Final Paper: Mental Health Prevention Research Paper

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Post-traumatic stress disorder, also known as PTSD, is a disorder that many people struggle with that can result from one specific traumatic event or series of events. These people may experience extreme feelings of stress, fear, anxiety, and nervousness. PTSD can cause people to feel constantly in danger and make it very difficult to function in everyday activities (Post-Traumatic Stress Disorder). I chose this mental health condition because I've always wanted to research about this condition and learn more about it. I have heard only a few things about PTSD. I grew up not knowing a lot about post-traumatic stress disorder, and I thought it would be fascinating to educate, dive deeper, and spread awareness on the topic. This topic relates to the field of mental health because people who experience PTSD may also experience things like panic disorder, depression, substance use, or suicidal thoughts (U.S. Department of Health and Human Services).

The approaches for PTSD prevention span a variety of psychological and pharmacological categories which are divided into three subgroups. The three subgroups are primary prevention, secondary prevention, and tertiary prevention (Miao pg. 4). Primary prevention takes place before the traumatic event and includes prevention of the event itself (Miao). Primary prevention efforts could take the form of general health promotion or attempts to prevent a specific disease (Howlett pg. 359). Secondary prevention takes place between the traumatic event and the development of PTSD (Miao). Secondary prevention occurs after a disease has originated but before it becomes symptomatic (Howlett pg. 359). Tertiary prevention takes place after the first symptoms of PTSD become apparent (Miao). Tertiary prevention refers to prevention of further decline or disability after a disease has already manifested and overlaps with treatment (Howlett pg. 359). The secondary and tertiary prevention of PTSD have several

methods, which include different forms of debriefing, treatments of Acute Stress Disorder or acute PTSD as well as targeted intervention strategies. The process of primary prevention still faces a lot of challenges (Miao). Based on current research on primary prevention of post-trauma pathology, psychological and pharmacological interventions for groups or individuals with a high risk of traumatic event exposure were applicable for PTSD sufferers. Training generally included a psychoeducational component and a component relating to stress responses, anxiety reducing and relaxation techniques, coping strategies and identifying thoughts, emotion and body tension, choosing how to act, attentional control, emotional control and regulation (Miao pg. 5).

There are two major historical systems for classifying disease prevention. The first system comprises primary, secondary, and tertiary prevention based on the stage of disease pathophysiology. The second system consists of universal, selective, and indicated prevention based on the population or group being targeted for prevention. A guy named Gordon advanced a critique of the distinction between primary and secondary prevention on the basis that this distinction requires a mechanistic biologic understanding of disease and that is often difficult to identify a origin in complex diseases that may have risk factors (Howlett pg. 359). He proposed an alternative system in which prevention approaches are classified according to the population or group to which they are targeted. Universal prevention is targeted toward the entire population. Selective prevention is targeted toward a subgroup of the population, which has been shown to be at higher risk for the disorder. Subgroups could be distinguished by age, gender, occupation, family history, or other characteristics. Indicated prevention is targeted toward individuals with a condition or abnormally that identifies them as at higher risk for disease (Howlett pg. 359).

Another thing I learned was about the prevention and care of combat-related PTSD. PTSD-reducing interventions are delivered during individuals' deployment and can be separated into two broad categories which are prevention strategies and clinical interventions to those who have symptoms. The first group are population health strategies including COSC and comprehensive soldier fitness programs as well as trauma-focused approaches. Clinical interventions include early treatment with protocols developed for chronic PTSD as well as newer interventions specifically designed to address the needs of acute trauma survivors (Riggs pg. 16). The Army's comprehensive solider fitness program and the Marine Corps' COSC program are prevention programs that include components delivered before, during, and after deployment (Riggs pg. 17).

The topic of PTSD relates to COUN 4010 because we covered this diagnosis in class. We talked about the impact of stress, PTSD, some PTSD history, and C-PTSD. We learned what kind of questions would be asked on trying to assess someone with PTSD. For example, a person who has PTSD would've had direct exposure to a death, serious injury, or sexual violence one or multiple times. While assessing for PTSD, there are also instruments and neurobiology. There are psychometric and psychological assessments. There is an increased sensitivity and augmentation of the acoustic-startle eye blink reflex. We also went over some recovery processes people with PTSD can partake in. Prolonged exposure is something that can lead to recovery. Prolonged exposure is gaining control by facing negative feelings. It involves talking about trauma with a provider and doing some of the things one avoided since trauma. Cognitive processing therapy can help people recover from PTSD too. Cognitive processing therapy is reframing negative thoughts about the trauma. In some research I have found, cognitive therapy is very popular when it comes to helping people with PTSD. Eye Movement Desensitization and

Reprocessing is the process that helps make sense of trauma. It involves calling the trauma to mind while paying attention to a back-and-forth movement or sound. “C-PTSD is a more severe form of post-traumatic stress disorder. It is delineated from this better-known trauma syndrome by five of its most common and troublesome features: emotional flashbacks, toxic shame, self-abandonment, a vicious inner critic and social anxiety” (Pete Walker, 2013).

PTSD relates to my own career aspirations and goals because I might encounter people who suffer from this diagnosis. In my future job, regardless of what it is, I’ll encounter people who struggle with PTSD and have encountered trauma in their lives. I’m not looking into being a counselor, but I’ll most likely have a job where I’ll be working with different teams and groups on specific projects. Knowing what I know about PTSD will help me give guidance and advice to my co-workers or teammates. I can point those people towards resources to help them recover. I’m a person that loves helping others so if they look to me for comfort I’ll try my best to assist them.

I learned a lot while writing this paper. I learned key points surrounding how big of a role prevention plays in helping individuals with PTSD. I learned how prevention can play a significant role in dealing with combat-related PTSD individuals. I learned the important instruments and neurobiology surrounding PTSD. I got to reflect on what I learned about PTSD in COUN 4010 and connect it to a little of the material I learned in this paper. Post-traumatic stress disorder is an important topic for mental health because a lot of individuals in this society struggle with it. PTSD ties into my career field by the fact that individuals that I might work on writing projects with may struggle with this disorder, and I’ll know how to better help them.

References

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