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POST-TRAUMATIC STRESS DISORDER IS HIGHLY TREATABLE©

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In the past four decades, we have seen tremendous strides in the evidence-based treatment of Post-Traumatic Stress Disorder, also known as PTSD. In the next few pages, we will explain

- ✓the history behind this diagnosis
- ✓the kinds of events that lead to PTSD
- ✓the kinds of symptoms people have in PTSD
- ✓some of the evidence-based treatments that we now have

The result of these treatments is a cessation of PTSD symptoms in between 80% and 90% of cases of cases for single trauma cases or for people with a few traumatic events.

Complex PTSD (C-PTSD) is a more severe form characterized by prolonged, inescapable trauma during childhood. Researchers are working hard to develop ever more effective treatments for C-PTSD.

Treatments for PTSD have advanced recently. If you suspect you or a loved one may have PTSD, this article will prove most helpful.

Introduction

Post Traumatic Stress Disorder (PTSD) is often a severe mental health condition triggered by witnessing or experiencing a traumatic event. PTSD affects individuals differently. Some 2/3 of people who experience a serious event, such as those on the list on page 3, do not develop PTSD, while 25-33% do.

When PTSD does occur, it causes significant distress and impairment. PTSD effects include changes in personal, social, and occupational areas of life. A person may be triggered at work or by loud noises or have troubled sleep or be on edge all the time.

History. During World War I, Charles Meyers described shell shock and Sigmund Freud also described a similar condition. In World War II, Roy Grinker described war neurosis. During the Viet Nam war, in the 1970s, it was called Post-Viet Nam Syndrome. In 1980, PTSD was finally recognized as a mental disorder, a war experience was no longer required as a starting point, and the current symptoms for PTSD were determined. It was still thought then that the trauma had to be a threat to life or the body. But over the next decade, mental health workers found the same set of symptoms in people who had a similar level of shock to the mind, but without the triggering event having to be such a severe threat.

We now have a broader view. The exposure can be a threat to life, but also a serious injury, sexual violence, witnessing such an event, learning a loved one has had a violent or accidental death, or exposure to some gruesome details such as first responders may experience in their work.

Prevalence. We now recognize that PTSD occurs in almost 4% of the population at a time. People have close to a 7% chance of developing it in their lifetimes. It is more common in women than men. Children have a slightly higher rate than adults!

Support during a crisis can provide safety and protection, and that may prevent PTSD.

Events That May Cause PTSD

PTSD can be triggered by a wide range of traumatic events. Remember, with strong community and family support and a resilient state of mind, about 1/3 of people will not have symptoms after these events, about 1/3 will have some symptoms (.e.g, bad dreams, jumpiness, can't get it out of the mind), and 1/3 will develop full PTSD.

Some of the kinds of events that may lead to PTSD include:

Airplane or train crashes
Car crashes
Childhood neglect or abuse
Domestic violence as the victim, or as a childhood witness to family violence
Extreme bullying or harassment, prolonged or repeated bullying in childhood or adolescence
Fire or explosion
Kidnapping, being held hostage
Loss of a loved one in sudden and traumatic circumstances
Medical trauma, such as disfiguring surgeries, serious health diagnosis (e.g., cancer, MS)
Military combat
Natural disasters (e.g., earthquakes, hurricanes, tornados)
Physical assault, mugging
Prison stay or torture
Robbery or burglary, break-ins
Severe human-caused disasters (e.g., industrial accidents)
Severe car accidents, usually with injury, perhaps injury or death to a loved one, perhaps with the patient the driver
Sexual assault or sexual abuse or molestation, rape
Terrorist attacks
Witnessing a death or severe injury or an assault
Most of these events are about being the victim or witness to some severe threat of harm or a directly harmful experience.

What Causes a PTSD Reaction

The development of PTSD is believed to involve a combination of neurobiological, psychological, and environmental factors. The theory of "fear conditioning" suggests that PTSD develops when the fear response is permanently wired into the brain during a traumatic event, leading to an abnormal response to fear in the future. This is supported by neuroimaging studies showing alterations in the amygdala, prefrontal cortex, and hippocampus areas involved in fear response and memory (Pitman et al., 2012). The hippocampus loses volume. That suggests trauma teaches the nervous system not to

explore all new situations as if they were novel, but to experience them as if they were in the same channel, namely, dissolving new experiences into the filter of the trauma. Then, escape from the situation brings some relief. That reinforces future avoidance of all reminders of the trauma.

Occasionally, we find someone drawn to the trauma situation as if trying to master it by repeated exposure.

When a traumatic event happens, the nervous system becomes over-aroused and produces a fear reaction. After this occurs, anything connected with that situation, including the memory itself, can evoke the same high level of arousal. Because the brain wants to protect us from danger, it will keep the experience in a vivid state, as if they just happened. The brain will keep the individual who experienced the traumatic event on high alert, called hyperviglance, just in case a threatening event should recur. This can lead people avoid anything or any place connected with that situation causing the anxiety reduces and reinforcing more and more avoidance. It also reinforces the PTSD. Future events that unconsciously remind us of the event also elicit anxiety, however, we may not perceive that connection. To protect us, the brain may repress the connection.

In some cases, instead of noticing one's high anxiety, what may occur instead is a numbing, dissociative reaction. This occurs due to one's nervous system disconnecting from the present reality in order to cope. This can be in the form of dissociation (disconnection from emotion or out-and-out flashbacks), de-realization (the world feels unfamiliar and odd), or de-personalization (the body feels odd or feeling outside the body).

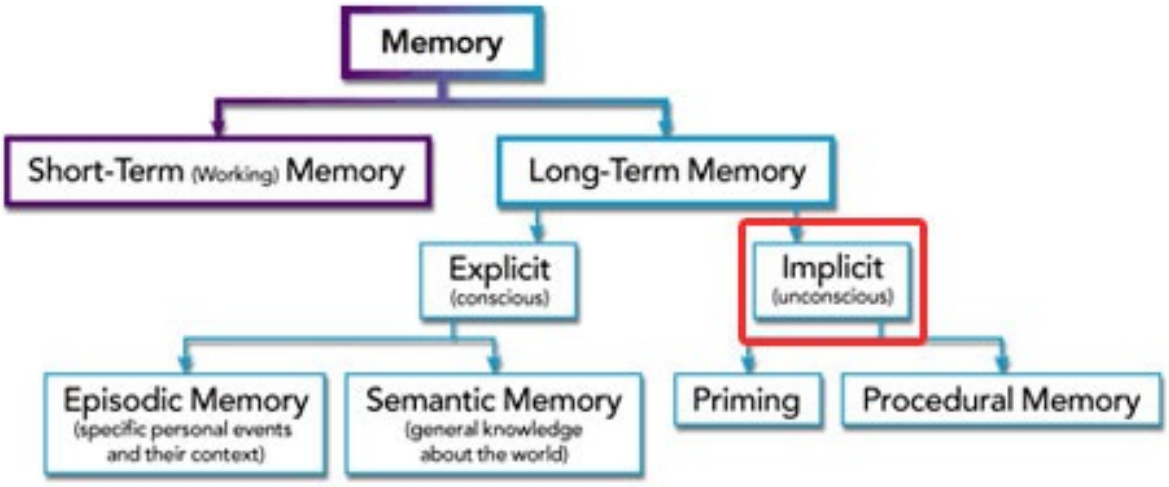
Trauma and Memory.

We have several memory systems. PTSD can affect these systems..

Iconic Memory is a part of the short-term memory system that stores sensory information for a short period of time. In a shocked state, we might dwell on the sights, sounds, and feel of the event.

Long-Term Memory is our more permanent storage system. The trauma is locked there in a state that prevents it from becoming just a historical event like any other.

Explicit Memory is conscious memory, things we can bring to mind. Whenever the mind is not otherwise occupied, the trauma memory may intrude.



Semantic Memory tracks facts, knowledge, language, and meaning. Attention to trauma and anxiety can affect concentration and retention of facts and details.

Episodic Memory is autobiographical details, the who, what, and where of experiences. However, trauma creates a template that we use to filter experiences and that gets in the way of seeing things as they are and remembering them as they are.

Implicit memory is more unconscious. It is information that we do not store purposely and is unintentionally memorized. That might include all the stimuli that surround the event. For instance, one might be anxious in a part of town near where a collision occurred.

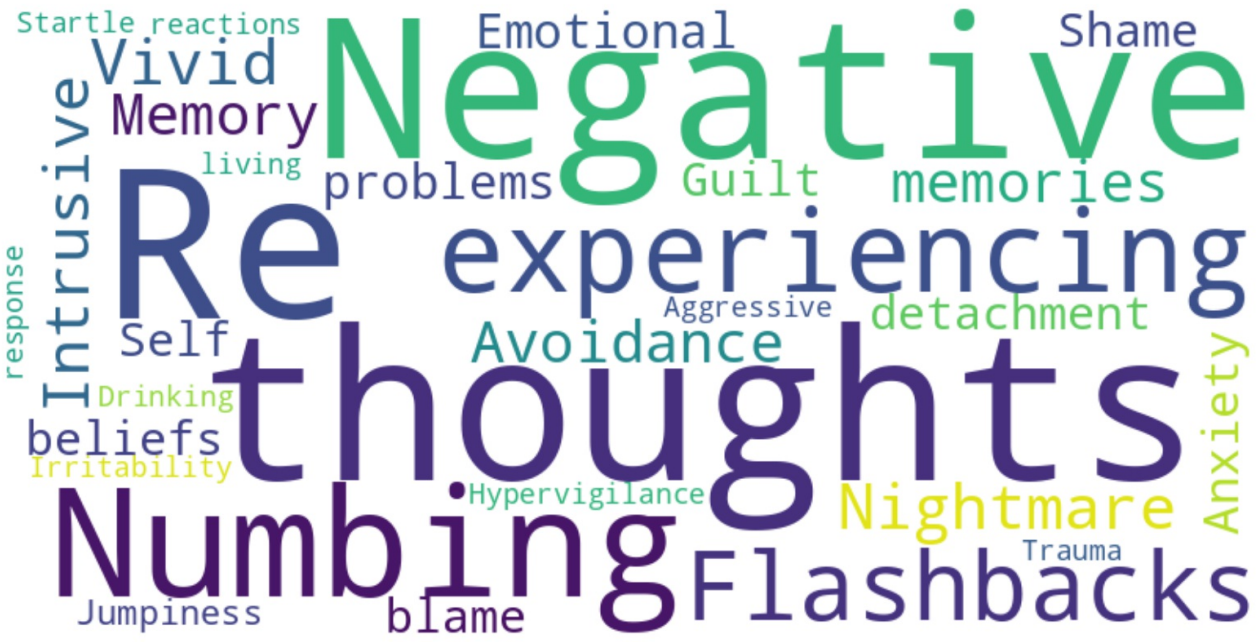
Emotional Memory connects feelings with experiences. Now, trauma connects experiences with anxiety, shame, fear. Hypervigilance leads us to be emotionally reactive.

Procedural Memory is how we perform activities without thinking because they are well-learned (like riding a bike) and trauma can affect physical performance.

Short-term memory (Working Memory) is our immediate focus. We can hold 5 to 9 bits of information in working memory. We can recall a small amount of incoming information for a short period of time. That is how we track a conversation and follow a movie or paragraphs in a book. The brain will move many short term memories to long-term memories. Trauma causes distractability and problems with concentration. That can in turn overwhelm short-term memory.

Trauma significantly affects attention and concentration, and that affects our ability to keep details in working memory.

After experiencing a traumatic event, one may also filter experiences through the lens of trauma and may not be accurate in their perception of events.



Symptoms of PTSD

PTSD symptoms are categorized into four types:

Re-experiencing: flashbacks, nightmares about the trauma, intrusive thoughts, vivid memories as if they were fresh and new
Avoidance: steering clear of reminders of the trauma, places connected with the trauma
Negative alterations in cognition and mood: memory problems, negative thoughts and feelings, emotional detachment, numbing, negative beliefs about the self ("I should have done ...." "It'ss my fault." "If only ...." "I am a failure."
Alterations in arousal and reactivity: hypervigilance, exaggerated startle response, aggressive reactions as if to eliminate the threat, irritability, self-destructive behavior

Co-Occurring Conditions with PTSD

PTSD often co-exists with other conditions. These co-morbidities complicate the treatment and management of PTSD, necessitating a comprehensive, individualized treatment plan so we can treat the PTSD and the additional set of problems.

- ✓ Depression can pre-date the trauma, but long-standing PTSD often causes depression.
- ✓ Anxiety disorders, especially phobic and socially phobic reactions, commonly overlap with PTSD, which has been considered a type of anxiety disorder. We sometimes find client being afraid to shower or sleep in a bedroom.
- ✓ Substance use disorders can occur by trying to cope with the trauma and/or trauma may have happened during substance use. Substance users may be exposed to gun violence, sexual assault in a 'coke house,' or accidents.
- ✓ Sleep disorders, especially insomnia and nightmares, commonly occur with PTSD.
- ✓ Chronic pain can result from an injury in a car accident.
- ✓ Traumatic grief occurs when the deceased died in a traumatic way, such as a shooting or a horrible accident.

A Word About Complex Trauma and Developmental Trauma

After years of debate, the World Health Organization adopted a diagnosis of Complex Trauma, C-PTSD. This term describes what happens when trauma takes place in early life, from early childhood through around early adolescence, and the trauma is repeated and inescapable. For example, a child may experience repeated sexual abuse or repeated emotional abuse or was a witness to repeated domestic violence. As a result, the child forms a much more complicated type of PTSD.

In addition to all the PTSD symptoms, the person develops some much more challenging symptoms like:

- ✓ Rapid emotional dysregulation and difficulty with calming
- ✓ Quickly becoming highly angry or upset, with difficulty re-regulating
- ✓ That dysregulation may be accompanied by disturbed coping such as excessive use of alcohol or medications or self-cutting or thoughts of suicide, all in an effort to manage sometimes-overwhelming emotions.
- ✓ Negative self-concept that is near constant, with feelings of worthlessness, perhaps an identity as defective or inadequate.

- ✓ Disturbed relationships with others with the knowledge the person's early relationships were damaging, perceiving others as either caretakers to substitute for the unsafe environment of their youth or having volatile and unstable relationships.

These events in essence warp or distort emotional development. They make the world seem as though it were some unsafe mirror of the early experiences. Then, the self is unsafe in such a world and feels inadequate, inferior, and defective.

Multi-Generational Trauma

Trauma can pass through generations! In his book, It Didn't Start With You, Mark Wolynn (2017) shows how a person may have quite disturbed reactions and relationships due to traumatic events from one or two generations before.

Caregivers can pass their own trauma experience in a few ways. One is in utero. Mother's cortisol (stress hormone) affects the child's nervous system. That may make it more reactive. As a parent, the caregiver may be more irritable and get upset more easily, leading the child's sense of self to be more oriented to self-doubt and self-criticism. The traumatized parent or grandparent may give message driven by the painful experiences, being overprotective or, on the other side, neglectful. That passes messages of insecurity to the next generation. The child may subsequently be more prone to PTSD in the face of troubling events. Treatment can sometime work on the them so that "Generational trauma ends here and now."

Post-Traumatic Growth (PSG)

Not all PTSD leads to long term, unremitting symptoms. Sometimes, post-traumatic growth also occurs. An example is the founder of MADD, Mothers Against Drunk Driving, whose daughter was killed by an intoxicated motorist. We sometimes see positive psychological changes and/or positive social actions that come from a trauma. We often see a shift in one's life philosophy, self-awareness, social consciousness, and appreciation of life. We may see a level of dedication to a cause. PSG and PTSD can be found in the same person. Sometimes, the resolution of the latter leads to the increase in the former, in growth.

Major Treatments for PTSD

Fortunately, we have effective treatments for PTSD! Some treatments can eliminate the symptoms. Others can help manage the symptoms so they are less disturbing. In the case of Complex PTSD, it may take several years to understand repair the damage done to the person's development.

The major treatments for PTSD include psychotherapy, medication, or a combination of both. As for the psychotherapies, they are often used in combination.

Treatment falls into two categories.

1) One is to manage the symptoms, helping reduce all that arousal and to reduce the intrusive thoughts.
2) The other is **Memory Reconsolidation**, that is, actually changing the memory. For example, one client was recovering from an industrial accident. His intrusive thoughts were of the equipment that caused the accident. When the memory was evoked and the whole event re-evaluated, he realized how much his co-workers and the medical personnel helped him and how this all worked out better than it could have. After that, his symptoms stopped.

Exposure. Most treatments that resolve the symptoms use exposure. That means going back into one's memories of the events in the safe confines of the therapist's office, with empathic support from the therapist, and directions that help the brain re-process the memory, in effect, shifting how it is remembered.

Cognitive Behavioral Therapy (CBT) helps reframe (change our perspective) negative thoughts about the trauma. It involves exposure therapy to desensitize trauma reminders, and cognitive restructuring to change negative thought patterns.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a well-researched method for trauma in youth.

Prolonged Exposure Therapy is a form of CBT that involves reliving the traumatic event in a safe environment to help reduce the power it holds over the patient.

Eye Movement Desensitization and Reprocessing (EMDR) involves focusing on traumatic memories while receiving bilateral sensory input (e.g., eye movements) to help

process and integrate traumatic memories rapidly and effectively. It is highly researched and shown to be effective and rapid.

Psychodynamic Therapy helps uncover deeper beliefs and behaviors that may not have been understood previously to be trauma-related, and helps understand adult behaviors that have roots in earlier trauma.

Seeking Safety is a program for overcoming the impact of sexual abuse.

Brainspotting is a technique that takes advantage of the fact that our eye position tends to be part of the conditioned (learned) behaviors associated with the trauma event and its recall. That suggests brain activation occurs when the eyes fixate on those positions. The therapist guides you to find those spots and recall the memories behind them.

A number of other approaches have been promising for PTSD, such as **Acceptance and Commitment Therapy**, some approaches using mental imagery such a **Imagery Rescripting**, **hypnosis**, and **mindfulness**, in which we learn to disconnect from the mental images.

Evidence for the Efficacy of These Treatments

A wealth of research supports the efficacy of these treatments. For example, a meta-analysis by Cusack et al. (2016) found that CBT, EMDR, and stress management techniques are effective in treating PTSD, with CBT and EMDR showing the most promise. Medications, particularly SSRIs, (e.g., sertraline) have been endorsed by the American Psychiatric Association for PTSD treatment. That is based on extensive clinical trials demonstrating their efficacy in reducing PTSD symptoms (American Psychiatric Association, 2017).

Conclusion

PTSD is often a debilitating condition that requires a nuanced understanding of its triggers, symptoms, and treatments. The combination of evidence-based psychotherapies and, sometimes pharmacotherapy, remains the cornerstone of PTSD management. As research advances, our understanding of PTSD and its treatment will continue to evolve, offering hope and healing to those affected.

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