PTSD: A Literature Review

TraciAnne Atkinson

Argosy University- Draper, Utah

 At one point or another in their lives, 70% of the population of the United States of America will be exposed to some sort of trauma (Bedard-Gilligan, et al., 2015). That is over two thirds of the population! Traumas that individuals are exposed to can vary widely and can include experiences such as physical or sexual violence or threatened violence, natural disasters, war, and severe car accidents (DSM-5, 2013) Experiencing symptoms of posttraumatic stress disorder (PTSD) after being exposed to a trauma is extremely common, so common in fact that it is almost universal. Most of those who experience these symptoms, however, find that they fade as time moves on from their traumatic experience. (Kearns, et al.,2012)

 24% of those who are exposed to traumas, however, will find that their symptoms do not fade. (Bedard-Gilligan, et al., 2015). Their memories are recurrent, they have dreams about their trauma that haunt them and they avoid things, people or places that remind them of what they have experienced. They can even experience mood changes and find it difficult to experience positive emotion. (DSM-5, 2013) These individuals often have other risk factors for developing PTSD; they may have a family history of psychiatric disorders, poor support from their social circles, or have a greater perceived threat to their lives than other individuals. Of these additional risk factors, around 1/3 can be genetically inherited. (Kearns, et al.,2012) PTSD can have a negative effect on an individual’s social relations, academic performance, and employment. Those who struggle with PTSD and comorbid depression are 8 times more likely to attempt suicide. (Lenz, et al.,2014)

With so many potential negative impacts to the life of the client and with so many of the general population exposed to traumas that could potentially lead to PTSD it is the responsibility of every counselor to be as informed about PTSD as possible. PTSD is a chronic disorder that can span over years of an individuals life. Given its long span over the years PTSD can also create a significant financial burden for those whom it affects. It has a high comorbidity rate with other disorders as well, so individuals are likely to be suffering under the burden of more than one disorder and it affects men and women in different ways. Both the comorbidity with other disorders and PTSD’s difference in men and women can make it difficult for counselors to know how to treat those who struggle with it.

Chronicity of PTSD

A diagnosis of PTSD carries with it a high probability of it being a chronic disorder. Around 1/3rd of all individuals diagnosed with PTSD will develop chronic PTSD (Lewis, et al., 2013). PTSD has a low remission rate. In one study 40% of individuals with PTSD presented with significant symptoms 10 years after the initial onset of those symptoms. (Kearns, et al.,2012) Another study found that the remission rate of PTSD over a period of 15 years was just 0.20, with only 13 of their 90 study participants in full recover after the 15 years. (Perez Benitez, et al., 2013)

The lifetime prevalence rate of PTSD is quite high. Here we see the role that gender begins to play in a diagnosis of PTSD. While women had a lifetime prevalence rate of 8.5-17.7%, men had a much lower prevalence rate of 3.4-9.8%. (Perez Benitez, et al., 2013) This could be due to the differences in how women and men perceive and organize traumas, which will be discussed later. Another factor that affects the chronicity of PTSD in individuals is the number of times they have been exposed to a trauma. One study showed that those who experience 3 or more traumas in their lifetime develop worse symptoms of PTSD than those who experienced only 1 (Perez Benitez, et al., 2013). Another study found that individuals with a high level of trauma exposure over the course of their lifetime is a marker of the severity of PTSD they develop. (Bedard-Gilligan, et al., 2015)

There are a few factors that do help to lower the chronicity of PTSD and promote remission. If interventions can be implemented in the hours immediately after the trauma it can have a significant effect in lowering the prevalence of PTSD (Kearns, et al.,2012) This means that it is very important to have informed and competent counselors responding to public traumas as quickly as possible. It also has implications to the obligations the government might carry in ensuring that counseling services are immediately available to soldiers experiencing trauma due to the wars they serve in.

 Finally it means that counselors have an obligation to find ways to inform the general public about the need to seek counseling immediately after experiencing a trauma. If more of the general public is aware of these facts, it may be possible to lower the prevalence of PTSD chronicity as a whole. Another factor that is highly correlated to recovery from PTSD is the support an individual receives from his or her social circles. (Bedard-Gilligan, et al., 2015)

Financial Burden

The chronicity of PTSD can also lead to an increased financial burden on those who are diagnosed with it. Hospital stays, medication costs, and counseling fees add up over time to create a crushing cost that can place a significant burden on the individual (Ferry, et al., 2015). If the individual with PTSD has a comorbid diagnosis with another disorder this can add to their counseling needs, which will ultimately add to the costs of their treatment. There are also the indirect costs that come through lost productivity at work or the incapacity to work at all due to the severity of the symptoms presenting. This means that while the costs of their treatment are rising, their income and ability to meet those costs are declining. (Ferry, et al., 2015) In fact PTSD with its costs for treatment and its lost potential income for the individual is responsible for higher costs than any of the anxiety disorders. (Kearns, et al.,2012)

Comorbidity

As mentioned before when discussing the costs of a PTSD diagnosis to an individual, PTSD is often comorbid with another mental disorder diagnosis. The most common of these comorbid diagnoses is panic with agoraphobia, then general anxiety disorder and social anxiety disorder. (Perez Benitez, et al., 2013) In one study, 43% of individuals who presented with PTSD symptoms for a period of 12 months had a comorbid anxiety disorder and 41.30% had a comorbid mood disorder. Another 7.9% of participants in the study had a substance abuse disorder. (Ferry, et al., 2015). These are very clearly high rates of comorbidity. So high in fact that one study even went so far as to proclaim that pure PTSD without any comorbidity might not exist at all except perhaps theoretically. (Bedard-Gilligan, et al., 2015)

In particular, PTSD comorbidity with meeting the full criteria for social phobia can lead to worsening PTSD symptoms over an extended period of time. This is likely due to the perceived trauma that social situations inflict upon the individual struggling with social phobia. Conversely if a counselor working with the client addresses the social phobia and the phobia goes into remission an improvement of PTSD symptoms is seen. Perhaps more dangerous, however is PTSD with a comorbidity of major depressive disorder (MDD). Individuals with both PTSD and MDD show an increase in severe symptoms of PTSD (Bedard-Gilligan, et al., 2015) and as mentioned earlier are 8 times more likely to attempt suicide.

Gender Differences

It is a consistently stated fact that female individuals tend to report both higher quantities of symptoms and more severe presenting symptoms (Ferry, et al., 2015; Jin et al., 2014; Komarovskaya, et al., 2011; Lenz, et al., 2014) In fact one study found that the percentage of incarcerated females presenting with PTSD was 40.2 % compared to the 12.5% of males presenting with PTSD. (Komarovskaya, et al., 2011) This does not mean, however, that women are exposed to more trauma than men or that the trauma that they are exposed to is more severe than the traumas that males are exposed to. (Jin, et al., 2014). While it is true that women are exposed to different types of trauma than men tend to be, there is no indication that those traumas are worse than those that men are exposed to.

A study of inmates showed that women ten to be exposed to more interpersonal sexual traumas while men tend to be exposed to more interpersonal nonsexual violence. If fact the study found that the only significant predictor of PTSD in incarcerated males was interpersonal nonsexual trauma. Another difference that the study found is that women tend to be exposed to traumas throughout their whole lives where male inmates trauma experiences tended to happen earlier in development during childhood or adolescence. (Komarovskaya, et al., 2011) It is also interesting to note that even though females have a higher percentage rate of PTSD diagnosis than males, males lost more workdays and paid more in PTSD related costs than females did in a study done in Northern Ireland (Ferry, et al., 2015)

As stated before however, this greater rate of PTSD in females is not due to more exposure to trauma. Instead it is likely due to the way female’s process traumas. After all females also have a greater rate of posttraumatic growth than males do. (Jin, et al., 2014) As one study puts it “emotion is a central organizational aspect of trauma memories.” (Boals, et al., 2011) Which basically means that the way individuals organize and process their memories has a lot to do with how they organize and process their emotions. Women are much more prone than men to both do deliberate and brooding rumination. (Jin, et al., 2014) Which means that they have a greater tendency to process emotionally whether for good or ill than men do which shows in their greater rates of both PTSD and posttraumatic growth.

Treatment Options

A number of different therapies are recommended to help those who struggle with PTSD. The most common and agreed upon is Cognitive Behavioral Therapy. (Boals, et al., 2011; Ferry, et al., 2015; Kearns, et al., 2012; Lewis, et al., 2013 Najavits et al., 2011). Another therapy with a lot of support behind it is exposure therapy. (Boals, et al., 2011, Kearns, et al.,2012; Najavits et al., 2011). Perhaps the most controversial is the use of EMDR, which is recommended by some studies (Ferry, et al., 2015, Lewis, et al., 2013) but which another warns is of no value for those struggling with PTSD (Najavits et al., 2011). Further studies should be performed in order to see whether this warning is valid or not. Other possibilities include cognitive processing therapy and support therapy. One method of treatment that is generally agreed upon to hold little value for PTSD is medication. (Kearns, et al., 2012; Lewis, et al., 2013 Najavits et al., 2011)

Conclusion

PTSD is a complex and multifaceted diagnosis that should be treated with care. Counselors should always keep in mind the financial obligations that their clients are likely to incur due to the chronicity of PTSD and its likelihood of interfering with their everyday life including work. They should also remember to check for possible comorbid diagnoses with PTSD so as to appropriately manage risks to their client’s health. They should keep in mind the differences that men and women bring to PTSD and treat their clients accordingly. Finally they should do further research into how these factors affect which treatment options would be best for their clients.

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