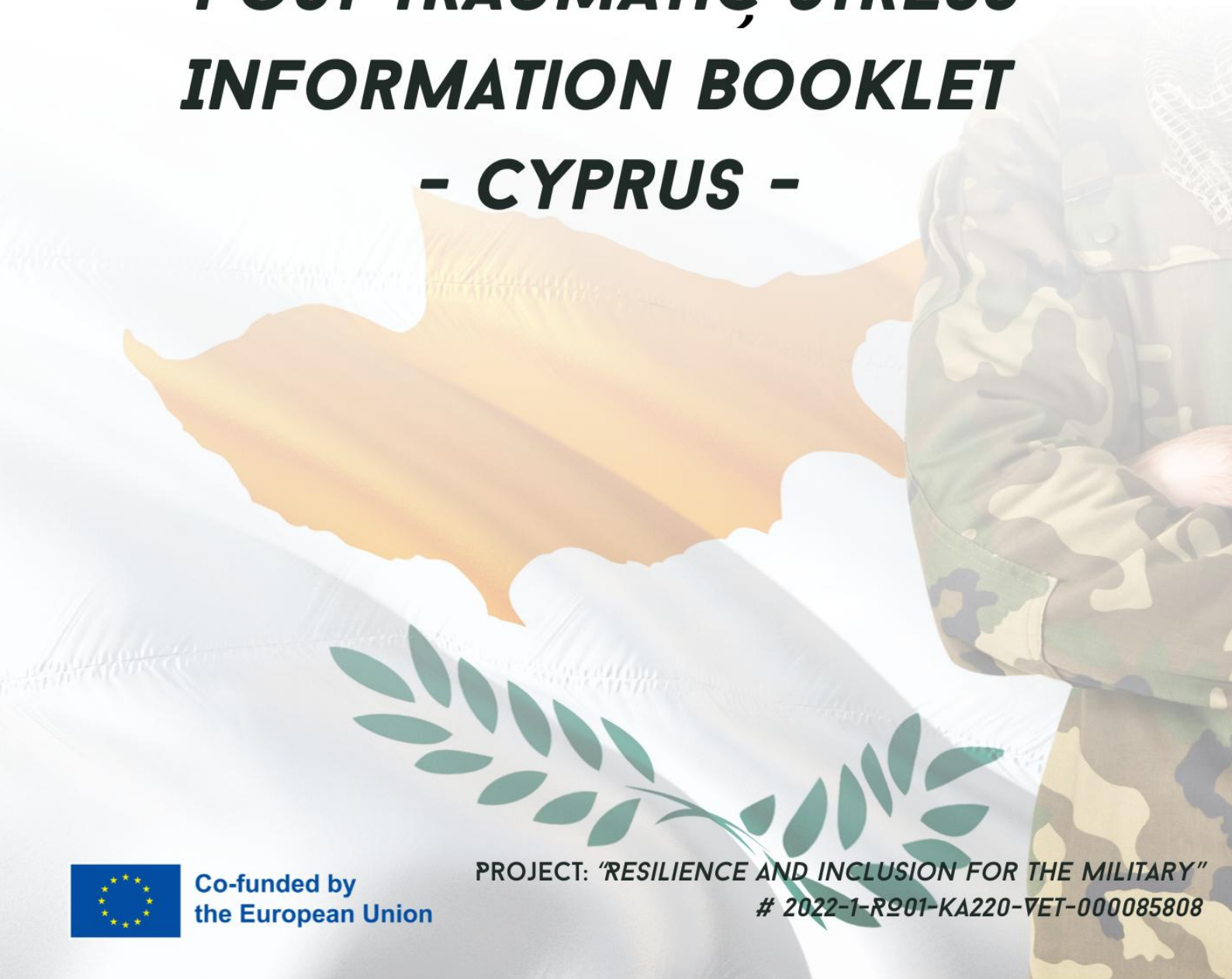
RESILIENCE AND INCLUSION
FOR THE MILITARY

POST TRAUMATIC STRESS INFORMATION BOOKLET

- CYPRUS -



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Brochure on PTSD - Post Traumatic Stress Disorder - Cyprus

1. Introduction

At a meeting organized by the Organization for Promotion of European Issues, with experts in International Relations, Clinical Psychologists, Medical and relevant experts on Post Traumatic Stress Disorder; we developed this useful brochure.

Post-traumatic stress is a clinical syndrome (PTSD = Post Traumatic Stress Disorder) that appears in a person after a traumatic experience, a shocking experience. an event that caused physical/psychological damage or a situation that was life threatening, bringing man face to face with death. This event can either concern directly the individuals or they may have witnessed it in an indirect way. They may have experienced it themselves, or they may have witnessed, for example, a traffic accident. For example, families of victims of a natural disaster or war can experience post-traumatic stress, as can emergency personnel and first responders. In regards to military personnel, there is a high percentage of army staff and veterans that suffer from PTSD, due to exposure to painful experiences that occur in military conflicts. A soldier might have survived unharmed the war, but witnessing the loss of a leg or a hand of a fellow soldier might also be a traumatic experience.

Most people who have experienced a traumatic event may have reactions such as shock, anger, fear, nightmares and guilt. These reactions are common, and for most people, they go away over time in a few months. But in a person suffering from post-traumatic stress disorder, these feelings not only persist, but worsen and become so intense that they hinder the person in their daily

life. To be diagnosed, PTSD patients must have symptoms for more than a month and their daily functioning must be affected. Military personnel that survived wars or were injured during a war, have a good chance to suffer from PTSD due to the shocking experiences that occur during conflict times.

2. Symptoms of Post-traumatic stress

PTSD symptoms usually appear within three months of the traumatic event. In some cases, however, they appear several years later. The severity and duration of the disease varies. Some people recover within six months, while others suffer for much longer.

PTSD symptoms are mainly categorized into four groups, including:

• **Reliving – Intrusive memories**: PTSD patients experience traumatic thoughts and memories repeatedly and intensely. These may include flashbacks, hallucinations and nightmares. They also feel intense anxiety when things remind them of the traumatic event, such as the anniversary of the event.

- Recurrent, unwanted distressing memories of the traumatic event
- Reliving the traumatic event as if it were happening again (flashbacks)
- Upsetting dreams or nightmares about the traumatic event
- Severe emotional distress or physical reactions to something reminding you the traumatic event

• **Avoidance**: the person may avoid people, places, thoughts, or situations that remind them of the trauma. Avoidance can lead to feelings of withdrawal and isolation from family and friends, as well as loss of interest in activities that the person previously enjoyed.

- Avoidance of specific areas, sights, situations and sounds that remind of the event.

- Anxiety, depression, emotional numbness or guilt

• **Increased arousal**: The person is overstimulated, has excessive emotions, problems communicating with other people, difficulty sleeping, irritability, outbursts of anger, difficulty concentrating, nervousness or is easily frightened. The person may also have physical symptoms such as high blood pressure and rapid heart rate, rapid breathing, muscle twitching, nausea and diarrhea.
- Anger, irritability and overstimulation.
- Aggressive, reckless behavior, including self-injury.
- Sleep Disorders.

• **Bad mood**: This category includes thoughts and feelings related to guilt and regret, alienation and memories of the traumatic event.
- Loss of interest in activities that were once considered enjoyable.
- Difficulty remembering details of the painful event.
- Change in habits or behavior after the trauma.

Brain and post-traumatic stress

The brain has an “alarm system” that helps ensure our survival. But in post-traumatic stress, this system becomes oversensitive and easily activated. That is, in PTSD the brain gets "stuck" in a state of danger, and even though you are no longer in danger (and you recognize this logically), the brain remains alert, in a state of alert, continuing to send stress signals (hormones such as adrenaline and other neurotransmitters), which lead to the psychological and physical symptoms of post-traumatic stress. Studies show that the part of the brain associated with fear and emotion (the amygdala) is more active in people with PTSD.

Persons who may have PTSD?

Each person can react to traumatic events in a very different way, because each person has a unique personality with different abilities to manage fear and stress from a traumatic event. This is the main reason, why not all people develop PTSD after a traumatic event (such as the death of a loved one). Also, the type of help and support a person receives from friends, family and professionals affects the onset of PTSD or the severity of its symptoms.

PTSD was first seen in war veterans and first was identified in the first world war. This was the war of wrenches, since rival armies were fighting close to each other in their own wrenches, fighting body to body. The first war, was also named as a war of annihilation, due to the brutality and the high cost of human lives, without any clear winners. Many soldiers of the first world war faced horrible atrocities that had an impact on them; causing a PTSD.

This disorder can occur in anyone who has experienced a shock or traumatic event that is violent/life threatening. People who have been abused as children or who are repeatedly exposed to life-threatening situations have a higher risk of developing PTSD. Victims of physical and sexual abuse have the highest risk of developing PTSD.

3. How common is PTSD?

It is estimated that approximately 3.6% of adults suffer from PTSD. Women are more likely to develop PTSD than men. This may be due to the fact that women are more likely to be victims of domestic violence, abuse and rape. PTSD can occur at any age, even in childhood. Young children suffering from

PTSD may show a different - atypical - picture, such as delayed development in some areas, such as toilet training, motor skills and speech.

4. How is PTSD diagnosed?

Although there are no specific diagnostic tests for PTSD, a psychiatrist may use various tests to rule out a physical illness as the cause of the symptoms. If no physical illness is found, the doctor will refer the person to a psychiatrist-psychotherapist who is the right doctor to diagnose and treat mental illnesses. Psychiatrists use the interview, questionnaires, and other tools to assess the person for PTSD. The psychiatrist bases his diagnosis on the reported symptoms, which include the functional problems resulting from the symptoms, and assesses whether the symptoms indicate PTSD. For a person to be diagnosed with PTSD, the symptoms must last for more than a month.

Can PTSD be prevented?

Some studies show that immediate (i.e. within hours of the traumatic event) psychotherapeutic and pharmaceutical intervention in people who have experienced a traumatic event can reduce or prevent future PTSD symptoms.

What is the treatment for PTSD?

Recovery from PTSD is a gradual and evolving process. The goal of PTSD treatment is to reduce emotional and psychosomatic symptoms, improve daily life, and help the person better manage the causes of the disorder. PTSD treatment may include psychotherapy, medication, or both.

Medications and post-traumatic stress

Psychiatrists often recommend antidepressant medications to treat PTSD—to control feelings of depression, anxiety, and physical symptoms—including SSRIs (selective serotonin reuptake inhibitors), anxiolytics (such as benzodiazepines, such as Xanax), and depending on the severity may complement the treatment with tricyclic antidepressants, mood stabilizers and atypical antipsychotics.

Many times certain drugs that regulate hypertension and heart function are given to control specific symptoms: for example, prazosin may be used for nightmares, or propranolol (Inderal) is used to minimize traumatic memories and accompanying tachycardia.

Psychotherapy

Psychotherapy for post-traumatic stress helps the person overcome the shock and fear associated with the traumatic event. Many psychotherapeutic approaches are used to treat PTSD and include:

• EMDR (Eye Movement Desensitization and Reprocessing) which is a new form of psychotherapy for processing memories, with the aim of reducing anxiety and stress from traumatic events.

• Psychotherapy, which teaches the person to recognize and change the way of thinking and negative beliefs that lead to disturbing feelings and behaviors. It also focuses on helping the person examine their beliefs and feelings caused by the traumatic event.

• Exposure therapy, a type of behavioral psychotherapy in which the person relives the traumatic experience or is exposed to stressful situations. This is done in a controlled and secure environment. Exposure therapy helps the

person face the fear and gradually become more comfortable with situations that frighten them and cause them anxiety.

• Family psychotherapy which is helpful when the behavior of the person with PTSD affects other family members.

• Group psychotherapy, which is useful as it allows the person to share their thoughts, fears and feelings with other people who have experienced a traumatic event or other difficulties in life.

Examples/ Manifestations of PSTD

It is possible for an individual to not to be able to move forward, due to the traumatic experiences caused by PSTD. This inability to move forward - as he remains constantly haunted by the terrifying past - reinforces the presence of other clusters of symptoms. Any successful therapy, therefore, must target these traumatic memories, and exposure therapy is specifically designed to achieve this.

Exposure therapy is a common sense approach in order to give back to the individual the control and counter avoidance. We are all familiar with the phrase "taking the reins back into our own hands" - controlling and facing what scares us rather than avoiding it. The most successful treatments for all anxiety disorders are built around this concept. For example, to treat someone who is afraid of an insect, let’s say spiders, we will help them deal with their fear.

Starting with placing a small insect/spider in a jar at the edge of the room, we will gradually move it closer to the patient and reducing the distance in the same way will reduce their fear and enable them to face larger spiders. At

each step, the anxiety will increase, but by staying with that feeling and not leaving, it gradually diminishes or "gets used to" the phobic object, so that we can move on to the next step.

Treatment for PTSD is essentially the same process. We have helped the person to gradually deal with the situations, places and activities that they have been avoiding since experiencing the traumatic event, because they all cause them great anxiety. We call this "in vivo" (or living) exposure. In PTSD, however, the main "phobic object" is not outside the person but is the memory of the traumatic experience.

People with PTSD - consciously or unconsciously - block out and avoid these painful memories. Exposure therapy helps them gradually deal with the memories and "process" the experience in a safe and controlled way. We call this "virtual exposure". Each time they face that memory without avoiding it and manage to stay with it long enough to reduce the distress, they take another step toward recovery.

The first component of exposure therapy is for the psychologist to clearly explain to the patient what we are doing and why. We must not forget that we are asking them to do what they fear most and in case of military personnel, individuals may have faced atrocities and painful experiences. We explain the rationale and process in every detail, often using metaphors to highlight the mechanisms involved; while we teach them strategies for risk management. These should not be used during prolonged exposure, but it is important for people to feel safe, controlling their anxiety, at other times.

Then we ask the person to speak as if they were living the event and difficult times during the war; or the object they fear. Just as we evaluated our report on the spider as a phobic object, so we try to do the same for memory. In the

first moments, the person may speak with their eyes open, in the past tense (I walked into the park ...) avoiding the worst aspects.

In the subsequent report, however, it is important to address all aspects of the experience, to ensure that there are no "ghosts of the past" that will cause problems later. So we ask the patient to close their eyes, use present tense (I'm walking in the park ...), emphasizing all the senses (sights, sounds, smells, tastes, touch) and - as it progresses the treatment - they address the worst aspects of the experience in every detail.

We regularly monitor the pattern of bad feelings to make sure it subsides before moving on to the next level. Exposure therapy is a powerful process for both therapist and client. The intended effect is both to reduce anxiety and to better understand what happened and why. Putting the pieces of the puzzle together is vital to the patient's recovery and has long been recognized as an effective treatment. Early variations on prolonged exposure used medication to access memory, while more recent approaches (such as desensitization)

Post-traumatic stress disorder symptoms may start within one month of a traumatic event, but sometimes symptoms may not appear until years after the event. These symptoms cause significant problems in social or work situations and in relationships. They can also interfere with your ability to go about your normal daily tasks.

Diagnostic and Statistical Manual of Mental Disorders DSM-5

DSM stands for Diagnostic and Statistical Manual of Mental Disorders. It's a book that basically reads like a mental health encyclopedia. The book was originally published in 1952, but has been updated several times resulting in the current version of the DSM-5. The DSM was created by more than one hundred and sixty clinicians and researchers from around the world. The

purpose of creating the DSM is to provide a handbook for mental health professionals and other workers in the field. To be diagnosed with PTSD, you must be exposed to a stressful or traumatic event. And, the DSM has established criteria to show what counts as a traumatic event. To be diagnosed, the following criteria must be met:

Criterion A (at least one symptom)

To be diagnosed with PTSD, the person must have been exposed to death. That doesn't mean he had to be close to death. This means that there must be a threat of death or an injury that was serious enough to result in death. This section also includes sexual violence.

It is also important to demonstrate that the person should not be the one at risk. While it could be that they were directly exposed, it could also be witnessing the trauma, finding out about a loved one being exposed, or being indirectly exposed like those who work as first responders.

Criterion B (at least one symptom)

Before one is diagnosed, one must relive the event on an ongoing basis. This doesn't mean they have to live through the same thing over and over, but rather experience it through one of the following:

- Nightmares
- Flashbacks
- Involuntary memories
- Emotional distress after being reminded of the trauma
- A physical reaction after being reminded of the trauma

Criterion C (at least one symptom)

The person shows avoidance behaviors. This means they try to avoid anything that reminds them of the trauma. This can be done through physical reminders or things that make them think of the trauma.

Criterion D (at least two symptoms)

The person experiences negative thoughts and feelings because of the trauma. This can include feeling negative about the world or just themselves, not caring about activities they enjoy, isolation and difficulty recalling details of the event. This also includes blaming themselves or someone else for the trauma to an exaggerated level.

Criterion E (at least two symptoms)

A PTSD diagnosis requires at least two of the following symptoms:

• Increase aggression or irritability
• Hypervigilance (similar to paranoia)
• Engaging in risky behavior
• Difficult concentration time
• Problems sleeping
• Increased responsiveness

Other criteria

There are a few other criteria that must be present for someone to be diagnosed with PTSD. They include:

• Manage symptoms for at least one month
• Symptoms affect dysfunction or discomfort in normal life, such as socially or at work

Subtypes

There are two subtypes that have been defined for PTSD. They include the Preschool Subtype and the PTSD Dissociated Subtype.

The preschool secondary type is for children under the age of six. The Dissociate subdivision is for people who also experience feelings of detachment from their body or have experiences that make it seem as if the world isn't real.

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