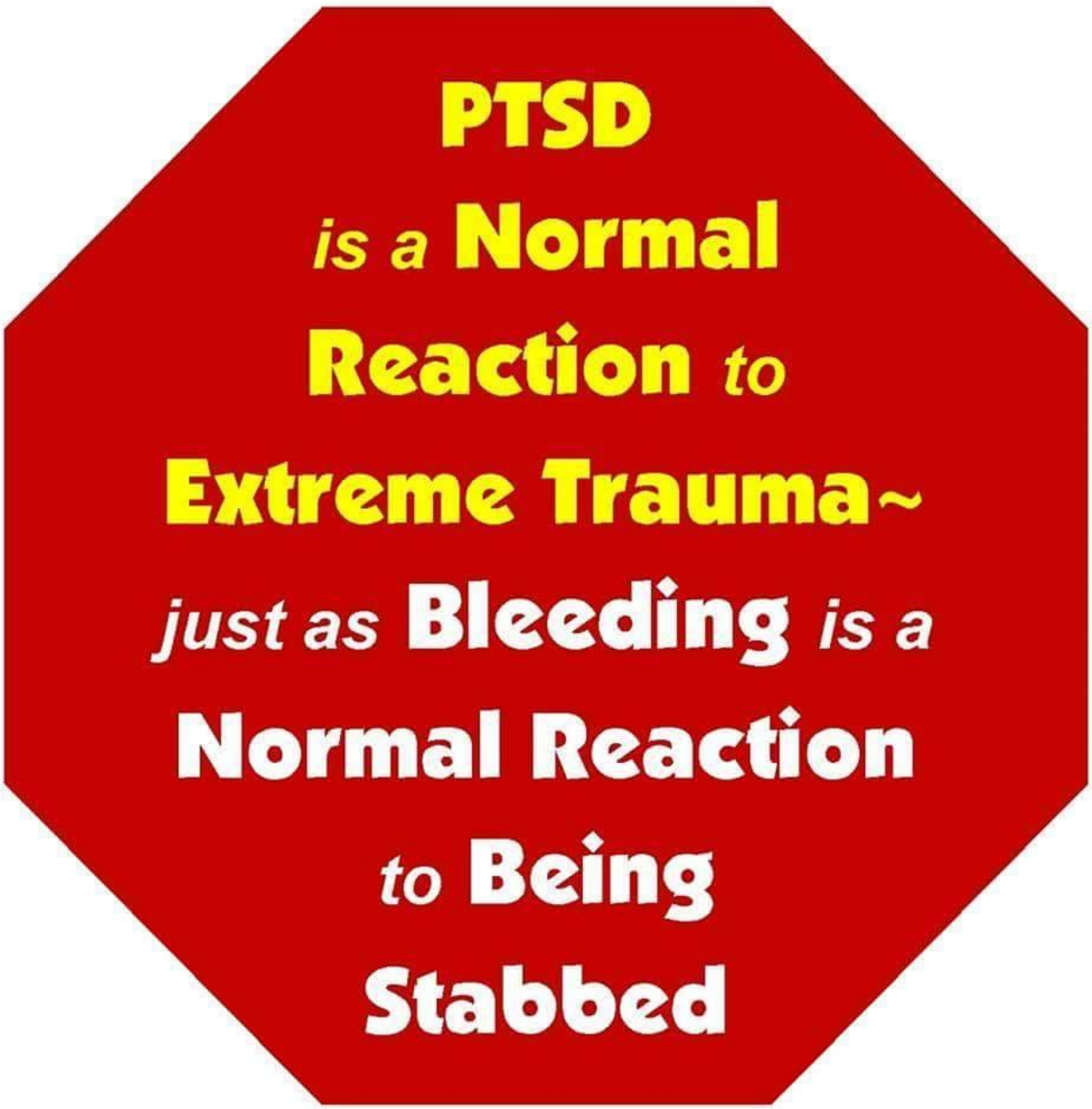
Posttraumatic Stress Disorder (PTSD)



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Abstract

Individuals who have been exposed to a stressful or a traumatic event, whether it is a first responder in your local community, someone being raped, witnessing a family member being murdered, or soldiers who have experienced combat operations, are likely to suffer posttraumatic stress disorder (PTSD). PTSD can be debilitating for the psychological distress can cause physical, social, emotional, as well as vocational impairments. For this reason, trauma in general and the aftermath have been the focus of research and clinical attention over the recent years. Military conflicts around the world, combined with the impact of these conflicts on soldiers diagnosed with PTSD have brought intense focus on trauma and stressor-related disorders for new treatment modalities to support this group of disorders.

PTSD can be found under the broader umbrella of "*Trauma & Stressor-Related Disorders*" in the latest DSM classification (American Psychiatric Association [APA], 2013). The risk and severity of PTSD differ across cultural populations, where individuals become exposed to a traumatic or an overwhelming event (APA, 2013). PTSD can develop when an individual experience or witness a life-threatening event, and go on to have upsetting memories. PTSD is treatable, and effective treatments include a combination of psychotherapy and medication (Popiel, Zawadzki, Pragłowska, & Teichman, 2015). However, the therapeutic alliance between clients and clinicians are essentials so that clients can feel like their traumatic experiences are understood by the clinician.

Psychotherapy combined with medication management have been effective in treating individuals diagnosed with PTSD, where clinicians use talk therapy to assist the client in getting more control of their thoughts and feeling of their traumatic experience. Meanwhile, medication is used to assist clients manage the stress they are experiencing from the traumatic experience.

Introduction to posttraumatic stress disorder

Posttraumatic stress disorder (PTSD) is a condition where an individual who has experienced an overwhelming event that may have been life-threatening becomes unable to cope with their stress reactions. The individual continues to have memories of the event, reliving the moments, avoiding anything that remind them of the event, and persist to have negative thoughts because of the exposure to the event. These individuals consistently experience feeling on edge. The exposure to a life-threatening event that goes beyond the individual's coping ability causes psychological, affective, and emotional disruptions where the individual struggles to live a normal, productive life. It may become necessary for individuals who have been exposed to traumatic and/or some life-threatening events to take direct action to aid in their recovery.

There are several factors associated with PTSD that can make an individual vulnerable to the symptoms. Individuals would be at a higher risk of developing PTSD if they are exposed to severe trauma, have premorbid personality characteristics, and /or live with certain ecological risks (McKeever & Huff, 2003). These variables can outline a stress pathway that overwhelm an individual beyond his/her ability to cope with their situation. These pathways can be situational, biological, or ecological. For instance, a First Responder running into a burning building to save the lives of elders and children, a soldier who have combat and other dangerous military experiences, or a female who experienced child sexual and physical abuse are all prone to situational stressors that can lead to PTSD. Second, an individual surrounding environment can contribute to his/her vulnerability to develop symptoms to PTSD. For instance, adolescents and young adults living in impoverished, high crime neighborhood who experience severe challenges of education, healthcare and housing may be more prone to ecological stressors that can lead to PTSD. Third, individuals with inherited traits of biological and genetic composition, and

neurological anomalies may become vulnerable to biological stressors that can lead to PTSD (McKeever & Huff, 2003). For instance, a child born to both parents diagnosed with serious mental disorders as well as substance use disorder, grows up in a household with continued and prolonged exposure to family dysfunctional dynamics. That child would be at a much higher risk of succumbing to the symptoms of PTSD than a child with different circumstances. So, there are many factors that contribute to an individual becoming vulnerable to the symptoms of PTSD. However, we need to keep in mind that it is the breaking point by which the individual becomes overwhelmed and no longer can cope with the stressors that lead them to develop the symptoms of PTSD. McKeever and Huff (2003) posit that the severity and nature of a trauma may be the primary factor, but not the only pathway to developing PTSD.

It is important to note that different cultures and populations reaction to stressors which contribute to PTSD may vary significantly, and determine the efficacy of treatment approaches to the symptoms of PTSD. As noted in the current DSM classification, the expression of PTSD is shaped by cultural syndromes, and risk of onset along with severity of symptoms will differ among cultural groups (APA, 2013). Some groups/cultures are more reluctant to seeking treatment for their symptoms than others, whether it's their belief in treatment or the availability of mental healthcare resources to them. The fact remains that symptoms of PTSD is treatable, and there are several treatment modalities that can assist individuals to reduce their distressing symptoms to help them live a more productive life. Psychotherapy and/or medication have shown an acceptable level of efficacy in treating the symptoms of posttraumatic disorder to help individuals reduce distressing symptoms. This paper reflects on the description, etiology, risk factors, cultural issues, comorbidity and differentiation to other disorders, biopsychosocial approach to conceptualization, and current treatment to reduce symptoms of PTSD.

Description of posttraumatic stress disorder

Posttraumatic stress disorder (PTSD) is a condition that can develop when someone experienced or witnessed a life-threatening incident. This condition causes the individual to feel on the edge, have upsetting memories, as well as have trouble sleeping after they have experienced a life-threatening incident. Individuals who suffer from PTSD usually experience psychological distress after they have been exposed to a trauma or an event that seemed life-threatening to them (APA, 2013). The individual symptoms then become the reaction to an extreme traumatic stressor that may have threatened death or severe injury (Seligman & Reichenburg, 2014). PTSD diagnosis have evolved over the years with updates of the DSM classification. However, four core features have remained stable: experiencing a stressful event; re-experiencing symptoms of the event through nightmares or flashbacks; efforts to avoid the situation that are reminders of the event, and hyperarousal symptoms that include problem sleeping; irritability and poor concentration (Sareen, 2014). These core features are the direct response to an individual who experienced intense fear, horror, and/or helplessness.

The current DSM classification have listed PTSD with a group of disorders where criterion for diagnosis include the individual being exposed to a stressful and/or a traumatic event (APA, 2013). As noted in the DSM-5, individuals who have been exposed to a life-threatening event are likely to display dysphoric, anhedonic, and aggressive behaviors (APA, 2013). They will experience negative alteration in their cognition and mood that make it difficult for them to do what use to be normal daily activities. Individuals are likely to have trouble feeling or expressing positive emotions (Vogt, Smith, Elway, Martin, Shultz, Drainoni, & Eisen, 2011). PTSD can turn an individual life around, for the symptoms if left untreated can inhibit the individual from having a quality life. The great news is PTSD symptoms are treatable.

Etiology of posttraumatic stress disorder

Diagnosis of posttraumatic stress disorder (PTSD) requires exposure of an individual to an event that involved an actual or possible threat of death, violence or serious injury. However, PTSD can also be related to various socioeconomic variables. The diathesis-stress model of PTSD has identified many variables that contributed to the symptoms of PTSD (McKeever & Huff, 2003). McKeever and Huff (2003) noted that these variables can be situational, biological, as well as ecological. When an individual experiences overwhelming trauma beyond his/her ability to cope with the situation, the condition can lead to distress.

Current research on the neurobiology of the response to stress has led to successful new treatments for posttraumatic stress disorder to assist individuals in having a normal and productive life after their exposure to the traumatic event. These researches include high levels of catecholamine release during stress rapidly impair the top-down cognitive functions of the prefrontal cortex (PFC), while strengthening the emotional and habitual responses of the amygdala and basal ganglia (Arnsten, Raskind, Taylor, & Connor, 2015). Results from these studies shown that stress alters brain physiology. The prefrontal cortex provides top-down regulation of behavior, thought and emotion, generating the mental representations needed for flexible, goal-directed behavior, including the ability to inhibit inappropriate impulses, regulation of attention, reality testing, and insight about the individual's actions. (Arnsten et al., 2015).

The neurobiology of stress has also shown the relationship between brain structures like the amygdala and hippocampus, and the role they play in the development of PTSD. It should be noted that an increase activation in the amygdala and hippocampus can be triggered from a childhood abuse, a rape situation, first responder or military personnel experiencing an overwhelming situation, or individual who seem to experience long-lasting, never-ending

trauma. Individuals who are predisposed to mental illness are also vulnerable to PTSD. Genetic composition, inherited traits, neurological anomalies, previous trauma experiences, and an individual's surrounding environment can all contribute to vulnerabilities and predisposition to PTSD (McKeever & Huff, 2003).

We have seen situations where a population may experience major challenges in meeting their health care needs or lack appropriate housing due to military conflicts and/or natural disasters. These situations have shown positive correlations to prevalence of PTSD among the population. For instance, a study conducted by Alpak and colleagues (2015) on Syrian refugees in Turkey resulted in frequency of PTSD up to thirty-four percent among the population. Many studies on posttraumatic stress disorder have presented clear evidence that chronic exposure to traumatic stress contribute to changes in brain structures like the amygdala and hippocampus which lead to PTSD (Alpak et al., 2015; Kessler et al., 2014; McKeever & Huff, 2003). So, there are several stress pathways to the symptoms of PTSD. The epidemiology of posttraumatic stress disorder has shown relative prevalence among military combat veterans, and other groups like first responders whose vocations would have higher probability of exposure to traumatic event (APA, 2013; Beidel et al., 2014). The DSM-5 classification noted the highest rates of prevalence for PTSD are among rape survivors, military combat veterans, and individuals who have been exposed to genocides (APA, 2013). Common among these individuals is that they have been exposed to disturbing images beyond their ability to cope with the emotions, and situations have led to overwhelming distress in their lives. Stress can lead to physical and psychological issues where the body will undergo a series of biological changes (Butcher, Mineka, & Hooley, 2012). Stress will affect the body, as well as the mind, and can trigger mental disorders like PTSD especially in vulnerable individuals.

Risk factors

There are several potential risk factors that can increase the likelihood of an individual suffering from posttraumatic stress disorder (PTSD). These types of factors are not limited to ecological, physiological, trauma severity, and residual stress (McKeever & Huff, 2003). There can also be etiological factors in PTSD which can be biological or environmental in nature. It should be noted that these risk factors can interact and overlap each other to contribute to the development of PTSD. However, experiencing a traumatic event is still the primary risk factor for posttraumatic stress disorder.

An individual who has been exposed to a traumatic event that appears to be life-threatening can become vulnerable to biological, psychosocial, or situational risk factors that are increasingly viewed as predictors of symptoms onset to posttraumatic stress disorder. PTSD affects multiple biological systems, such as brain circuitry and neurochemistry, and cellular, immune, endocrine and metabolic function (Yehuda, Hoge, McFarlane, Vermetten, Lanius, Nievergelt, & Hyman, 2015). There are also component risk factors that can be considered predictors of PTSD which are not limited to an individual's socio-demographic, exposure to a life-threatening incident, prior mental disorders, and interpersonal violence (Kessler, Rose, Koenen, Karam, Stang, Stein, …. & McLean, 2014). Risk factors to posttraumatic stress disorder can be very broad, and include several variables like a previous trauma exposure, preexisting psychiatric disorders, parental psychopathology, pre-trauma, and post-trauma support (Ramchand, Rudavsky, Grant, Tanielian, & Jaycox, 2015). The reliance of family members or close friends are essentials for emotional support after experiencing severe trauma.

Demographics are other risk factors that contribute to the development of posttraumatic disorder. Cheng and Mallinckrodt (2015) posit that race and ethnicity are risk factors in

developing PTSD symptoms in people of color. These individuals may experience racial and/or ethnic discrimination that can put them at risk for developing symptoms of PTSD (Cheng & Mallinckrodt, 2015). Demographics can pose conditional risks to developing PTSD. Individuals who are continuously exposed to stress may experience decreased hippocampal volume which represents a risk factor for developing posttraumatic stress disorder (Beidel et al., 2014). The DSM-5 also noted that lower socioeconomic status and lower education can become pretraumatic risk factors that contribute to the development of PTSD (APA, 2013). Individuals who live in high-crime neighborhoods that may be impoverished are more likely to experience interpersonal violence and/or a life-threatening incident than individuals who live in affluent neighborhoods.

Cultural issues

Different populations will respond to a natural disaster and/or a traumatic event in different ways. Cultural context can influence aspects of posttraumatic stress disorder (PTSD). Cultural norms and characteristics affect how an ethnic group will respond to tragic events. It should be noted that clinical expression of PTSD symptoms differs across cultural groups. As noted in the latest DSM classification, risks of onset and severity differ across cultural groups because of sociocultural and cultural factors (APA, 2013). Race and ethnicity are important variables to understand PTSD, and the impact of race-related stressors. PTSD symptoms expression are shaped by cultural syndromes (APA, 2013). Epidemiological surveys suggest that Hispanics often have higher rates of PTSD compared to African Americans or Caucasians (Beidel et al., 2014). Post-trauma support is essential to the recovery process after an individual experienced severe trauma. Moreover, culture, ethnic, and racial identities can be a source of strength to enhance resilience in individuals who have experienced trauma (APA, 2013).

Comorbidity

Stress symptoms are common after an individual has been exposed to extreme overwhelming psychosocial stressors, a traumatic and/or a life-threatening event. These symptoms are associated with several mental disorders that are not limited to depressive, bipolar, anxiety, or substance use disorders (APA, 2013). As reported in recent updated DSM-5 classification, individuals who meet criteria for posttraumatic stress disorder (PTSD) are eighty percent likely to meet criteria for other mental disorders like depressive, bipolar, anxiety, or substance use disorders (APA, 2013). So, comorbidity with mood, anxiety, and substance use can be of concern to clinicians when diagnosing for PTSD (Beidel, Frueh, & Hersen, 2014). It should be noted that common etiologic factors may play a role in the co-occurrence of these disorders. Symptoms overlap exist between PTSD and those other disorders.

Posttraumatic stress disorder involves symptoms of anxiety within physical, affective, cognitive, as well as behavioral systems which can reflect characteristics of disorders where individuals are reexperiencing, avoiding, and becoming numb to a tragic event (Seligman & Reichenburg, 2014). Individuals who have been traumatized and meet diagnostic criteria for PTSD are likely to exhibit symptoms that are consistent with other specific disorders. These include substance use disorder (SUD), anxiety, bipolar, and depressive disorder (APA, 2013). PTSD is associated with psychiatric morbidity, and its symptoms are prevalent mental health problem (Sareen, 2014). Moreover, dissociative identity disorder (DID) are commonly comorbid with PTSD, for individual who have been abused early in life or experienced trauma would present with numbing and flashback phenomena (Beidel et al., 2014). Comorbidity exist with PTSD and several other mental disorders due to symptoms overlap. Stress symptoms are associated with an array of mental disorders.

Differentiation from similar disorders

Disorders can differ in terms of their symptoms cluster, duration, and distress experienced by an individual that cause social, emotional, as well as vocational impairments. Posttraumatic stress disorder differs from the others in the group of *trauma & stressor-related disorders* in unique ways to include incidence, duration of symptoms, and risk factors. Trauma exposure is generally the precipitating event for PTSD to develop. PTSD includes elements of anxiety insomuch as a generalized feeling of fear and apprehension (Butcher, Mineka, & Hooley, 2012). Mental disorders like anxiety, major depressive, dissociative, obsessive-compulsive, adjustment, psychotic, and personality disorders share common symptoms with PTSD (APA, 2013). However, PTSD will have a specific triggering traumatic event that precedes symptoms. Diagnostic criteria for PTSD requires the presence of symptoms for more than one month in duration (APA, 2013). Both PTSD and obsessive-compulsive disorder have symptoms of intrusive thoughts, but the thoughts present in PTSD are manifested from a traumatic or life-threatening event. Meanwhile, in anxiety disorders, anxious feelings or excessive worrying can trigger symptoms. The PTSD symptom that are distinct from common symptoms shared with similar disorders is the recurrent intrusive symptom that contribute to persistent avoidance of stimulus associated with the trauma event. PTSD is a condition that can come about from the experience a life-threatening event which include natural disasters, a terrorist attack, a sexual and/or physical assault, or combat and/or military experience. Yehuda and colleagues (2015) posit that PTSD is characterized by symptoms of intrusive or distressing thoughts, nightmares, and flashbacks that are manifested from past exposure to traumatic events. Core symptomatic features of PTSD include the re-experiencing of trauma, deliberate avoidance of stimuli, and persistent perception of heightened threat that make the individual hypervigilance.

Biopsychosocial approach to conceptualizing posttraumatic disorder

Stress factors contribute to the symptoms of posttraumatic stress disorder (PTSD), and they are not limited to any specific pathway. Individuals who are biologically predisposed are vulnerable, as well as individuals who continue to struggle with healthcare and housing issues are also vulnerable to the stressors of PTSD. Recent studies have shown that racial and ethnic discriminations have contributed to individuals having symptoms of PTSD. However, we must consider that regardless of race/ethnicity or socioeconomic status, individuals may become vulnerable to PTSD symptoms if they have been exposed to military combat operations, sexual assaults, violent crimes, or natural disasters, and these individuals may turn to alcohol or other substances as coping mechanisms. (Kessler et al., 2014). Psychosocial factors are viewed as predictors of PTSD symptoms onset. Moreover, individuals who have served in the armed forces during military conflicts can become prone to PTSD than individuals who have not been part of the military (Bremner et al., 2017). PTSD symptoms can also be linked to domains like aggression, violence, economic well-being, and homelessness.

Psychosocial stressors may influence the development and expression of PTSD. For instance, military veterans who have been diagnosed with PTSD and other injuries are more hypervigilant and avoid specific activities after redeployment (Vogt et al., 2011). These individuals, after redeployment, tend to indulge in alcohol and substance use behaviors. It should be noted that trauma can contribute to neurobiological changes within an individual, and can increase vulnerability to mental disorder (Arnsten et al., 2015). Chronic exposure to stress can lead to neurochemical imbalance and emotional dysregulation. So, it may be necessary for individuals to control psychosocial stressors. McKeever and Huff (2003) noted that advances in technologies have enabled researchers to examine biological factors associated to PTSD.

Current treatment for posttraumatic disorder

There are effective treatments for posttraumatic stress disorder (PTSD) that currently exist today. They include treatment strategies that: help individuals improve their emotional control and restore their sense of control over turbulent emotions; help individuals make sense of the trauma they have experienced; teaches individuals how to change their upsetting thoughts and emotions; and teaches individuals how to gradually approach their trauma related memories they have been avoiding since their experience with traumatic event (Bremner et al., 2017; Monson et al., 2006; Morland et al., 2014; Popiel et al. 2015; Preston et al., 2013; van den Berg et al., 2015). Treatment approaches to PTSD may involve the use of medication management and/or talk therapy, or a combination of both, with talk therapy having great efficacy to medications. The neurobiology of stress has been the focus PTSD researches. These studies show the relationship in brain functions and behaviors, and best approach to extinct memories that are fearful which may have come about from a traumatic event. However, there have been increasing emphasis on identifying potential factors that may explain an individual difference in his/her response to trauma. These studies have call for the promotion of resilience as a response to possible effects which may have precipitated from childhood trauma and overwhelming moments that may have experienced during the lifetime (Yehuda et al., 2015). Current treatment for PTSD help individuals gradually adjust to facing their painful memories that came about from their traumatic experience.

Medication management

Treatment of post-traumatic stress disorder help individuals to better control their emotions, and regain control over their life. Psychotherapy has become the preferred treatment

modality; however, other treatment may involve pharmacotherapy. Pharmacological treatment may be necessary, and antidepressants medications are regarded as a first line treatment for PTSD (Bae, Kim, Jang, Lee, & Kim, 2016). There are several medications (MEDs) that can help relief the symptoms of PTSD. These MEDs include antidepressants and anti-anxiety MEDs. Preston and colleagues (2013) posit that second-generation antipsychotics and anticonvulsants have been relatively effective in treating PTSD. Medication compliance is also essential in treating PTSD. As for psychopharmacological treatment, selective serotonin reuptake inhibitor (SSRI) medications like sertraline (Zoloft) and paroxetine (Paxil) have been approved by the Food and Drug Administration (FDA) for treatment of PTSD (Preston et al., 2013). These MEDs promote emotional and behavioral balance by increasing the number of neurotransmitters, including serotonin and norepinephrine present in the body (Preston et al., 2013). Medication management, when combined with psychotherapy, can be very effective in treating symptoms of posttraumatic stress disorder.

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is an eight-phase psychotherapeutic protocol that is designed to address the individual's past negative experiences, current triggers of their symptoms that came about from a traumatic experience, and any future block to effective functioning by the individual (Cox & Howard, 2007). EMDR has helped individuals make sense of their traumatic experience (Bae et al., 2016; Cox & Howard, 2007; van den Berg et al., 2015; Vogt et al., 2011). Many studies in recent years, on the utility of EMDR with a veteran population of recent wars have shown EMDR to have achieved symptom reduction in a variety of clinical domains like anxiety, depression, anger, physical pain (Vogt,

Smith, Elway, Martin, Shultz, Drainoni, & Eisen, 2011). EMDR protocol was designed to address past negative experiences, current triggers of the symptoms developed from those experiences, and any future blocks to effective functioning. The treatment protocol gave clients the necessary tools to manage their symptoms that have hinder them from living a productive life. EMDR as a cognitive behavioral therapy assimilate and accommodate disturbing experiences with the individual's cognitive structures. (Wells & Colbear, 2012). Eye movement desensitization and reprocessing appears to be well suited for use with combat veterans and rape victims, for the treatment technique encourages the resolution of disturbances manifested physically, emotionally, and cognitively (Wells & Colbear, 2012; Vogt et al., 2011). EMDR has been approved for use in treating symptoms of PTSD my insurance providers as well as the veteran administration (VA) healthcare system.

Prolonged Exposure

Prolonged exposure (PE) is a manualized protocol, based on emotional processing theory, accomplished through in vivo and imaginal exposure to assist clients to interrupt and reverse the process of blocking cognitive and behavioral avoidance of trauma-related thoughts (van den Berg, de Bont, van der Vleugel, de Roos, de Jongh, Van Minnen, & van der Gaag, 2015). This treatment protocol has help clients to reduce their symptoms of anger and anxiety that may have contributed to them feeling on the edge (Popiel, Zawadzki, Pragłowska, & Teichman, 2015). Clients can correct information, and better process their trauma memories. Prolonged exposure is based on emotional processing theory, and help clients to block cognitive and behavioral avoidance (Popiel et al., 2015). Several recent studies with military combat veterans have demonstrated that prolonged exposure therapy is an effective treatment for posttraumatic stress

disorder (Popiel et al., 2015; van den Berg et al., 2015). Prolonged exposure therapy helps clients to better discriminate safe and unsafe situations to improve their daily functioning. Prolonged exposure is a safe and feasible treatment protocol that assist clients in moving forward and deal with the things and situations they have been avoiding since their traumatic experience.

Cognitive Processing Therapy

Cognitive processing therapy (CPT) protocol is a 12-session therapy, which are solely based in a social cognitive theory. The approach focuses on how the traumatic event experienced by the individual was constructed and their coping mechanism to regain their sense of control (Monson, Schnurr, Resick, Friedman, Young-Xu, & Stevens, 2006). CPT process was initially focused on rape victims, but has expanded to wider ranges of traumatic events like military related traumas. CPT can assist individuals in refocusing their thoughts and feelings since their traumatic experience (Tran, Moulton, Santesso, & Rabb, 2016). Clients learn how to change their upsetting thought so that they can move forward. The efforts to avoid anything that would remind clients of their traumatic event remained one of the core diagnostic characteristics of PTSD, and CPT has been effective in disrupting the fear network in clients' memory that elicit escape and avoidance (Monson et al., 2006). CPT protocol can be used and have shown efficacy in a group format, not just with individual therapy. CPT have achieved large clinically significant improvements for PTSD, and it is approved to be used within the veteran administration (VA) healthcare system for treating military veterans. Posttraumatic stress disorder has become a significant problem for military veterans. Monson and colleagues (2006) have noted that CPT can be used in residential treatment programs in conjunction with other treatments like pharmacotherapy.

Conclusion

In concluding, we saw how an event or an experience that is life-threatening can become the prominent factor for posttraumatic stress disorder. Events like the 9/11 attack on the World Trade Centers in New York City are one from recent memories. Other experiences include a natural or man-made disaster; a sexual or physical assault; combat experiences; and first responder encountering a tragic event. Over the last two decades, several high-profile traumatic events have triggered sharp increases in studies of posttraumatic stress disorder (Sareen, 2014). These events include military campaigns in Afghanistan and Iraq which have been major risk factors for U.S. servicemen and servicewomen of developing PTSD. PTSD has become a common mental health issue with substantial impact on the individual, families, as well as society. It should be noted that PTSD can be diagnosed from one month to several years after these soldiers have experienced trauma (Beidel et al., 2014).

Over the last decades the American Psychiatric Association have updated the definition of posttraumatic stress disorder. However, four core features remained unchanged (Sareen, 2014). These features which are criteria for reaching a PTSD diagnosis include: experiencing a traumatic event; re-experiencing symptoms like flashbacks and/or nightmares; hyperarousal symptoms like sleep disturbances and poor concentration; and a conscious effort to avoid places, situation, or people who bring back memories to the event (APA, 2013; Sareen, 2014). There have also been a plethora of studies and clinical trials on PTSD since the wars in Iraq and Afghanistan because of the significant impact of this mental disorder on soldiers and their families. Today, we have evidence-based treatment protocols that include eye movement desensitization and reprocessing, prolonged exposure cognitive processing therapy, and medication management with a high degree of efficacy in treating PTSD.

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