Post-traumatic stress disorder

This article contains information about...

- How and when PTSD might be diagnosed.
- Some problems with the PTSD classification and diagnosis.
- An intervention (CIST) that might be used with traumatic stress
- Criticisms of the appropriateness of this intervention

Psychological Effects of Disaster and Catastrophe

During a disaster, individuals are typically affected by negative emotions such as fear and shock. It might seem logical that most people will attempt to hide during a disaster, but this is not typically the case. In fact, a range of responses can be seen from numb disbelief (Leach, 1994) through to anti-social behaviour such as looting (Cave, 1998). In the immediate aftermath of a disaster, social cohesion may increase (Bowman, 1964) and there may be evidence of constructive behaviour, such as helping the injured. There is no clear pattern of behaviour common to all disaster situations. However, it is worth stressing that **panic**, defined as flight behaviour that does not take into account the safety needs of others, is actually very rare. Reporting on the behaviour of those caught up in the attacks on the World Trade Centre, Floroiu and Sylves (2002) state that, in common with many disaster situations, the behaviour of most individuals was group-oriented with much evidence of people sharing information and helping those in need.

Those that are affected by extreme stressors of any sort usually show some evidence of psychological disturbance. Some researchers suggest the existence of an **acute stress disorder** (ASD) whose onset occurs rapidly follows exposure to the stressor. ASD is said to be characterised by severe **dissociative symptoms** including amnesia for the traumatic event, emotional numbness and feelings of derealisation, where the individual loses their sense of the reality of the external world (Barlow and Durand, 1995). Dubouloz and Rerat (1998) describe a range of other psychological symptoms that may accompany exposure to a disaster situation including grief, depression, anxiety and substance (e.g. alcohol) abuse, as well as a variety of social problems including disturbances within the family and at work. Although not all survivors of disaster will experience symptoms severe enough to warrant psychiatric diagnosis, almost all are affected by psychological symptoms to some degree. The psychological effects of disasters are not necessarily limited to those people directly involved. Others may also be affected by what is sometimes called **secondary traumatisation**. Those most at risk from the indirect effects of disasters include the spouses and loved ones of victims, emergency services and medical workers that are immediately involved in helping the victims and whose job is to treat them following the disaster. Other groups that may be at risk include journalists that cover the disaster and, occasionally, people not involved at all but who feel in some way affected. As an illustration, three months after the attack on the World Trade Centre, the prevalence of depressive symptoms amongst a sample of Manhattan residents was about 10 per cent, compared with an expected prevalence of about 3.5 per cent (Galea, 2002). Similarly, Franklin et al (2002) found that the attacks appeared to be related to an exacerbation of depressive and anxiety symptoms in a sample of American psychiatric patients. The patients most likely to be affected were those who saw themselves as similar to the victims and those who viewed the event as highly personal.

Post Traumatic Stress Disorder

Between 5 and 22 per cent of those directly affected by disaster go on to develop a set of psychological problems now referred to as **post traumatic stress disorder** (PTSD; Green and Lindy, 1994). The main symptoms of PTSD (as described in **DSM – IV**) are:

- **Re-experiencing** the event. The person may have intrusive and uncontrollable memories of the event, or recurring dreams about it. At times, they may feel as if the event is reoccurring. Additionally, they may react very strongly to cues that resemble aspects of the event.
- Heightened **arousal**. The person is affected by abnormally high arousal and may have difficulty sleeping and concentrating on things. Additionally, they may become irritable and experience outbursts of anger.
- **Avoidance** of trauma cues. The person typically avoids thoughts, feelings, conversations and situations that may remind them of the event. They may have partial amnesia for the event.

Additionally, their interest in their normal activities and their ability to relate normally to others may be impaired.

Rates of PTSD symptoms in disaster affected populations increase with the severity of the event. People who suffer injury or significant personal or financial loss tend to have the most symptoms (Green, 1993). Those most at risk of developing PTSD

symptoms are people who had some degree of psychological disturbance before the disaster occurred (Smith et al, 1990).

PTSD reflects both the psychological impact of the extreme stressor (flashbacks, abnormal arousal levels) and the person's attempt to deal with this(amnesia and avoidance behaviours). The latter are interesting because they illustrate people's propensity to use the emotion focused coping strategy of avoidance. The tendency to avoid trauma cues is an adaptive short-term response as it helps the survivor avoid emotionally arousing memories of the original stressor. However, a response that is adaptive in the short term may present problems in the longer term.

Many researchers agree that recovery from PTSD can be facilitated by an exploration of the painful traumatic memories (e.g. Hodgkinson & Stewart, 1991). However, the motivation to avoid trauma cues may result in those most affected by a disaster being the least likely to seek psychological assistance. Reflecting on the usefulness of PTSD as a concept, Cassidy (1997) makes a number of observations. First, the PTSD diagnostic category has highlighted the similarities that exist between the survivors of a wide range of different traumatic events. Second, the existence of an 'official' diagnostic category for traumatic stress symptoms has given legitimacy to the distress of trauma survivors who in the past might have been dismissed as 'weak' or 'over reacting'. The possible consequences of such a view are starkly illustrated by the 306 British and Commonwealth soldiers who were executed by their own commanders for cowardice and desertion during World War I. Many, if not all, of these men would nowadays be recognised as suffering from a reaction to the unimaginable stresses of the WWI battlefield.

However, Cassidy also identifies a number of drawbacks associated with the PTSD diagnosis. First, it encourages professionals to view all those with the diagnosis as very similar when in fact there can be marked differences between them. It could even be questioned whether it is scientifically justifiable to group together under the same diagnostic umbrella such a diverse range of possible symptoms. A second problem is that an official diagnostic category can lead to a lack of flexibility when treating those affected by disasters. A diagnosis of PTSD requires the presentation of a minimum number of symptoms from all three groups (reexperiencing, arousal, avoidance) for at least a month. Those who do not meet these rather arbitrary requirements may not be offered appropriate support because they do not warrant an official diagnosis. However, they may be in no less personal distress than someone who meets the criteria. Alternately, there is the danger that psychological symptoms predating the disaster may be assumed by the diagnosing clinician to be PTSD symptoms. This could lead to inappropriate treatment. A final problem identified by Cassidy is that PTSD represents a psychiatric approach to stress response rather than a psychological one. In other words, the PTSD classification construes traumatic stress reactions as a mental illness or abnormality. It may be more appropriate to view such responses as a normal reaction to an abnormal set or circumstances.

After the Event

For a number of years it has been common (where possible) for survivors of disasters and catastrophes to be offered some sort of counselling or therapy in the immediate aftermath. The assumptions on which such interventions are based are first, that those exposed to disasters are at an increased risk of mental health problems and second, that the earlier they are given help the fewer psychological problems they will experience. Although a number of different interventions have been used, one that has caused particular controversy is '**Critical Incident Stress Debriefing**' (CISD) or 'Psychological Debriefing'. CISD takes a range of different forms, but usually has the following features:

- **On-scene or near-scene debriefing**: the survivor discusses the disaster as near as possible to the scene and as soon as possible after the event. The counsellor observes them for signs of acute stress reaction.
- **Initial defusing**: within a few hours of the disaster, survivors are invited to discuss their feelings and reactions. The aim is to provide a supportive atmosphere and any insensitive or overly 'tough' comments are discouraged.
- **Formal CISD**: within 48 hours of the event, survivors engage in a structured debriefing session in which they describe what they did during the incident and how they felt about it as well as any stress symptoms they are experiencing.
- **Follow up**: weeks or months after the initial CISD, survivors are reassessed on a group or individual basis in order to provide additional support and counselling if necessary.

Because of the nature of their work, adoption of CISD-type interventions has been greatest amongst emergency services organisations. However, it has also been used in more general healthcare settings, in commercial organisations and in education as a response to a variety of 'critical incidents' including accidents, suicides, workplace violence and terrorist attacks. In some organisations, belief in the effectiveness of CISD – coupled with a belief that nonintervention is actively damaging to the survivor – has led to it being introduced as a compulsory measure for workers exposed to a critical incident. Although the rapid and widespread adoption of CISD might suggest an effective psychological intervention for disaster survivors, some commentators (e.g. Gist 2002) propose that its popularity has more to do with aggressive marketing and widespread coverage in the specialist media than clinically demonstrable effectiveness. A number of well-conducted studies have more recently suggested that, at best, CISD does not improve the prognosis for survivors of disasters and, at worst, may actually inhibit normal recovery for some people. A major review by Rose et al (2001) of a

number of clinical trials concluded that CISD was not effective in preventing or reducing PTSD and that its compulsory use after critical incidents should stop. National Health Service guidelines on the treatment of trauma victims now classify CISD and similar interventions as contraindicated (i.e. specifically not to be used; Parry, 2001). Gist (2002) draws several conclusions about why CISD can be counterproductive when used with disaster survivors. Amongst these are:

- Forcing people to relive traumatic events very soon after they have happened can overload their coping systems. It appears to be more useful for survivors to cognitively distance themselves from events, in order to be able to reframe them in a more positive way later on.
- Giving immediate and obvious help to survivors may undermine their feelings of self-efficacy, especially if they are able to cope effectively without assistance. However, feelings of self-efficacy appear to be very important in successful psychological adjustment following traumatic stress.

This does not mean that psychologists and counsellors have nothing to offer those affected by disasters. There will always be people affected to a sufficient degree, or sufficiently cut off from effective social support to benefit from formal psychological intervention. However, many researchers now agree that many of those so affected recover from the initial shock and trauma without psychological treatment, usually within a few weeks or months of the disaster (Salzer and Bickman, 1999). Recovery in these cases is assisted by informal ‘therapeutic’ processes such as support from peers and family.