PTSD: Research into the diagnosis

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Abstract

PTSD is a serious disorder that is always preceded by a traumatic stressor. It presents serious concerns with chronicity, comorbidity and financial burdens placed on clients. It presents differently in clients of different ages and genders. PTSD can usually be effectively treated through the use of cognitive behavioral therapy, although an alternative type of therapy will likely be needed for children presenting with PTSD.

Introduction

A diagnosis of posttraumatic stress disorder (PTSD), like its fellow trauma and stressor disorders, requires that the individual in question be exposed to a traumatic stressor at some point in their life. This in and of itself is unfortunately not as rare as one might hope. In fact 70% of people or 7 out of every 10 people living in the United States of America (USA) are exposed to some sort of trauma during their lifetimes (Bedard-Gilligan, et al., 2015). Not everyone who is exposed to a traumatic event in his or her life, however, develop PTSD.

 In fact in any given year, only 3.5% or 7 out of 200 adults in the USA will develop PTSD due to their exposure to a traumatic stressor. This number, however, is lower in European, Asian, African and Latin American countries. In those countries only 0.5% to 1.0% of adults will develop PTSD (DSM-5, 2013). This is equivalent to roughly 1-2 adults out of every 200 adults. In other words, those who reside in the USA are roughly 3 to 7 times more likely to develop PTSD in any given year than adults living elsewhere. This means that this diagnosis will likely have a bigger impact on our society in the USA than in other countries.

We are more likely to know those affected. They could be our mother or father, a brother, sister or close friend. The ones affected by PTSD could even be us ourselves. Such is the case in my own life. My sister was diagnosed with PTSD this last year. Both she herself and all who are close to her are still learning what this diagnosis means for her and for them.

Overview

As mentioned earlier those who struggle with PTSD have always experienced at least one traumatic stressor in their lifetime. A traumatic stressor is “any event (or events) that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member, or a close friend.” This means that the trauma that an individual struggles with may have happened to them or they may have witnessed it happen to another (DSM-5, 2013). The risk of developing PTSD over the course of an individual’s lifetime in the U.S. is 8.7%.

Those who struggle with PTSD are often plagued by memories or dreams of the trauma they have experienced. They may begin to avoid things, places and people that remind them of the trauma and exhibit behaviors that demonstrate a change in cognition such a more persistently showing negative emotions, showing a lower level of interest in activities or withdrawing socially. They may also become more reactive to things around them and have difficulty concentrating.

Like every other diagnosis given to individuals who are struggling with mental disorders, a diagnosis of PTSD should be handled with great care. The impact any diagnosis can carry in an individual’s life is great and PTSD is no exception. For many receiving a diagnosis of PTSD can be a life sentence. This is due to the chronicity of PTSD. One study of 90 individuals with PTSD found that after a period of 15 years only 13 of their participants had fully recovered (Perez Benitez, et al., 2013). Another study found similar results with 40% of individuals diagnosed with PTSD still presenting with significant symptoms 10 years after those symptoms originally started (Kearns, et al., 2012).

PTSD can also be a tremendous financial burden on those who are diagnosed with it. The many costs associated with it, such as counseling fees, medication, and hospital stays add up over the years that individuals are treated. At the same time lost productivity at work or even incapacity to work at all cut into the individual’s available resources to pay the costs that their treatment demands (Ferry, et al., 2015). Counselors should keep these concerns in mind when deciding on a treatment course for their client.

PTSD is also often a comorbid diagnosis. In a study in 2015 43% of individuals who had symptoms for at least 12 months presented with comorbid anxiety disorder and 41.30% presented with a comorbid mood disorder (Ferry et al., 2015). Given the high rates of comorbidity, counselors should approach treatment with caution given the interplay multiple diagnoses can have in an individual. One study that highlights this very well states that those individuals who struggle with both major depressive disorder and PTSD are 8 times more likely to attempt suicide (Lenz, et al., 2014).

Effective Treatment Approaches

There are two main treatments that are recommended for clients who struggle with PTSD. The first is exposure based cognitive therapy and the second is eye movement desensitization and reprocessing therapy (EMDR). (Boals, et al., 2011; Ferry, et al., 2015; Kearns, et al., 2012; Lewis et al., 2013; Stapleton, et al., 2006) Although most are supportive of both therapies, there are some concerned about EMDR.

A study that surveyed 205 participating professionals about their experience with various therapies in treating PTSD found that among the most preferred models for use was cognitive behavioral therapy. The same study found EMDR to be one of the least preferred methods for treating PTSD. The study did point out, however that this is possibly because the clinicians surveyed may simply like using the model they are more familiar with more and thus may be biased towards it. It suggested that results could change if the clinicians had a greater exposure to EMDR and other lower rated methods (Najavits, et al., 2011).

Another study that was looking into the efficacy of exposure, EMDR and relaxation training therapies on trauma-related anger and guilt within PTSD found that all three therapies produced lower levels of anger and guilt in clients. Although this study focuses on just one aspect of PTSD symptomology it seems salient that both EMDR and exposure therapies were able to produce similar results in the target symptoms and it raises questions about whether they would produce similar results when treating the full range of PTSD symptoms (Stapleton, et al., 2006) This perhaps further backs up the 2011 study that conjectured about clinicians exposure to EMDR and their satisfaction with it as a treatment option.

Social and Cultural Implications

Both age and gender can play significant roles in a diagnosis of PTSD. Females and males report different severity of symptoms and experience different types of traumas. They also experience these traumas at different ages. Children and adults with PTSD have different symptomology and this plays an important part in treating them.

 There is a significant difference in reported symptomology between men and women. Women report more symptoms than men and report a higher severity of their symptoms (Ferry, et al., 2015; Jin et al., 2014; Komarovskaya, et al., 2011; Lenz, et al., 2014). This is thought to possibly be because of an increased risk of exposure to traumatic stressors in females. Females also have more chronic PTSD, experiencing their symptoms for longer periods of time than males do (DSM-5, 2013).

There is also a difference in the type of trauma that they originally were exposed to. In a study of incarcerated individuals with PTSD, men were exposed to more interpersonal non-sexual trauma; women were exposed to more interpersonal sexual trauma. They also reported experiencing these traumas in every development stage of their life; childhood, adolescence, and adulthood. Men, however, reported that most of their traumatic experiences occurred during childhood and adolescence (Komarovskaya, et al., 2011)

Age can also play a significant role PTSD. Although PTSD can appear at any age it is more prevalent in adults than in children. Children also exhibit symptoms in a different way, often experiencing nightmares that do not reflect directly to the trauma they have experienced. Their symptoms may also manifest through their play either directly or symbolically. Their cognition changes are also more often than not displayed as negative mood changes. On the other side of the spectrum older adults display more sleeping problems, crying spells and suicidal ideation than younger adults. (DSM-5, 2013)

Assessment of Treatment

Given that more females than males present with PTSD for longer periods of time and that PTSD is more prevalent in adults than it is in children it is concluded the cognitive behavioral therapy would be the best treatment available. Females process traumas in a different way than men. Women are more likely than men to perform both deliberate and brooding rumination (Jin, et al., 2014) This means that they process events more emotionally than men do. CBT is an ideal therapy to help address their way of organizing traumatic events emotionally (Boals, et al., 2011) rather than cognitively.

Limitations of this therapy are evident. Children do not tend to do as well with cognitive behavioral therapy. A possible alternative therapy for them would be play therapy, especially in cases where children are already expressing symptoms symbolically or directly through their play. Another possible limitation is that CBT may not be able to help with any comorbid diagnosis that presents with the PTSD in an individual. Counselors should be aware of this and should plan treatment accordingly.

Conclusion

PTSD is a serious mental disorder. Its diagnosis should be treated with care, keeping in mind the potential chronicity, financial burden and comorbidity with other diagnoses that are often present with PTSD. Both gender differences and age differences should be kept in mind when developing a treatment plan for those who struggle with PTSD. Overall cognitive behavioral therapy is the most helpful treatment for those who struggle with PTSD though it may not be the best option in every case, as with children. Further research should be done into what treatment options could be best for children, as CBT is unlikely to be an ideal treatment for young clients.

**Bibliography**

 American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: Fifth edition DSM-5* (5th ed.). Arlington, VA: American Psychiatric Association.

 Bedard-Gilligan, M., Duax Jakob, J. M., Doane, L. S., Jaeger, J., Eftekhari, A., Feeny, N., & Zoeliner, L. A. (2015). An investigation of depression, trauma history, and symptom severity in individuals enrolled in a treatment trial for chronic PTSD. *Journal of Clinical Psychology, 71(7),* 725-740

Boals, A., & Rubin, D. C. (2011) The integration of emotions in memories: cognitive-emotional distinctiveness and posttraumatic stress disorder. *Applied Cogntive Psychology,* 25(5), 811-816

Ferry, F. R., Brady, S. E., Bunting, B. P., Murphy, S. D., Bolton, D., & O’Neill, S. M. (2015). The Economic Burden of PTSD in northern Ireland. *Journal of Traumatic Stress, 28(3),* 191-197

Jin Y., Xu, J., & Liu, D. (2014). The relationship between post traumatic stress disorder and post traumatic growth: gender differences in PTG and PTSD subgroups. *Social Psychiatry & Psychiatric Epidemiology, 49(12),* 1903-1910

Kearns, M. C. , Ressler, K. J. , Zatzick, D. , & Rothbaum, B. (2012) Early interventions for PTSD: a review. *Depression & Anxiety (1091-4269), 29(*10), 833-842

 Komarovskaya, I. A., Booker Loper, A., Warren, J., &Jackeson, S. (2011). Exploring gender differences in trauma exposure and the emergence of symptoms of PTSD among incarcerated men and women. *Journal of Forencis Psychiatry &Psychology, 22(3),* 395-410

 Lenz, S., Bruijn, B. , Serman, N. S. , Bailey, L. (2014). Effectivness of cognitive processing therapy for treating posttraumatic stress disorder, *Journal of Mental Health Counseling,* 36(4), 360-376

Lewis, Catrin, Neil Roberts, Tracey Vick, Jonathan I. Bisson 2013. “Development of a guided self-help (GSH) program for the treatment of mild-to-moderate posttraumatic stress disorder (PTSD). *Depression and Anxiety (1091-4269), 30(11),* 1121-1128

 Najavits, L. M. , Kivlahan, D. , & Kosten, T. (2011). A national survey of clinicians’ views of evidence-based therapies for PTSD and substance abuse. *Addiction Research & Theory,* 19(2), 138-147

 Perez Benitez; Caron Zlotnick, C. I., Dyck, I., Stout, R., Angert, e., Weisberg, R., & Keller, M. (2013). Predictors of the long-term course of comorbid PTSD: A naturalistic prospective study. *International Journal of Psychiatry in Clinical Practice, 17(3),* 232-237.

 Stapleton, J. A., Talor, S., &Asmundson, G. G. (2006). Effects of three PTSD treatments on anger and guilt: Exposure therapy, eye movement desensitization and reprocessing, and relaxation training *Journal of Traumatic Stress, 19(1),* 19-28 doi:10.1002/jts.20095