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Managing Post Traumatic Stress: The Aftermath of Traumatic Events

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Abstract : *Tragic events such as those of September 11, 2001, underscore the increasingly prominent role that psychiatrists play in aiding survivors, emergency workers, and broader communities to cope with disaster. The present review was undertaken to identify whether there exists a scientific basis for the practice of psychiatry in the aftermath of disasters. Most of the literature suggests that disasters have psychopathological consequences as well as medical and social ones. Pre-existing mood and anxiety disorders, although surprisingly not psychotic illness, appear to be risk factors for further psychopathology after a disaster. Thus, both acute psychopharmacological and psychotherapeutic interventions at disaster sites may prevent long-term sequelae, although their efficacy remains uncertain.*

Keywords: *Post Traumatic Stress, Psychopathology, Reaction Index, Natural Disasters*

Introduction

Post-traumatic stress disorder (PTSD) is a widespread disorder that affects certain individuals psychologically, behaviorally, and emotionally following the experience of a traumatic event. PTSD may develop after a person is exposed to one or more traumatic events, such as sexual assault, serious injury, or the threat of death. The diagnosis may be given when a group of symptoms, such as disturbing recurring flashbacks, avoidance or numbing of memories of the event, and hyperarousal (high levels of anxiety) continue for more than a month after the traumatic event (American Psychiatric Association, 2013).

Five months after a tornado devastated a rural community in eastern North Carolina, Madakasira & O'Brien (1987) survey the mental health status of 116 disaster victims, using the Hopkins Symptom Checklist (HSCL) expanded to include most of DSM III criteria for Post Traumatic Stress Disorder (PTSD). These findings suggest a high incidence of acute PTSD in victims of natural disasters and the potential value of HSCL in screening for PTSD in larger populations.

Self-report data for 5,687 children ranging in age from 9 to 19 years were collected approximately three months after Hurricane Hugo devastated the rural community where the children lived. Information about the children's perceptions of hurricane severity, degree of home damage suffered as a result of

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the hurricane, and hurricane-related parental job loss was used to categorize children into four levels of hurricane exposure. Reports of anxiety were obtained via the Revised Children's Manifest Anxiety Scale (RCMAS) and reports of posttraumatic stress disorder (PTSD) symptoms were obtained via the Reaction Index (RI). Significantly higher anxiety scores and significantly more PTSD symptomatology were found for children experiencing more or more severe exposure to the hurricane. Girls reported more anxiety and PTSD symptoms than boys, and black children were more likely than the white children to report PTSD symptomatology. Additionally, girls were more severely affected by increasing levels of hurricane exposure as indicated by their RI scores. These results indicate that, similar to adult and child victims of crime and adult victims of disaster, the development of PTSD symptoms in children exposed to a natural disaster is a function of the degree of exposure to the traumatic event. The results also suggest that children's trait negative affectivity may moderate the effects of exposure on the development of PTSD symptoms (Lonigan etal., 1991).

McFarlane (1988) investigated the onset of post-traumatic stress disorders in a group of firefighters who had an intense exposure to a bushfire disaster using a longitudinal research design. Contrary to expectation, the intensity of exposure, the perceived threat, and the losses sustained in the disaster, when considered independently, were not predictors of post-traumatic stress disorder. By contrast, introversion, neuroticism, and a past history and family history of psychiatric disorder were pre-morbid factors significantly associated with the development of chronic post-traumatic stress disorders.

In another study conducted by Green et al. (1991), psychiatric reports of 179 children aged 2 to 15 years who were exposed to the Buffalo Creek dam collapse in 1972 were rated for post-traumatic stress disorder (PTSD) symptoms 2 years after the disaster. Age and gender effects and the impact of the level of exposure and parental functioning were examined according to a conceptual model addressing factors contributing to adaptation to a traumatic event. Results showed fewer PTSD symptoms in the youngest age group and higher symptom levels for girls than boys. Approximately 37% of the children were given a "probable" diagnosis of PTSD. Multiple regression analysis showed that life threat, gender, parental psychopathology, and an irritable and/or depressed family atmosphere all contributed to the prediction of PTSD symptomatology in the children.

Nolen-Hoeksema & Jannay (1991) obtained measures of emotional health and styles of responding to negative moods for 137 students 14 days before the Loma Prieta earthquake. A follow-up was done 10 days and again 7 wks after the earthquake to test predictions about which of the students would show the most enduring symptoms of depression and posttraumatic stress. Regression analyses showed that students who, before the earthquake, already had elevated levels of depression and stress symptoms and a ruminative style of responding to their symptoms had more depression and stress symptoms for both follow-ups. Students who were exposed to more dangerous or difficult circumstances because of the earthquake also had elevated symptom levels 10 days after the earthquake. Similarly, students who, during the 10 days after the earthquake, had more rumination about the earthquake were still more likely to have high levels of depressive and stress symptoms 7 wks after the earthquake.

Most people having experienced a traumatizing event will not develop PTSD (NCCMH, 2005). Women are more likely to experience higher impact events, and are also more likely to develop PTSD than men. Children are less likely to experience PTSD after trauma than adults, especially if they are less than ten years of age (NCCMH, 2005). War veterans are commonly at risk to PTSD.

Signs & Symptoms

PTSD can cause many symptoms. These symptoms can be grouped into three categories:

1. Re-experiencing symptoms

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

Re-experiencing symptoms may cause problems in a person's everyday routine. They 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.

2. Avoidance symptoms

- Staying away from places, events, or objects that are reminders of the experience
- Feeling emotionally numb
- Feeling strong guilt, depression, or worry
- Losing interest in activities that were enjoyable in the past
- Having trouble remembering the dangerous event.

Things that remind a person of the traumatic event can trigger avoidance symptoms. These symptoms may cause a person to change his or her personal routine. For example, after a bad car accident, a person who usually drives may avoid driving or riding in a car.

3. Hyperarousal symptoms

- Being easily startled
- Feeling tense or "on edge"
- Having difficulty sleeping, and/or having angry outbursts.

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

It's natural to have some of these symptoms after a dangerous event. Sometimes people have very serious symptoms that go away after a few weeks. This is called acute stress disorder, or ASD. When the symptoms last more than a few weeks and become an ongoing problem, they might be PTSD. Some people with PTSD don't show any symptoms for weeks or months.

Do children react differently than adults?

Children and teens can have extreme reactions to trauma, but their symptoms may not be the same as adults. In very young children, these symptoms can include:

- Bedwetting, when they'd learned how to use the toilet before
- Forgetting how or being unable to talk
- Acting out the scary event during playtime
- Being unusually clingy with a parent or other adult.

Older children and teens usually show symptoms more like those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Older children and teens may feel guilty for not preventing injury or deaths. They may also have thoughts of revenge.

Risk factors for PTSD include

- Living through dangerous events and traumas
- Having a history of mental illness
- Getting hurt
- Seeing people hurt or killed
- 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.

Resilience factors that may reduce the risk of PTSD include

- Seeking out support from other people, such as friends and family
- Finding a support group after a traumatic event
- Feeling good about one's own actions in the face of danger
- Having a 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.

Researchers are studying the importance of various risk and resilience factors. With more study, it may be possible someday to predict who is likely to get PTSD and prevent it.

Diagnosis

Not every traumatized person develops full-blown or even minor PTSD. Symptoms usually begin within 3 months of the incident but occasionally emerge years afterward. They must last more than a month to be considered PTSD. The course of the illness varies. Some people recover within 6 months, while others have symptoms that last much longer. In some people, the condition becomes chronic. A doctor who has experience helping people with mental illnesses, such as a psychiatrist or psychologist, can diagnose PTSD. The diagnosis is made after the doctor talks with the person who has symptoms of PTSD.

To be diagnosed with PTSD, a person must have all of the following for at least 1 month:

- At least one re-experiencing symptom
- At least three avoidance symptoms
- At least two hyperarousal symptoms

Symptoms that make it hard to go about daily life, go to school or work, be with friends, and take care of important tasks. PTSD is often accompanied by depression, substance abuse, or one or more of the other anxiety disorders.

Psychological Treatments

The main treatments for people with PTSD are psychotherapy ("talk" therapy), medications, or 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 with PTSD. Some people with PTSD need to try different treatments to find what works for their symptoms. If someone with PTSD is going through an ongoing trauma, such as being in an abusive relationship, both of the problems need to be treated. Other ongoing problems can include panic disorder, depression, substance abuse, and feeling suicidal.

Psychotherapy

Psychotherapy is "talk" therapy. It involves talking with a mental health professional to treat a mental illness. Psychotherapy can occur one-on-one or in a group. Talk therapy treatment for PTSD usually lasts 6 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.

One helpful therapy is called cognitive behavioral therapy, or CBT. There are several parts to CBT, including:

Exposure therapy

This 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 place where the event happened. The therapist uses these tools to help people with PTSD cope with their feelings.

Cognitive restructuring

This therapy helps people make sense of the bad memories. Sometimes people remember the event differently than how it happened. They may feel guilt or shame about what is not their fault. The therapist helps people with PTSD look at what happened in a realistic way.

Stress inoculation training

This therapy 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.

Other types of treatment can also help people with PTSD. People with PTSD should talk about all treatment options with their therapist.

How Talk Therapies Help People Overcome PTSD

- Talk therapies teach people helpful ways to react to frightening events that trigger their PTSD symptoms. Based on this general goal, different types of therapy may:
- Teach about trauma and its effects.
- Use relaxation and anger control skills.
- Provide tips for better sleep, diet, and exercise habits.
- Help people identify and deal with guilt, shame, and other feelings about the event.
- Focus on changing how people react to their PTSD symptoms. For example, therapy helps people visit places and people that are reminders of the trauma.

Treatment after Mass Trauma: Sometimes large numbers of people are affected by the same event. For example, a lot of people needed help after Hurricane Katrina in 2005 and the terrorist attacks of September 11, 2001. Most people will have some PTSD symptoms in the first few weeks after events like these. This is a normal and expected response to serious trauma, and for most people, symptoms generally lessen with time. Most people can be helped with basic support, such as: Getting to a safe place; seeing a doctor if injured; getting food and water; contacting loved ones or friends; learning what is being done to help; etc.

Conclusion

Viewing disasters as multi-dimensional events, of which one faces is psychiatric, may help to ease unnecessary suffering and dysfunction both as victims try to overcome the immediate social, political, and economic obstacles to restoring normality to their lives, and as the 'dust settles' in the future and these victims try to finally return to their old lives. Early psychiatric intervention appears crucial to halt progressive long-term debilitation. Disasters are unique among the traumas in their very public nature, making them perhaps uncommonly accessible for the sake of treating and studying traumas.

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