Post-Traumatic Stress Disorder in Adults

Description/Etiology

In the past, post-traumatic stress disorder (PTSD) was classified as an anxiety disorder that affected military personnel and war veterans. Today, the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5), identifies PTSD as a trauma and stressors-related disorder that can manifest in anyone who has been exposed to a traumatic or stressful event. PTSD may develop after a person witnesses or otherwise experiences an event involving death, the threat of death, serious physical injury, or a threat to his or her physical safety and who continues to experience the event in the form of thoughts, flashbacks, dreams, delusions, or phobias.

According to the DSM-5, social workers should use the following criteria when assessing a client for a diagnosis of PTSD:

- **Criterion A:** Stressor—witnessing or experiencing a trauma or being confronted with a life-threatening event
- **Criterion B:** Intrusion symptoms—persistent re-experiencing of the event in the form of thoughts, flashbacks, nightmares, delusions, or hallucinations
- **Criterion C:** Avoidance—avoidance of stimuli associated with the traumatic event (e.g., avoidance of thoughts, avoidance of people or places, detachment, inability to recall details of the event)
- **Criterion D:** Negative alterations in cognition and moods—thoughts and moods worsen (e.g., persistent negative beliefs, feelings of alienation, constricted affect, diminished interest in activities)
- **Criterion E:** Arousal—alterations in arousal and reactivity (e.g., irritability, aggressive behavior, hypervigilance, problems in concentration)
- **Criterion F:** Duration—persistence of symptoms for more than one month
- **Criterion G:** Functional significance—significant distress or functional impairment
- **Criterion H:** Exclusion—disturbance not due to medication, substance abuse, or illness

Successful treatment of PTSD is best achieved through early intervention with cognitive behavioral therapy (CBT), group therapy, eye movement desensitization and reprocessing (EMDR), and strengths-focused approaches. A client should be assessed to determine if he or she may benefit from pharmacological therapy; selective serotonin reuptake inhibitors (SSRIs), for example, can help with panic attacks, sleep disruption, and severe symptoms of hyperarousal.

Facts and Figures

PTSD is one of the most common psychiatric disorders; in the United States the estimated lifetime prevalence of PTSD is 7.8% to 12.3% (Compton & May, 2015). Approximately 30% of men and women who have spent time in a war zone experience symptoms that meet the criteria for PTSD (Bramson et al., 2014). Among U.S. military personnel who served in the Afghanistan and Iraq wars, 15% developed PTSD. PTSD is diagnosed in twice as many women as men (lifetime prevalence 10–14% for women and 5–6% for men), with 50% of cases in women related to sexual assault (Compton & May, 2015). Remission rates for PTSD vary. Results from a recent meta-analysis showed that almost half of the subjects with PTSD experienced a remission after a mean of 3 years (Morina et al., 2014). Remission rates in studies that examined rates within 5 months after the traumatic event.
were higher, averaging 51.7%, whereas rates in studies that examined remission after 5 months averaged 36.9%, indicating the possibility that PTSD is more likely at this stage to be chronic (Morina et al., 2014). The lower prevalence of PTSD found among older adults may be due in part to confounding factors: the increased likelihood that older adults will report psychological symptoms as somatic complaints and older adults’ reluctance to disclose trauma. Assessment of older adults for PTSD can also be more difficult if any cognitive or sensory issues are present (Dinnen et al., 2015).

**Risk Factors**

Two types of risk may be assessed: risk of exposure to a traumatic event and risk of PTSD in those who have experienced a traumatic event. Persons who are at higher risk for witnessing or experiencing a traumatic event include undereducated males, those with extroverted personalities, and those with a personal history of conduct problems and/or a history of psychiatric illness. The risk factors for development of PTSD after trauma exposure include female gender, neuroticism, lower level of social support, lower intelligence quotient (I.Q.), preexisting psychiatric illness, traumatic brain injury, and a family history of mood, anxiety, or substance abuse disorders. Individuals who are victims of violence (e.g., terror attacks, childhood abuse, sexual assault) and military veterans are at a high risk for PTSD. Individuals who experience severe trauma in the first decade of life may have a greater risk of experiencing PTSD after experiencing a traumatic event as an adult. Persons who have extended exposure to a traumatic event, are exposed to more than one traumatic event, or experience extreme violence are at a higher risk for developing chronic PTSD.

**Signs and Symptoms/Clinical Presentation**

- **Psychological:** Client’s thoughts and perceptions may be affected; may experience hallucinations, delusions, nightmares, flashbacks, suicidal ideation, and exaggerated reactions to stimuli; memory may be affected, especially regarding details of the event; may have poor concentration and impulse control; may experience symptoms of depression, anxiety, guilt, or fear
- **Behavioral:** Client may attempt to avoid places, people, thoughts, conversations, and activities associated with the traumatic event; may engage in disassociation by detaching from feelings; may seem easily agitated or experience extreme startle reactions or psychological numbness
- **Physical:** Client may have physical injuries resulting from the traumatic event; general appearance may be affected: may have disheveled appearance or poor personal hygiene; may have somatic complaints, including gastrointestinal disturbances, muscle aches, headaches, sleep disturbances
- **Social:** Client may withdraw from social contact; orientation and behavior may affect client’s ability to perform daily tasks (e.g., cleaning, grooming) and impair his or her ability to work, go to school, or engage in social activities

**Social Work Assessment**

- **Client History**
  - Ask about history/response to traumatic event; note physical findings, overall presentation, and level of functioning; assess psychiatric history; assess for history of substance abuse, childhood abuse, and exposure to violence
  - Do not force patient to recount details of the event—flashbacks may occur and result in further trauma
  - Conduct a biopsychosocial/spiritual assessment to include information on physical, mental, environmental, social, financial, and medical factors as they relate to client’s treatment
  - Assess client’s stress-management skills and coping mechanisms
  - Obtain permission from client to ask family members for client’s history whenever possible
- **Laboratory and Diagnostic Tests of Interest to the Social Worker**
  - The Clinician-Administered PTSD Scale (CAPS) is a 30-item structured interview with questions based on the *DSM-IV-TR* criteria for PTSD that takes approximately 45-60 minutes to administer; used to determine the impact of symptoms on a client’s level of functioning
  - Impact of Event Scale (IES) is a 22-item self-report questionnaire designed to assess the level of stress caused by a traumatic event; items are based on *DSM-IV-TR* criteria

**Social Work Treatment Summary**

The sooner treatment is initiated, the better the prognosis. Many mental health professionals believe that treatment is best approached with a combination of pharmacologic and non-pharmacologic therapies (Rahmoun & Hadid, 2012). The most effective and widely used form of treatment is CBT with a trauma focus, which helps the client identify irrational beliefs and replace them with more adaptive thought processes. This method has evolved to include education on stress response, breathing training, and prolonged mental recounting of the event to decrease emotional response. CBT currently is considered the standard of care for PTSD by the U.S. Department of Defense. EMDR is a CBT technique that involves use of imagery.
and rapid eye movement to desensitize the client through prolonged exposure to stimuli; however, this therapy is infrequently endorsed or used by clinicians because of the costly training required (Craig & Sprang, 2010). Clients should be referred for a psychiatric evaluation in order to determine if they may benefit from pharmacological therapy with beta blockers (e.g., propranolol), SSRIs (e.g., sertraline, fluoxetine), antianxiety agents (e.g., benzodiazepines), or antipsychotics (e.g., risperidone). Pharmacology may be needed to address sleep disruption, nighttime hyperarousal, and nightmares that are associated with PTSD. Clients will also often benefit from supportive psychotherapy and instruction on stress-reduction techniques.

Social workers should be aware of their own cultural values, beliefs, and biases and develop specialized knowledge about the histories, traditions, and values of their clients. Social workers should adopt treatment methodologies that reflect their knowledge of the cultural diversity of the communities in which they practice.

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<tr>
<th>Problem</th>
<th>Goal</th>
<th>Intervention</th>
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<td>Client is demonstrating symptoms consistent with PTSD</td>
<td>Determine if criteria for diagnosis are met</td>
<td>Conduct a complete psychosocial history; obtain history of/response to traumatic event; use assessment tools (CAPS or IES)</td>
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<tr>
<td>Client meets criteria for PTSD</td>
<td>To decrease response to stimuli and stabilize mood</td>
<td>Use CBT (individual or group therapy) with a trauma focus to reduce hyperarousal and gradually reduce discomfort associated with stimuli; refer for psychiatric evaluation for pharmacology therapy</td>
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<td>Client may experience future exposure to trauma/stressors or triggers for PTSD</td>
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<td>Use strengths-focused approach to teach stress-reduction techniques, relaxation exercises, and breathing techniques to assist client in reducing his or her reaction to stressful events; exposure therapy to promote emotional processing of traumatic memories; help client to develop stress-management skills and foster development of coping mechanisms</td>
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**Applicable Laws and Regulations**

› There are no applicable laws or regulations that relate to the treatment of PTSD
› Each country has its own standards for cultural competency and diversity in social work practice. Social workers must be aware of the standards of practice set forth by their governing body (National Association of Social Workers, British Association of Social Workers, etc.) and practice accordingly

**Available Services and Resources**

› U.S. Department of Veterans Affairs National Center for PTSD, [http://www.ptsd.va.gov](http://www.ptsd.va.gov)
Factors associated with a good prognosis include early initiation of treatment, ongoing social support, avoidance of re-exposure to trauma, and absence of psychiatric disorders and substance abuse. Individuals with PTSD are at increased risk for panic disorders, obsessive-compulsive disorder, social phobias, specific phobias, major depressive disorder, and suicidal and homicidal behaviors. Interpersonal violence is more likely than automobile accidents and natural disasters to result in PTSD.

Red Flags

Social workers who assist survivors of family violence can be at risk for experiencing secondary traumatic stress (Figley, 2002).

References