9.6: Post-Traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is diagnosed in individuals who have been exposed to a traumatic event with chronic stress symptoms lasting more than one month that are so severe they interfere with relationships, school, or work. PTSD was formerly classified as an anxiety disorder but was placed in a new diagnostic category in the DSM-5 called “Trauma and Stressor-Related Disorders.”

Post-traumatic stress disorder has similar characteristics to severe anxiety and phobia-related disorders because of the physiological stress response that occurs. Post-traumatic stress disorder (PTSD) can develop in some people who have experienced a shocking, frightening, or dangerous event. It is natural to feel afraid during and after a traumatic situation, and the “fight-or-flight” stress response is a physiological reaction intended to protect a person from harm. Most people recover from the range of reactions that can occur after experiencing trauma. However, people who do not recover from these reactions and continue to experience problems are diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger.  

Symptoms

Symptoms of PTSD typically begin three months of the traumatic incident, but they may also begin years afterward. If symptoms occur within one month of the traumatic event, it is diagnosed as acute stress disorder. Symptoms must last more than a month and be severe enough to interfere with social or occupational functioning to be considered PTSD. The course of the illness varies; some people recover within six months, while others have symptoms that last much longer. In some people, the condition becomes chronic.  

To be diagnosed with PTSD, an adult must have the following types of symptoms for at least one month:  

[1][2][3][4][5]
• At least one “re-experiencing” symptom
• At least one “avoidance” symptom
• At least two “arousal and reactivity” symptoms
• At least two “cognition and mood” symptoms

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Re-Experiencing Symptoms

Re-experiencing symptoms include the following:

• Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
• Bad dreams
• Frightening thoughts

Re-experiencing symptoms can start from the person’s own thoughts and feelings. Words, objects, or situations that are reminders of the event can also trigger re-experiencing symptoms. Re-experiencing symptoms may cause problems in a person’s everyday routine and relationships.

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Avoidance Symptoms

Avoidance symptoms are as follows:

• Staying away from places, events, or objects that are reminders of the traumatic experience
• Avoiding thoughts or feelings related to the traumatic event

These symptoms may cause a person to change their personal routine. For example, after a car accident, a person who usually drives may avoid driving or riding in a car.

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Arousal and Reactivity Symptoms

Arousal and reactivity symptoms include the following:

• Being easily startled
• Feeling tense or “on edge”
• Having difficulty sleeping
• Having angry outbursts

Arousal symptoms are usually constant instead of being triggered by things that remind one of the traumatic events. These symptoms can make the person feel stressed and angry and can make it hard to do daily tasks, such as sleeping, eating, or concentrating.
Cognition and Mood Symptoms

Cognition and mood symptoms are as follows:\[11\]:

- Trouble remembering key features of the traumatic event
- Negative thoughts about oneself or the world
- Distorted feelings like guilt or blame
- Loss of interest in enjoyable activities

Cognition and mood symptoms can begin or worsen after the traumatic event and make the person feel alienated or detached from friends or family members.\[12\]

It is natural to have some of these types of symptoms for a few weeks after a traumatic event. However, when the symptoms last more than a month, seriously affect a person’s functioning, and are not related to substance use, medical illness, or anything except the event itself, they can be symptoms of PTSD. PTSD is also often accompanied by depression, substance abuse, or other anxiety disorders.\[13\]

Life Span Considerations

Children and teens can have extreme reactions to trauma, but they may exhibit different symptoms than adults. Symptoms of PTSD can be seen in young children (less than six years old) and may include the following:

- Bedwetting after having learned to use the toilet
- Forgetting how to talk or being unable to talk (i.e., selective mutism)
- Acting out the scary event during playtime
- Being unusually clingy with a parent or other adult

Older children and teens are more likely to show symptoms similar to those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Hypersexual behavior may occur if the trauma was related to a sexual assault. Older children and teens may also feel guilty for not preventing injury or death in certain traumatic situations and may have thoughts of revenge.\[14\]

Risk and Resilience Factors

 Anyone can develop PTSD at any age, including war veterans; children who have experienced trauma; or adults who have experienced a physical or sexual assault, abuse, accident, disaster, being a refugee, or some other serious event. According to the National Center for PTSD, about 6 out of every 100 people will experience PTSD symptoms at some point in their lives. Women are more likely to develop PTSD than men, and genes may make some people more likely to develop PTSD than others.\[15\]

Not everyone with PTSD has directly experienced a dangerous event. Some people develop PTSD after a friend or
family member experiences danger or harm. The sudden, unexpected death of a loved one can also lead to PTSD. PTSD is triggered by events that are perceived to be life-threatening, and this can vary from individual to individual. It disrupts the general sense of safety that allows individuals to function in the world.

It is important to remember that not everyone who lives through a dangerous event develops PTSD. In fact, most people will not develop the disorder. Many factors play a part in whether a person will develop PTSD. Risk factors make a person more likely to develop PTSD, but other factors, called resilience factors, can help reduce the risk of developing the disorder or promote recovery from the disorder.

These factors increase the risk for developing PTSD:

- Living through dangerous events and traumas
- Being injured from a traumatic event
- Seeing another person hurt or seeing a dead body
- Experiencing childhood trauma or adverse childhood events (ACEs)
- Feeling horror, helplessness, or extreme fear
- Having little or no social support after the event
- Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home
- Having a history of mental illness or substance abuse

Review information about adverse childhood events (ACEs) in the “Mental Health and Mental Illness” section of Chapter 1.

Resilience factors that may promote recovery after trauma include the following:

- Receiving support from other people, such as friends and family
- Finding a support group after a traumatic event
- Learning to feel good about one’s own actions in the face of danger, recognizing that we controlled what we could in an uncontrollable situation
- Having a positive coping strategy or a way of getting through the bad event and learning from it
- Being able to act and respond effectively despite feeling fear

If a child or adolescent discloses traumatic events to caregivers, teachers, or other adults, it is important for them to feel their concerns are validated by the adult in order to develop resilience.

Researchers are studying the importance of risk and resilience factors, as well as the impact of genetics and neurobiology. With more research, it may be possible to someday predict who is likely to develop PTSD and how to prevent it from occurring. See Figure 9.8 for an image of a veteran with PTSD using a service dog as an effective coping strategy.
Treatments

For people with PTSD, treatments include medications, psychotherapy, or a combination of both. Everyone is different, and PTSD affects people differently, so a treatment that works for one person may not work for another. It is important for anyone with PTSD to be treated by a mental health provider who has experience treating PTSD. If someone with PTSD is also experiencing an ongoing trauma, such as an abusive relationship, both of the problems need to be addressed. Other ongoing problems can include panic disorder, depression, substance use disorder, and suicidal ideation.

Medications

Antidepressants can help control PTSD symptoms such as sadness, worry, anger, and feeling numb inside. For example, two FDA-approved medications for PTSD are sertraline and paroxetine. Other medications may be helpful for treating specific PTSD symptoms, such as sleep problems and nightmares.

Psychotherapy

Psychotherapy can occur one-on-one or in a group setting. It typically lasts 6 to 12 weeks, but it can continue for as long as the individual finds it helpful. Research shows that additional support from family and friends can be an important part of recovery.

Many types of psychotherapy can help people with PTSD. Some target the symptoms of PTSD directly, whereas other therapies focus on social, family, or job-related problems. Effective psychotherapies emphasize key components such as education about symptoms, identification of triggers or symptoms, and skills to manage the symptoms. Examples of psychotherapies used to treat PTSD are cognitive behavioral therapy, exposure therapy, eye movement desensitization and reprocessing, and animal therapy programs.

Cognitive behavioral therapy (CBT) combined with exposure therapy helps people face and control their fear by
gradually exposing them to the trauma they experienced in a safe way. It uses imagining, writing, or visiting the place where the event happened to help reduce the intensity of PTSD symptoms. Read more about CBT in the "Depressive Disorders" chapter.

Cognitive restructuring helps individuals create new thought patterns about the trauma. Sometimes events are remembered differently than how they truly happened, and individuals may experience feelings of guilt or shame in relation to the trauma, regardless of whether they played an active role or not. They may feel guilty or shame about something that is not their fault. Therapists can help individuals assess the trauma through a variety of lenses to process and continue the healing journey.

Eye movement desensitization and reprocessing (EMDR) is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. During EMDR therapy, the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist-directed lateral eye movements are the most commonly used external stimulus, but a variety of other stimuli such as hand-tapping and audio stimulation are also used. It is hypothesized that EMDR therapy facilitates the individual’s access of their traumatic memory network so that new associations can be forged between the traumatic memory and more adaptive memories or information. These new associations are thought to result in elimination of emotional distress and development of cognitive insights.\[26\] \[27\]

Animal assisted intervention (AAI), also referred to as animal therapy, is a commonly used complementary treatment for PTSD. It most often includes dogs or horses. A systematic review examined the outcomes in studies using AAI with trauma survivors. Although the reviewed studies were diverse and limited, all reported positive outcomes of AAI, such as reduced depression, PTSD symptoms, and anxiety. \[28\]

In 2017 a new therapy called methylenedioxymethamphetamine (MDMA) – assisted psychotherapy received Breakthrough Therapy Designation from the FDA for the treatment of PTSD. MDMA (also referred to by the illicit drug name Ecstasy) is administered under direct observation with psychotherapy in three monthly eight-hour sessions. Due to the limited number of sessions with direct observation, there is less chance of diversion, overdose, or withdrawal symptoms upon discontinuation.\[29\]

View the following YouTube video on PTSD—\[30\]: NIMH-Funded Researcher Dr. Barbara Rothbaum Discusses Post-Traumatic Stress Disorder.

3. American Psychiatric Association. (2013). Desk reference to the diagnostic criteria from DSM-5.\[2\]
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