reasons, one of the main reasons that they are treated separately is because of the fact that counselors and therapists may feel that it would be too overwhelming to treat both disorders at the same time.

Dr. Thomas Kosten, who is a professor of psychiatry at Baylor University, Houston, and is the research director of the VA Substance Use Disorders Quality Enhancement Research Initiative, stated that he had an epiphany that the PTSD treatment community came across when speaking about the treatment of PTSD suffers. It was stated that the new veterans with PTSD cannot be effectively treated with behavioral therapies like prolonged exposure unless their binge alcohol abuse is controlled” (Bates, 2010). Dr. Thomas Kosten states that if the client goes through an outpatient therapy process and has to return home their triggers and their inward trauma, all of the progress that has been made would have been for nothing seeing as they would probably use their weekends to revert back to the substances that have helped them cope so far.

A study done by Brown, Recupero, and Stout speaks about PTSD and substance abuse comorbidity and the ways in which these things should be treated. Their study showed that “ an evaluation of 98 male veterans admitted to an inpatient substance abuse program showed that 35% of the sample suffered from PTSD (Brief et al., 1992). Similarly, a study of 33

females receiving inpatient substance abuse treatment revealed that nearly 40% evidenced clinically significant PTSD symptomatology (Kovach, 1986)" (Brown et al., 1995). Brown et al. also state that their studies found that " our treatment utilization findings show that subjects with possible PTSD used inpatient substance abuse services more than their non-PTSD counterparts.

Given that high treatment rates may hallmark the presence of concomitant PTSD, substance abuse treatment providers should consider the possibility of a trauma history for any of their revolving-door patient." (Brown et al., 1995). Brown also states that " although it is beyond the scope of our study to isolate the specific mechanism(s) by which PTSD affects treatment rates, we may speculate that PTSD substance abusers relapse at higher rates and/or require more intensive treatment if their trauma is not specifically targeted" (Brown et al., 1995). The Connection and the Therapy

It is stated that " approximately 50% of individuals in inpatient substance abuse treatment centers will also meet criteria for comorbid PTSD (Brown et al., 1999)" (Souza & Spates, 2008). Souza and Spates state that " this combination of disorders has severe consequences for the individual in terms of course, symptom severity, and effectiveness of treatment" (Souza & Spates, 2008). The connection between the two disorders is clear, but like most disorders, there are differing opinions about the ways in which to treat. Some believe that the disorders should be treated separately while others believe that they should be treated in conjunction with one another.

The majority of researchers believe that the substance abuse should be treated prior to the treatment of the post-traumatic stress disorder. Doweiko

states that “ many people with substance use disorders do not perceive the need for rehabilitation” (Doweiko, 2012, p 379). One of the most difficult things for people with addiction to understand and come to terms with is the idea that they have an addiction. Doweiko also states that “ this is the first step – making individuals with an SUD face the reality of their addiction – that forms the core concept of intervention” (Doweiko, 2012, p 380).

Doweiko states that “ the outpatient substance abuse rehabilitation program might best be defined as (a) a formal treatment program involving one or more rehabilitation professionals, (b) designed to help the person with an SUD develop and maintain a recovery program, (c) which will utilize a variety of treatment approaches (psycho-educational, family and marital therapies, individual and group therapy formats), which is (d) designed to do so on an outpatient basis” (Doweiko, 2012, p 388). Doweiko states that in outpatient therapy, “ a formal treatment plan is established at the beginning of treatment, with review sessions and appropriate goals, being scheduled on a regular basis to monitor the client’s progress toward mentally agreed-upon goals” (Doweiko, 2012, p 389).

Doweiko also mentions that “ abstinence from alcohol and illicit drugs is not only expected but is a prerequisite for participation in outpatient treatment” (Doweiko, 2012, p 389). Souza and Spates research shows that it is possible to treat the two in conjunction successfully. It is stated that “ early students have shown that joint PTSD-SA treatment, regardless of treatment modality, is essential in achieving and maintaining abstinence from substances” (Souza & Spates, 2008). It is also stated that “ those individuals who receive PTSD treatment in addition to SA treatment in the first three months are 3. 7

times more likely to be free of substances at a 5-year follow-up than individuals who receive only SA treatment" (Souza & Spates, 2008). A Biblical Close-up

The Bible states " come to Me, all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from Me, for I am gentle and humble in heart, and you will find rest for your souls. For My yoke is easy and My burden is light" (Matthew 11: 28-30). Those coming home from war and those who have suffered from traumatic life events, the Bible can be a refuge when all hope is lost. Tick (2010) states that " PTSD has proven exceptionally resistant to successful treatment".

Tick also states that " while the conventional response to PTSD may be helpful, it does not take into account the massive frustration of veterans who have no achieved healing or homecoming and are asking their helpers and our nation for something more. Nor does it take into account the unique and complex moral, ethical, and religio-spiritual dimensions of warfare that are inevitably troubling to the survivors and need to be addressed if healing is to occur" (Tick, 2010).

Tick states that " biblical wisdom, traditional and spiritually based cultures and veterans' testimonies all affirm that PTSD is a holistic wound, affecting the survivor's body, mind, heart and spirit, causing despair and loss of meaning and impacting the entire community" (Tick, 2010). Tick continues " because of this holistic and comprehensive nature of the wound, we can best understand it as a wound to the soul, to our spiritual and moral essence, to the core of who and what we are and to our communities" (Tick, 2010).

Post-Traumatic Stress Disorder has seen many different options for therapy. Allen Clark explains that “ PTSD may be viewed as a faith deficit disorder. Fair is the antidote of fear. Hope is the antidote of depression” (Clark, 2009). The Bible states that “ now faith is being sure of what we hope for and certain of what we do not see” (Hebrews 11: 1). One of the most powerful and thought provoking verses from the Bible states “ Finally, be strong in the Lord and in his mighty power. Put on the full armor of God, so that you can take your stand against the devil’s schemes. For our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms.

Therefore put on the full armor of God, so that when the day of evil comes, you may be able to stand your ground, and after you have done everything, to stand. Stand firm then, with the belt of truth buckled around your waist, with the breastplate of righteousness in place, and with your feet fitted with the readiness that comes from the gospel of peace. In addition to all this, take up the shield of faith, with which you can extinguish all the flaming arrows of the evil one. Take the helmet of salvation and the sword of the Spirit, which is the word of God. And pray in the Spirit on all occasions with all kinds of prayers and requests. With this in mind, be alert and always keep on praying for all of the Lord’s people.” (Ephesians 6: 10-18).

PTSD is a difficult disorder to live through and may be equally as difficult to treat. If individuals stand firm in their beliefs of the Lord, they can accomplish anything. It is simply important to remember that the Lord is always with us. We will have difficult days, but He will never abandon us. He

is always there and we need to harness the power of prayer in order to move forward with our lives and away from the darkness.

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