POSTTRAUMATIC STRESS DISORDER AND THE MILITARY: AN OVERVIEW

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Abstract

Posttraumatic stress disorder (PSTD) is a psychological disorder caused by exposure to traumatic and noxious experiences. It is an enduring psychological disturbance attributed to the personal experience of a major traumatic event involving actual or threatened death. PTSD is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma. The horrifying experience leads to general increase in anxiety and arousal, avoidance of emotionally charged situations, and the frequent reliving of the traumatic events. This condition has consequential personal, economic and efficiency cost on the military of any country. Experimental evidences and observations support a biological predisposition to PTSD, while the Cognitive behavioural school explains PTDS as learned helplessness; a condition necessary to elicit assistance and possible de-listing from dangerous assignments. It is also plausible that sufferer's faulty evaluation of stressful stimuli in juxtaposition with personal aspirations may precipitate PTDS with frustration as a mediating variable. Combination of chemo, and psycho therapies is advocated for faster and long lasting relief.

Keywords*: Posttraumatic, stress, disorder, military.*

Introduction

Military service is generally believed to be very stressful hence officers and men are required to take specialized physical training before full enrolment and placement in the various arms. Notwithstanding the training, the strain sometimes becomes unbearable to some men, culminating in a pattern of physical and psychological breakdown. As noted by Kalat (1998), the experience of post-war breakdown was first called battle fatigue, and later, shell shock. Spitzer, Skodol, Gibbon and Williams, (1983) opined that many war-time experiences could lead to severe negative reactions for as long as they engender severe prolonged stress. It is this reaction after experiencing noxious stress that is currently known as posttraumatic stress disorder.

Coleman (2006) defined posttraumatic stress disorder as an anxiety disorder arising as a delayed and protracted response after experiencing or witnessing a traumatic event involving actual or threatened death or serious injury to self or others. The DSM-IV- TR (2005) explained that posttraumatic stress disorder is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma, while Oltmanns and Emery (1995) are of the view that the horrifying experience leads to general increase in anxiety, and arousal, avoidance of emotionally charged situations, and the frequent reliving of the traumatic events. Again, the American Psychological Association (1994) saw posttraumatic stress disorder as enduring psychological disturbance attributed to the personal experience of a major traumatic event involving actual or threatened death. The traumatic events experienced directly include military combat, violent personal assault, being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war in a concentration camp, natural or man-made disasters, severe automobile accidents, and so on. From the foregoing, it is understandable that this is a severe psychological condition which has consequential personal, economic and efficiency costs on the military of any country. In Nigeria,

the armed forces (military) are currently engaged in combat operations in different parts, of the country. This combat operation has potentials to induce combat-related stress, which according Lahey, (2004) is the most common single cause of posttraumatic disorder. This paper will therefore consider the concept, history and diagnosis of posttraumatic stress disorder then the theoretical background and psychological treatment options for posttraumatic stress disorder.

Studies have been undertaken in order to determine the prevalence of PTSD in population of trauma victims. Rachman (1978) did a study with the British citizenry, who endured numerous life-threatening air raids during World War H. He found that majority of people endured air raids extraordinarily well, contrary to the universal expectation of m ass panic. Kilpatrick, Best, Veronen, Amick, Villeporteaux, & Ruff (1985) studied more than 2,000 adult women who had personally experienced such trauma as rape, sexual molestation, robbery, and aggravated assault. They were asked whether they had thought about suicide, or had a nervous breakdown. They found that rape had the most significant emotional impact, that 19 of rape victims had attempted suicide, and 44 reported suicidal ideation at some time after the rape. Furthermore, Resnick, Kilpatrick, Dansky, Saunders, and Best, (1993) found that 32 of rape victims met criteria for PTSD at some point in their lives. Indeed, there is enough proof that combat and sexual assault are the most common traumas (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

Posttraumatic stress disorder: History and etiological factors

Historically, a British diarist known as Samuel Pepys in 1966 captured the Great fire that ravaged London, which caused substantial death and loss of properties. He experienced this fire first-hand, and did not escape the effects of the traumatic and horrific event. In recounting his experience, Pepys has this to say "it is strange to think how to this very day I cannot sleep a night without great terrors of fire." Posttraumatic stress was officially recognized as a psychiatric distress following disaster in 1978. This disorder was first mentioned in 1980s in DSM-III (Diagnostic and Statistical Manual of Mental Disorder by American Psychiatric Association, 1980), nevertheless, it has a very long history. The DSM¬II has official acknowledged PTSD as a psychiatric illness (APA, 1980). Posttraumatic stress disorder has been with us for a very long time. It is however only in recent year that studies of psychiatric disorder following warfare and major disaster have become documented with the frequency, scientific and methodological rigour which it deserved.

Before now other syndromes had been described based on morbidity (e.g. Bereavement syndrome, survivor Syndrome, camp psychosis, gross stress reaction, traumatic war neurosis, and so on) (Leach, 1994). However, it is important to note that not everyone involved in a life-threatening situation will experience this disorder and definitely many will not exhibit the severe chronic psychiatric symptoms which would require hospital management. Nevertheless, far too many people do suffer severe psychiatric disturbance following disaster.

This condition has been known in post war periods throughout history under such terms as battle fatigue or shell shock (Kalat, 1998). The DSM-IV- TR is of the opinion that the setting event for PTSD is exposure to traumatic event during which some one experiences fear, helplessness, or horror. Later, victims re-experience the event through memories and nightmares. In the event of memories occurring suddenly the victims find themselves reliving the event, and usually have flashbacks. Victims often consciously avoid anything that reminds them of the event. This display of a characteristic restriction or numbing of emotion, usually affects their interpersonal functioning (Barlow & Durand, 2009). Victims are atimes unable to remember certain features of the trauma, as this could be related to an unconscious attempt to avoid the experience of emotion itself. Indeed, victims are typically chronically over-aroused, easily startled, and quick to anger.

Although, the etiology of PTSD is well known, it must be noted that the development of this condition could be influenced by biological, psychological and social factors. Biologically, according to Foy, Resnick, Sipprelle, & Carroll (1987), if certain characteristics run in the family, the likelier one is to develop the disorder. Further a family history of anxiety suggests a generalized biological vulnerability for PTSD (Barlow & Durand, 2009). In the same vein, Breslau, Davis, and Andreski (1995) found in a study of 1,200 individuals, that characteristics such as tendency to be anxious, as well as factors such as minimal education, predict exposure to traumatic events and hence, an increased risk for PTSD. Also, early experience/exposure to unpredictable or uncontrollable events increases vulnerability to PTSD. For example, family instability is a factor that may instill a sense that the world is an uncontrollable and potentially-dangerous place (Chorpita &Barlow, 1998). Thus, it is believed that individuals from unstable families are at risk of developing the disorder if they encounter trauma.

Again, social and cultural factors have positive effect in the development of PTSD. Results from a number of studies consistently show that if one has a strong and supportive group of people around, then the likelihood of developing PTSD is much rare after experiencing a trauma (Carroll, Rueger, Foy, & Donahoe, 1985). Furthermore, Schuster, Stein, Jaycox, Collins, Marshall, Elliot, et al (2001) reported that people who experienced PTSD symptoms following the terrorist attack of9111 coped with the stress mostly by looking to friends and families for support.

Diagnosis of Posttraumatic Stress Disorder

Although the symptoms of PTSD have been around for centuries, however, for a person to be classified as suffering from PTSD the following must be satisfied:

1. That the symptoms follow a stressful event
2. The victim re-experiences the traumatic event through (a) recurrent dreams, (b) intrusive recollections and (c) behavior and feelings as if the event were actually re-occurring.
3. The individual's response to the outside world becomes numbed. This psychological number begins sometime after the traumatic event and is characterized by (a) feelings of detachment from others (b) decrease in interest in significant activities, (c) constriction of effective (emotional) responses.
4. The presence of at least two of the following symptoms providing they were not present in the victim previously

    (a) Hyper-alertness or exaggerated startle response
    (b) Sleep disturbance
    (c) Guilt about surviving
    (d) Impairment in memory or loss of concentration
    (e) Avoidance of activities that arouse recollection of the event.
    (f) Intensification of the symptoms by events that resemble or symbolize the original traumatic event.

PTSD is categorized into two: Acute and Chronic types. Acute PTSD usually manifest one month after the event occurs while chronic PTSD continues longer than three months. The chronic type is often associated with more prominent avoidance behavior (Davidson, Hughes, Blazer, & George, 1991). According to leach (1994) some of the above symptoms are likely to be founded in varying degree following a misadventure. It is only when the symptoms persist, show resistance to recovery and impair the survivors ability to function in his everyday life does the victim becomes classified as suffering from posttraumatic stress disorder.

Theoretical Background

Posttraumatic stress disorder IS categorized as an anxiety disorder. Indeed, various theoretical models have been put forward to explain the causes of posttraumatic stress disorder. Biologically, evidence shows that we inherit tendency to be tense and anxious (Clark, 2005). As with most psychological disorders, no single gene seems to cause post-traumatic stress disorder, instead, contributions from collection of genes in several areas on chromosomes make up vulnerability to anxiety (Kendler, 2006). Again, the tendency to panic also seems to run in families and may have genetic component (Barlow, 2002). Further, anxiety is associated with specific brain circuits and neurotransmitter systems. Evidence shows that depleted levels of GAB A, part of the GABA-benzodiazepine system are associated with increased anxiety (Barlow & Durand, 2009). The area of the brain commonly associated with anxiety is the limbic system (Le Doux, 2002) which acts as a mediator between the brain stem and the cortex. Research has shown that a brain circuit in the limbic system of animals is heavily involved in anxiety (Gray, 1985) and this may be relevant to humans. These evidences and observations support a biological predisposition to PTSD.

Cognitive behavioural school explain PTDS as learned helplessness; a condition necessary to elicit assistance and possible de-listing from dangerous assignments. It is also plausible that sufferer's faulty evaluation of stressful stimuli in juxtaposition with personal aspirations may precipitate PTDS with frustration as a mediating variable.

Principles of Management

There are two major approaches to management of PTSD. First is chemotherapy and the other is psychotherapy. However, most therapists find combination of the two successful. The chemotherapeutic approach to the management of PTSD involves the use of drugs to reduce the symptoms of PTSD. Antidepressants, particularly, selective serotonin reuptake inhibitors (e.g. Prozac and Paxil) have been found to be effective in reducing symptoms of PTSD, especially the severe anxiety and panic attacks that are always prominent in PTSD. Psychotherapy implied the application of purely psychological techniques and principles in the treatment of PTSD. Most clinicians are of the opinion that victims of PTSD should face the original trauma in order to develop effective coping procedures and to overcome the debilitating effects of the disorder (Keane & Barlow, 2002; Nagavits, 2007). From the psychoanalytic perspective, reliving emotional suffering is called catharsis. In the case of PTSD, the therapist will arrange the re-exposure in such a way that it will not be traumatic again, but rather, therapeutic. However, based on the mere fact that traumatic events are difficult to recreate, imaginal exposure, in which the content of the trauma and the emotions associated with it are often a common choice (Barlow & Durand, 2009). In therapy, the therapist works in collaboration with the victim to develop a narrative of the traumatic experience which will be consecutively reviewed in therapy.

Further, cognitive therapy via cognitive restructuring is always an effective instrument for correcting the negative assumptions of the client about the trauma. Most victims of PTSD often blame themselves for the experience, feel consistently guilty or both and may be depressed. The therapist has the responsibility of applying cognitive principles or approaches in attacking the irrational and erroneous beliefs and perception of the victim, which is aimed at alleviating the symptoms of PTSD.

Conclusion

Posttraumatic stress Disorder, an anxiety based disorder, which is a consequence of traumatic experience particularly among those in military combat situations was examined. The disorder which has an acute and chronic type usually occurs one month after the experience of traumatic event.

Evidence showed that the disorder could be influenced by certain biological, social, and psychological factors. The paper also observed that this condition could be eclectic ally managed through the application of psychotherapy and chemotherapy. The author therefore suggests that trained clinical psychologist psychotherapist should be made a compulsory part of the military organization whenever they are facing combat situations. This in order to manage any psychological experience particularly PTSD that could arise from such exposure. Again, Psycho-education and sensitization programs should be organized for the men of the armed forces in order to inculcate preventive and coping strategies.

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