**Posttraumatic stress disorder (PTSD)**

**Ruqeeb jan(Msc.Mental Health Nursing) tutor college of nursing ,GMC ,Srinagar,ruqeeb1235jan@gmail.com,8491864279.**

Post-traumatic Stress Disorder is a debilitating mental health disorder that occurs as a result of a traumatic event, like combat, a natural disaster, a car accident, or sexual assault, manifested in a variety of symptoms, including hyper arousal behavior, flashbacks, and avoidance behavior. Co morbidity with other mental health disorders is also a common occurrence. It’s normal to have upsetting memories, feel on edge, or have trouble in sleeping after an event. At first, it may be hard to do normal daily activities, like go to work, go to school, or spend time with people whom you care. But most of the people feel better after few weeks or month. If it remains longer than few months and having symptoms, it may be referred **as PTSD.**

**Puri & Treasaden** (2011) describes PTSD as a reaction to extreme trauma which causes pervasive distress to everyone. PTSD symptoms are not related to common experiences such as bereavement, marital disharmony or chronic illnesses but are associated with events that markedly cause distress and individual may experience trauma alone or in presence of others.

Posttraumatic stress disorder (PTSD) is defined as a serious mental illness characterized by symptoms of avoidance and nervous system arousal after experiencing or witnessing a traumatic event. While often experience by people who serve in combat military operations, PTSD is also regularly seen in other types of trauma too, ranging from automobile accidents and injuries, to rape and abuse. Although PTSD was once considered a type of [anxiety](https://psychcentral.com/disorders/anxiety/) disorder, it is now categorized as a **Trauma and Stress-related Disorders, according to DSM-V (2013)**.

According to **ICD-10, PTSD** is defined as protracted response to a stressful event or situation of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost everyone.

CLINICAL MANIFESTATIONS
Symptoms may develop after a period of latency usually 6 months to one year after the trauma or events. That may include: Anger, irritability, insomnia, shame, self blame, guilt, dissociation, anorexia, hypervigilance, avoidance, substance abuse, self mutilation, feeling of mistrust or betrayal, depression, hopelessness, suicidal thoughts/suicide etc

**There are four main types of symptoms.**

Symptoms of PTSD #1: Re-experiencing the traumatic event

* Intrusive, upsetting memories of the event
* Flashbacks (acting or feeling like the event is happening again)
* Nightmares (either of the event or of other frightening things)
* Feelings of intense distress when reminded of the trauma
* Intense physical reactions to reminders of the event (e.g. pounding heart, rapid breathing, nausea, muscle tension, sweating)

### Symptoms of PTSD #2: Avoidance and numbing

* Avoiding activities, places, thoughts, or feelings that remind you of the trauma
* Inability to remember important aspects of the trauma
* Loss of interest in activities and life in general
* Feeling detached from others and emotionally numb
* Sense of a limited future (you don’t expect to live a normal life span, get married, have a career)

### Symptoms of PTSD #3: Hyperarousal

* Sleep problems
* Irritability or angry outbursts
* Hypervigilance (on constant “red alert”)
* Feeling jumpy and easily startled
* Aggressive, self-destructive, or reckless behavior

### Symptoms of PTSD #4: Negative thought & mood changes

* Guilt, shame, or self-blame
* Feeling alienated and alone
* Feelings of mistrust and betrayal
* Difficulty concentrating or remembering things
* Depression and hopelessness

#### PTSD symptoms in children

In children—especially very young children—the symptoms of PTSD can be different from adults and may include:

* Fear of being separated from parent
* Losing previously-acquired skills (such as toilet training)
* Sleep problems and nightmares
* Somber, compulsive play in which themes or aspects of the trauma are repeated
* New phobias and anxieties that seem unrelated to the trauma (such as fear of monsters)
* Acting out the trauma through play, stories, or drawings
* Aches and pains with no apparent cause
* Irritability and aggression

**Criteria for diaginosing Posttraumatic Stress Disorder**: (DSM-V)

**Criterion A: Traumatic event**

Trauma survivors must have been exposed to actual or threatened:

* death
* serious injury
* sexual violence

The exposure can be:

* direct
* witnessed
* indirect, by hearing of a relative or close friend who has experienced the event—indirectly experienced death must be accidental or violent

Many professionals who work in trauma **differentiate between “big T-traumas,” the ones listed above, and “little-t traumas.” Little-t traumas can include complicated grief, divorce, non-professional media exposure to trauma, or** [**childhood**](https://blogs.psychcentral.com/happiness/2010/08/childhood-of-dreams-if-you-build-it/) **emotional abuse, and clinicians recognize that these can result in post-traumatic stress, even if they don’t qualify for the PTSD diagnosis.**.

**Criterion B: Intrusion or Re-experiencing:** These symptoms envelope ways that someone re-experiences the event. like:

* Intrusive thoughts or memories
* [Nightmares](https://psychcentral.com/disorders/nightmare-disorder-symptoms/) related to the traumatic event
* Flashbacks, feeling like the event is happening again
* Psychological and physical reactivity to reminders of the traumatic event, such as an anniversary

**Criterion C: Avoidant symptoms**

Avoidant symptoms describe ways that someone may try to avoid any [memory](https://psychcentral.com/blog/archives/2010/09/03/8-tips-for-improving-your-memory/) of the event, and may include the following:

* Avoiding thoughts or feelings connected to the traumatic event
* Avoiding people or situations connected to the traumatic event

**Criterion D: Negative alterations in mood or cognitions**

This criterion is new, capturing many symptoms that may be observed longer by PTSD sufferers and clinicians. Basically, there is a decline in someone’s mood or though patterns, which include:

* Memory problems that are exclusive to the event
* Negative thoughts or beliefs about one’s self or the world
* Distorted sense of blame for one’s self or others, related to the event
* Being stuck in severe emotions related to the trauma (e.g. horror, shame, sadness)
* Severely reduced interest in pre-trauma activities
* Feeling detached, isolated or disconnected from other people

**Criterion E: Increased arousal symptoms**

Increased arousal symptoms are used to describe the ways that the brain remains “on edge,” wary and watchful of further threats. Symptoms include the following:

* Difficulty concentrating
* Irritability, increased temper or anger
* Difficulty falling or staying asleep
* Hypervigilance
* Being easily startled

**Criteria F, G and H**

These criteria all describe the severity of the symptoms listed above. Basically, they have lasted at least a month, seriously affect one’s ability to function and can’t be due to substance use, medical illness or anything except the event itself.

CAUSES/ETIOLOGY:

There are complex causes — including neurological, stress, life experiences, personality, and genetics

1.[Post-traumatic stress disorder](https://psychcentral.com/disorders/ptsd/) (PTSD) primarily focuses on the way that the mind is affected by traumatic experiences. Researchers shown that, facing overwhelming [trauma](https://blogs.psychcentral.com/mindfulness/2010/03/mindfulness-and-trauma-an-interview-with-john-briere-ph-d/), the mind is unable to process information and feelings in a normal way. It is as if the thoughts and feelings at the time of the traumatic event take on a life of their own, later intruding into consciousness and causing distress.

2.Pre-traumatic psychological factors (for example, low self-esteem) may make this process worse (for example, low self-esteem may be reinforced by a brutal rape). Post-traumatic reactions by others (for example, a raped woman who is viewed by her family as being “dirty” or “unclean”) and by the self (for example, physical discomfort caused by memories of the rape) may also play a role in influencing whether such symptoms persist.

 Brain imaging studies conducted over the past decade place emphasis on two brain structures: the amygdala and [hippocampus](https://psychcentral.com/news/2010/09/18/physically-fit-kids-have-bigger-hippocampus/18316.html). The **amygdala** is involved with how we learn about fear, and there is some evidence that this structure is hyperactive in people with PTSD (this can be conceptualized as a “false alarm”). The **hippocampus** plays an important role in the formation of [memory](https://psychcentral.com/blog/8-tips-for-improving-your-memory/), and there is some evidence that in people with PTSD there is a loss of volume in this structure, perhaps accounting for some of the memory deficits and other symptoms in PTSD.

Other researches has focused on the **Neuro-chemicals** that are involved in PTSD. For example, there is evidence that a hormonal system known as the **hypothalamic-pituitary-adrenal (HPA) axis** becomes disrupted in people with PTSD. This system is involved in normal stress reactions, and its disruption in people with PTSD can again be conceptualized as a kind of “false alarm”. Some scientists have suggested that dysfunction of the HPA system results in hippocampus damage in people with PTSD.

[Emotional and Psychological Trauma:](https://www.helpguide.org/articles/ptsd-trauma/coping-with-emotional-and-psychological-trauma.htm)

Many risk factors revolve around the nature of the traumatic event itself. Traumatic events are more likely to cause PTSD when they involve a severe threat to their life or personal safety: the more extreme and prolonged the threat, the greater the risk of developing PTSD in response. Intentional, human-inflicted harm—such as rape, assault, and torture— also tends to be more traumatic than “acts of God” or more impersonal accidents and disasters. The extent to which the traumatic event was unexpected, uncontrollable, and inescapable also plays a role.

### Other risk factors for PTSD include:

* [Previous traumatic experiences](https://www.helpguide.org/articles/ptsd-trauma/coping-with-emotional-and-psychological-trauma.htm), especially in early life
* Family history of PTSD or depression
* History of physical or sexual abuse
* History of substance abuse
* History of [depression](https://www.helpguide.org/articles/depression/depression-symptoms-and-warning-signs.htm), [anxiety](https://www.helpguide.org/articles/anxiety/anxiety-disorders-and-anxiety-attacks.htm), or another mental illness
* High level of stress in everyday life
* Lack of support after the trauma
* Lack of coping skills

**PATHOPHYSIOLOGY**
Stress is an essential and normal physiological response to the environment and greatly influences memory. Stress is the number one risk factor in the development of PTSD, and prominent memory disturbances are a central feature of this disorder. Pathophysiological research to date has focused on areas of the brain associated with processing fear and memory. These areas are the **hippocampus, the amygdala**, and the **medial prefrontal cortex**, including the **anterior cingulate gyrus** (which is a part of the limbic system involved with the processing of emotions and the regulation of behavior as well as regulating autonomic motor function). Both the **hippocampus and amygdala** are key elements in human memory. The hippocampus is responsible for the processing and storage of short-term memory, and the **amygdala** is responsible for activities that include emotion and moods and appears to modulate all reactions to events that are important to survival.

Types of post traumatic stress disorder
\* Acute PTSD - This subsides after a duration of few weeks to 3 months
\* Chronic PTSD - symptoms persist more than three months
\* Delayed PTSD - this progresses from months to years and decades after the event

There are five main types of post-traumatic stress disorder: normal stress response, acute stress disorder, uncomplicated [PTSD](https://psychcentral.com/disorders/ptsd/), co-morbid PTSD and complex PTSD.

**Normal Stress Response:** The normal stress response occurs when healthy adults are exposed to a single discrete traumatic event in adulthood experience intense bad memories, emotional numbing, feelings of unreality, being cut off from relationships or bodily tension and distress. Such individuals usually achieve complete recovery within a few weeks.

**Acute Stress disorder:** Acute stress disorder is characterized by [panic](https://psychcentral.com/disorders/anxiety/panic-disorder-symptoms/) reactions, mental confusion, dissociation, severe insomnia, suspiciousness, and being unable to manage even basic self care, work, and relationship activities. Here single traumas have more severe reaction, except when the trauma is a lasting catastrophe that exposes them to death, destruction, or loss of home and community. Treatment includes immediate support, removal from the scene of the trauma, use of medication for immediate relief of grief, [anxiety](https://psychcentral.com/disorders/anxiety/), and insomnia, and brief supportive [psychotherapy](https://psychcentral.com/psychotherapy/) provided in the context of crisis intervention.

**Uncomplicated PTSD:** Uncomplicated PTSD involves persistent re-experiencing of the traumatic event, avoidance of stimuli associated with the trauma, emotional numbing, and symptoms of increased arousal. It may respond to group, psychodynamic, [cognitive-behavioral](https://psychcentral.com/lib/about-cognitive-psychotherapy/), pharmacological, or combination approaches.

**Co-morbid PTSD:** PTSD co-morbid with other psychiatric disorders is actually much more common than uncomplicated PTSD. PTSD is usually associated with at least one other major psychiatric disorder such as [depression](https://psychcentral.com/disorders/depression/), alcohol or substance abuse, panic disorder, and other anxiety disorders. The best 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 or substance abuse. The same treatments used for uncomplicated PTSD should be used for these patients, with the addition of carefully managed treatment for the other psychiatric or addiction problems.

**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. These individuals often are **diagnosed with borderline or antisocial personality disorder or dissociative disorders.** They exhibit behavioral difficulties (such as impulsivity, aggression, sexual acting out, [eating disorders](https://psychcentral.com/disorders/eating-disorders/), alcohol or drug abuse, and self-destructive actions), extreme emotional difficulties (such as intense rage, depression, or panic) and mental difficulties (such as fragmented thoughts, dissociation, and amnesia). The treatment of such patients often takes much longer, may progress at a much slower rate, and requires a sensitive and highly structured treatment program delivered by a team of trauma specialists.

###  Treatment for PTSD

**Trauma-focused cognitive-behavioral therapy** involves gradually "exposing" yourself to feelings and situations that remind you of the trauma, and replacing distorted and irrational thoughts about the trauma with a more balanced picture.

**Family therapy** can help your loved ones understand what you’re going through and help the family work through relationship problems.

**Medication** is sometimes prescribed to people with PTSD to relieve secondary symptoms of depression or anxiety, although they do not treat the causes of PTSD.

**EMDR (Eye Movement Desensitization and Reprocessing)** incorporates elements of cognitive-behavioral therapy with eye movements or other forms of rhythmic, left-right stimulation, such as hand taps or sounds. These techniques work by "unfreezing" the brain’s information processing system, which is interrupted in times of extreme stress.

#### Positive ways of coping with PTSD:

* Learn about trauma and PTSD
* Join a PTSD support group
* Practice [relaxation techniques](https://www.helpguide.org/articles/stress/relaxation-techniques-for-stress-relief.htm)
* Pursue outdoor activities
* Confide in a person you trust
* Spend time with positive people
* Avoid alcohol and drugs
* Enjoy the peace of nature
* Medications
* **Antidepressants**
* The most commonly prescribed class of medications for PTSD (and the one approved by the U.S. Food and Drug Administration) are the **selective serotonin reuptake inhibitor (SSRI) antidepressants**. These include drugs such as fluoxetine (Prozac), sertraline (Zoloft), and paroxetine (Paxil). Research shows that this group of medicines tends to decrease [anxiety](https://psychcentral.com/disorders/anxiety/), [depression](https://psychcentral.com/disorders/depression/), and panic associated with PTSD in many people. These types of antidepressants may also help reduce aggression, impulsivity, and suicidal thoughts that can occur in people with PTSD. This class of antidepressants generally takes 6 to 8 weeks to work, so patience is needed when taking them.
* **Other Medications:**. The most common alternative to antidepressants are the **atypical antipsychotics**. Atypical antipsychotics include medications such as risperidone (Risperdal), olanzapine (Zyprexa), and quetiapine (Seroquel).
* [**Antipsychotic**](https://psychcentral.com/lib/antipsychotic-medications/) medicines seem to be most useful in the treatment of PTSD in those who suffer from agitation, dissociation, hypervigilance, intense suspiciousness (paranoia), or brief breaks in being in touch with reality (brief psychotic reactions).Medications for managing PTSD include mood stabilizers like lamotrigine (Lamictal), tiagabine (Gabitril), and divalproex sodium (Depakote). Medicines that help decrease the physical symptoms associated with PTSD include drugs such as clonidine (Catapres), guaneficine (Tenex), and propranolol.
* **Benzodiazepine**s (commonly referred to as minor tranquilizers, sleeping tablets, or anti-anxiety medications) are sometimes prescribed for certain symptoms of PTSD because they provide rapid relief of anxiety.

 **NURSING MANAGEMENT OF PTSD**
The main treatments for people with PTSD are psychotherapy, medications or both. Everyone is different, and PTSD affects people differently so a treatment that works for one person may not work for another..

**NURSING INTERVENTIONS** :This may include:
1.HISTORY TAKING/ASSESSMENT.
2. CREATING THERAPEUTIC MILIEU: PSYCHOTHERAPY
3.Psychotherapy /CBT can include:
#Exposure therapy. This helps people face and control their fear. It gradually exposes them to the trauma they experienced in a safe way. It uses imagining, writing, or visiting the place where the event happened. The therapist uses these tools to help people with PTSD cope with their feelings.
# Cognitive restructuring. This helps people make sense of the bad memories. Sometimes people remember the event differently than how it happened. They may feel guilt or shame about something that is not their fault.

**NURSING DIAGNOSIS FOR A PATIENT WITH PTSD**
Nursing diagnoses that are appropriate to the patient suffering from PTSD include, but are not limited to includes:
\* Hopelessness/powerlessness
\* Ineffective coping
\* Sleep pattern disturbance
\* Dysfunctional grieving
\* Impaired social interaction
\* Ineffective relationships
\* Impaired individual resilience
\* Risk for suicide

**PREVALENCE OF PTSD**

According to Kessler and Coworkers (1995) 75% of the population have experiencing and extreme trauma but only 7.5% have suffered ptsd .The National Co-morbidity 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
* 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
* CONCLUSION
PTSD is one of the unnoticed and debilitating mental illness that causes dysfunctional state or maladaptive response to stressors that is characterized by partial or complete disintegration of individual's personality. Nurses play such an integral role in noticing the symptoms of PTSD and are able to use some techniques and tools to support these patients. However, it is important to note that nurses are at the frontlines of meeting and caring for these patients. Therefore, it is imperative that nurses should acquaint themselves more on update courses and research on PTSD.

REFERENCES:
* www.ptsd.va.gov | February 2018 cited on 5/5/2018
* Kukkonen Rinat Sharifullin , Bachelor’s Degree Programme in Nursing
* (Bachelor’s Thesis )May 2017
* LAHTI UNIVERSITY OF APPLIED SCIENCES ,cited on 6/5/18 cited on 10/5/18
* American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders: Fifth edition. Arlington, VA.
* National Center for PTSD. (2018). DSM 5 Criteria for PTSD. Retrieved on February 20, 2018. PTSD causes cited on 10/5/18
* Hohn M. Grohol, Psy.D. on 9 Nov 2017 PsychCentral.com cited on 9/5/18
* Nurse Dedrey Ogunnoiki ,[Management Of Post Traumatic Stress Disorder (PTSD)](http://nursesarena.com/news/management-of-post-traumatic-stress-disorder-%28ptsd%29-by-nurse-dedrey-ogunnoiki/msg7918/?PHPSESSID=d6588cj02v0q97o0kbj9svhun5#msg7918)  : January 05, 2018.
* Mary C. Townsend ,concepts of care in Evidence Based Practice (MHN) ,8TH Edition page no 560-561
* Dorothy D. Theodore Text Book of Mental Health Nursing 1st edition 2015 page no.227
* .