PTSD 101 Course

Transcript for: PTSD Overview

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[Video introduction]
-My name is Corporal Bradley Joseph Seitz.
-Kate Weber.
-Jerry Reed
-Will Sanchez
-And I have PTSD.
-I have PTSD.
-I have PTSD.

My name is Dr. Jessica Hamblen. I am a clinical psychologist and the Deputy Director for Education at the VA's National Center for PTSD. I'm also an Assistant Professor at the Geisel School of Medicine at Dartmouth. Today, I'm going to provide an overview of PTSD, or Posttraumatic Stress Disorder.

PTSD is an interesting psychological phenomenon because it has a known etiology - a traumatic event. Over 60% of men and over half of all women experience at least one traumatic event. That means that most of the people you meet every day have probably experienced a trauma in their lifetime.

It's adaptive to have strong reactions to trauma; we want to remember what's dangerous and stay away from it. So, thousands of years ago, if you were chased by a saber-toothed tiger, you would want to remember it, and react quickly the next time you saw one.

But what we want to see is that these reactions decrease once the threat has been removed. For most people, these reactions will lessen within the first few days or weeks after the traumatic event. But for people with PTSD, these reactions don't go away. If there's no reduction in symptoms one year after the traumatic event, it's extremely unlikely that the symptoms will resolve without treatment.

Of those who experience trauma, most do not develop PTSD. Only about 7% of all people develop PTSD in their lifetime.

Let's take a moment and define what a trauma is. We all experience stressors every day. There are the daily hassles – things like the car breaking down or having to pay bills. Then there are larger, more stressful events; losing a job, getting a divorce or even good things like buying a home or getting married fall into this category.

Traumatic stressors are different though. These are events in which someone feels that their life or the lives of others are being threatened. They can be witnessed or experienced directly. Or you can learn about a traumatic stressor happening to someone close to you. These include events such as warzone exposure, physical or sexual assault, serious accidents, child sexual or physical abuse, disasters and torture.

For some people, stressful events such as having a spouse who cheats on you might be worse than some traumatic events. But the events don't result in PTSD.

According to the DSM-5 for a PTSD diagnosis, you need one of these specific types of trauma exposure –

- Directly experiencing a traumatic event, such as being in combat or a hurricane
- Witnessing an event that happened to someone else, such as seeing a serious car accident
- Learning about a traumatic event that happened to friends or family, such as learning about the homicide or suicide of a family member. (Having a family member die of natural causes does <u>not</u> qualify).
- Or, experiencing repeated or extreme exposure to aversive details of traumatic events such as collecting human remains after combat or terrorist attacks.

In the DSM-5, it is explicit that choosing to view media images on TV such as watching coverage of the 9/11 attacks on television is not a traumatic event.

In addition to the type of trauma experienced, a diagnosis of PTSD requires a combination of symptoms from specific symptom clusters: re-experiencing, avoidance, negative alterations in cognition or mood, and hyperarousal. These symptoms must be present for more than one month and must cause significant distress or impairment.

People with PTSD re-experience the trauma. You need one re-experiencing symptom for a diagnosis. Re-experiencing includes intrusive thoughts about the trauma, nightmares or flashbacks of the event where it feels like the event is happening again, or becoming emotionally or physically upset by reminders of the trauma. For example, because bridges are dangerous in Iraq, a veteran of the wars in Iraq or Afghanistan might feel nervous and have a racing heart when driving under a bridge. A sexual assault survivor might become distressed when seeing someone who resembles the perpetrator.

[Video interview with SPC Rob Tucker (US Army) about re-experiencing]
Once I got back home, you know, I was driving. I mean I did a lot of driving when I was over there, almost every day. so driving here is a lot different than driving over there. Over there you avoid every pothole you possibly can because who knows what's inside of it. Here usually a pothole is just a pothole. A bag of trash or something beside the road here is usually a bag of trash. Over there, who knows what's inside of it.

So you swerve you know, stuff like that I for…a couple of months I did that here. Even still I kind of look at things like, whoa what's that? Your heart races or mind does anyway. My heart starts to race,things tighten up, muscles tighten up. I actually start looking around like almost like I'm looking for a trigger man. Stuff like that. And you know I try to swerve away from it. You know get on the other side of the road and stuff like that. But yeah, little things like that it's like… it's not normal I guess for here, you know?

People with PTSD avoid things that remind them of the trauma. For a diagnosis you need 1 avoidance symptom. They may avoid thinking or talking about the trauma or they may avoid people, places and activities that remind them of the trauma. People with PTSD will often avoid crowds because they feel unsafe or they may avoid conversations about the traumatic event. Motor vehicle accident survivors might avoid driving, while hurricane survivors might avoid going outside in bad weather.

[Video interview with Craig "Stu" Shipley (US Marine Corps) about avoidance]:
The most, probably the most prominent thing that I realized at first was I didn't…I trusted no one. Absolutely zero trust even in my own family, my own sons, my immediate family and friends that I had…lost total trust in my friends because I just, I felt like if I trusted somebody and somewhat opened up, I was gonna get hurt. I was gonna get screwed in the process. This wasn't going to work. And I didn't want to be around anybody so I isolated myself from life, totally. I was a truck driver, which suited me well. I'm very much a loner and I liked being alone so, I was on the road three, four or five weeks at a time. You are in the truck by yourself, got a lot of time to think about these things and I found myself as the years rolled on…I didn't want to be around anybody. Don't go to the movies – too many crowds. I don't want people sitting behind me, beside me. You don't go to a baseball game, ice hockey game. You totally isolate yourself from the world. And that's a horrible thing to live with that on a daily basis. And, and at first I accepted it and I thought it is what it is. But after ten or twenty years of this – it really, really wears on you. Hard. It gets worse.

In DSM-IV, numbing symptoms included the classic numbing symptoms of diminished interest or pleasure in activities (such as not enjoying social events), feeling detached from people, and an inability to feel positive emotions (such as love or happiness). An inability to recall important parts of the trauma was also included in DSM-IV. In DSM-5, the numbing symptoms of PTSD were expanded to include negative cognitions such as having negative beliefs about oneself, others and the world or assigning blame to self or others. For a diagnosis you need two symptoms from this cluster.

[Video interview with CPT Sarah Humphries (US Army) about negative alterations of cognition and mood]:
Let's see, I got home in June of 2006 and that summer, I don't, it might have been July or August, I don't know, I wanted to go for a walk. Sure, I was just trying to get away from it all, and my son, he was probably six or seven at the time. He wanted to ride his bike with me. And we had just started walking down the street and riding the bike and a lot of neighbors were out talking. It's the time of the night where everybody comes out 'cause it's so hot. He almost got hit by a car on his bike and it…it was so close that the driver stopped and was crying in tears, and my son was in tears, my neighbors were screaming, and my husband came running down the street, and I had no…reaction at all. You know, the mom that I was before I deployed would have had a screaming adrenaline fit. You know and, and then…I realized that the focus was on me now that they realized my son was OK and I was just, aha, Lance almost got hit by a car and just no emotion to it which really made my husband mad. It was quite the scene. You know, he yelled that I was some kind of a zombie freak or something and went into the house and my son was crying and said I didn't care. And you know, when I caught on to it, I tried to fake it but it was a little late and you know, that's not me. And of course I care about my son, it's just that I did not have the ability…and you have enough experiences like that and you just don't want to be bothered with people.

The emotional numbness I think is the most …it's…it'll just tear away all relationships in your life, you know. If you don't learn to unlock them and get those emotions out so...

It makes sense that people with PTSD often feel cranked up or in a state of hyperarousal. They are constantly thinking about the trauma and working hard to push those reminders out of their heads. That takes effort, and as a result, it is hard to relax. You need two hyperarousal symptoms for a diagnosis. People with PTSD often have trouble sleeping. They can be irritable, and have trouble concentrating. They are on guard, and constantly scanning for danger. They may engage in reckless or risky behavior such as driving too fast, and they may startle easily.

[Video interview with Jeff McDowell (US Army) about hyperarousal]:
When you go over there, the first firefight is like "ugh" and then you get over that, and you think that wasn't so bad, and then it goes on, and it keeps escalating. And the next thing you know every day is more intense, spun up a little bit more. You come back and you have…you don't realize you change as…that much. Things

like…some of the things that I have problems with was sleeping. It seemed like I was quick to anger. Things that made some people really excited and didn't even, you know, cause a ripple in the pond to me. Other times, I would go ballistic over nothing. I didn't like hanging around. Never was really a huge mall guy that I just…the whole idea of a crowd thing was just too overwhelming. You find yourself going out in large crowds whether it's to go out to eat or go to a movie and you spend all your time analyzing everybody around you and assessing them. And it's like…after awhile, you just…it just gets to be too much. You think oh, I just don't want to go out. And you start making excuses. So, the hypervigilance was a bad thing, anxiety and anger. And then I was having a terrible time with sleep.

So why do some people develop PTSD and others don't? There are several factors that have an impact on whether someone develops PTSD.

Personal factors such as prior trauma exposure and demographic characteristics have some effect on who develops PTSD. Several variables that are consistently found to be related to PTSD include: female gender, some genetic factors, adverse childhood experiences, previous psychiatric problems, lower levels of education, lower socioeconomic status, and minority race.

Characteristics of the trauma exposure show a larger contribution to the development of PTSD than the personal factors. One of the most consistent findings is that the greater the severity of exposure, the greater the likelihood you're going to develop PTSD. Greater perceived life threat, feelings of helplessness, and unpredictability or uncontrollability of the trauma are also significant risk factors.

Some types of traumatic events are more likely than others to result in PTSD. In general, interpersonal traumas such as combat, or sexual or physical assault are more likely to result in PTSD than events not caused by another human being, such as an accident, a disaster, or illness.

It makes sense that PTSD is a common consequence of war given the degree of life threat, unpredictability and its interpersonal nature. About 15% of returning veterans from Iraq and Afghanistan have PTSD, and 9% of Vietnam Veterans have current PTSD.

The recovery environment risk factors are the ones that are the most interesting and important, because they are the ones we can do something about. Among those is social support following the event. Another factor that's proving really important is subsequent life stress. Basically, the more life stress, the more likely someone is to develop PTSD. So, if service members come home and they can't find work, that financial hardship or that stress can contribute to PTSD. Or if a hurricane survivor can't get an insurance settlement to rebuild their home, that can contribute to PTSD.

If you have PTSD then it is highly likely you have another mental health problem as well. About 80% of people with PTSD have another problem and many have more than one. People with PTSD have an increased risk of depression, anxiety, and substance use disorders.

People with PTSD are also more likely to have greater functional impairment and a reduced quality of life. Concentration problems, irritability and avoidance can cause trouble at work and can result in higher unemployment rates. People with PTSD may struggle to maintain relationships, and some may engage in interpersonal violence. They are more likely to have a wide range of medical problems, as well. PTSD is also a risk factor for suicide.

The gold standard as of now for medication are the SSRI's or selective serotonin reuptake inhibitors. Sometimes, doctors will prescribe medicines called "benzodiazepines" for people with PTSD. These medications are often given to people who have problems with anxiety, and while they may be of some help at first, they do not treat the core PTSD symptoms. They also may lead to addiction, especially for people who

have had problems with alcohol or drugs. So, benzodiazepines are not recommended for long-term PTSD treatment.

In this course, we'll be focusing on psychosocial treatments since they have been shown to be more effective than medication for treating PTSD in the long term. If you would like more information on using medication for the treatment of PTSD, you can view the PTSD 101 course, Pharmacological Treatments.

There is a good news story to be told about psychosocial treatments. Cognitive behavioral therapies or CBT combine building new cognitive skills and engaging in new behaviors or changing existing ones. Numerous randomized, controlled studies on cognitive behavioral therapies for PTSD demonstrate that treatment works. Two of the most consistently proven types of CBT are Prolonged Exposure therapy and Cognitive Processing Therapy.

CAPS stands for the Clinician-Administered PTSD Scale. It's our gold standard for measuring PTSD. A CAPS in the 70s would be considered severe PTSD. Both Prolonged Exposure and Cognitive Processing Therapy result in very large changes that are maintained at post-treatment and 9 month follow up. But even more exciting, is that when the researchers went back 5-10 years later to check on these people (and a few new people who had enrolled since the study started), they looked even better. These CAPS scores are in the mild or sub-threshold range - about 80% of the study participants no longer met criteria for PTSD.

It is important to be able to describe the most effective cognitive behavioral therapies to trauma survivors so that you can help them understand what these treatments are and encourage them to seek treatment. In the next section we'll take a look at these therapies in more depth.

Prolonged Exposure or PE involves repeated exposure to thoughts, feelings, and situations that the trauma survivor has been avoiding to help them learn that reminders of the trauma do not have to be avoided. There are four main components. PE begins with education about the symptoms of PTSD to help clients better understand those symptoms. Then breathing retraining is taught to help clients manage their anxiety. Exposure comes next. This is really the key component of PE. There are two types of exposure in prolonged exposure. In in vivo, or live exposure, you help the client identify situations that they have been avoiding and then help them to repeatedly confront those situations until their distress decreases. Then the client begins imaginal exposure to the trauma. Imaginal exposure involves the retelling of the trauma in the present tense with as much detail as possible until the client is able to recall the traumatic event without becoming distressed.

[Video interview with VA therapist Dr. Matthew Yoder about PE therapy]:
Prolonged Exposure is a…evidence-based treatment, it's a…8 to 12 week time-limited therapy. It's an individual format so we offer it one clinician and one veteran. And like I said, it takes anywhere between 8 to 12 weeks. The average in our clinic is about 10 weeks. And the general idea with Prolonged Exposure is confronting things that one is afraid of, OK? Things that are actually safe but that one is afraid of. And with PTSD, those are things like memories and certain situations that make people feel really nervous or on guard or jumpy. And one…the therapy helps people confront those situations and memories as a way to get over the anxiety.

Cognitive Processing Therapy takes a slightly different approach. Here, the focus is on examining and changing trauma related thoughts that may be keeping the client stuck. Like PE, it begins with education about the symptoms of PTSD.

The second step is processing, which can be done with or without a written account of the trauma. In this step, the client is asked to reflect on how they made sense of what happened at the time of the trauma.

In the third step of CPT, the client learns cognitive skills to challenge thoughts such as “it was all my fault,” or the “the world is completely unsafe”. Then, in the fourth step, the client applies these new skills to their own thoughts and feelings about the traumatic event.

[Video interview with VA therapist Dr. Karen Kattar about CPT]:
Cognitive processing therapy or CPT is an evidence-based therapy, which means it has a lot of research behind it to show that it works. It’s cognitive behavioral in that the cognitive piece is we look at your thoughts and the behavioral piece is that after your thoughts begin to change or begin to expand, your behavior tends to change as well. So if you’ve been avoiding things that trigger your traumatic memories and emotions that go along with that, after you examine your thoughts through the writings that you do in CPT, you tend to be able to go out and do those things that you’ve been avoiding. So it helps you, through your thinking, to be able to do things and have more comfort with your own skin and in the rest of the world.

[Video interview with VA therapist Dr. Ron Acierno about the right time to seek therapy]:
Sometimes veterans ask: How do I know if I’m ready for treatment? Well, if you wait, you’re never going to be ready. Getting ready for treatment is like: How do I know I’m ready to get in better shape? How do I know I’m ready to be a better father? How do I know I’m ready to be a better person? If you’re feeling pain, you are ready for treatment. If you can’t do the things you used to do before you served your country, you’re ready for treatment. If your freedom has been impinged, diminished, restricted because you fought for our freedom, you’re ready for treatment. Don’t wait until you feel ready for treatment. That might never come. If you see signs that you can’t do what you used to do, then you’re ready for treatment.

I hope you have found this presentation to give you a good overview of PTSD and what we know about effective treatments. The National Center for PTSD has extensive resources for clinicians, trauma survivors, and family members and we urge you to take a look at these resources to learn more about PTSD diagnosis and treatment.