



## "PTSD - SYMPTOMS AND TREATMENT"

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# PTSD - SYMPTOMS AND TREATMENT

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### **Course Description:**

This course provides an intensive overview of PTSD and Acute Stress Reactions, and offers treatment strategies for varied populations.

### **Course Objectives:**

The primary objectives of the course are to enable a mental health professional to:

1. Understand how and why Post-Traumatic Stress Disorder occurs.
2. Develop treatment strategies for impacting sufferers of PTSD.

### **Purpose of this course:**

The purpose of this CEU course is to provide discussion relevant to the mental health counselor on treatment issues concerning Post-Traumatic Stress Disorder.

### **Course Outline:**

Part 1: Course organization, Documentation and Introduction.

Part 2: Reading of the course materials (this document)

Part 3: Administration and Completion of the Evaluation of Learning Quiz

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**3 Clock Hours / CE Credits**



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# **PTSD - SYMPTOMS AND TREATMENT**

## **What is Posttraumatic Stress Disorder?**

Posttraumatic Stress Disorder, or PTSD, is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own, or may even get worse over time. These individuals may develop PTSD. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life.

PTSD is marked by clear biological changes as well as psychological symptoms. PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. The disorder is also associated with impairment of the person's ability to function in social or family life, including occupational instability, marital problems and divorces, family discord, and difficulties in parenting.

## **Understanding PTSD**

PTSD is not a new disorder. There are written accounts of similar symptoms that go back to ancient times, and there is clear documentation in the historical medical literature starting with the Civil War, when a PTSD-like disorder was known as "Da Costa's Syndrome." There are particularly good descriptions of posttraumatic stress symptoms in the medical literature on combat veterans of World War II and on Holocaust survivors.

Careful research and documentation of PTSD began in earnest after the Vietnam War. The National Vietnam Veterans Readjustment Study estimated in 1988 that the prevalence of PTSD in that group was 15.2% at that time and that 30% had experienced the disorder at some point since returning from Vietnam.

PTSD has subsequently been observed in all veteran populations that have been studied, including World War II, Korean conflict, and Persian Gulf populations, and in United Nations peacekeeping forces deployed to other war zones around the world. There are remarkably similar findings of PTSD in military veterans in other countries. For example, Australian Vietnam veterans experience many of the same symptoms that American Vietnam veterans experience.

PTSD is not only a problem for veterans, however. Although there are unique cultural- and gender-based aspects of the disorder, it occurs in men and women, adults and children, Western and non-Western cultural groups, and all socioeconomic strata. A national study of American civilians

conducted in 1995 estimated that the lifetime prevalence of PTSD was 5% in men and 10% in women. A revision of this study done in 2005, reports that PTSD occurs in about 8% of all Americans.

## **How does PTSD develop?**

Most people who are exposed to a traumatic, stressful event experience some of the symptoms of PTSD in the days and weeks following exposure. Available data suggest that about 8% of men and 20% of women go on to develop PTSD, and roughly 30% of these individuals develop a chronic form that persists throughout their lifetimes.

The course of chronic PTSD usually involves periods of symptom increase followed by remission or decrease, although some individuals may experience symptoms that are unremitting and severe. Some older veterans, who report a lifetime of only mild symptoms, experience significant increases in symptoms following retirement, severe medical illness in themselves or their spouses, or reminders of their military service (such as reunions or media broadcasts of the anniversaries of war events).

## **How is PTSD assessed?**

In recent years, a great deal of research has been aimed at developing and testing reliable assessment tools. It is generally thought that the best way to diagnose PTSD-or any psychiatric disorder, for that matter-is to combine findings from structured interviews and questionnaires with physiological assessments. A multi-method approach especially helps address concerns that some patients might be either denying or exaggerating their symptoms.

## **How common is PTSD?**

An estimated 7.8 percent of Americans will experience PTSD at some point in their lives, with women (10.4%) twice as likely as men (5%) to develop PTSD. About 3.6 percent of U.S. adults aged 18 to 54 (5.2 million people) have PTSD during the course of a given year. This represents a small portion of those who have experienced at least one traumatic event; 60.7% of men and 51.2% of women reported at least one traumatic event. The traumatic events most often associated with PTSD for men are rape, combat exposure, childhood neglect, and childhood physical abuse. The most traumatic events for women are rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.

About 30 percent of the men and women who have spent time in war zones experience PTSD. An additional 20 to 25 percent have had partial PTSD at some point in their lives. More than half of all male Vietnam veterans and almost half of all female Vietnam veterans have experienced "clinically serious stress reaction symptoms." PTSD has also been detected among veterans of the Gulf War, with some estimates running as high as 8 percent.

## **Who is most likely to develop PTSD?**

1. Those who experience greater stressor magnitude and intensity, unpredictability, uncontrollability, sexual (as opposed to nonsexual) victimization, real or perceived responsibility, and betrayal
2. Those with prior vulnerability factors such as genetics, early age of onset and longer-lasting childhood trauma, lack of functional social support, and concurrent stressful life events
3. Those who report greater perceived threat or danger, suffering, upset, terror, and horror or fear
4. Those with a social environment that produces shame, guilt, stigmatization, or self-hatred

## **What are the consequences associated with PTSD?**

PTSD is associated with a number of distinctive neurobiological and physiological changes. PTSD may be associated with stable neurobiological alterations in both the central and autonomic nervous systems, such as altered brainwave activity, decreased volume of the hippocampus, and abnormal activation of the amygdala. Both the hippocampus and the amygdala are involved in the processing and integration of memory. The amygdala has also been found to be involved in coordinating the body's fear response.

Psychophysiological alterations associated with PTSD include hyper-arousal of the sympathetic nervous system, increased sensitivity of the startle reflex, and sleep abnormalities.

People with PTSD tend to have abnormal levels of key hormones involved in the body's response to stress. Thyroid function also seems to be enhanced in people with PTSD. Some studies have shown that cortisol levels in those with PTSD are lower than normal and epinephrine and norepinephrine levels are higher than normal. People with PTSD also continue to produce higher than normal levels of natural opiates after the trauma has passed. An important finding is that the neurohormonal changes seen in PTSD are distinct from, and actually opposite to, those seen in major depression. The distinctive profile associated with PTSD is also seen in individuals who have both PTSD and depression.

PTSD is associated with the increased likelihood of co-occurring psychiatric disorders. In a large-scale study, 88 percent of men and 79 percent of women with PTSD met criteria for another psychiatric disorder. The co-occurring disorders most prevalent for men with PTSD were alcohol abuse or dependence (51.9 percent), major depressive episodes (47.9 percent), conduct disorders (43.3 percent), and drug abuse and dependence (34.5 percent). The disorders most frequently comorbid with PTSD among women were major depressive disorders (48.5 percent), simple phobias (29 percent), social phobias (28.4 percent), and alcohol abuse/dependence (27.9 percent).

PTSD also significantly impacts psychosocial functioning, independent of comorbid conditions. For instance, Vietnam veterans with PTSD were found to have profound and pervasive problems in their daily lives. These included problems in family and other interpersonal relationships, problems with employment, and involvement with the criminal justice system.

Headaches, gastrointestinal complaints, immune system problems, dizziness, chest pain, and discomfort in other parts of the body are common in people with PTSD. Often, medical doctors treat the symptoms without being aware that they stem from PTSD.

## **How is PTSD treated?**

PTSD is treated by a variety of forms of psychotherapy (talk therapy) and drug therapy. There is no definitive treatment, but some treatments appear to be quite promising, especially cognitive-behavioral therapy, group therapy, and exposure therapy. Exposure therapy involves having the patient repeatedly relive the frightening experience under controlled conditions to help him or her work through the trauma. Studies have also shown that medications help ease associated symptoms of depression and anxiety and help with sleep. The most widely used drug treatments for PTSD are the selective serotonin reuptake inhibitors, such as Prozac and Zoloft. At present, cognitive-behavioral therapy appears to be somewhat more effective than drug therapy. However, it would be premature to conclude that drug therapy is less effective overall since drug trials for PTSD are at a very early stage. Drug therapy appears to be highly effective for some individuals and is helpful for many more. In addition, the recent findings on the biological changes associated with PTSD have spurred new research into drugs that target these biological changes, which may lead to much increased efficacy.

## **Epidemiological Facts about PTSD**

### **What causes Posttraumatic Stress Disorder? How common is it?**

### **Who gets it?**

These questions are asked by epidemiologists, and two major epidemiological studies have produced some answers. The National Vietnam Veterans Readjustment Survey (NVVRS), conducted between November 1986 and February 1988, comprised interviews of 3,016 American veterans selected to provide a representative sample of those who served in the armed forces during the Vietnam era. The National Comorbidity Survey (NCS), conducted between September 1990 and February 1992, comprised interviews of a representative national sample of 8,098 Americans aged 15 to 54 years.

### **The National Comorbidity Survey Report provided the following information about PTSD in the general adult population:**

The estimated lifetime prevalence of PTSD among adult Americans is 7.8%, with women (10.4%) twice as likely as men (5%) to have PTSD at some point in their lives. This represents a small portion of those who have experienced at least one traumatic event; 60.7% of men and 51.2% of women reported at least one traumatic event. The most frequently experienced traumas were:

- Witnessing someone being badly injured or killed
- Being involved in a fire, flood, or natural disaster
- Being involved in a life-threatening accident
- Combat exposure

The majority of the people in the NCS experienced two or more types of trauma. More than 10% of men and 6% of women reported four or more types of trauma during their lifetimes.

The traumatic events most often associated with PTSD in men were rape, combat exposure, childhood neglect, and childhood physical abuse. For women, the most common events were rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.

However, none of these events invariably produced PTSD in those exposed to it, and a particular type of traumatic event did not necessarily affect different sectors of the population in the same way.

The NCS report concluded that "PTSD is a highly prevalent lifetime disorder that often persists for years. The qualifying events for PTSD are also common, with many respondents reporting the occurrence of quite a few such events during their lifetimes."

**The National Vietnam Veterans Readjustment Survey (NVVRS) report provided the following information about PTSD among Vietnam War veterans:**

The estimated lifetime prevalence of PTSD among American Vietnam theater veterans is 30.9% for men and 26.9% for women. An additional 22.5% of men and 21.2% of women have had partial PTSD at some point in their lives. Thus, more than half of all male Vietnam veterans and almost half of all female Vietnam veterans -about 1,700,000 Vietnam veterans in all- have experienced "clinically serious stress reaction symptoms."

15.2% of all male Vietnam theater veterans (479,000 out of 3,140,000 men who served in Vietnam) and 8.1% of all female Vietnam theater veterans (610 out of 7,200 women who served in Vietnam) are currently diagnosed with PTSD ("Currently" means 1986-88 when the survey was conducted).

**The NVVRS report also contains these figures on other problems of Vietnam veterans:**

Forty percent of Vietnam theater veteran men have been divorced at least once (10% had two or more divorces), 14.1% report high levels of marital problems, and 23.1% have high levels of parenting problems.

Almost half of all male Vietnam theater veterans currently suffering from PTSD had been arrested or in jail at least once -34.2% more than once- and 11.5% had been convicted of a felony.

The estimated lifetime prevalence of alcohol abuse or dependence among male theater veterans is 39.2%, and the estimate for current alcohol abuse or dependence is 11.2%. The estimated lifetime prevalence of drug abuse or dependence among male theater veterans is 5.7%, and the estimate for current drug abuse or dependence is 1.8%.

Because the NVVRS sample size underrepresented members of certain ethnic minorities, the Matsunaga Vietnam Veterans Project undertook further epidemiological research among Native American, Asian American, and Pacific Islander veterans.

# **Traumatic Stress and Motor Vehicle Accidents**

## **Introduction**

Researchers are looking more closely at motor vehicle accidents (MVAs) as a common cause of traumatic stress. In one large study, accidents were shown to be the traumatic event most frequently experienced by males (25%) and the second most frequent traumatic event experienced by females (13%) in the United States. Over 100 billion dollars are spent every year to take care of the damage caused by auto accidents. Survivors of MVAs often also experience emotional distress as a result of such accidents. Mental-health difficulties such as posttraumatic stress, depression, and anxiety are problems survivors of severe MVAs may exhibit. This fact sheet addresses important issues related to MVAs, including how many people experience serious MVAs, how many people develop MVA-related Posttraumatic Stress Disorder (PTSD) and other psychological reactions, what the risk factors are for MVA-related PTSD, and what kind of treatments help MVA-related PTSD.

## **How many people experience serious motor vehicle accidents?**

One unfortunate consequence of the high volume of commuter and personal travel in the U.S. is the number of accidents that result in personal injury and fatalities. In any given year, approximately 1% of the U.S. population will be injured in motor vehicle accidents. Thus, MVAs account for over 3 million injuries annually and are one of the most common traumas individuals experience.

## **How many people develop MVA-related PTSD and other psychological reactions?**

Research on individuals seeking treatment and individuals in the general population suggests that the majority of those who survive a serious MVA do not develop mental-health problems that warrant professional treatment. However, a substantial minority of MVA survivors suffer from mental-health problems, the most common of which are Posttraumatic Stress Disorder (PTSD), Major Depression, and Anxiety Disorders.

Studies of the general population have found that approximately 9% of MVA survivors develop PTSD. Rates are significantly higher in samples of MVA survivors who seek mental-health treatment. Studies show that between 14% and 100% of MVA survivors who seek mental-health treatment have PTSD, with an average of 60% across studies. In addition, between 3% and 53% of MVA survivors who seek treatment and have PTSD also have a mood disorder such as Major Depression. Finally, in one large study of MVA survivors who sought treatment, 27% had an anxiety disorder in addition to their PTSD, and 15% reported a phobia of driving.

## **What are the risk factors for MVA-related PTSD?**

Recent research has identified variables that have predictive value when trying to determine who might experience PTSD after a serious accident. The use of such research allows clinicians to identify individuals at risk for long-term mental-health problems secondary to their accident.

The research focusing on identifying at risk individuals has been directed at three sets of variables: characteristics about the individual that were present prior to the MVA, accident-related variables, and postaccident variables.

- Pre-accident variables such as poor ability to cope in reaction to previous traumatic events, the presence of a pre-accident mental-health problem (e.g., depression), and poor social support have all been linked to the development of PTSD following severe MVAs.
- With respect to accident-related variables, the amount of physical injury, potential life-threat, and loss of significant others have been predictive of the development of mental-health problems such as PTSD. That is, as the amount of physical injury and fear of dying increase, the chance of developing PTSD also increases.
- Postaccident variables that are predictive of PTSD following MVAs are: the rate of physical recovery from injury, the level of social support from friends and family, and the level of active reengagement in both work and social activities. To the extent that physical limitations will allow, survivors of MVAs should be encouraged to maintain as much of their pre-accident lifestyle as possible, with as much support from family and friends as possible. Such coping strategies appear to be linked with positive mental-health outcomes.

## **What treatments are available for MVA-related PTSD?**

One aspect of MVA-related PTSD that is different from PTSD caused by other traumas is the increased likelihood of being injured or developing a chronic pain condition following the trauma. As a result, many people who have been in an MVA present first to their primary care physicians for treatment and do not consider psychological treatment for some time. Unfortunately, studies have shown that of the people who develop PTSD and do not seek psychological treatment, approximately half continue to have symptoms for more than six months or a year. Therefore, it is important to identify the symptoms early on and seek appropriate psychological treatment.

A number of different treatment approaches have proven effective for MVA-related PTSD. Treatments include behavior therapy, cognitive therapy, and medications. In addition, it may be useful to work with a chronic pain specialist to help manage the physical pain caused by the injury. Sometimes these treatments are provided in conjunction with one another. Readers who are interested in more extensive information regarding treatment and provider contacts will find the websites listed below to be useful.

## **Additional Information**

Readers can find a full exposition of the personal and accident-related characteristics associated with poor mental-health outcomes after MVAs in an excellent book, *After the Crash*, by Blanchard and Hickling (1997). This book also explains a comprehensive approach to treatment for clinicians working with severe accident survivors.

## **Treatment of PTSD**

This fact sheet describes elements common to many treatment modalities for PTSD, including education, exposure, exploration of feelings and beliefs, and coping-skills training. Additionally, the most common treatment modalities are discussed, including cognitive-behavioral therapy, pharmacotherapy, EMDR, group treatment, and psychodynamic treatment.

## **Common Components of PTSD Treatment**

Treatment for PTSD typically begins with a detailed evaluation and the development of a treatment plan that meets the unique needs of the survivor. Generally, PTSD-specific treatment is begun only after the survivor has been safely removed from a crisis situation. If a survivor is still being exposed to trauma (such as ongoing domestic or community violence, abuse, or homelessness), is severely depressed or suicidal, is experiencing extreme panic or disorganized thinking, or is in need of drug or alcohol detoxification, it is important to address these crisis problems as a part of the first phase of treatment.

- It is important that the first phase of treatment include educating trauma survivors and their families about how persons get PTSD, how PTSD affects survivors and their loved ones, and other problems that commonly come along with PTSD symptoms. Understanding that PTSD is a medically recognized anxiety disorder that occurs in normal individuals under extremely stressful conditions is essential for effective treatment.
- Exposure to the event via imagery allows the survivor to re-experience the event in a safe, controlled environment, while also carefully examining his or her reactions and beliefs in relation to that event.
- One aspect of the first treatment phase is to have the survivor examine and resolve strong feelings such as anger, shame, or guilt, which are common among survivors of trauma.
- Another step in the first phase is to teach the survivor to cope with posttraumatic memories, reminders, reactions, and feelings without becoming overwhelmed or emotionally numb. Trauma memories usually do not go away entirely as a result of therapy but become manageable with the mastery of new coping skills.

## ***Therapeutic Approaches Commonly Used to Treat PTSD:***

***Cognitive-behavioral therapy (CBT)*** involves working with cognitions to change emotions, thoughts, and behaviors. *Exposure therapy* is one form of CBT that is unique to trauma treatment. It uses careful, repeated, detailed imagining of the trauma (exposure) in a safe, controlled context to help the survivor face and gain control of the fear and distress that was overwhelming during the trauma. In some cases, trauma memories or reminders can be confronted all at once ("flooding"). For other individuals or traumas, it is preferable to work up to the most severe trauma gradually by using relaxation techniques and by starting with less upsetting life stresses or by taking the trauma one piece at a time ("desensitization").

Along with exposure, CBT for trauma includes:

- learning skills for coping with anxiety (such as breathing retraining or biofeedback) and negative thoughts ("cognitive restructuring"),
- managing anger,
- preparing for stress reactions ("stress inoculation"),
- handling future trauma symptoms,
- addressing urges to use alcohol or drugs when trauma symptoms occur ("relapse prevention"), and
- communicating and relating effectively with people (social skills or marital therapy).

***Pharmacotherapy*** (medication) can reduce the anxiety, depression, and insomnia often experienced with PTSD, and in some cases, it may help relieve the distress and emotional numbness caused by trauma memories. Several kinds of antidepressant drugs have contributed to patient improvement in most (but not all) clinical trials, and some other classes of drugs have shown promise. At this time, no particular drug has emerged as a definitive treatment for PTSD. However, medication is clearly useful for symptom relief, which makes it possible for survivors to participate in psychotherapy.

***Eye Movement Desensitization and Reprocessing (EMDR)*** is a relatively new treatment for traumatic memories that involves elements of exposure therapy and cognitive-behavioral therapy combined with techniques (eye movements, hand taps, sounds) that create an alternation of attention back and forth across the person's midline. While the theory and research are still evolving for this form of treatment, there is some evidence that the therapeutic element unique to EMDR, attentional alternation, may facilitate the accessing and processing of traumatic material.

***Group treatment*** is often an ideal therapeutic setting because trauma survivors are able to share traumatic material within the safety, cohesion, and empathy provided by other survivors. As group members achieve greater understanding and resolution of their trauma, they often feel more confident and able to trust. As they discuss and share how they cope with trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, they prepare themselves to focus on the present

rather than the past. Telling one's story (the "trauma narrative") and directly facing the grief, anxiety, and guilt related to trauma enables many survivors to cope with their symptoms, memories, and other aspects of their lives.

**Brief psychodynamic psychotherapy** focuses on the emotional conflicts caused by the traumatic event, particularly as they relate to early life experiences. Through the retelling of the traumatic event to a calm, empathic, compassionate, and nonjudgmental therapist, the survivor achieves a greater sense of self-esteem, develops effective ways of thinking and coping, and learns to deal more successfully with intense emotions. The therapist helps the survivor identify current life situations that set off traumatic memories and worsen PTSD symptoms.

## **Psychiatric disorders that commonly co-occur with PTSD**

Psychiatric disorders that commonly co-occur with PTSD include depression, alcohol/substance abuse, panic disorder, and other anxiety disorders. Although crises that threaten the safety of the survivor or others must be addressed first, the best treatment results are achieved when both PTSD and the other disorder(s) are treated together rather than one after the other. This is especially true for PTSD and alcohol/substance abuse.

## **Complex PTSD**

Complex PTSD (sometimes called "Disorder of Extreme Stress") is found among individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, such as childhood sexual abuse. Developmental research is revealing that many brain and hormonal changes may occur as a result of early, prolonged trauma, and these changes contribute to difficulties with memory, learning, and regulating impulses and emotions. Combined with a disruptive, abusive home environment that does not foster healthy interaction, these brain and hormonal changes may contribute to severe behavioral difficulties (such as impulsivity, aggression, sexual acting out, eating disorders, alcohol/drug abuse, and self-destructive actions), emotional regulation difficulties (such as intense rage, depression, or panic), and mental difficulties (such as extremely scattered thoughts, dissociation, and amnesia). As adults, these individuals often are diagnosed with depressive disorders, personality disorders, or dissociative disorders. Treatment often takes much longer than with regular PTSD, may progress at a much slower rate, and requires a sensitive and structured treatment program delivered by a trauma specialist.

## **PTSD and Problems with Alcohol Use**

PTSD does not automatically cause problems with alcohol use; there are many people with PTSD who do not have problems with alcohol. However, PTSD and alcohol together can be serious trouble for the trauma survivor and his or her family.

## **How do PTSD and alcohol use affect each other and make problems worse?**

### **PTSD and alcohol problems often occur together.**

People with PTSD are more likely than others with similar backgrounds to have alcohol use disorders both before and after being diagnosed with PTSD, and people with alcohol use disorders often also have PTSD.

Being diagnosed with PTSD increases the risk of developing an alcohol use disorder.

Women exposed to trauma show an increased risk for an alcohol use disorder even if they are not experiencing PTSD. Women with problematic alcohol use are more likely than other women to have been sexually abused at some point in their lives.

Men and women reporting sexual abuse have higher rates of alcohol and drug use disorders than other men and women.

Twenty-five to seventy-five percent of those who have survived abusive or violent trauma also report problems with alcohol use.

Ten to thirty-three percent of survivors of accidental, illness, or disaster trauma report problematic alcohol use, especially if they are troubled by persistent health problems or pain.

Sixty to eighty percent of Vietnam veterans seeking PTSD treatment have alcohol use disorders. Veterans over the age of 65 with PTSD are at increased risk for attempted suicide if they also experience problematic alcohol use or depression. War veterans diagnosed with PTSD and alcohol use tend to be binge drinkers. Binges may be in reaction to memories or reminders of trauma.

### **Alcohol problems often lead to trauma and disrupt relationships.**

Persons with alcohol use disorders are more likely than others with similar backgrounds to experience psychological trauma. They also experience problems with conflict and intimacy in relationships.

Problematic alcohol use is associated with a chaotic lifestyle, which reduces family emotional closeness, increases family conflict, and reduces parenting abilities.

### **PTSD symptoms often are worsened by alcohol use.**

Although alcohol can provide a temporary feeling of distraction and relief, it also reduces the ability to concentrate, enjoy life, and be productive.

Excessive alcohol use can impair one's ability to sleep restfully and to cope with trauma memories and stress.

Alcohol use and intoxication also increase emotional numbing, social isolation, anger and irritability, depression, and the feeling of needing to be on guard (hyper-vigilance).

Alcohol use disorders reduce the effectiveness of PTSD treatment.

Many individuals with PTSD experience sleep disturbances (trouble falling asleep or problems with waking up frequently after falling asleep). When a person with PTSD experiences sleep disturbances, using alcohol as a way to self-medicate becomes a double-edged sword. Alcohol use may appear to help symptoms of PTSD because the alcohol may decrease the severity and number of frightening nightmares commonly experienced in PTSD. However, alcohol use may, on the other hand, continue the cycle of avoidance found in PTSD, making it ultimately much more difficult to treat PTSD because the client's avoidance behavior prolongs the problems being addressed in treatment. Also, when a person withdraws from alcohol, nightmares often increase.

**Individuals with a combination of PTSD and alcohol use problems often have additional mental or physical health problems. As many as 10-50% of adults with alcohol use disorders and PTSD also have one or more of the following serious disorders:**

Anxiety disorders (such as panic attacks, phobias, incapacitating worry, or compulsions)

Mood disorders (such as major depression or a dysthymic disorder)

Disruptive behavior disorders (such as attention deficit or antisocial personality disorder)

Addictive disorders (such as addiction to or abuse of street or prescription drugs)

Chronic physical illness (such as diabetes, heart disease, or liver disease)

Chronic physical pain due to physical injury/illness or due to no clear physical cause

## **What are the most effective treatment patterns?**

Because the existence of both PTSD and an alcohol use disorder in an individual makes both problems worse, alcohol use problems often must be addressed in PTSD treatment. When alcohol use is (or has been) a problem in addition to PTSD, it is best to seek treatment from a PTSD specialist who also has expertise in treating alcohol (addictive) disorders. In any PTSD treatment, several precautions related to alcohol use and alcohol disorders are advised:

The initial interview and questionnaire assessment should include questions that sensitively and thoroughly identify patterns of past and current alcohol and drug use.

Treatment planning should include a discussion between the professional and the client about the possible effects of alcohol use problems on PTSD, sleep, anger and irritability, anxiety, depression, and work or relationship difficulties.

Treatment should include education, therapy, and support groups that help the client address alcohol use problems in a manner acceptable to the client.

Treatment for PTSD and alcohol use problems should be designed as a single consistent plan that addresses both sources of difficulty together. Although there may be separate meetings or clinicians devoted primarily to PTSD or to alcohol problems, PTSD issues should be included in alcohol treatment, and alcohol use ("addiction" or "sobriety") issues should be included in PTSD treatment.

Relapse prevention must prepare the newly sober individual to cope with PTSD symptoms, which often seem to worsen or become more pronounced with abstinence.

## **Anger and Trauma**

### **Why is anger a common response to trauma?**

Anger is usually a central feature of a survivor's response to trauma because it is a core component of the survival response in humans. Anger helps people cope with life's adversities by providing us with increased energy to persist in the face of obstacles. However, uncontrolled anger can lead to a continued sense of being out of control of oneself and can create multiple problems in the personal lives of those who suffer from PTSD.

One theory of anger and trauma suggests that high levels of anger are related to a natural survival instinct. When initially confronted with extreme threat, anger is a normal response to terror, events that seem unfair, and feeling out of control or victimized. It can help a person survive by mobilizing all of his or her attention, thought, brain energy, and action toward survival. Recent research has shown that these responses to extreme threat can become "stuck" in persons with PTSD. This may lead to a survival mode response where the individual is more likely to react to situations with "full activation," as if the circumstances were life threatening, or self-threatening. This automatic response of irritability and anger in individuals with PTSD can create serious problems in the workplace and in family life. It can also affect the individuals' feelings about themselves and their roles in society.

Another line of research is revealing that anger can also be a normal response to betrayal or to losing basic trust in others, particularly in situations of interpersonal exploitation or violence.

Finally, in situations of early childhood abuse, the trauma and shock of the abuse has been shown to interfere with an individual's ability to regulate emotions, which leads to frequent episodes of extreme or out of control emotions, including anger and rage.

### **How can posttraumatic anger become a problem?**

Researchers have described three components of posttraumatic anger that can become maladaptive or interfere with one's ability to adapt to current situations that do *not* involve extreme threat:

\* **Arousal:** Anger is marked by the increased activation of the cardiovascular, glandular, and brain systems associated with emotion and survival. It is also marked by increased muscle tension. Sometimes with individuals who have PTSD, this increased internal activation can become reset as the normal level of arousal and can intensify the actual emotional and physical *experience* of anger. This can cause a person to feel frequently on-edge, keyed-up, or irritable and can cause a person to be more easily provoked. It is common for traumatized individuals to actually seek out situations that require them to stay alert and ward off potential danger. Conversely, they may use alcohol and drugs to reduce overall internal tension.

\* **Behavior:** Often, the most effective way of dealing with extreme threat is to act aggressively, in a self-protective way. Additionally, many people who were traumatized at a relatively young age do not learn different ways of handling threat and tend to become stuck in their ways of reacting when they feel threatened. This is especially true of people who tend to be impulsive (who act before they think). Again, as stated above, while these strategies for dealing with threat can be adaptive in certain circumstances, individuals with PTSD can become stuck in using only one strategy when others would be more constructive. Behavioral aggression may take many forms, including aggression toward others, passive-aggressive behavior (e.g., complaining, "backstabbing," deliberately being late or doing a poor job), or self-aggression (self-destructive activities, self-blame, being chronically hard on oneself, self-injury).

\* **Thoughts and Beliefs:** The thoughts or beliefs that people have to help them understand and make sense of their environment can often overexaggerate threat. Often the individual is not fully aware of these thoughts and beliefs, but they cause the person to perceive more hostility, danger, or threat than others might feel is necessary. For example, a combat veteran may become angry when others around him (wife, children, coworkers) don't "follow the rules." The strength of his belief is actually related to how important it was for *him* to follow rules during the war in order to prevent deaths. Often, traumatized persons are not aware of the way their beliefs are related to past trauma. For instance, by acting inflexibly toward others because of their need to control their environment, they can provoke others into becoming hostile, which creates a self-fulfilling prophecy. Common thoughts people with PTSD have include: "You can't trust anyone," "If I got out of control, it would be horrible/life-threatening/intolerable," "After all I've been through, I deserve to be treated better than this," and "Others are out to get me, or won't protect me, in some way."

## **How can individuals with posttraumatic anger get help?**

In anger management treatment, arousal, behavior, and thoughts/beliefs are all addressed in different ways. Cognitive-behavioral treatment, a commonly utilized therapy that shows positive results when used to address anger, applies many techniques to manage these three anger components:

\* For **increased arousal**, the goal of treatment is to help the person learn skills that will reduce overall arousal. Such skills include relaxation, self-hypnosis, and physical exercises that discharge tension.

\* For **behavior**, the goal of treatment is to review a person's most frequent ways of behaving under perceived threat or stress and help him or her to expand the possible responses. More adaptive responses include taking a time out; writing thoughts down when angry; communicating in more verbal, assertive ways; and changing the pattern "act first, think later" to "think first, act later."

\* For **thoughts/beliefs**, individuals are given assistance in logging, monitoring, and becoming more aware of their own thoughts prior to becoming angry. They are additionally given alternative, more positive replacement thoughts for their negative thoughts (e.g., "Even if I am out of control, I won't be threatened in this situation," or "Others do not have to be perfect in order for me to survive/be comfortable"). Individuals often role-play situations in therapy so they can practice recognizing their anger-arousing thoughts and applying more positive thoughts.

There are many strategies for helping individuals with PTSD deal with the frequent increase of anger they are likely to experience. Most individuals have a combination of the three anger components listed above, and treatment aims to help with all aspects of anger. One important goal of treatment is to improve a person's sense of flexibility and control so that he or she does not feel re-traumatized by his or her own explosive or excessive responses to anger triggers. Treatment is also meant to have a positive impact on personal and work relationships.

## **Cautions Regarding Cognitive-Behavioral Interventions** **Provided Within a Month of Trauma**

### **How effective is Cognitive-Behavioral Therapy for early intervention?**

Researchers have conducted over 30 studies examining the effectiveness of Cognitive-Behavioral Therapy (CBT) in treating PTSD and several studies examining a brief, five-session treatment for Acute Stress Disorder (ASD). In general, CBT has proven very effective and produced significant reductions in PTSD symptoms. CBT treatments are often carefully scripted in treatment manuals. There are more published well-controlled studies of CBT than of any other PTSD treatment. Furthermore, the magnitude of treatment effects appears greater with CBT than with any other treatment.

Bryant et al.<sup>1</sup>, in treating motor vehicle and industrial accident victims who met criteria for ASD, compared five sessions of nondirective supportive counseling (providing support and education and teaching problem-solving skills), with brief cognitive-behavioral treatment (trauma education,

progressive muscle relaxation, imaginal exposure, cognitive restructuring, and graded in vivo exposure to avoided situations). At the conclusion of treatment, 8% of the participants in the CBT group and 83% of the participants in the supportive counseling (SC) group met criteria for PTSD. Six months posttrauma, 17% in the CBT group and 67% in the SC group met criteria for PTSD. There were also significant reductions in depressive symptoms in the CBT group compared to the SC group. Clearly, this is one of the most important developments in years regarding early intervention.

## **Complex PTSD**

### **What are the differences between the effects of short-term trauma and the effects of chronic trauma?**

The diagnosis of PTSD accurately describes the symptoms that result when a person experiences a short-lived trauma. For example, car accidents, natural disasters, and rape are considered traumatic events of time-limited duration. However, **chronic** traumas continue for months or years at a time. Clinicians and researchers have found that the current PTSD diagnosis often does not capture the severe psychological harm that occurs with such prolonged, repeated trauma. For example, ordinary, healthy people who experience chronic trauma can experience changes in their self-concept and the way they adapt to stressful events. Dr. Judith Herman of Harvard University suggests that a new diagnosis, called **Complex PTSD**, is needed to describe the symptoms of long-term trauma.

### **What are examples of captivity that are associated with chronic trauma?**

Judith Herman notes that during long-term traumas, the victim is generally held in a state of captivity. In these situations the victim is under the control of the perpetrator and unable to flee.

Examples of captivity include:

- Concentration camps
- Prisoner of War camps
- Prostitution brothels
- Long-term domestic violence
- Long-term, severe physical abuse
- Child sexual abuse
- Organized child exploitation rings

### **What are the symptoms of Complex PTSD?**

The first requirement for the diagnosis is that the individual experienced a **prolonged period (months to years) of total control by another**. The other criteria are symptoms that tend to result from chronic victimization. Those symptoms include:

- \* **Alterations in emotional regulation**, which may include symptoms such as persistent sadness, suicidal thoughts, explosive anger, or inhibited anger
- \* **Alterations in consciousness**, such as forgetting traumatic events, reliving traumatic events, or having episodes in which one feels detached from one's mental processes or body
- \* **Alterations in self-perception**, which may include a sense of helplessness, shame, guilt, stigma, and a sense of being completely different than other human beings
- \* **Alterations in the perception of the perpetrator**, such as attributing total power to the perpetrator or becoming preoccupied with the relationship to the perpetrator, including a preoccupation with revenge
- \* **Alterations in relations with others**, including isolation, distrust, or a repeated search for a rescuer
- \* **Alterations in one's system of meanings**, which may include a loss of sustaining faith or a sense of hopelessness and despair

## **What other difficulties do those with Complex PTSD tend to experience?**

Survivors may avoid thinking and talking about trauma-related topics because the feelings associated with the trauma are often overwhelming.

Survivors may use alcohol and substance abuse as a way to avoid and numb feelings and thoughts related to the trauma.

Survivors may also engage in self-mutilation and other forms of self-harm.

## **There is a tendency to blame the victim.**

A person who has been abused repeatedly is sometimes mistaken as someone who has a "weak character."

Because of their chronic victimization, in the past, survivors have been misdiagnosed by mental-health providers as having Borderline, Dependent, or Masochistic Personality Disorder. When survivors are faulted for the symptoms they experience as a result of victimization, they are being unjustly blamed.

Researchers hope that a new diagnosis will prevent clinicians, the public, and those who suffer from trauma from mistakenly blaming survivors for their symptoms.

## **Summary**

The current PTSD diagnosis often does not capture the severe psychological harm that occurs with prolonged, repeated trauma. For example, long-term trauma may impact a healthy person's self-concept and adaptation. The symptoms of such prolonged trauma have been mistaken for character weakness. Research is currently underway to determine if the Complex PTSD diagnosis is the best way to categorize the symptoms of patients who have suffered prolonged trauma.

## **Recommended Reading:**

**Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror**, by Judith Herman, M.D. (1997). Basic Books; ISBN 0465087302

## **Recommendations for Pharmacological Treatment of Acute Stress Reactions**

### **Who should receive pharmacological treatment?**

Pharmacological treatment for acute traumatic stress reactions (within one month of the trauma) is generally reserved for individuals who already have received individual or group debriefing and/or brief crisis-oriented psychotherapy. If these approaches are ineffective, clinicians should consider pharmacotherapy. To date there have been no controlled pharmacological treatment trials for acute stress reactions. Consequently, the present recommendations are based on controlled studies of insomnia, anxiety, and depression, as well as anecdotal evidence. Furthermore, there are no FDA approved medications for acute stress reactions and the only FDA approved medication for PTSD is sertraline.

Prior to receiving medication, the trauma survivor should have a thorough psychiatric and medical examination. Ongoing medical conditions, psychiatric diagnoses, current medications, and possible drug allergies should be assessed. In addition, clinicians should ask questions regarding alcohol, marijuana, and other drugs since these substances may interact with prescribed medications and may complicate an individual's psychological and physiological response to the trauma. For individuals with medical and/or surgical concerns, a clinician may need to take special precautions when prescribing psychotropic medications. It is also extremely important to consider possible drug interactions for individuals who are taking other prescribed or over-the-counter medications.

## **When should pharmacological treatment begin?**

In some cases, a clinician may need to prescribe psychotropic medications even before he or she has completed the medical and psychiatric evaluation. The acute use of medications may be necessary when the survivor is dangerous, extremely agitated, or psychotic. In such circumstances, the individual should be taken to an emergency room. In the emergency room, short-acting benzodiazepines (e.g. lorazepam) or high potency neuroleptics (e.g. haldol) with minimal sedative, anticholinergic, and orthostatic side effects may prove effective. Atypical neuroleptics (e.g. risperidone), at relatively low doses, may also be useful in treating impulsive aggression.

After a disaster, some survivors experience extreme and persistent arousal in the form of anxiety, panic, hyper-vigilance, irritability, and insomnia. Empirical research has shown that hyper-arousal during the first few weeks following trauma is a risk factor for the development of PTSD. Techniques to reduce arousal include relaxation and breathing exercises, utilizing social supports, psychotherapy, and pharmacotherapy. Pharmacological agents for the treatment of trauma-related arousal include benzodiazepines and antiadrenergic agents such as clonidine, guanfacine and propranolol.

## **What pharmacological agents should clinicians prescribe?**

Benzodiazepines are useful because they are effective and fast acting. In recent-trauma survivors, benzodiazepines can reduce anxiety and arousal and improve sleep. However, prolonged use may not be effective. In a study of trauma survivors with acute stress disorders (i.e., occurring 1-3 months after the trauma), the short-term use of benzodiazepines for sleep was associated with an acute reduction in posttraumatic stress symptoms (Mellman et al., 1998). However, another study found that the early and more prolonged use of benzodiazepines was actually associated with a higher rate of subsequent PTSD (Gelpin et al., 1996). It is recommended that benzodiazepines be used to treat extreme arousal, insomnia, and anxiety, but their use should be time limited. Other pharmacological agents may also be helpful in treating insomnia in persons suffering from acute traumatic stress. Low doses of trazadone, nefazadone, and amitriptyline are possible choices.

Antiadrenergic agents have not been studied for the treatment of acute stress reactions. However, several open trials have been conducted relating to chronic PTSD. These agents have been useful for some patients in controlling hyper-arousal, irritable aggression, intrusive memories, and insomnia. Low doses of propranolol have also been successfully used to combat stage fright and performance anxiety because it modulates physical and cognitive manifestations of stress. However, clinicians should prescribe clonidine, guanfacine and propranolol judiciously for survivors with cardiovascular disease. This is because these medications may reduce blood pressure. In addition, clonidine may induce rebound hypertension if the client's blood levels fall due to infrequent dosing or a sudden discontinuation. Furthermore, these agents should not be prescribed to persons with diabetes as they may interfere with counterregulatory hormone responses to hypoglycemia.

## **What other factors need to be considered?**

Recent trauma survivors may also suffer from debilitating symptoms of depression. Since all three symptom clusters of PTSD respond to selective serotonin reuptake inhibitors (SSRIs), and because depressive symptoms originating soon after trauma may predict PTSD, it is recommended that SSRIs be considered for persistent posttraumatic depression. In addition, SSRIs may be useful for controlling anxiety and irritability. It is important to note that traumatized women, compared to men, may be particularly responsive to the beneficial effects of SSRIs. SSRIs as well as other antidepressants should be administered in a "start low and go slow" dosing regimen because some individuals may develop increased anxiety or agitation in response to them. In addition, individuals occasionally develop psychotic or manic symptoms in response to SSRIs.

Some individuals have preexisting psychiatric disorders, including preexisting PTSD, at the time that they experience trauma. The most recent trauma may exacerbate these preexisting conditions, making it essential to carefully assess the individual's psychotherapeutic and pharmacological needs. It is imperative that a clinician contact any other current treaters and maintain continuity of care.

It is also possible that trauma will precipitate disorders other than depression, traumatic grief, Acute Stress Disorder, or PTSD. In such cases, careful assessment and diagnosis should inform appropriate treatment.

Finally, it is essential that treaters educate patients about their medication's interactions with alcohol, other medications, or substances of abuse. Treaters also need to (1) inform their patients of the medication's potential side effects, and (2) remain in close touch with their patients after initiating the use of these and other psychotropic agents. This will allow treaters to gauge the severity of any side effects, encourage compliance, and forestall complications that might arise as a result of extreme or otherwise idiosyncratic reactions to these medications. In addition, the added therapeutic support can help relieve the psychological burden from which people with posttraumatic distress suffer.

## **Effects of Traumatic Experiences**

When people find themselves suddenly in danger, sometimes they are overcome with feelings of fear, helplessness, or horror. These events are called traumatic experiences. Some common traumatic experiences include being physically attacked, being in a serious accident, being in combat, being sexually assaulted, and being in a fire or a disaster like a hurricane or a tornado. After traumatic experiences, people may have problems that they didn't have before the event. If these problems are severe and the survivor does not get help for them, they can begin to cause problems in the survivor's family. This fact sheet explains how traumas can affect those who experience them. This fact sheet also describes family members' reactions to the traumatic event and to the trauma survivor's symptoms and behaviors. Finally, suggestions are made about what a survivor and his or her family can do to get help for PTSD.

## How do traumatic experiences affect people?

People who go through traumatic experiences often have symptoms and problems afterward. How serious the symptoms and problems are depends on many things including a person's life experiences before the trauma, a person's own natural ability to cope with stress, how serious the trauma was, and what kind of help and support a person gets from family, friends, and professionals immediately following the trauma.

Because most trauma survivors are not familiar with how trauma affects people, they often have trouble understanding what is happening to them. They may think the trauma is their fault, that they are going crazy, or that there is something wrong with them because other people who experienced the trauma don't appear to have the same problems. Survivors may turn to drugs or alcohol to make themselves feel better. They may turn away from friends and family who don't seem to understand. They may not know what to do to get better.

## What do trauma survivors need to know?

- Traumas happen to many competent, healthy, strong, good people. No one can completely protect him- or herself from traumatic experiences.
- Many people have long-lasting problems following exposure to trauma. Up to 8% of individuals will have PTSD at some time in their lives.
- People who react to traumas are not going crazy. They are experiencing symptoms and problems that are connected with having been in a traumatic situation.
- Having symptoms after a traumatic event is not a sign of personal weakness. Many psychologically well-adjusted and physically healthy people develop PTSD. Probably everyone would develop PTSD if they were exposed to a severe enough trauma.
- When a person understands trauma symptoms better, he or she can become less fearful of them and better able to manage them.
- By recognizing the effects of trauma and knowing more about symptoms, a person is better able to decide about getting treatment.

## What are the common effects of trauma?

During a trauma, survivors often become overwhelmed with fear. Soon after the traumatic experience, they may re-experience the trauma mentally and physically. Because this can be uncomfortable and sometimes painful, survivors tend to avoid reminders of the trauma. These symptoms create a problem that is called posttraumatic stress disorder (PTSD). PTSD is a specific set of problems resulting from a traumatic experience and is recognized by medical and mental-health professionals.

**Re-experiencing Symptoms:**

Trauma survivors commonly re-experience their traumas. This means that the survivor experiences again the same mental, emotional, and physical experiences that occurred during or just after the trauma. These include thinking about the trauma, seeing images of the event, feeling agitated, and having physical sensations like those that occurred during the trauma. Trauma survivors find themselves feeling as if they are in danger, experiencing panic sensations, wanting to escape, getting angry, and thinking about attacking or harming someone else. Because they are anxious and physically agitated, they may have trouble sleeping and concentrating. The survivor usually can't control these symptoms or stop them from happening. Mentally re-experiencing the trauma can include:

- Upsetting memories such as images or thoughts about the trauma
- Feeling as if the trauma is happening again (flashbacks)
- Bad dreams and nightmares
- Getting upset when reminded about the trauma (by something the person sees, hears, feels, smells, or tastes)
- Anxiety or fear, feeling in danger again
- Anger or aggressive feelings and feeling the need to defend oneself
- Trouble controlling emotions because reminders lead to sudden anxiety, anger, or upset
- Trouble concentrating or thinking clearly

People also can have **physical** reactions to trauma reminders such as:

- Trouble falling or staying asleep
- Feeling agitated and constantly on the lookout for danger
- Getting very startled by loud noises or something or someone coming up on you from behind when you don't expect it
- Feeling shaky and sweaty
- Having your heart pound or having trouble breathing

Because trauma survivors have these upsetting feelings when they feel stress or are reminded of their trauma, they often act as if they are in danger again. They might get overly concerned about staying safe in situations that are not truly dangerous. For example, a person living in a safe neighborhood might still feel that he has to have an alarm system, double locks on the door, a locked fence, and a guard dog. Because traumatized people often feel like they are in danger even when they are not, they may be overly aggressive and lash out to protect themselves when there is no need. For example, a person who was attacked might be quick to yell at or hit someone who seems to be threatening.

Re-experiencing symptoms are a sign that the body and mind are actively struggling to cope with the traumatic experience. These symptoms are automatic, learned responses to trauma reminders. The trauma has become associated with many things so that when the person experiences these things, he or she is reminded of the trauma and feels that he or she is in danger again. It is also possible that re-experiencing symptoms are actually a part of the mind's attempt to make sense of what has happened.

### **Avoidance Symptoms:**

Because thinking about the trauma and feeling as if you are in danger is upsetting, people who have been through traumas often try to avoid reminders of the trauma. Sometimes survivors are aware that they are avoiding reminders, but other times survivors do not realize that their behavior is motivated by the need to avoid reminders of the trauma.

Ways of avoiding thoughts, feelings, and sensations associated with the trauma can include:

- Actively avoiding trauma-related thoughts and memories
- Avoiding conversations and staying away from places, activities, or people that might remind you of the trauma
- Trouble remembering important parts of what happened during the trauma
- Shutting down emotionally or feeling emotionally numb
- Trouble having loving feelings or feeling any strong emotions
- Finding that things around you seem strange or unreal
- Feeling strange
- Feeling disconnected from the world around you and things that happen to you
- Avoiding situations that might make you have a strong emotional reaction
- Feeling weird physical sensations

- Feeling physically numb
- Not feeling pain or other sensations
- Losing interest in things you used to enjoy doing

Trying to avoid thinking about the trauma and avoiding treatment for trauma-related problems may keep a person from feeling upset in the short term, but avoiding treatment means that in the long term, trauma symptoms will persist.

## **What are common secondary and associated posttraumatic symptoms?**

**Secondary** symptoms are problems that arise because of the posttraumatic re-experiencing and avoidance symptoms. For example, because a person wants to avoid talking about a traumatic event, she might cut off from friends, which would eventually cause her to feel lonely and depressed. As time passes after a traumatic experience, more secondary symptoms may develop. Over time, secondary symptoms can become more troubling and disabling than the original re-experiencing and avoidance symptoms.

**Associated** symptoms don't come directly from being overwhelmed with fear; they occur because of other things that were going on at the time of the trauma. For example, a person who is psychologically traumatized in a car accident might also be physically injured and then get depressed because he can't work or leave the house.

All of these problems can be secondary or associated trauma symptoms:

**Depression** can develop when a person has losses connected with the trauma or when a person avoids other people and becomes isolated.

**Despair and hopelessness** can result when a person is afraid that he or she will never feel better again.

Survivors may lose **important beliefs** when a traumatic event makes them lose faith that the world is a good and safe place.

**Aggressive behavior toward oneself or others** can result from frustration over the inability to control PTSD symptoms (feeling that PTSD symptoms run your life). People may also become aggressive when other things that happened at the time of trauma make the person angry (the unfairness of the situation). Some people are aggressive because they grew up with people who lashed out and they were never taught other ways to cope with angry feelings. Because angry feelings may keep others at a distance, they may stop a person from having positive connections and getting help. Anger and aggression can cause job problems, marital and relationship problems, and loss of friendships.

**Self-blame, guilt, and shame** can arise when PTSD symptoms make it hard to fulfill current responsibilities. They can also occur when people fall into the common trap of second-guessing what they did or didn't do at the time of a trauma. Many people, in trying to make sense of their experience, blame themselves. This is usually completely unwarranted and fails to hold accountable those who may have actually been responsible for the event. Self-blame causes a lot of distress and can prevent a person from reaching out for help. Sometimes society also blames the victim of a trauma. Unfortunately, this may reinforce the survivor's hesitation to seek help.

People who have experienced traumas may have **problems in relationships with others** because they often have a hard time feeling close to people or trusting people. This is especially likely to happen when the trauma was caused or worsened by other people (as opposed to an accident or natural disaster).

Trauma survivors may **feel detached or disconnected from others** because they have difficulty feeling or expressing positive feelings. After traumas, people can become overwhelmed by their problems or become numb and stop putting energy into their relationships with friends and family.

Survivors may get into **arguments and fights with other people** because of the angry or aggressive feelings that are common after a trauma. Also, a person's constant avoidance of social situations (such as family gatherings) may create hurt feelings or animosity in the survivor's relationships.

**Less interest or participation in things the person used to like to do** may result from depression following a trauma. When a person spends less time doing fun things and being with people, he or she has fewer chances to feel good and have pleasant interactions.

**Social isolation** can happen because of social withdrawal and a lack of trust in others. This often leads to the loss of support, friendships, and intimacy, and it increases fears and worries.

Survivors may have **problems with identity** when PTSD symptoms change important aspects of a person's life such as relationships or whether the person can do his or her work well. A person may also question his or her identity because of the way he or she acted during a trauma. For instance, a person who thinks of himself as unselfish might think he acted selfishly by saving himself during a disaster. This might make him question whether he really is who he thought he was.

**Feeling permanently damaged** can result when trauma symptoms don't go away and a person doesn't believe they will get better.

Survivors may develop **problems with self-esteem** because PTSD symptoms make it hard for a person to feel good about him- or herself. Sometimes, because of how they behaved at the time of the trauma, survivors feel that they are bad, worthless, stupid, incompetent, evil, etc.

**Physical health symptoms and problems** can happen because of long periods of physical agitation or arousal from anxiety. Trauma survivors may also avoid medical care because it reminds them of

their trauma and causes anxiety, and this may lead to poorer health. For example, a rape survivor may not visit a gynecologist and an injured motor vehicle accident survivor may avoid doctors because they remind him or her that a trauma occurred. Habits used to cope with posttraumatic stress, like alcohol use, can also cause health problems. In addition, other things that happened at the time of the trauma may cause health problems (for example, an injury).

Survivors may turn to **alcohol and drug abuse** when they want to avoid the bad feelings that come with PTSD symptoms. Many people use alcohol and drugs as a way to try to cope with upsetting trauma symptoms, but it actually leads to more problems.

### **Remember:**

Although individuals with PTSD may feel overwhelmed by their symptoms, it is important for them to remember that there are other, positive aspects of their lives. There are helpful mental-health and medical resources available (see link below), and survivors have their strengths, interests, commitments, relationships with others, past experiences that were not traumatic, desires, and hopes for the future.

Treatments are available for individuals with PTSD and associated trauma-related symptoms.

Understanding the effects of trauma on relationships can also be an important step for family members or friends.

## **Effects of Traumatic Stress in a Disaster Situation**

### **Normal Reactions to an Abnormal Situation**

It is important to help survivors recognize the normalcy of most stress reactions to disaster. Mild to moderate stress reactions in the emergency and early post-impact phases of disaster are highly prevalent because survivors (and their families, community members and rescue workers) accurately recognize the grave danger in disaster (Young et al., 1998). Although stress reactions may seem 'extreme', and cause distress, they generally do not become chronic problems. Most people recover fully from even moderate stress reactions within 6 to 16 months (Baum & Fleming, 1993; Green et al., 1994; La Greca et al., 1996; Steinglass & Gerrity, 1990). (From Disaster Mental Health Response Handbook, NSW Health, 2000, p. 27.)

In fact, resilience is probably the most common observation after all disasters. In addition, the effects of traumatic events are not always bad. Although many survivors of the 1974 tornado in Xenia, Ohio, experienced psychological distress, the majority described positive outcomes: they learned that they could handle crises effectively, and felt that they were better off for having met this type of challenge (Quarantelli, 1985). Disaster may also bring a community closer together or reorient an individual to

new priorities, goals or values. This concept has been referred to as 'posttraumatic growth' by some authors (e.g., Calhoun, 2000), and is similar to the 'benefited response' reported in the combat trauma literature (Ursano et al., 1996). (From Disaster Mental Health Response Handbook, p. 27.)

There are a number of possible reactions to a traumatic situation that are considered within the norm for individuals experiencing traumatic stress.

## **Common Traumatic Stress Reactions**

**(modified from Disaster Mental Health Response Handbook, p. 28)**

### **Emotional Effects**

- shock
- terror
- irritability
- blame
- anger
- guilt
- grief or sadness
- emotional numbing
- helplessness
- loss of pleasure derived from familiar activities
- difficulty feeling happy
- difficulty experiencing loving feelings

### **Physical Effects**

- fatigue, exhaustion
- insomnia
- cardiovascular strain
- startle response
- hyper-arousal
- increased physical pain
- reduced immune response
- headaches
- gastrointestinal upset
- decreased appetite
- decreased libido

### **Cognitive Effects**

- impaired concentration
- impaired decision making ability
- memory impairment
- disbelief
- confusion
- nightmares
- decreased self-esteem
- decreased self-efficacy
- self-blame
- intrusive thoughts/memories
- worry
- dissociation (e.g., tunnel vision, dreamlike or "spacey" feeling)

### **Interpersonal Effects**

- increased relational conflict
- social withdrawal
- reduced relational intimacy
- alienation
- impaired work performance
- impaired school performance
- decreased satisfaction
- distrust
- externalization of blame
- externalization of vulnerability
- feeling abandoned/rejected

- vulnerability to illness
- overprotectiveness

Although many of the above reactions seem negative, it must be emphasized that people also show a number of positive responses in the aftermath of disaster. These include resilience and coping, altruism, e.g., helping save or comfort others, relief and elation at surviving disaster, sense of excitement and greater self-worth, changes in the way they view the future, and feelings of "learning about one's strengths" and "growing" from the experience (Disaster Mental Health Response Handbook, p. 28).

## **Problematic Stress Responses**

The following responses are less common and indicate that the individual will likely need assistance from a medical or mental-health professional:

- Severe dissociation (feeling as if the world is unreal, not feeling connected to one's own body, losing one's sense of identity or taking on a new identity, amnesia)
- Severe intrusive re-experiencing (flashbacks, terrifying screen memories or nightmares, repetitive automatic reenactment)
- Extreme avoidance (agoraphobic-like social or vocational withdrawal, compulsive avoidance)
- Severe hyper-arousal (panic episodes, terrifying nightmares, difficulty controlling violent impulses, inability to concentrate)
- Debilitating anxiety (ruminative worry, severe phobias, unshakeable obsessions, paralyzing nervousness, fear of losing control/going crazy)
- Severe depression (lack of pleasure in life, feelings of worthlessness, self-blame, dependency, early awakenings)
- Problematic substance use (abuse or dependency, self-medication)
- Psychotic symptoms (delusions, hallucinations, bizarre thoughts or images)

Some people will be more affected by a traumatic event for a longer period of time than others, depending on the nature of the event and the nature of the individual who experienced the event. One of the most debilitating effects of traumatic stress is a condition known as Posttraumatic Stress Disorder (PTSD). The current trauma literature suggests that many factors are related to the increased or decreased risk for PTSD. The likelihood of developing PTSD and the severity and chronicity of symptoms experienced is a function of many variables, the most important being exposure to a traumatic event. It is therefore important to bear in mind that, even among vulnerable individuals, PTSD would not exist *without* exposure to a traumatic event.

## **Symptoms of PTSD**

Posttraumatic Stress Disorder (PTSD) is a mental disorder resulting from exposure to an extreme, traumatic stressor. PTSD has a number of unique defining features and diagnostic criteria, as published in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, 1994). These criteria include:

- Exposure to a traumatic stressor
- Re-experiencing symptoms
- Avoidance and numbing symptoms
- Symptoms of increased arousal
- Duration of at least one month
- Significant distress or impairment of functioning

#### Exposure to a traumatic stressor (Criterion A)

To be diagnosed with PTSD, the person must have been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others; and
- (2) the person's response to the trauma involved intense fear, helplessness, or horror. (In children, this may be expressed by disorganized or agitated behavior.)

Stressful events of daily life that do not meet these conditions include divorce and financial crises, which may lead to adjustment problems but are not sufficient to satisfy the criterion for a traumatic event (i.e., Criterion A) for PTSD.

Qualifying stressors must induce an intense emotional response. According to DSM-IV, a qualifying stressor must not only be threatening, but it must also induce a response involving intense fear, helplessness, or horror. Some severely traumatized individuals may dissociate during a stressor or have a blunted response due to defensive avoidance and numbing. Often, the intense emotional response to the stressor may not occur until considerable time has elapsed after the incident has terminated.

#### Re-experiencing symptoms

One set of PTSD symptoms involves persistent and distressing re-experiencing of the traumatic event in one or more ways. With these symptoms, the trauma comes back to the PTSD sufferer through memories, dreams, or distress in response to reminders of the trauma. An extreme example of this is flashbacks, where individuals feel as if they are reliving the traumatic experience. This is a severe, less common re-experiencing symptom. PTSD is distinguished from normal remembering of past events by the fact that re-experiencing memories of the trauma(s) are unwanted, occur involuntarily, elicit distressing emotions, and disrupt the individual's functioning and quality of life.

### Avoidance and numbing symptoms

Another set of PTSD symptoms involves the numbing of general responsiveness and the persistent avoidance of stimuli associated with the trauma. These symptoms involve avoiding reminders of the trauma. Reminders can be internal cues, such as thoughts or feelings about the trauma, and external stimuli in the environment that spark unpleasant memories and feelings. To this limited extent, PTSD is not unlike a phobia, where the individual goes to considerable length to avoid stimuli that provoke emotional distress. PTSD symptoms also involve general symptoms of impairment, such as pervasive emotional numbness, feeling out of sync with others, and not expecting future goals to be met.

### Symptoms of increased arousal

Symptoms of increased arousal include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper-vigilant watchfulness, and an exaggerated startle response. Individuals suffering from PTSD experience heightened physiological activation, which may occur in a general way even while at rest. More typically, this activation is evident as excessive reactions to specific stressors that are directly or symbolically reminiscent of the trauma. This set of symptoms is often linked to reliving the traumatic event. For example, sleep disturbance may be caused by nightmares, intrusive memories may interfere with concentration, and excessive watchfulness may reflect concerns about preventing the occurrence of a traumatic event similar to the previous trauma.

### Required duration of symptoms

For a diagnosis of PTSD to be made, **the symptoms must endure for at least one month.**

### PTSD symptoms must be clinically significant

PTSD symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Some individuals may experience a great deal of subjective discomfort and suffering owing to their PTSD symptoms without displaying conspicuous impairment in their day-to-day functioning. Other individuals show clear impairment in one or more spheres of functioning, such as social relating, work efficiency, or ability to engage in and enjoy recreational or leisure activities.

## **Symptoms of Acute Stress Disorder (ASD)**

For some trauma survivors, acute stress reactions are severe enough to meet DSM-IV criteria for Acute Stress Disorder (ASD). A growing body of evidence suggests that there are specific stress symptoms that may occur almost immediately following a traumatic event that may predict the development of PTSD (see review by Koopman, Classen, Cardena & Spiegel, 1995). The observation of acute stress reactions in these and other studies of natural and human-caused disasters led to the formation of the Acute Stress Disorder (ASD) diagnosis in the Diagnostic and Statistical Manual, Fourth Edition. Acute Stress Disorder is conceptually similar to PTSD and shares many of the same symptoms. Diagnostic criteria include dissociative (emotional numbness, feeling "unreal" or

disconnected from emotions or the environment), intrusive, avoidance, and arousal symptoms. To meet a diagnosis of ASD, symptoms must occur between 2 days and 4 weeks after a traumatic experience. After 4 weeks, a PTSD diagnosis should be considered (Bryant & Harvey, 1997).

## Who develops Acute Stress Disorder and Posttraumatic Stress Disorder?

The percentage of those exposed to traumatic stressors who then develop Posttraumatic Stress Disorder (PTSD) can vary depending on the nature of the trauma. At the time of a traumatic event, many people feel overwhelmed with fear; others feel numb or disconnected. **Most trauma survivors will be upset for several weeks following an event but will recover to a variable degree without treatment.** The percentage of trauma victims that will continue to have problems and develop Posttraumatic Stress Disorder will depend on many factors, including the severity of trauma exposure. In research on disasters, prevalence rates have been:

Natural disaster:	4-5%
Bombing:	34%
Plane crash into hotel:	29%
Mass shooting:	28%

The following types of exposure place survivors at high risk for a range of post-disaster problems:

- Exposure to mass destruction or death
- Toxic contamination
- Sudden or violent death of a loved one
- Loss of home or community

The rates of Acute Stress Disorder (as cited in Bryant, 2000) following traumatic incidents vary, with higher rates reported for human-caused trauma.

Typhoon	7%
Industrial accident	6%
Mass shooting	33%
Violent assault	19%
MVA:	14%
Assault, burn, indust.:	13%

Given that an individual must be exposed to a traumatic event in order to develop PTSD, other risk factors that have been shown to contribute to the development of PTSD include magnitude, duration, and type of traumatic exposure. Variables such as earlier age when exposed to the trauma and a lower level of education are also associated with increased risk for developing PTSD. Additional factors related to vulnerability for developing PTSD include: severity of initial reaction; peri-traumatic dissociation (i.e., feeling numb and having a sense of unreality during and shortly following a trauma); early conduct problems; childhood adversity; family history of psychiatric disorder; poor social support after a trauma; and personality traits such as hypersensitivity, pessimism, and negative reactions to stressors. Women are more likely to develop PTSD than men, independent of exposure type and level of stressor, and a history of depression in women increases the vulnerability for developing PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Breslau, 1990; Kulka et al., 1990). While exposure to a traumatic event may result in an increased vulnerability to subsequent traumas, several studies have also reported that exposure to trauma can have a "stress inoculation" effect and can

strengthen an individual's protective factors. This is because the individual has gained experience in successfully mastering traumatic events (Ursano, Grieger, & McCarroll, 1996).

Several factors present in the acute-phase recovery environment of a disaster have been found to aggravate stress reactions and therefore increase survivors' risk of developing negative outcomes (Emergency Management Australia, 1999). (From Disaster Mental Health Response Handbook, p. 36). These include:

- Lack of emotional and social support
- Presence of other stressors such as fatigue, cold, hunger, fear, uncertainty, loss, dislocation, and other psychologically stressful experiences
- Difficulties at the scene
- Lack of information about the nature and reasons for the event
- Lack of, or interference with, self-determination and self-management
- Treatment [given] in an authoritarian or impersonal manner
- Lack of follow-up support in the weeks following the exposure

Protective factors that may mitigate negative effects include:

- Social support
- Higher income and education
- Successful mastery of past disasters and traumatic events
- Limitation or reduction of exposure to any of the aggravating factors listed above
- Provision of information about expectations and availability of recovery services
- Care, concern and understanding on the part of the recovery services personnel
- Provision of regular and appropriate information concerning the emergency and reasons for action

Finally, community-related mediators that may help alleviate distress are rapid disaster relief and a positive community response that does not single out certain survivors as victims (Solomon et al., 1993).

Studies show that while there is no singular pattern of psychological consequences to disasters, typically the very early responses following disaster impact will be similar for both natural and human-made disasters (Burkle, 1996). However, the persistence of responses may differentiate the two. The effects of natural disasters seem no longer detectable in comparison to control populations after about two years, whereas several studies have shown that the effects of human-made events may be much more prolonged (Green & Lindy, 1994) (From Disaster Mental Health Response Handbook, p. 44). The degree of death, destruction, horror, inescapability, shock, loss and dislocation will still be influencing factors in determining pathological outcomes for both types of disasters, but these may be more marked in many human-made disasters. Furthermore, the element of human contribution to the disaster, particularly human malevolence, is likely to add to the complexities and difficulties of

psychological adjustment, thus leading to more adverse mental health effects (From Disaster Mental Health Response Handbook, p. 45).

## **Associated Disorders**

In addition to PTSD and ASD, individuals who have experienced trauma are at heightened risk for developing other psychiatric disorders, including:

- Depression
- Substance abuse
- Panic Disorder
- Obsessive-Compulsive Disorder
- Sexual dysfunction
- Eating disorders

## **Bereavement and bereavement complications**

(From Disaster Mental Health Response Handbook, pp. 41-43).

In situations of traumatic or catastrophic loss the bereaved person may demonstrate both traumatic stress reaction phenomena and bereavement phenomena, with either predominating or appearing intermittently (Raphael, 1997). Although a discussion of loss usually focuses upon death, loss that results from postdisaster experience may thus include (Cohen, 1998):

- Loss by death of loved one, family, or friend
- Property destruction
- Sudden unemployment
- Impaired physical, social, or psychological capacities and processes

It is generally agreed that there may be an initial and usually brief period of shock, numbness and disbelief, and to a degree, denial. While this period may be more prolonged if there is the additional impact of psychological trauma (see below), it is usually brief. This initial period usually gives way to intense separation distress or anxiety. The bereaved person is highly aroused, seeking for or scanning the environment for the lost person on higher alert. There may be searching behaviors, particularly if it is not certain that the person is dead, or the body has not been identified. In a disaster setting the bereaved person may place himself or herself at further risk through agitated searching behaviors. There is also likely to be a sense of anger, protest and abandonment anger that may be recognized as irrational by the bereaved person but nevertheless amounts to anger towards the deceased for not being there and for being among those who died. Anger is also directed towards those who may be seen as having caused or been associated with the death, who are alive when the deceased is not.

These reactions progressively abate and give way to a mourning dimension where the bereaved person is focused more on the psychological bonds with the dead person, the memories of the relationship, painful reminders of the absence of the person, and progressively accepting the death, although with ongoing feelings of sadness or loss. These latter reactions are more likely to appear during the recovery phase with progressive attenuation as the bereaved person adapts to life without the person who has died. These complex emotions of anxiety, protest, distress, sadness and anger are usually referred to as grief. The acute distress phase usually settles in the early few weeks or months after the loss, but emotions and preoccupations may occur over the first year or years that follow.

Normal bereavement shows both attenuation of psychological distress and progressive functional adaptation during the first few months. Complications may include adverse mental health outcomes such as impact on immune function (Bartrop et al., 1977), development of depressive or anxiety disorders, and adverse social or health effects (Byrne & Raphael, 1994; Middleton et al., 1998). In addition, it has been shown that about 9% of a normal community sample of bereaved people may develop 'chronic grief.' This is a form of abnormal grief where the initial acute distress continues with other manifestations for six months or more, and often for many years. 'Traumatic grief' and complicated grief disorder are similar forms (Raphael & Minkov, 1999).

Risk factors for complications of bereavement have been identified by a number of researchers (Parkes & Weiss, 1983; Raphael, 1977; Raphael & Minkov, 1999; Vachon et al., 1980). These include:

- Perceived lack of social support
- Other concurrent crises or stressors
- High levels of ambivalence in relation to the deceased
- An extremely dependent relationship
- Circumstances of death which are unexpected, untimely, sudden or shocking

Personality vulnerabilities and a past history of losses may also contribute. Thus it is clear that many circumstances of disaster deaths may be likely to lead to higher risk of bereavement complications. It has also been shown that inability to see the body of the dead person may further contribute to risk of adverse outcomes (Singh & Raphael, 1981), perhaps disrupting opportunities for farewell (Schut et al., 1991). In this context the concept of traumatic bereavement is highly relevant.

Studies of traumatic bereavement have identified traumatic circumstances of the death as a risk factor for adverse mental health outcome (Raphael, 1977; Parkes & Weiss, 1983). Lundin's (1984) studies of sudden and unexpected bereavement found increased morbidity compared with those where bereavement was expected. Unexpected loss resulted in more pronounced psychiatric symptoms, especially anxiety, which was more difficult to resolve. The phenomena identified at long-term follow-up included high levels of numbing and avoidance and could be interpreted as reflecting traumatic stress effects. Lehman et al. (1987) studied bereavement after motor vehicle accidents, likely to involve traumatic and unexpected losses, especially when the bereaved had been an occupant of the vehicle and thus involved in and potentially traumatized by the accident. Even 4 to 7 years later, spouses showed significantly higher levels of phobic anxiety, general anxiety, somatization,

interpersonal sensitivity, obsessive-compulsive symptoms and poorer well-being. For more than 90% of participants, memories, thoughts or mental pictures of the deceased intruded into the mind frequently, and for more than half of these they were 'hurt or pained' by these memories. These phenomena did not appear to be the sad, nostalgic memories of someone who has recovered from a loss, but were more like the intrusive re-experiencing of posttraumatic memories.

<END >

## **THANK YOU FOR YOUR PARTICIPATION IN THIS COURSE**

To receive continuing education credit for this course, you must have read this entire text file.

You must also complete and return the Evaluation of Learning Quiz and pay the CEU fee. (Instructions are on the next page.)

We always appreciate constructive input from our customers - even when it's 'negative', so please feel free to fill in the "Additional Comments" section of the Grade This Course evaluation when you submit your quiz and payment.



Richard K. Nongard, LMFT, CCH, CPFT  
Executive Director

# "PTSD - SYMPTOMS AND TREATMENT"

## 3 Continuing Education Clock Hours

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**Scottsdale, AZ 85260**

# EVALUATION OF LEARNING QUIZ - PAGE 1 of 4

PRINT & FAX or MAIL THIS PAGE AND THE ANSWERS PAGES TO OUR OFFICE

**\* \* \* \* OR \* \* \* \***

You may complete and submit this information **ONLINE** by following this link:

<https://www.fastceus-store.com/quizzes/index.php?extension=ptsd>

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## EVALUATION OF LEARNING QUIZ - PAGE 2 of 4

### "PTSD: SYMPTOMS AND TREATMENT"

#### 3 Hours of Approved Continuing Education Credit

*The purpose of the following Evaluation of Learning questions is to:*

- A.) Verify that you have read the required course materials
- B.) Demonstrate an understanding of the practical application of the course materials
- C.) Officially document your participation and completion of this course

#### ➞ PLEASE ANSWER THE 20 T/F EVALUATION OF LEARNING QUESTIONS.

- T F** 1. I have read all of the required reading material for this course.
- T F** 2. PTSD, is a psychiatric disorder that can occur following the experience or witnessing of life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, or violent personal assaults like rape.
- T F** 3. PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health.
- T F** 4. PTSD is a new disorder that has recently emerged.
- T F** 5. Men are twice as likely as women to develop PTSD.
- T F** 6. PTSD is associated with the increased likelihood of co-occurring psychiatric disorders.
- T F** 7. Cognitive-behavioral therapy appears to be somewhat more effective than drug therapy.
- T F** 8. Accidents were shown to be the traumatic event most frequently experienced by males and the second most frequent traumatic event experienced by females in the United States.
- T F** 9. One aspect of MVA-related PTSD that is different from PTSD caused by other traumas is the increased likelihood of being injured or developing a chronic pain condition following the trauma.
- T F** 10. Generally, PTSD-specific treatment is begun only after the survivor has been safely removed from a crisis situation.
- T F** 11. Exposure therapy is the antithesis of cognitive-behavioral therapy.
- T F** 12. Being diagnosed with PTSD does not increase the risk of developing an alcohol use disorder.

**CONTINUED →**

**EVALUATION OF LEARNING QUIZ - PAGE 3 of 4****"PTSD: SYMPTOMS AND TREATMENT"**

- T F** 13. Anger is a core component of the survival response in humans.
- T F** 14. There are more published well-controlled studies of CBT than of any other PTSD treatment.
- T F** 15. Recent trauma survivors may also suffer from debilitating symptoms of depression.
- T F** 16. When people find themselves suddenly in danger, sometimes they are overcome with feelings of fear, helplessness, or horror.
- T F** 17. Up to 38% of individuals will have PTSD at some time in their lives.
- T F** 18. Re-experiencing symptoms are a sign that the body and mind are actively struggling to cope with the traumatic experience.
- T F** 19. Secondary symptoms are problems that arise because of the posttraumatic re-experiencing and avoidance symptoms.
- T F** 20. It is important to help survivors recognize the normalcy of most stress reactions to disaster.

## **GRADE THIS ONLINE COURSE! – Page 4**

***It is helpful to us if you return this form via snail mail or fax, along with your Quiz and Payment, if you are not completing the form online. Thank-you!***

### **Participant Assessment of Home Study CEU Course**

#### **“PTSD: SYMPTOMS AND TREATMENT”**

#### **3 Credit Hours**

**Please Rate the Following Statements from 1-5**

***(1 being the Lowest, 5 being the Highest.)***

- \_\_\_\_\_ 1. I found the PeachTree Online Home Study Course Instructions simple to follow.
- \_\_\_\_\_ 2. I found the PeachTree Online Home Study Course materials to be of professional quality, and easy to read.
- \_\_\_\_\_ 3. I found the PeachTree Online Home Study Course materials to be of educational value, relative, and useful to my counseling practice.
- \_\_\_\_\_ 4. I completed the 3 Hour PeachTree Online Home Study Course in approximately 3 hours.
- \_\_\_\_\_ 5. I would take another PeachTree Online Home Study Course, and/or recommend them to a co-worker.

**ADDITIONAL COMMENTS:**