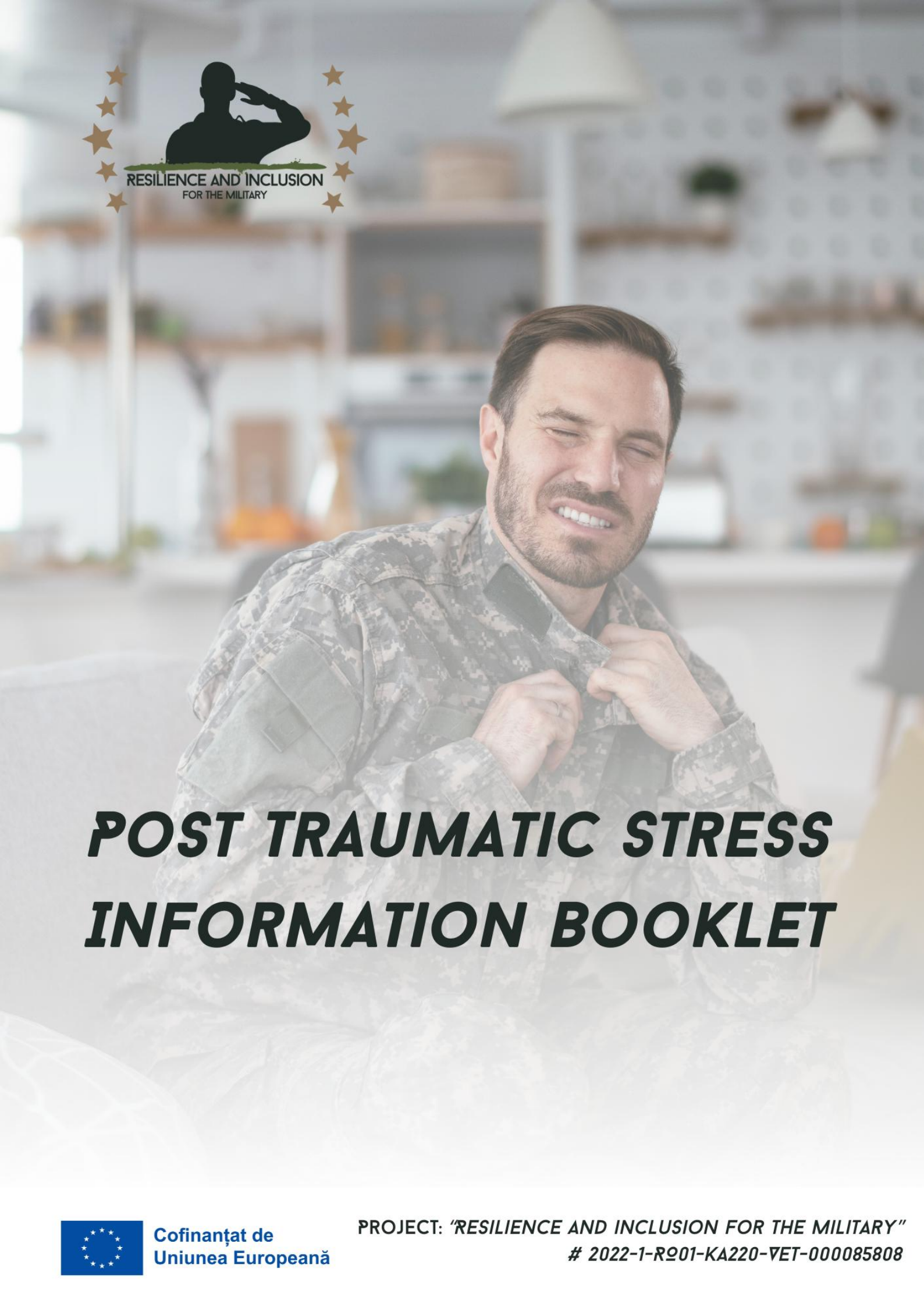
RESILIENCE AND INCLUSION
FOR THE MILITARY



# POST TRAUMATIC STRESS INFORMATION BOOKLET

Cofinanțat de Uniunea Europeană

PROJECT: "RESILIENCE AND INCLUSION FOR THE MILITARY"
# 2022-1-RO01-KA220-VET-000085808

# Post Traumatic Stress Information Booklet

**Project Erasmus +: „Resilience and inclusion for the military”**
**Project no. #2022-1-RO01-KA220-VET-000085808**

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**Content**

## Introduction

This notebook contains information on post-traumatic stress, collected on the occasion of the meeting between experts, for the project Resilience and Inclusion for the Military.

The information is a structure that will form the basis of building a handbook and application about PTSD that can be used by the military. Both for information and for understanding what PTSD is, how it manifests itself, how it can be treated and how it can be managed, in simple steps, in a first stage, until the person considers it useful to reach a psychotherapist.

The booklet contains information that stops short of describing PTSD as a disorder, its manifestations, and how it can be evaluation.

## 1. What is post-traumatic stress disorder?

PTSD or Post Traumatic Stress Disorder is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) under "Disorders associated with traumatic and stressful events". PTSD is a consequence of direct or indirect exposure to one or more traumatic events with a threat to the life or physical integrity of a person or others in close proximity.

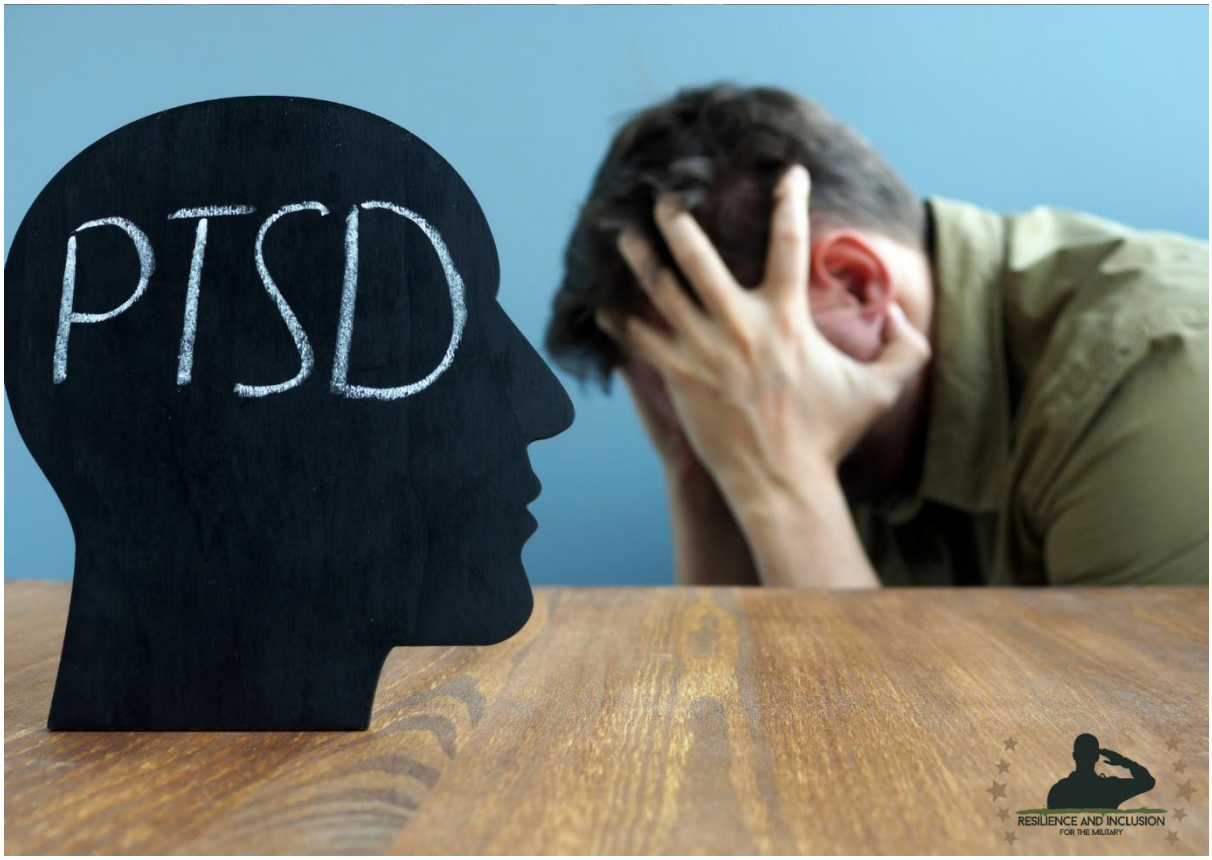

In order to diagnose post-traumatic stress disorder, we note that it can occur up to 6 months after the event and the duration of symptoms must be longer than one month. Alterations in physiological, cognitive and psychological mechanisms cause clinically significant discomfort or impaired functioning in social, occupational or other important areas. Sometimes the full expression of symptoms is delayed, and may occur several months or even years after the traumatic event. A transient post-clinical picture of acute, traumatic stress disorder can frequently occur, which may vary from individual to individual, but usually involves an anxiety response caused by

reliving the traumatic event, which is distinct from post-traumatic stress disorder. In some individuals it may be predominantly a dissociative or detached manifestation,

Others may have a strong anger response with verbal or physical aggression, even in mildly challenging situations. It is common for panic attacks to occur spontaneously or triggered by factors that bring up memories of trauma. Symptoms must be present for at least three days after the traumatic event. This acute reaction tends to regress within a month with a rapid and positive re-processing of emotional experiences related to the event, thanks to individual psychological resources, social support and the intervention of a professional psychologist. PTSD and acute stress disorder are usually associated with traumatic experiences, including chronic ones. According to classical behavioural theories, post-traumatic stress derives from classical conditioning and operant conditioning processes. According to classical conditioning, exposure to a traumatic situation (unconditioned stimulus) generates intense physiological activation in the individual accompanied by fear (unconditioned response). Subsequently, even in the presence of stimuli without a threatening component, which have nevertheless been associated with the critical event (conditioned stimuli), the same somatic and emotional manifestations are experienced€ (conditioned response). In general, after repeated exposure to harmless stimuli, conditioned responses should diminish, eventually fading completely. When this does not occur, operant conditioning has been triggered, which favours new learning through a system of positive or negative reinforcement and punishment, before, during or after the traumatic event. If the subject introduces avoidance behaviours, in order to reassure and protect him/herself from anxiety, fear or distress, by not exposing him/herself to the conditioned stimulus, he/she has no opportunity to learn that the stimulus is not a danger, but is neutral, thus favouring a negative reinforcement mechanism. Consequently, the conditioned response is not reduced. This approach seems to explain the causes of the psychological distress and physical distress typical of PTSD. The flashbacks and nightmares associated with PTSD represent an attempt to re-process the traumatic event. The failure of this re-processing process and the resulting emotional distress leads the individual to avoid anything that can be associated with the traumatic experience, i.e. places, people, situations, etc. Each person deals with even the most critical or difficult life experiences according to personal cognitive schemas, consisting of a series of ideas, views about the world, the self and others. Trauma erupts as an event that disrupts

the beliefs and beliefs of the individual's previous patterns, generating cognitive and dysfunctional distortions. New cognitive schemas are created, new patterns of interpreting reality, which stem from the traumatic experience and which are organised around beliefs and perceptions of a threatening and dangerous world in which the individual feels vulnerable and inadequate and finds it very difficult to remain socially included.

## 2. Manifestations and symptoms




- *Intrusive symptoms associated with the traumatic event*
  - Memories of the traumatic event, which may be very frequent, repetitive, always the same and may be expressed as flashbacks or nightmares.
- *Symptoms of persistent avoidance of stimuli associated with the traumatic event*

- The person may feel the need to move away from places or situations reminiscent of the experience.

- *Symptoms of cognitive and emotional changes*

  - The person may experience total or partial amnesia, with an inability to recall important aspects of the traumatic event and feelings of guilt
  - Emotional withdrawal may occur with loss of interest in previously meaningful activities
  - Psychosomatic reactions may occur as a result of an inability to identify and translate somatic sensations into emotions such as anger or fear.

- *Symptoms of hyperactivity and reactivity*
  - Aggressive or self-destructive behaviour, hypervigilance, concentration problems, sleep-wake rhythm disturbances may occur in the person.
  - Some individuals also experience persistent dissociative symptoms of detachment from their body, with distortions of perception of themselves or parts of themselves as if they were external observers (depersonalisation), or of detachment from the external world that is experienced as unreal or distorted (derealisation).

- *Transitory dissociative states (uncommon)*
  - Events are re-experienced as if they are happening (hallucinations), sometimes causing the individual to react in the same way as they did in the original situation (for example, loud noises such as fireworks may trigger a memory of a fight, which may cause the person to seek shelter or throw themselves to the ground for protection).

- *Depression, other anxiety disorders and substance use are common among patients with chronic PTSD.*

- *Guilt*
  - Individuals may feel guilty for their behaviour during the event or for surviving, unlike others.

- *Persistent inability to experience positive emotions*
  - Happiness
  - Satisfaction
  - Feelings of love

## 3. Post-traumatic stress in the military environment

Military personnel are highly exposed to post-traumatic stress disorder. Military personnel experiencing a certain level of emotional stress during an operation have a professional technical background, which in principle guarantees them a good capacity to adapt and understand such a complex working environment. However, military personnel, because they are exposed to death, sudden threat and/or injury with physical injuries associated with disability and pain, are at even greater risk of PTSD than an individual who does not work in this field.

*In this way, the main studies have highlighted that:*

- The mental health of staff suffers significantly
- Private and professional life is disrupted
- From the Vietnam War to today, the number of soldiers affected by PTSD has increased
- The increase in the number of soldiers with PTSD is closely related to the nature of the conflict, the characteristics of the operating environment, and the modern methodologies used to detect the diagnosis of PTSD

*The main risk factors for PTSD in the military are:*


- Involvement in combat actions presents the main risk factor that exposes soldiers to PTSD. In such activities military personnel are subjected to a complex set of stressors that result in a variety of somatic and emotional responses that may overlap with symptoms seen in PTSD making it difficult to diagnose
- Managing family dynamics:
- Frequent departures from home limit social integration and often lead to loss of family support and divorce.
- Management of acquired disability, the psychological impact following a serious injury and the daily recognition of a disability can cause great emotional disturbance and increased distress which facilitates the onset of the illness and is often diagnosed as a result of acts of anger and violence that the subject directs towards or relatives;
- Reintegration into the social work context, which, if also difficult, can make the subject vulnerable and prone to drug or alcohol use in a vain attempt to salvage self-image
- Poor sleep quality which is one of the most typical phenomena of the symptom picture

## 4. Evaluation

*Post-traumatic stress assessment is carried out by:*

- Anamnesis
- Observation
- Psychological testing
- Self-testing
- Self observation
- Identification of symptoms

*The psychological tools that can be used are:*

- PTSD administered by clinician
- Structured clinical interview for DSM-IV-PTSD
- Acute Stress Disorder
- Anxiety Disorders Interview Schedule Revised-PTSD
- Diagnostic Interview Schedule-PTSD
- International Composite Diagnostic Interview-PTSD
- International Mini Neuropsychiatric Interview-PTSD
- Structured Interview for PTSD
- Trauma Symptom Inventory
- PTSD Checklist
- Diagnosis of posttraumatic stress disorder
- Minnesota Multiphasic Personality Inventory-2
- Symptom Checklist-90 Revised-PTSD
- Comprehensive Posttraumatic Stress Assessment
- Mississippi Combat PTSD
- PTSD Symptoms
- Personality Assessment Inventory-PTSD
- Posttraumatic Cognition Inventory

Following the discussions, the most popular and widely used tool, namely the **PTSD Checklist - PCL**, was selected from the tools listed above by mutual agreement, with pros and cons, to be used for the development of the intellectual outcomes of the project. This tool was developed by Frank Weathers and colleagues at the National Center for Posttraumatic Disorder in 1993. It was originally constructed to assess Vietnam War veterans and then used in nearly all military and national security institutions. Thus, to have a case of PTSD (post-traumatic stress disorder) one must score > 3 on at least one item that meets criterion B (questions 1-5), score > 3 on at least three items that meet criterion C (questions 6-12), and score > 3 on at least two items that meet criterion D (questions 13-17). Thus, a minimum score of 18 would assess a diagnosis of PTSD (post-traumatic stress disorder).

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