

PTSD: Caring for Patients and Their Families

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Purpose

The purpose of this course on post-traumatic stress disorder (PTSD) is to educate healthcare professionals on the identification, symptoms, course, and management of PTSD. Areas of focus will include:

- Identification of risk factors for PTSD.
- Assessment of PTSD symptoms.
- Evaluation of the care of patients diagnosed with PTSD.
- Development of interventions designed to assist the patient and families in their recovery.

Learning Objectives

After successful completion of this course, you will be able to:

- Discuss the impact of PTSD rates in the United States
- Identify PTSD risk factors, including high risk populations
- Describe DSM criteria for diagnosing PTSD
- Recognize at least two potential consequences of PTSD
- Discuss individualized interventions designed to treat PTSD
- Identify educational and support needs of the patient and family members.
- Identify community resources.

Introduction

Post-traumatic stress disorder (PTSD) is a psychological phenomenon which is caused by a traumatic event. Approximately 60% of men and 50% of all women experience at least one traumatic event in their lifetime. PTSD is the result of continued reactions to trauma for a prolonged period of time after the event is over. Most individuals who experience trauma do not develop PTSD; only about 7-8% of all people develop PTSD in their lifetime (Hamblen, 2013).

Statistics: Trauma

Unfortunately, a traumatic experience is a common occurrence in the United States. Statistics show that six out of every 10 men experience at least one trauma during their lives. For men, these experiences are usually assault, accidents, disaster, combat, or witness to injury or death (National Center for PTSD, 2015b). Five out of every 10 women have at least one traumatic experience in their lifetime. With women, sexual assault and abuse are the most common experiences (National Center for PTSD, 2015b).

Statistics: PTSD

The statistics in the United States show that of those who experience trauma fewer will actually develop PTSD. Approximately seven or eight out of every 100 people will develop PTSD at some point in their lives. Following a traumatic experience; four out

of every 100 men will develop PTSD. Unfortunately, the statistics are higher for women; 10 out of every 100 developing PTSD. In the United States, about eight million adults have PTSD during a given year (National Center for PTSD, 2015b).

Risk Factors

It is encouraging to know that not every individual who experience trauma, will go on to develop PTSD. There are certain factors that increase the likelihood a person will develop PTSD. These risk factors include:

- Direct exposure to a trauma as a victim or witness
- Serious injury with the traumatic event
- Long-lasting or severe traumatic event
- Previous trauma or life-threatening event (such as child abuse)
- Personal or family history of mental illness
- History of alcohol abuse
- Female gender
- Low socioeconomic status
- Recent, unexpected loss of a loved one
- Recent, stressful life changes
- African-American or Hispanic races

Other risk factors exist from the individual's experience during the trauma. These include:

- The individual believed he or she, or a family member, was in danger
- The individual experienced a severe reaction during the event (such as shaking, crying, vomiting, disassociation)
- The individual felt helpless during the trauma

(National Center for PTSD, 2015b; National Institute of Mental Health [NIMH], n.d.)

Resilience Factors

Resilience factors are those components that may reduce the risk of developing PTSD (National Institute of Mental Health [NIMH], n.d.). These include:

- Social support, such as friends and family
- Attending a support group after a traumatic event
- Self-confidence and self-worth
- History of effective coping
- Effectual actions and responses despite feeling fear

Interactive Activity

Match the following descriptions with the correct category (risk factor or resilience factor)

Description	Factor
A. Attending a support group	Risk factor
B. History of alcohol abuse	Risk factor
C. Personal history of mental illness	Resilience factor
D. Feelings of self-confidence	Resilience factor

Answer: Risk factors= B, C; Resilience factors= A, D

Traumatic Events

PTSD is triggered by exposure to a traumatic event. These may be a single occurrence or repeated exposure to trauma. Traumatic events are those considered to have a psychological effect, and often have a direct, violent physical impact. Examples of traumatic events include combat, sexual assault, and surviving a natural disaster or a terrorist attack (National Alliance on Mental Illness [NAMI], 2011).

Severe traumatic events, proximity to an event, and duration of exposure to trauma increase post-traumatic responses and PTSD risk. Veterans and victims of physical or sexual abuse are at high risk of developing PTSD (NAMI, 2011).

Trauma Evolving into PTSD

Short-term responses of people exposed to life-threatening or overwhelming distressing events are common. Responses can last for days or even weeks. Types of responses include:

- Nightmares
- Increased fear
- Dissociation
- Flashbacks
- Inability to concentrate
- Anxiety
- Insomnia

When these responses do not persist, PTSD can develop (NAMI, 2011).

Test Yourself

Which of the following individuals would be at a higher risk for developing PTSD?

- A. Caucasian
- B. Female gender
- C. Someone who watched a traumatic event on TV

Answer: B

Identifying PTSD

It is important to recognize individuals who may be experiencing PTSD. This is done through a history and physical, as well as an in-depth interview to identify PTSD symptoms. The use of screening tools can be useful to determine the symptoms a person is experiencing (National Center for PTSD, 2015c). Although there are multiple tools available for use, the most commonly used screening tools include:

- The Beck Anxiety Inventory- Primary Care (BAI-PC): This tool is a self-report of seven items that screens for anxiety, depression, and PTSD; it is a subset of the original 21-item Beck Anxiety Inventory tool. The main benefit to the use of this screen is that it simultaneously screens for PTSD as well as other disorders that are associated with PTSD. Respondents are asked to rate items on a 4-point scale (ranging from 0 = "Not at all" to 3 = "Severely") to indicate the severity of each of the symptoms. The authors use a total score of five to indicate a positive screen for anxiety, depression, or PTSD. This screen showed good sensitivity and specificity. Individuals who screen positive should then be assessed with a structured interview for PTSD. This tool can be viewed at http://www.scielo.br/img/revistas/rcefac/2012nahead/en_137-11fig03.jpg

More screening tools include:

- Primary Care PTSD Screen (PC-PTSD): The PC-PTSD is a four-item screen that was designed for use in primary care and other medical settings. This tool is currently used to screen for PTSD in Veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events (National Center for PTSD, 2015c). An example of this tool can be viewed at <http://img.medscape.com/article/746/071/746071-fig2.jpg>
- Trauma Screening Questionnaire (TSQ): The TSQ is a 10-item symptom screen that was designed for use with survivors of all types of traumatic stress. The TSQ has five re-experiencing items and five arousal items. Respondents are asked to endorse those items that they have experienced at least twice in the past week. The screen is considered "positive" when at least six items are

endorsed. It is recommended that the screening be conducted three to four weeks post-trauma to allow for normal recovery processes to take place. Those screening positive should then be assessed with a structured interview for PTSD (National Center for PTSD, 2015c). This tool can be viewed at http://media.self-help.tools/worksheets/english_us/trauma_screening_questionnaire_en-us.pdf

Diagnosing PTSD

Post-traumatic stress disorder is diagnosed based on the American Psychological Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders*, currently in the fifth edition (DSM-V; APA, 2013). All of the DSM-V criteria must be met to confirm a diagnosis of PTSD. According to the DSM-V, there must be a history of exposure to a traumatic event that meets specific specifications. Symptoms must also be present from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. Eight criteria are evaluated for diagnosis (APA, 2013). These include:

- A. Stressor
- B. Intrusion symptoms
- C. Avoidance
- D. Negative alterations in cognition and mood
- E. Alterations in arousal and reactivity
- F. Duration
- G. Functional significance
- H. Exclusion

Criterion A: Stressor

For a diagnosis of PTSD, the person has to have been exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one is required)

1. Direct exposure to the event
2. Witnessing the event in person.
3. Indirectly experiencing the event, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental (not natural causes).
4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-personal exposure through electronic media, television, movies, or pictures.

(APA, 2013)

Criterion B: Intrusion Symptoms

The DSM-V criterion for symptoms state that the patient persistently re-experiences the traumatic event in the following way(s): (one is required)

1. Recurrent, involuntary, and intrusive memories.
2. Traumatic nightmares.
3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness.
4. Intense or prolonged distress after exposure to traumatic reminders.
5. Marked physiologic reactivity after exposure to trauma-related stimuli.

(APA, 2013)

Criterion C: Avoidance

This criterion identifies persistent and effortful avoidance of distressing trauma-related stimuli after the event: (one is required)

1. Trauma-related thoughts or feelings.
2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).

(APA, 2013)

Criterion D: Negative Alterations in Cognitions and Mood

This criterion requires the person to have negative alterations in cognitions and mood that began or worsened after the traumatic event: (two are required)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; cannot be due to head injury, alcohol, or drugs).
2. Persistent and often distorted negative beliefs and expectations about oneself or the world (such as "I am bad," "The world is completely dangerous").
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.

4. Persistent negative trauma-related emotions (such as fear, horror, anger, guilt, or shame).
5. Markedly diminished interest in significant activities from the pre-traumatic state.
6. Feeling alienated from others (such as detachment or estrangement).
7. Persistent inability to experience positive emotions, also known as a constricted affect.

(APA, 2013)

Criterion E: Alterations in Arousal and Reactivity

With this criterion, the person has trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two are required)

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hyper-vigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

(APA, 2013)

Criteria F through H

Criterion F states that the person must have persistence of symptoms, as outlined in criteria B through E, for more than one month (APA, 2013).

Criterion G is that the person has significant symptom-related distress or functional impairment, such as occupational or social impairment (APA, 2013).

Criterion H is an exclusion criterion, demonstrating that the disturbance is not due to medication, substance use, or other illness (APA, 2013).

Test Yourself

True or false:

For a diagnosis of PTSD, the individual must have direct exposure to a traumatic event.

Answer: False. Individuals can experience a traumatic event either directly, by witnessing an event or indirect exposure to trauma.

Symptoms of PTSD

The symptoms of PTSD may start within three months of a traumatic event, but sometimes may not actually appear until years after the event. These symptoms cause significant problems in social or work situations and in relationships.

The DSM-V criteria describe the symptoms required for diagnosis. But what does this mean for the person living with PTSD? Here are some further descriptions of what a person experiences:

- unwanted memories of the traumatic event that are recurrent
- Reliving the traumatic event as if it were happening again and again (flashbacks)
- Experiencing upsetting dreams about the traumatic event
- Experiencing severe emotional distress or physical reactions to something that reminds the individual of the event
- Trying to avoid thinking or talking about the traumatic event
- Avoiding places, activities or people that remind the person of the traumatic event
- Suffering from negative changes in thinking and mood
- Experiencing negative feelings about his or herself, or others
- inability to experience positive emotions
- Feeling emotionally numb
- lack of interest in activities he or she once enjoyed
- Feelings of hopelessness about the future
- Having memory problems, including not remembering important aspects of the traumatic event
- difficulty in maintaining close relationships
- changes in emotional reactions
- Suffering from irritability, angry outbursts or aggressive behavior
- Always being on guard for danger
- Feelings of overwhelming guilt or shame
- Undergoing self-destructive behavior, such as drinking too much or driving too fast
- Having difficulty concentrating
- Experiencing trouble sleeping
- Being easily startled or frightened

(NAMI, 2011)

Intensity of Symptoms

PTSD symptoms can vary in intensity over time. An individual may have more PTSD symptoms when he or she is stressed in general, or when he or she experiences reminders of what they went through. For example, someone may hear a car backfire and relive combat experiences. Or another person may see a report on the news about a sexual assault and feel overcome by memories of his or her own assault.

Personal Stories: Miss P.

One woman describes her story:

“My PTSD was triggered by several traumas, including a childhood laced with physical, mental, and sexual abuse, as well as an attack at knifepoint that left me thinking I would die...For months after the attack, I couldn't close my eyes without envisioning the face of my attacker. I suffered horrific flashbacks and nightmares. For four years after the attack I was unable to sleep alone in my house. I obsessively checked windows, doors, and locks. By age 17, I'd suffered my first panic attack...Then another traumatic event re-triggered the PTSD. It was as if the past had evaporated, and I was back in the place of my attack, only now I had uncontrollable thoughts of someone entering my house and harming my daughter. I saw violent images every time I closed my eyes. I lost all ability to concentrate or even complete simple tasks. Normally social, I stopped trying to make friends or get involved in my community. I often felt disoriented, forgetting where, or who, I was. I would panic on the freeway and become unable to drive, again ending a career. I felt as if I had completely lost my mind.” (Philips, 2015).

Personal Stories: Mr. H.

One soldier talks about his story:

“I don't know what the trigger was. Maybe it was the young Soldier, a mother of two who was just redeployed, who I watched cut down after she hanged herself weeks after returning from battle earlier. Maybe it was the faces of the children I see on all the doors I knocked on to tell them their father or mother was not coming home. Maybe it was because it was the same time of year when my uniform was covered with the blood and brains of a 6-year-old Iraqi child who was caught in an IED during Ramadan.

I don't know what the trigger was, but it hit me hard. I went home one evening and all of sudden, I felt a tightness in my chest, it was hard to breathe, I felt closed in and panicky. I bolted out of bed thinking I was dying. I paced the room in the dark for hours before I exhausted myself. I almost went to the ER that night, but the Soldier in me said to stick it out” (Huerta, 2012).

“The morning came and it hit again, a panic, a fear of being closed off, claustrophobia, and pains in the chest. I thought maybe I was having a heart attack and, if I was, I needed to see a doctor.

A heart attack was honorable, PTSD was not. I went to sick call and they ordered a battery of tests to exclude any heart condition. When my heart was cleared, the doctors recommended I see someone in CHMS. I thought to myself, "I wasn't crazy, why do I need to see them? If I see them, I know the 'big' Army will find out and tag me as 'broken'" (Huerta, 2012).

Interactive Activity

The most powerful way to learn about the experience of living with PTSD is to hear from someone who has the diagnosis. Watch this brief video from an interview with a person diagnosed with PTSD: <https://www.youtube.com/watch?v=amoS1sZTEfU>

Potential Consequences of PTSD

Developing PTSD can also put an individual at higher risk for developing other conditions (McFarlane, 2010). These can include physical and psychological co-morbidities. There is a high correlation between PTSD, depression, and substance abuse (McFarlane, 2010). PTSD and depression are often seen together. Results from a large national survey showed that depression is nearly three to five times more likely in those with PTSD than those without PTSD (National Center for PTSD, 2015a).

Substance Abuse

The symptoms of PTSD can be extremely distressing. An individual with PTSD has impaired coping, and may turn to using drugs or alcohol as a means of escape. This form of self-medication places a person with PTSD at a high risk for substance abuse. Over 50% of PTSD sufferers also have alcohol dependence, and over 30% have drug dependence (Foundations Recovery Network, 2015).

The use of alcohol or drugs may be influenced by endorphin withdrawal in a person with PTSD. Endorphins are the neurotransmitters that reduce pain, and create a sense of well-being. When someone experiences a traumatic event, his or her brain produces endorphins as a way of coping with the stress of the moment. When the event is over, the body experiences an endorphin withdrawal, causing anxiety, depression, physical pain, emotional distress, and increased cravings for a substance to bring back the positive feelings. This is similar to symptoms of withdrawal from drugs or alcohol. Many of those with PTSD will turn to alcohol or drugs as a means of replacing the feelings brought on by the brain's naturally produced endorphins. However, these positive effects of substance use are only temporary (Foundations Recovery Network, 2015).

Physical Consequences: Musculoskeletal

Symptoms and disorders related to the musculoskeletal system may also be related to PTSD. The effects of stress on health have been continually studied, including the effects on the hypothalamic pituitary adrenal axis and the autonomic nervous system. These systems are normally regulated, and the body may have a physiological dysregulation in response to repeated cycles of stress. Pain syndromes, such as fibromyalgia and chronic fatigue, share commonalities of symptoms as those physical characteristics associated with PTSD (McFarlane, 2010).

Physical Consequences: Cardiac

Studies have also been done which demonstrate a relationship between PTSD and hypertension, as well as hyperlipidemia. Other studies have shown a higher incidences of obesity in persons with PTSD, as much as a 2-3 times higher risk than those without PTSD (McFarlane, 2010).

The risk of heart disease has also been studied in populations with PTSD. Development of hypertension, hyperlipidemia, and obesity are all risk factors for cardiac disease. There is also a potential that exaggerated catecholamines from increased traumatic response with PTSD correlates with the higher risk for developing cardiac disease. In addition, PTSD may increase the mortality risk associated with heart disease (McFarlane, 2010).

Dementia and PTSD

Although evidence shows that PTSD may impair cognitive performance and that older individuals with PTSD have a greater decline in cognitive performance, little was known about PTSD as a risk factor for developing dementia.

A stratified, retrospective cohort study by Yaffe et al. (2010) included 181,093 veterans, ages 55 years and older, who originally did not have dementia. Follow up after the study initiation demonstrated 31,107 veterans who developed dementia within a seven year period. Within this group, veterans with PTSD had a 7-year cumulative incident dementia rate of 10.6%, whereas those without PTSD had a rate of 6.6% (Yaffe et al., 2010).

Research conducted by Pless Kaiser et al. (2012) also stated that older adults and veterans with dementia may display more PTSD symptoms. In addition, PTSD may be a risk factor for dementia, and as a study by Yaffe et al. (2010) indicated; individuals diagnosed with PTSD were almost twice as likely to develop dementia, when compared to those not diagnosed with PTSD (Pless Kaiser et al., 2012).

Traumatic Brain Injury and PTSD

One significant co-morbidity associated with PTSD is a traumatic brain injury, or TBI. Traumatic brain injury (TBI) is the disruption of normal brain function caused by a blow or jolt to the head or penetration of the skull by a foreign object, which may occur with trauma. Patients who have experienced TBI are also at increased risk for psychiatric disorders compared to the general population, including depression and PTSD.

In the military population, the primary causes of TBI in Veterans are blasts, motor vehicle accidents, gunshot wounds, or a combination. Exposure to blasts is unlike other causes of TBI and may produce different symptoms and natural history. For example, Veterans seem to experience TBI symptoms for longer than the civilian population; some studies show most will still have residual symptoms 18-24 months after the injury. In addition, many Veterans have multiple medical problems. The comorbidity of PTSD, history of TBI, chronic pain and substance abuse is common and may complicate recovery from any single diagnosis (National Center for PTSD, 2015d).

For more information on TBI and dementia, refer to RN.com's course *Dementia: An In-Depth Review*

Test Yourself

A comorbidity associated with PTSD is:

- A. Schizophrenia
- B. Personality disorder
- C. Depression

Answer: C

Interventions

Common treatments for people with PTSD are psychotherapy, use of medications, or a combination of both. Everyone is different, 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 care provider who is experienced treating PTSD. Some people with PTSD need to try different treatments or combinations to find what works for their symptoms.

Treatment of PTSD is also complicated by existing co-morbidities, such as those previously described. Individuals who have a concurrent mental or physical illness will need individualized treatment for each disorder (NIMH, n.d.).

Psychotherapy

Psychotherapy involves talking with a mental health professional to treat a mental illness. It can occur one-on-one or in a group. This form of treatment for PTSD usually lasts six to 12 weeks, but can take more time. Research shows that support from family and friends can be an important part of therapy.

Many types of psychotherapy can help people with PTSD. Some types target the symptoms of PTSD directly. Other therapies focus on social, family, or job-related problems. The doctor or therapist may combine different therapies depending on each person's needs.

Cognitive Behavior Therapy

Research has confirmed the effectiveness of cognitive therapy in treating PTSD (Friedman, 2013; NIMH, n.d.). CBT is based on a theory claiming it's not actual events that upset us, but the meanings we give them. Cognitive-behavioral therapy involves structured sessions, based on goal setting for specific problems. The patient is given "homework" to determine the problems that they want to work on, and are viewed as partners in structuring the therapy. CBT assists in problem solving, developing coping strategies, forming new relationships, and changing beliefs or behaviors.

CBT is further divided into three forms to treat PTSD: cognitive processing or reconstructive therapy, exposure therapy, and stress inoculation training (also known as eye movement desensitization). These forms of CBT can be used individually or in combination with other treatments.

Cognitive Processing Therapy

Cognitive processing therapy (CPT, also known as reconstructive therapy) helps people make sense of the bad memories. Often people remember the event differently than how it happened. They may feel guilt or shame about what was not their fault. The therapist helps people with PTSD look at what happened in a realistic way.

CPT is a short-term treatment that helps people understand how the trauma has changed the way they think. This is important because people who have been exposed to a traumatic event often have inaccurate thoughts that haunt them and are a source of distress. They think didn't do what they needed to do, they should have done something differently, they cannot cope, or that the world is a bad place. The goal of CPT therapy is to alter these cognitions, which can alter the emotional experience and the symptoms that go along with it (Friedman, 2013; NIMH, n.d.).

The therapist uses CPT, through discussion and use of written narratives, to challenge these negative thoughts and give the person the tools to challenge these thoughts on his or her own. CPT includes education, such as learning about the symptoms and

symptom management (Friedman, 2013). CPT can provide answers to questions PTSD sufferers have, such as:

- What is PTSD?
- How is it affecting my life?
- How can I label these thoughts and feelings that are making my life so miserable?
- How can I develop the skills to challenge these thoughts and feelings?

Exposure Therapy

Exposure therapy helps people face and control their fear. It exposes them to the trauma they experienced in a safe way. It uses mental imagery, writing, or visits to the location where the event occurred. The therapist uses these tools to help people with PTSD cope with their feelings. Exposure therapy is a short term treatment, and focuses on the feelings associated with a traumatic experience (whereas cognitive therapy focuses on the thoughts that occur after a trauma exposure). Common feelings that are addressed with exposure therapy are panic, fear, anger, and anxiety that occur as a result of the traumatic event or following exposure to traumatic reminders. It helps an individual learn that he or she does not have to avoid a reminder of trauma, and that the memory can't harm him or her.

Just as with CBT, there is a psycho-education component. In addition, relaxation techniques are taught to the individual. The person is also exposed to reminders of his or her trauma, either actual exposure through visual stimuli, or imaginal exposure, where the person is asked to remember what happened to him or her. The combination of techniques assists the individual in identifying feelings associated with the trauma, and providing tools to cope with these feelings (Friedman, 2013; NIMH, n.d.).

Stress Inoculation Training

Stress inoculation training, also known as eye movement desensitization and remodeling, tries to reduce PTSD symptoms by teaching a person how to reduce anxiety. Like cognitive restructuring, this treatment helps people look at their memories in a healthy way. Although the mechanism of action for this type of therapy isn't understood, many studies demonstrate the effectiveness of this treatment with PTSD.

Stress inoculation training focuses on repetitive motor movement, such as hand movements, tapping or having the person following the therapist's finger with their eyes. Once the person begins the repetitive movement, they are instructed to think about the traumatic event. While the individual does this, they are taught how to hold that thought, and to relax, and to handle whatever emotional distress occurs. Similar to exposure therapy, with repeated presentations of this therapy, the person's amount of distress experienced while holding that thought becomes less and less. The individual

is then instructed to insert or substitute a more positive thought rather than the distressing traumatic-related thought (Friedman, 2013; NIMH, n.d.).

Benefits of Psychotherapy

The use of psychotherapies teach patients helpful ways to react to frightening events that trigger their PTSD symptoms. Based on this general goal, benefits may include:

- Learning about trauma and its effects.
- Use of relaxation and anger control skills.
- Providing tips for better sleep, diet, and exercise habits.
- Helping people identify and deal with guilt, shame, and other feelings about the event.
- Focusing on changing how people react to their PTSD symptoms.

(NIMH, n.d.)

Group Therapy

Group therapy is used a great deal in many different settings, although there are a variety of approaches used. Groups can include a cognitive behavioral therapy, a traditional psychodynamic group, or a more supportive type of therapy groups. Regardless of the style of group therapy suggested, people who participate in groups seem to experience the same degree of benefit. Although group therapy has been shown with studies to have a positive effect with individuals who have PTSD, it is not as beneficial as individual treatments. The combination of individual and group therapies may show the greater benefit (Friedman, 2013).

Test Yourself

Which of the following statements is true regarding therapies?

- A. Group therapy is the most effective form of therapy
- B. A combination of individual and group therapy may produce a greater benefit
- C. Exposure therapy can be dangerous to use with someone diagnosed with PTSD

Answer: B

Pharmacological Treatment

Currently, the U.S. Food and Drug Administration (FDA) has approved two medications for treating adults with PTSD; sertraline (Zoloft®) and paroxetine (Paxil®). Both medications are antidepressants, which are also used to treat depression. These medications are classified as selective serotonin reuptake inhibitors (SSRIs). SSRIs are believed to treat PTSD by slowing down the reuptake of serotonin by pre-synaptic

neurons. Serotonin molecules then remain in the synapse longer than they normally would, and have more time to activate the post-synaptic neuron.

There are several types of serotonin receptors, and some medications work on specific receptors better than others. The neurotransmitter serotonin has a well-recognized role in the treatment of a number of mood and anxiety disorders. A deficiency in amygdala serotonin transport has been identified in some individuals with PTSD. SSRIs may help control PTSD symptoms such as sadness, worry, anger, and feeling numb inside. These medications are most beneficial when used in conjunction with psychotherapy (Jeffreys, 2015; Friedman, 2013; NIMH, n.d.).

Medication Considerations

It is important to know that it could take as many as six to eight weeks for the full therapeutic effect to occur and all patients being treated with antidepressants should be monitored appropriately and observed closely for worsening depression symptoms, suicidal thoughts or behavior, and unusual changes in behavior, especially during the first few months of treatment, or when the dose is increased or decreased.

Side effects associated with these antidepressants are common, but generally resolved as tolerance develops. The most typical side effects your patients starting on antidepressants will report are:

- Fatigue, weakness
- Nervousness, trembling
- Upset stomach, constipation, or diarrhea
- Appetite and weight changes
- Headache, drowsiness, dizziness
- Dry mouth, sweating, excessive thirst
- Nightmares, insomnia
- Sexual dysfunction
- Increased skin sensitivity to sunlight

(Jeffreys, 2015; McEvoy, 2011).

Effects on the Family

Because the symptoms of PTSD and other trauma reactions change how the affected person acts and feels, traumatic experiences that happen to one member of a family can affect everyone else in the family. Individual responses to trauma can make individuals hard to get along with or cause them to withdraw from the rest of the family. When trauma responses are severe and go on without treatment, they can cause major problems in a family (NIMH, 2011). Family members can react in a variety of ways, including:

- **Sympathy.** Usually one of the first reactions many family members feel is sympathy for their loved one who has experienced trauma. Too much sympathy can actually impede relationships, as the person with PTSD may perceive that his or her family members do not believe they are competent enough to deal with their reactions to the trauma.
- **Conflict.** This occurs when the person with PTSD experiences irritability or anger. This can cause conflict amongst family members.
- **Disconnection.** A symptom of PTSD is detachment, which can cause a disconnection between family members.
- **Depression.** Just as a person with PTSD can experience depression, other members of the family may also develop depression.
- **Fear and worry.** A person with PTSD often experiences fear for their own safety, as well the safety of their loved ones. This type of fear and anxiety can become contagious amongst family members.
- **Avoidance.** Many times family members will avoid discussing anything that could be a trigger for their loved one with PTSD. This may also include avoiding events or activities which could be viewed as a trigger.
- **Guilt and shame.** Just as a person with PTSD may have unfounded feelings of guilt or shame over the traumatic event, a family member may also feel the same way. He or she may feel that there could have been something different that they could have done, to prevent the traumatic event from happening. ..
- **Anger.** This is a common reaction when a loved one has been through a trauma. The anger may be directed at the person(s) believed to have caused the trauma, it may be directed at God, or the anger could actually be caused by the person's continued reactions to the traumatic event.
- **Negative feelings.** A family member may also experience negative feelings towards their loved one with PTSD. This may be in reaction to the changes in behavior the person with PTSD demonstrates, or mistaken beliefs of how his or her loved one could have avoided the traumatic event.
- **Substance abuse.** Ineffective coping with the PTSD experience can lead a family member to turn to drugs or alcohol, just as the person with PTSD may.
- **Health problems.** A family member may experience difficulty sleeping or even develop health problems in response to the worry and anxiety over his or her loved one with PTSD.
- **Caregiver burden.** Caregiver burden is used to describe the difficulties associated with caring for someone with a chronic illness. This term also applies to families who have a member with PTSD. Caregiver burden includes the objective and subjective demands, such as financial and emotional strain. Family members of persons with PTSD can experience high levels of caregiver burden that includes psychological distress, negative mood, and anxiety. In general, the worse the loved one's PTSD symptoms, the more severe the caregiver burden experienced.

(NIMH, 2011)

Family Experience

It is important for families to understand what they can do to help their loved one who has PTSD. This video discusses what a loved one can do as a family member:

<https://www.youtube.com/watch?v=0q517PRZnK0>

Patient and Family Support

Trauma survivors and their families typically don't know what to do to care for themselves. First, it is important for the person who experienced a traumatic event to seek professional help. This is the first step towards diagnosis and appropriate treatment. It is also important for the individual and his or her family to continue to learn more about trauma and its effects. Educational classes and use of resources may be helpful (see Resources section).

It is challenging to live with someone who has PTSD and it is important for families to take steps to care for themselves, as well as help their loved one. Some suggestions include:

- Spend time with other people. Coping is easier with social support, including family, friends, church, or other community groups.
- Join or develop a support group.
- Self-care. Family members frequently devote themselves totally to those that they care for, and in the process, neglect their own needs. It is important to watch diet, exercise, rest, and relaxation.
- Try to maintain family routines, including socialization and recreational outings.
- Take time to listen to all family members and show caring.

(NAMI, 2011)

Test Yourself

The effects of PTSD on a member of the family may include:

- A. Caregiver burden
- B. Health issues
- C. Depression
- D. All of the above

Answer: D

Conclusion

PTSD is a commonly misunderstood disorder. Persons who suffer from PTSD can have serious and long-lasting consequences. This disorder also affects the families of those diagnosed with PTSD. It is important that the diagnosis is made early so that

treatment can be initiated. A combination of therapies and the use of appropriate resources can assist individuals and families cope with PTSD.

Resources

For individuals in crisis:

- Suicide Prevention Lifeline 1-800-273-8255

For patients and families:

- National Alliance on Mental Illness (NAMI) 1-800-950-NAMI (6264)

NAMI provides a family to family support, including an educational program to assist families going through a mental illness diagnosis. More information is found at <http://www.nami.org/Find-Support/NAMI-Programs/NAMI-Family-to-Family>

- Sidran Institute <http://www.sidran.org/>

The Sidran Institute provides education and resources for treatment and support.

- National Institute of Mental Health (NIMH) <http://www.nimh.nih.gov>

This website has information on numerous topics of mental illness, including PTSD

For veterans and their families:

- Veterans Crisis Line: 1-800-273-8255, press 1
- Vet Center Combat Call Center 877-WAR-VETS

This call center allows a veteran to speak with another veteran

- Caregiver Support Line: 1-855-260-3274

This support line provides a resource for families of veterans diagnosed with PTSD

- National Center for PTSD <http://www.ptsd.va.gov>

This website provides information on PTSD, as well as available resources for persons with PTSD, specifically for veterans and their families

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