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Chronic Posttraumatic Stress Disorder: A Prolonged Nightmare of Aftershocks

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Abstract: This article is an overview of chronic posttraumatic stress disorder incorporating its etiology, treatments, certain controversies, and recommendations for future development. Based on the diagnostic criteria of DSM-5 and ICD-10 and the research and summary of previous literature. This paper summarizes the etiology of chronic posttraumatic stress disorder under the theoretical models of five schools (including the biological, psychodynamic, cognitive/information processing model, behavioral model, and current etiological conceptualization based on anxiety disorders). Their influence and application, the current commonly used treatment methods and their effectiveness, the current controversies regarding the definition and treatment of chronic PTSD, and recommendations for future research. Overall, based on previous theoretical research and practical treatment, this paper discusses chronic posttraumatic stress disorder from different perspectives and puts forward the existing problems in current research, thus not only offering readers a relatively comprehensive understanding of chronic traumatic stress disorder but also having multiple orientations of summarizing historical research and facing the future.

Keywords: chronic posttraumatic stress disorder; recurrent flashbacks; excessive arousal

1. Introduction

The American psychiatric association in 1980 in the third edition of the diagnostic and statistical manual of mental disease, will be exposed more than normal people can afford a traumatic event related to the trauma of insert sex thinking and memory, continue to escape, related to the trauma associated with the trauma of sustained growth state of alert, established as a separate diagnosis of obstacles, And officially named this trauma-related mental and behavioral disorder post-traumatic stress disorder. PTSD was officially included in the tenth edition of the International Classification of Diseases in 1993. The third edition of the Chinese Diagnostic and Classification Criteria for Mental Disorders first used the term and included it as a stress-related disorder.

These individuals who did not recover after one year developed chronic posttraumatic stress disorder, with anxiety and depression as significant predictors and clinical symptoms, accompanied by typical symptoms.

Most previous studies on chronic posttraumatic stress disorder focused on fundamental research of its neurophysiology, clinical treatment, and prevention. Less attention was paid to the pathological exploration of chronic PTSD. The primary purpose of this paper is to provide an overview of chronic PTSD. Based on including the clinical symptoms, treatment methods, and effects of chronic PTSD,

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this study highlights the current pathological theory, its application, impact, and existing problems. It provides a theoretical basis for future research and treatment.

2. Methodology

This paper is a review based on research and studies collected using Google Scholar and Z-library to gain insight into chronic posttraumatic stress disorder. Basic information about PTSD is obtained from DSM-V [1]. At the same time, chronic PTSD is a more extreme version of PTSD, which lasts longer and is featured by anxiety and depression. The treatment overview is based on Terence M. Keane, Amy D. Marchall, and Casey T. Taft's research results on the etiology, epidemiology, and treatment outcomes of chronic PTSD. The document not only introduced the potential etiology of posttraumatic stress disorder but also provided a clinical guideline on the PTSD treatment process.

3. Discussion

This part summarizes the etiology and treatment of chronic posttraumatic stress disorder, covering the mainstream etiological theory of chronic PTSD and its evaluation, and states the current commonly used treatment methods and their effects.

3.1. Etiology

There is still no conclusion on the causes of chronic posttraumatic stress disorder in the academic community [2]. This paper lists the theoretical models proposed by four schools with significant influence in the past and the current popular conceptual models based on stress theory.

3.1.1. Biological Model

Boyd, Greenburg, and Van der Kolk proposed a hypothetical biological model in 1984 to understand the development of posttraumatic stress disorder. Van der Kolk stated that, according to similar models found in animals, how and why posttraumatic stress disorder developed is the consequence of the biochemical and behavioral differences that occur because of the traumatic event (namely conditions of unavoidable or/and inescapable shock). The primary thesis of this model is that the activities of neurotransmitter cushion trauma-related behavioral changes.

It is undeniable that biochemical variables play a significant role in the origins and process of anxiety and stress. Nevertheless, at the time when Van der Kol et al. proposed their model, information regarding the precise mechanisms of how neurotransmitter activities influence human behavior was lacking, and the model consequently failed to adequately explain the fact that according to literature at that time, development of typical symptoms was often reported as procrastinated and delayed. In addition, the biological model also fails to deal with variables that are significant to the development of PTSD [3].

3.1.2. Psychodynamic Model

The psychodynamic model of the development of PTSD was proposed in 1986 by Horowitz, who described his model as not only psychodynamic-oriented but also has essential features of cognitive and information processing theory. This model explains that PTSD is developed because a person fails to integrate a traumatic event into their existing thinking patterns, or to say, cognitive and information processing schema; that is to say, PTSD is the reflection and symbol of the deviation of the tendencies of standard stress response mechanisms. As the numbing symptoms are a defense mechanism against the intrusion of stress, an individual typically shifts between the intrusion and avoidance phases [4]. In summary, denial, as a noticeable defense mechanism according to

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psychodynamic theorists, causes information processing to slow down, thus reducing anxiety levels. Based on the logic, when the denial mechanism breaks down because of the intensity of traumatic events and ends up ineffective, intrusion occurs and disrupts an individual's mental wellness and mental stability.

Horowitz has developed a model that has integrated both the psychodynamic orientation and the cognitive processing theory and has considered the characteristic signs and symptoms of PTSD. Despite these positive traits, this theory has its limitation in that it does not successfully incorporate explicitly and integrate an individual's perception of control. However, Horowitz's psychodynamic model successfully explains how symptoms of post-traumatic stress disorder develop, maintain, and delay, making it possible for empirical evidence to back up this theory [5]. As a result, the psychodynamic model is viewed as one of the most comprehensive theories among the theories listed in this paper.

3.1.3. Cognitive/Information Processing Model

Based on Lang's analysis of fear structures, Chemtob, Hamada, Roitblat, Carlson, and Twentyman and Steketee, Foa, and Olasov-Rothbaum have proposed cognitive/information processing models of the development of PTSD [6]. They hypothesize that the fear structure related to traumatic events differs from those in other stress disorders because traumatic events are much more severe and violate an individual's sense of safety. As a result of the interruption of safety assumptions, situations previously considered safe by an individual become dangerous. Compared to other types of information structures, the associated fear structure is correspondingly more intense and easier to be activated because of the intensity and severity of traumatic events. Accordingly, there are much more stimuli that can activate the fear structure.

A beautiful feature of the cognitive model is that it considers the significant variables of predicting and controlling. However, a limitation of this model is that it does not discuss variables of known significance. Additionally, this model fails to account sufficiently for the fact that PTSD develops in some victims but not others when facing traumatic events.

3.1.4. Behavioral Model

Based on the fundamental framework, namely the two-factor theory, proposed by Mowrer in 1947, Keane, Caddell, Fairbank, Bender, and Zimering, and Zimering, Keane, and Cadell have developed what they name the learning theory model of posttraumatic stress disorder. Keane, Fairbank, et al. state that trauma leads to an individual forming conditioned reflection to numerous stimuli present in traumatic events that were previously neutral to the individual, and these stimuli consequently become irritants that are contaminated with harmful colors just as adverse life events, and can cause stress in the individual. And since these stimuli can be a myriad of objects such as sounds, tastes, and smells, the impact of trauma on the individual is chronic and severe.

Moreover, this model contributes significantly to the etiology of PTSD by attempting to clear up the complicated interactions among multiple potentially essential variables. Assuming that the basic principles of this theory are reasonable, two primary factors must be taken into account: the level of social support that an individual receives and the types and quantities of stimuli that constitute the conditioning. The traumatic event, interplaying with various levels of social support, determines the intensity, duration, and form of conditioning. Although the significance of these two variables is given much account, this model still fails to explain that adverse life events and stimuli of similar intensity affect individuals to a very different extent.

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3.1.5. A New Etiological Conceptualization

Even though many people have experienced traumatic events, most do not develop chronic posttraumatic stress disorder. When experiencing the same or similar stressors, individuals may or may not develop mental disorders; those who develop PTSD experience the disease to a distinctive extent. The studies trying to identify factors that may contribute to these differences can help us better understand the etiology of chronic PTSD, thus developing prevention approaches for individuals with a higher risk of developing this mental disorder. There are mainly three categories of potential risk factors for PTSD: preexisting factors specific to the individual, such as psychological and physiological vulnerability as well as social identity; factors associated with the traumatic event, for instance, an individual's immediate response when the traumatic event happens; and events that occur after the trauma, for example, whether an individual gets enough social support after experiencing a traumatic event.

For the preexisting factors, psychological and physiological vulnerability, as well as social identity, counts. Research in mammals suggests that a specific genetic component might be associated with vulnerability to stress. Social identity, such as age, race, gender, and marital status, also affects posttraumatic stress disorder. For example, women are more likely to develop PTSD than men, while the elderly are at a higher risk of developing PTSD than young people.

Although the third category typically is not considered a risk factor for PTSD, variables in this category may have a great chance of contributing to a better understanding of the procrastinated development of PTSD, complex PTSD, and cases of severe, chronic PTSD.

3.2. Treatment

Treatments vary regarding posttraumatic stress disorder, especially severe and chronic symptoms. Types of therapy that may help treat PTSD can reduce anxiety and depression symptoms, decrease the chance of relapse of depression symptoms, and improve skills needed for daily activities and mental health.

3.2.1. Psychotherapy

Different forms of psychotherapy, also known as talk therapy, are effective treatment methods for PTSD. Most of them are based on cognitive behavioral therapy (CBT), a talk therapy that aims to identify and correct unhealthy and unrealistic thought patterns.

Cognitive/Information processing therapy (CPT) has its basis in the idea that immediately after the traumatic event, an individual is probably unable to understand what happened and process the information thoroughly. In trying to understand the traumatic event and how it would affect people, individuals might later reconstruct the event and understand what it meant. The purpose of CPT is to identify the incorrect conclusions that the victim made and restructure them more healthily. This therapy usually takes place in about 12 sessions, during which patients and therapists would work together to process the information related to the traumatic event by talking and writing about the experience.

Prolonged exposure therapy addresses an individual's tendency to take relatively unhealthy thinking patterns when processing the aftershocks of traumatic experiences [6]. During exposure therapy, patients are channeled into a lively remembering of the traumatic event until the extinction of the symptoms. This therapy involves forms of vivo and imaginal exposure. During vivo exposure, the patient has to return to the site when the traumatic event happens to reduce the patient's avoidance and promote a sense of mastery. For instance, if a person develops PTSD after an earthquake, therapy may guide the patient to return to the earthquake scene. When vivo exposure is implausible, imaginal exposure is used, but with the same purpose [7].

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Anxiety management training (AMT) aims at helping patients to manage better their emotions caused by traumatic events [8]. The therapist would teach patients various behavioral and cognitive strategies, such as breathing retraining, relaxation training, guided self-dialogue, etc. Research shows that AMT has a positive effect on improving the symptoms of depression, anxiety, and sleep quality.

3.2.2. Neurological Therapies

Chronic effects of PTSD are related to the brain and nervous system. As a result, treatments concentrating on the neurological system are particularly effective in treating chronic PTSD, restoring an individual's social function, and reducing symptoms [9].

Eye movement desensitization and reprocessing (EMDR) requires the therapist to guide the patient to move their eyes back and forth, left or right, tracking the movement of the therapist's index finger. The patient must also memorize the scene of the traumatic event while moving the eyes. Negative feelings and memories would be evoked through the treatment process while the patient is channeled to concentrate on positive emotions and cognitions. The therapy procedure would be repeated over and over till the extinction of the symptoms.

Due to a review of research in 2018, EMDR has been found helpful in reducing many symptoms of PTSD, including depression, fatigue, anxiety, and paranoid thinking patterns, when provided by an experienced therapist. Moreover, it is a relatively low-cost therapy, has few side effects, and is recommended by the WHO (World Health Organization) for treating PTSD.

The emotional freedom technique (tapping) is a massage treatment in 4 to 10 sessions. The therapist would use physical pressure on the patient's specific sensitive points to relieve muscle tension and pain. The patients would be taught to reconstruct trauma memories by a trained therapist, who would tap certain rhythms on the patient's head, face, hands, and collarbones.

Studies have found that EFT can reduce symptoms of PTSD, especially depression, anxiety, and pain. It is also suggested that EFT can cause the amount of cortisol to decrease in the patient's body.

3.2.3. Medication

Certain antidepressants for treating the symptoms of PTSD are recommended by the American Psychological Association (APA). The APA states that selective serotonin reuptake inhibitors (SSRIs) are often used to treat PTSD, and the most common SSRIs in clinical treatment are paroxetine (Paxil), fluoxetine (Prozac), and sertraline (Zoloft). The only FDA-approved SSRIs to treat PTSD are Paroxetine and sertraline.

3.2.4. Combination Treatment

Combination treatments entail six phases to treat severe and chronic PTSD: behavioral stabilization, trauma-based education, anxiety management training, trauma-focused work, rehabilitation and prevention skills training, and continuous aftercare and follow-up. Activities such as writing, yoga, and meditation have also been proven to be practical activities that reduce stress levels, help patients recover further, prevent relapse, and promote mental health in the long run.

3.3. Controversies

Since the emergence of PTSD in the DSM-III, the controversy over its definition and diagnosis has never ceased. Psychiatrists who oppose the inclusion of PTSD say that the combination of existing diagnoses already covers the problems caused by PTSD, so a diagnosis of PTSD screens and integrates parts of an existing mental disorder and is insufficient to constitute a disorder in its own right [10]. Other psychiatrists argue that PTSD is more of a political or social construct promoted by

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Vietnam veterans and anti-war psychiatrists than a naturally found mental illness or disorder with strong political meaning and orientation. In addition, scholars outside traumatology have also tried to criticize the legitimacy and necessity of PTSD as a mental disorder from different perspectives, such as sociology, anthropology, psychiatry, philosophy, and history.

4. Conclusions

Since the end of the last century, post-traumatic stress disorder (PTSD), a mental disorder, has been paid more and more attention in the academic and clinical fields. The theoretical research and treatment methods of PTSD have flourished, and opinions vary. As a more severe and long-term posttraumatic stress disorder, chronic posttraumatic stress disorder is a continuous aftershock after trauma, which brings great mental pain and negative impacts on the life of patients. Therefore, the study of chronic posttraumatic stress disorder is of great significance, not only for an individual's mental health and social function but also for the development of clinical psychology and academic theory. The theories of pathological research and treatment techniques for chronic post-traumatic stress disorder are various but well-developed and have been improved and perfected gradually through continuous development.

The problem remains; however, the mysteries surrounding the etiology of chronic PTSD remain unsolved. Current theoretical models based on chronic posttraumatic stress disorder are based on assumptions and conjecture rather than empirical evidence. Due to the arbitrary nature of interpreting this mental disorder at this stage, other areas of the social sciences have raised questions about the legitimacy of its existence. Conspiracy theorists have suggested that rather than mental disorders caused by war or significant traumatic events, PTSD may be a political joke played by psychiatrists in association with veterans. However, countless clinical cases and statistics tell us that PTSD is genuine and hurts individuals' lives. Therefore, pathological and epistemological research on PTSD is necessary and urgent. I think there are two paths ahead of us (at least as far as I can see): One is cause-oriented, which is what theorists in the last century have been trying to do —constructing different etiological models, continuing to study the etiology of PTSD, and proving the rationality and legitimacy of specific theoretical models; the other is postmodern, consequential-oriented — that is, based on the clinical symptoms and manifestations of PTSD, the shared belief that PTSD itself exists can be the only prerequisite for collaboration between the patient and the therapist.

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