POST TRAUMATIC STRESS DISORDER.
PART TWO

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"You can't beat PTSD but you can learn to manage it"
Chris Middleton, Rifles, bilateral leg amputee due to an IED

Three Deptherapy beneficiaries, what medical psychological Conditions do you think they have?
Answers at the end of this paper

If we step back into history, what we now know as PTSD, was known to the medical profession as far back at World War I. It was known in Germany, France and the UK, among many other countries. In the UK it was known as 'shell shock'. Thousands suffered from the condition and it was particularly prevalent among officers. A specialist hospital, staffed by psychiatrists, was established in Scotland and the symptoms that we now ascribe to PTSD, were identified. Sadly, at the same time soldiers were being executed by firing squad for deserting the frontline when suffering 'shell shock'

The condition was not defined and the world went through many major conflicts; World War II, Korea etc without defining the condition. The Vietnam War, was the catalyst to psychologists/psychiatrists, understanding and defining the condition.

It was not until 1980 that PTSD, appeared as an operational diagnosis in the American Psychiatric Association's Diagnostic and Statistical Manual. It is fair to say that many psychologists/psychiatrists refused to accept the condition well into the 1990s and beyond.

In 1988, 75% of psychiatrists did not acknowledge the condition.

We have moved a long way forward, but not far enough. Awareness of the symptoms of PTSD and how to support someone with the condition is woefully inadequate.

Many experience symptoms soon after trauma, however some, who served in the Falklands War, are now reporting symptoms for the first time.

Some people with PTSD experience long periods when their symptoms are less noticeable, followed by periods where they get worse. Other people have constant severe symptoms.

It is very important to note that the specific symptoms of PTSD can vary widely between individuals, but generally fall into the categories described below.

The NHS reports the symptoms as:

Re-experiencing

Re-experiencing is the most typical symptom of PTSD.

This is when a person involuntarily and vividly relives the traumatic event in the form of:

flashbacks

nightmares

night terrors

repetitive and distressing images or sensations

physical sensations, such as pain, sweating, feeling sick or trembling

Some people have constant negative thoughts about their experience, repeatedly asking themselves questions that prevent them coming to terms with the event.

For example, they may wonder why the event happened to them and if they could have done anything to stop it, which can lead to feelings of guilt or shame.

Avoidance and emotional numbing

Trying to avoid being reminded of the traumatic event is another key symptom of PTSD.

This usually means avoiding certain people or places that remind you of the trauma, or avoiding talking to anyone about your experience.

Many people with PTSD try to push memories of the event out of their mind, often distracting themselves with work or hobbies.

Some people attempt to deal with their feelings by trying not to feel anything at all. This is known as emotional numbing.

This can lead to the person becoming isolated and withdrawn, and they may also give up pursuing activities they used to enjoy.

Hyperarousal (feeling "on edge")

Someone with PTSD may be very anxious and find it difficult to relax. They may be constantly aware of threats and easily startled.

This state of mind is known as hyperarousal.

Hyperarousal often leads to:

irritability

angry outbursts

sleeping problems (insomnia)

difficulty concentrating

Other problems

Many people with PTSD also have a number of other problems, including:

other mental health problems, such as depression, anxiety or phobias

self-harming or destructive behaviour, such as drug misuse or alcohol misuse

other physical symptoms, such as headaches, dizziness, chest pains and stomach aches

PTSD sometimes leads to work-related problems and the breakdown of relationships.

Learning to understand the symptoms and how to support a person who appears to be suffering from PTSD is so important and the MHFA pneumonic referred to in Part One should trigger referring the individual to seek medical support through their GP.

In Part Three I will look at how I have experienced beneficiaries with PTSD, how we support them and how you can give sufferers their lives back.

Back to the photo:

Each of the three beneficiaries in the photo are happy for me to talk about their medical and psychological health.

Corey is the young guy in the wheelchair, he was in the Royal Anglian Regiment, just out of training. He was a passenger in a car accident that resulted in him suffering major spinal cord damage. The photograph was taken when Corey was undertaking his open water course at our base in Egypt's Red Sea; Roots Camp.

Michael is on the right, he was in the Royal Engineers, he has MS and Depression, he learned to dive with us and has progressed to qualify as an instructor.

Tom, standing (in the middle) was in the Royal Anglian Regiment, he climbs mountains for fun. In 2021 he climbed Mount Elbrus, the tallest mountain in Europe, he was the only one in the party to summit the mountain. He is a very fit , personable young man. The Tom I first met 5+ years ago, did not trust people, he could not form relationships and he was abusing alcohol.

Tom was medically discharged form the Army with – Survivor Guilt, Complex PTSD and Adjustment Disorder. He did two tours of Afghan, on the second he was shot by a sniper, losing 5 pints of blood and was only saved by the excellence of battlefield

medics. Working with Tom in those early days was so difficult, he was totally broken by war.

I met Tom for the first time in Central London, after that meeting, I said to a colleague that I thought Tom would be dead within six months. Fortunately, I was wrong.

Tom learned to dive with us, he is now one of our divemasters. I and the team trust him absolutely. He still has PTSD and always will, but with our support he manages his condition. At times he will need to talk, or need a hug. Now he trusts and has been in a relationship for several years. He leads our team that supports other beneficiaries with mental health conditions.