



**BSc in Psychology**  
**Department of Psychology**

What does the Icelandic Public know about Post-Traumatic  
Stress Disorder?

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## Foreword

Submitted in partial fulfilment of the requirements of the BSc Psychology degree, Reykjavik University, this thesis is presented in the style of an article for submission to a peer-reviewed journal. This thesis was completed in the Spring of 2020 and may therefore have been significantly impacted by the COVID-19 pandemic. The thesis and its findings should be viewed in light of that.

### Abstract

Post-traumatic stress disorder (PTSD) is a serious mental disorder that can have serious consequences. The current study examined PTSD knowledge amongst the Icelandic public to determine whether there is need for better PTSD education for the general public, so that people would know if they're suffering from the disorder and know about effective treatments. The study was conducted online and there were 182 participants that took part in the study, 147 females and 35 males. The sample was a snowball sample and participants were gathered through the social media outlet Facebook. Participants answered a PTSD knowledge questionnaire with questions that included PTSD treatments, symptoms and trigger events. Participants answered on average 66% questions correctly, they knew least about effective PTSD treatments and most about events that could lead to PTSD. Participants incorrectly identified anxiety medication as effective PTSD treatment, getting divorced as an event that could lead to PTSD and alcohol or drug use as a PTSD symptom. The findings indicate that there is need for greater PTSD education amongst the public.

*Keywords:* PTSD, post-traumatic stress disorder, trauma, treatments, knowledge.

### Útdráttur

Áfallastreituröskun er alvarleg geðröskun sem getur haft alvarlegar afleiðingar. Rannsókn þessi skoðaði þekkingu á áfallastreituröskun á Íslandi til að athuga hvort þörf sé á kennslu um áfallastreituröskun meðal almennings, til að fólk viti af því, þjáist það af röskuninni og viti um árangursríkar meðferðir. Rannsóknin var framkvæmd á netinu og voru 182 þátttakendur sem tóku þátt, 147 konur og 35 karlar. Úrtakið var snjóboltaúrtak og þátttakendum var safnað á samfélagsmiðlinum Facebook. Þátttakendur svöruðu spurningalista um áfallastreituröskun sem innihélt spurningar um meðferðir við áfallastreituröskun, einkenni og atburði sem leitt gætu til áfallastreituröskunar. Þátttakendur svöruðu að meðaltali 66% af spurningum rétt, þeir vissu minnst um árangursríkar meðferðir og mest um atburði sem gætu leitt til áfallastreituröskunar. Þátttakendur greindu ranglega frá kvíðalyfjum sem árangursríkri meðferð við röskuninni, skilnaði sem atburði sem leitt getur til áfallastreituröskunar og áfengis- eða vímuefnaneyslu sem einkenni áfallastreituröskunar. Niðurstöðurnar benda til þess að þörf sé á frekari kennslu um áfallastreituröskun meðal almennings.

*Lykilorð:* PTSD, áfallastreituröskun, áföll, meðferðir, þekking.

What does the Icelandic Public know about Post-Traumatic Stress Disorder?

Post-Traumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after an individual experiences life-threatening trauma. About 6-8% of the public in the United States suffers from PTSD. However only 22-53% of those who suffer from PTSD seek treatment (Tsai et al., 2018). The lifetime incidence of PTSD in Europe is lower than in the US, or around 1.9%, according to the European Study of the Epidemiology of Mental Disorders (ESEMeD) (Alonso et al., 2004).

PTSD is diagnosed if a person re-experiences the traumatic event (e.g. painful nightmares about the traumatic event or flashbacks), has emotional numbing about the event or shows avoidance behaviour (e.g. avoids talking about the traumatic event, avoids people that are a reminder of the event, have trouble remembering important things about the event or dissociate from things and people), and if the individual experiences increased arousal (e.g. having trouble sleeping, anger, hyper-alertness or experiences guilt). PTSD is only diagnosed if symptoms have been present for at least one month and they must have the effect on the person that he or she cannot fulfil his or her normal duties, such as work (Bisson, 2007). An individual is diagnosed with acute PTSD if the symptoms have lasted for three months or less. If the symptoms last for more than three months the acute PTSD becomes chronic (Bisson, 2007). PTSD is diagnosed if individuals go through a traumatic event themselves or witnesses someone else go through it, for example a family member or a close friend (Friedman et al., 2011). Numerous studies have been conducted on PTSD sufferers. The traumas that are mostly associated and studied in relation to PTSD are: Natural disasters, severe motor vehicle accidents, sexual abuse, war and terrorist acts (Frans et al., 2005). Studies have shown (e.g., Tolin & Foa, 2008) that although males are more likely to experience traumatic events females are more likely to develop PTSD.

Although there have been many studies conducted on those exposed to traumatic events, few have researched lay knowledge about PTSD. It is important for the general public to recognise PTSD symptoms and know about effective treatments, otherwise, people might not realise that they are suffering from the disorder and may not know that it can be treated or may seek inefficient and potentially harmful treatments (Harik et al., 2017). Studies have found that having knowledge of PTSD has many benefits, such as increased help seeking. One reason for this might be that people who are educated about PTSD might perceive it to be less shameful and might then be more open to seeking treatment (Palazzo et al., 2014). Those few studies that have examined PTSD knowledge, measure the changes in PTSD from before intervention and after intervention based on combined scores. Those studies do not tell us what, exactly, people know and do not know about PTSD. Also, most studies measure veterans knowledge of PTSD (Harik et al., 2017) and those results can not be generalised to the general public.

Harik, Matteo, Hermann and Hamblen (2017) investigated what those who suffer from PTSD know and do not know about PTSD and its treatments. Their findings were that the participants know most about traumas or which traumatic events can lead to the development of PTSD. Participants recognized that combat was related to PTSD, and most participants answered that correctly. However, there were many participants that falsely identified certain traumatic events as something that could lead to PTSD. Those events were getting fired, divorced and a partner's affair. More than half of the sample believed that one of the PTSD symptoms was to hear voices that tell you to hurt yourself or others. This might have the effect that people seek treatment for the wrong disorder. Those participants that had PTSD treatment before did have a better understanding of PTSD symptoms than those who had not had such treatment. The participants in the study knew least about treatment options

for PTSD, this suggests that although people have meet with a psychologist, they are unaware of which treatments are effective.

Tsai et al. (2018) examined the US populations attitudes and knowledge of PTSD, both among those who had PTSD symptoms and those who did not. The findings were that most of the participants were supportive of PTSD services. However, some of the participants (30%) were afraid of people diagnosed with PTSD showing violent behaviour and wanted to restrict their access to weapons. However, most of those with PTSD never show violent behaviour and should not be stereotyped (Tsai et al., 2018). Another finding was that most of the participants had good general PTSD knowledge, which has not been common in previous studies. However, they lacked knowledge about effective PTSD treatments as was found by Harik et al. (2017). Those who had PTSD symptoms had the same knowledge about treatment as those who did not have PTSD symptoms.

The current study measured PTSD knowledge in Iceland. The aim of the study was to determine what the population knows and does not know about PTSD and to determine whether there is need for better education for the general public in Iceland about PTSD. Based on previous findings seven hypotheses were suggested. The first hypothesis was that the sample would have insufficient knowledge about PTSD. The second hypothesis was that participants would have poor knowledge about effective PTSD treatments. Previous studies have not specifically studied demographic groups, such as different levels of education or gender. Therefore, the third hypothesis was that those with a university degree would have better knowledge about PTSD than those without a university degree. The fourth hypothesis was that females would have better knowledge of PTSD than males. The fifth hypothesis was that those who have had some sort of PTSD education before would have a better knowledge of PTSD than those who had never had any education. The sixth hypothesis was that those who know someone who has PTSD would have better PTSD knowledge than those who do

not know anyone with the disorder. The seventh hypothesis was that younger participants would have better PTSD knowledge than those who are older. A study of this kind has never been conducted in an Icelandic sample before.

## **Method**

### **Participants**

In total, there were 182 participants that took part in the study. The sample was a snowball sample and might therefore not adequately represent the general public. There were 35 (19%) male participants and 147 (81%) female participants. The participants age ranged from 18 to 60+ years old, divided into eight 5-year age bands (see Table 1). Most of the participants were 18-23 years old and there were eight participants that were 60 years old or older. There were 43 (24%) participants with a university degree and 125 (69%) participants without a university degree, 34 had finished primary school, 74 had a matriculation examination, 17 had other post-secondary education 41 had a bachelor degree and two had a masters degree. Also, there were 57 (31%) participants that had received some sort of PTSD education before and 125 (68%) participants that had never received any PTSD education before. There were 98 participants that knew someone with PTSD and 84 participants that did not. Most of the participants 72 (40%) believed that they neither had good nor little PTSD knowledge, 50 (28%) believed that they had good PTSD knowledge and 45 (25%) believed they had rather little PTSD knowledge.

Table 1.

*Participants age and education by gender.*

	Gender		Total
	Male	Female	
<b>Age</b>			
18-23	7	56	63
24-29	7	34	41
30-35	11	14	25
36-41	3	14	17
42-47	2	10	12
48-53	0	4	4
54-59	4	8	12
60+	1	7	8
<b>Total</b>	<b>35</b>	<b>147</b>	<b>182</b>
<b>Education</b>			
University degree	5	38	43
Less than university degree	30	95	125
<b>Total</b>	<b>35</b>	<b>133</b>	<b>168</b>

*Note.* 14 participants did not report their education. Therefore 14 were missing from total education.

### **Measures**

The study included 19 questions, those questions measured participants background as well as their PTSD knowledge. All the questions were in Icelandic.



**Background questions.** There were six background questions to determine whether the participants backgrounds could affect their knowledge of PTSD. Those questions were gender (male/female/other), age, education (primary school/matriculation examination/other secondary education/bachelor degree/master's degree/doctorate degree), prior education about PTSD (yes/no), knowledge of someone who has PTSD (yes/no) and how much knowledge participants think they have about PTSD (very little/rather little/neither good nor little/rather good/very good).

**Open-ended question.** There was one open-ended question in the questionnaire. The question was used for those participants that had received some PTSD education before, to determine where participants got their education.

**Knowledge about PTSD.** PTSD knowledge was measured using two questionnaires, questions from the PTSD Quiz on MedicineNet and Hariks PTSD knowledge survey.

***The PTSD Quiz from MedicineNet.*** PTSD knowledge was measured using the same questions as those used in the PTSD quiz that is available at [medicinenet.com](http://medicinenet.com) (*PTSD (Posttraumatic Stress Disorder) Quiz*, n.d.). This quiz is open to those who wants to test their PTSD knowledge. The questionnaire consisted of 13 questions about PTSD knowledge and of those 13 questions, nine were used in this study. The four questions that were not used were similar to those in Hariks PTSD knowledge survey used here (see below) and thus those were not used. Those questions that were used included what type of disorder is PTSD (anger/depression/anxiety/phobia), who is more likely to develop the disorder (males/females), PTSD symptoms in children (delayed growth spurt/hives/bedwetting/hearing loss), when is a person diagnosed with PTSD (one month/two weeks/three weeks/one week), hypervigilance means watchfulness for threats or danger (true/false), most people who have lived through dangerous events develop PTSD (true/false), what is extreme emotional psychological upset after tragedy called

(denial/shock/avoidance/fear), is PTSD preventable (true/false), PTSD was formerly known as battle fatigue syndrome (true/false) (see Appendix A).

***Hariks PTSD knowledge survey.*** The PTSD knowledge survey (Harik et al., 2017) consists of three parts (see Appendix B). The first part measured knowledge about events that could lead to PTSD (participants were asked to identify those from the list), the second part measured knowledge about PTSD symptoms and the third part measured knowledge about PTSD treatments. To determine traumatic events and symptoms Harik et al. used the Diagnostic and Statistical Manual: Fifth edition (DSM-5). To determine affective treatments, the treatments with the highest grade from the VA/DoD Clinical Practice Guidelines for Management of PTSD were used. To determine traumatic events, symptoms, and affective treatments the same methods were used in the current study.

The number of correct responses were calculated from both questioners to report a general PTSD knowledge score. The scores could range from zero to 51, correct responses got one point, and incorrect responses zero points.

### **Research design**

There were six independent variables in the study. The first one was gender, the second one was age, the third one was education, the fourth one was previous PTSD education, the fifth one was knowledge of someone who has PTSD and the sixth was participants belief about their PTSD knowledge. The dependent variable was PTSD knowledge. All participants got the same information before answering the questionnaire to ensure consistency.

### **Procedure**

The study was conducted online and participants were gathered on Facebook through snowball sampling from February 26 to March 9, 2020. Before answering the questionnaire, participants were made aware that only those who were not suffering from PTSD at the time,

and had never, as by self-report suffered from PTSD, and only those who were 18 years old or older were allowed to participate. Further, participants were informed of the procedure and that by answering the questionnaire, they were giving consent for their participation in the study, as well as being informed that the study would be fully confidential and that their answers could not be traced back to them. They were also informed that they were allowed to stop answering the questionnaire at any time. Participants did not get paid or rewarded in any other way for participating in the study. After reading about the study, participants first answered background questions and then the PTSD knowledge questions. After finishing the questionnaire participants were thanked for their participation.

### **Data analysis**

Data analysis was implemented using SPSS version 25. Descriptive statistics were used for all variables. The hypotheses were tested using independent sample t-test, ANOVA, and Spearman correlation. Four assumptions were tested for independent sample t-test and ANOVA (e.g. normality, independence, homogeneity of variance, additivity, and linearity). For Spearman correlation two assumptions were tested (e.g. monotonic relationship and variables should be interval, ratio, or ordinal) (Field, 2013). All assumptions were met.

## **Results**

### **Overall PTSD knowledge**

Data was collected from 182 participants, 35 males, and 147 females. Participants had an average score of 33.84 (66%) correct answers out of 51 on PTSD knowledge ( $SD = 4.59$ , range 43 - 88%). Most of the participants answered 34 (18 participants) and 35 (18 participants) questions correctly. There was no gender difference in PTSD scores, both males and females had an average score of 33 (66%). None of the participants answered all of the questions correctly. There were 57 (31%) participants that had received some sort of PTSD education before and 54 of those reported where they got their education from. Most of them

( $N = 36$ ) reported having learned about PTSD in school, most of them in universities and others in high schools. Others learned about PTSD at work, watching movies, doing own research, from friends, from psychologists and courses at the Red Cross. Table 2 shows PTSD knowledge according to gender, age, and education, as well as p values from an independent samples t-test comparing PTSD knowledge scores between genders within each group.

Table 2.

*PTSD knowledge according to gender, age, education and previous PTSD education.*

	Females	Males	p
<b>Age</b>			
18-29	34.16	33.21	0.453
30-47	33.47	34.38	0.532
45-60+	33.21	33.20	0.997
<b>Education</b>			
University degree	33.87	37.00	0.153
Less than university	33.78	33.20	0.549
<b>Previous PTSD education</b>			
No	32.70	32.62	0.925
Yes	36.16	37.00	0.607

### **Effective PTSD treatments**

The range for correct PTSD treatments was from four to 13 ( $M = 8.98$ ,  $SD = 2.34$ ). Males had an average score of 8.63 (54%) and females had an average score of 9.07 (57%). Those with a university degree had an average score of 8.95 (56%) and those without a

university degree had an average score of 8.98 (56%). Most of the participants (91%) correctly identified cognitive therapies as effective PTSD treatments. However, not many chose the other correct treatment options. Also, 63% of participants wrongly identified anxiety medication as effective PTSD treatment (see Table 3).

Table 3.

*Percentage of participants who chose each treatment option as effective PTSD treatment.*

	Males	Females	Total Percent
<b>Effective PTSD treatments</b>			
Cognitive therapies	80%	94%	91%
Antidepressants	23%	31%	29%
Stress inoculation training	17%	28%	26%
Exposure therapies	14%	16%	16%
EMDR	11%	27%	24%
<b>Not effective PTSD treatments</b>			
Support groups	54%	59%	58%
Anger management	29%	34%	33%
Family therapy	51%	47%	48%
PTSD therapy dogs	43%	38%	39%
Anti-anxiety medication	46%	67%	63%
Yoga	57%	54%	54%
Music therapy	23%	29%	28%
Equine therapy	23%	28%	27%
Antipsychotic medications	17%	13%	14%
Online self-help programs	11%	17%	16%
Medical marijuana	29%	5%	9%

### **Events that could lead to PTSD**

The range for correct PTSD events was from three to 12 ( $M = 8.93$ ,  $SD = 1.83$ ). Males had an average score of 9.03 (75%) and females had an average score of 8.90 (74%). Those with a university degree had an average score of 8.79 (73%) and those without a university

degree had an average score of 8.97 (75%). Most of the participants (98%) correctly identified being raped or sexually assaulted as an event that could lead to PTSD. However, 59% of participants wrongly identified getting divorced as an event that could lead to PTSD (see Table 4).

Table 4.

*Percentage of participants who chose each event as an event that could lead to PTSD.*

	Males	Females	Total Percent
<b>Events that could lead to PTSD</b>			
Being in combat	94%	91%	92%
Being in a severe car accident	91%	92%	92%
Being raped or sexually assaulted	94%	99%	98%
Seeing someone else get killed	91%	94%	95%
Being physically abused	86%	97%	95%
Learning that a loved one was seriously injured in an accident	31%	56%	51%
<b>Not events that could lead to PTSD</b>			
Getting divorced	51%	61%	59%
Getting fired from a job	37%	46%	44%
Learning your spouse had an affair	51%	57%	56%
Having serious financial problems	29%	30%	30%
Losing a grandparent to natural causes	11%	28%	25%
Watching TV coverage of a natural disaster	11%	17%	16%

### **PTSD symptoms**

The range for correct PTSD symptoms was from five to 14 ( $M = 9.84$ ,  $SD = 2.01$ ). Males had an average score of 10.37 (74%) and females had an average score of 9.71 (69%). Those with a university degree had an average score of 9.77 (70%) and those without a university degree had an average score of 8.82 (63%). Most of the participants (93%)

correctly identified having nightmares about the trauma as a PTSD symptom. However, 70% of participants wrongly identified alcohol or drug use as a PTSD symptom (see Table 5).

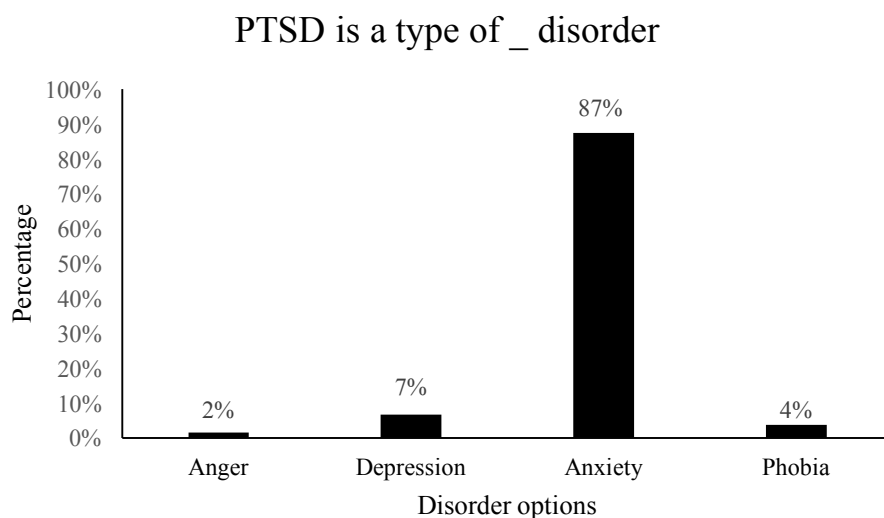
Table 5.

*Percentage of participants who chose each item as being a PTSD symptom*

	Males	Females	Total Percent
<b>PTSD symptoms</b>			
Nightmares about the trauma	89%	95%	93%
Feeling very upset when reminded of the trauma	77%	86%	84%
Avoiding places or people that remind you of the trauma	89%	91%	90%
Feeling irritable or having angry outbursts	77%	76%	76%
Avoiding thinking or talking about the trauma	83%	86%	85%
Being very alert, watchful, or on guard	60%	74%	71%
Negative feelings about the trauma, like anger or shame	83%	86%	85%
<b>Not PTSD symptoms</b>			
Alcohol or drug addiction	66%	71%	70%
Decreased appetite	60%	71%	69%
Feeling hyper or excited for several days straight	31%	35%	35%
Sleeping too much	37%	56%	52%
Chronic chest pain	11%	37%	32%
Hearing voices that tell you to harm others	6%	25%	21%
Washing your hands again and again	9%	25%	22%

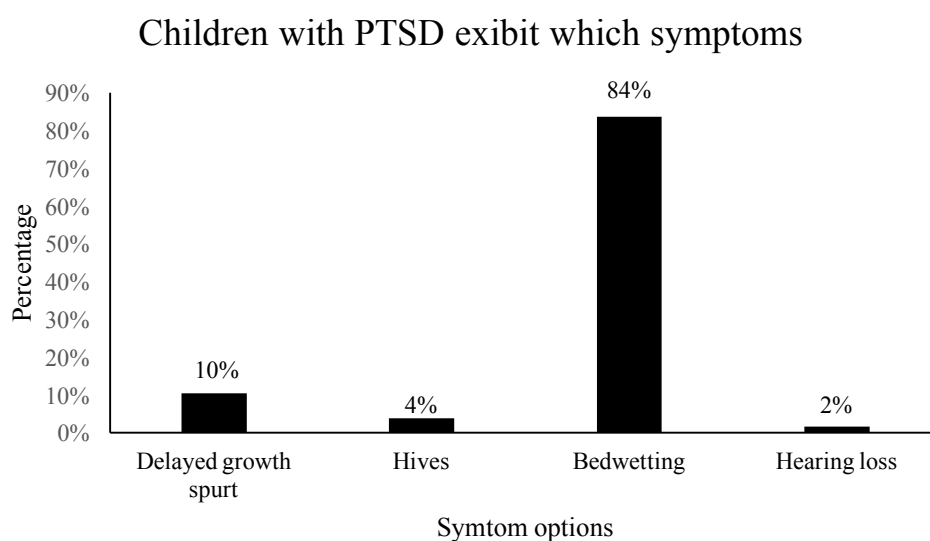
### Questions from the PTSD Quiz on MedicineNet

Most participants, or 87.4%, correctly identified PTSD as an anxiety disorder, rather than an anger, depression, or phobia disorder (see Figure 1).



*Figure 1.* Percentage of participants who chose each disorder option.

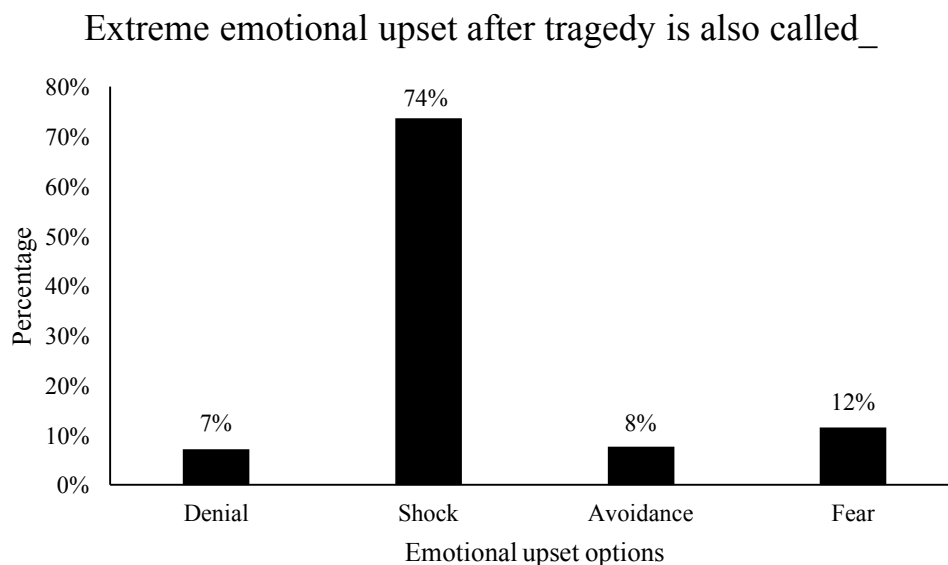
More than half of the sample (67.6%) correctly identified females as more likely to develop PTSD than males. Many (79.7%) correctly identified hypervigilance as the meaning of being watchful for threats or danger. A large proportion (83.5%) correctly identified bedwetting as a PTSD symptom in children, rather than hives, hearing loss, or delayed growth spurt (see Figure 2).



*Figure 2.* Percentage of participants who chose each symptom option.

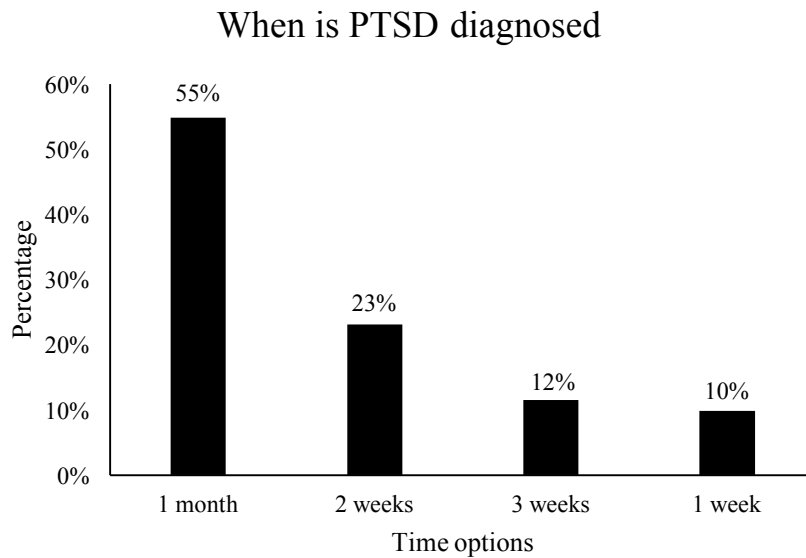


Some (58.8%) correctly identified that not most of the people that have lived through dangerous events develop PTSD, the rest believed this statement to be true. Many (73.6%) correctly identified extreme emotional psychological upset after tragedy as shock, rather than denial, fear, or avoidance (see Figure 3).



*Figure 3.* Percentage of participants who chose each emotional upset option.

Also, 64.3% incorrectly identified PTSD as being preventable. Many (68.1%) correctly identified PTSD as being formally known as battle fatigue syndrome. Some (54.9%) correctly identified PTSD as being diagnosed after having symptoms for at least one month, rather than two weeks, three weeks or one week (see Figure 4).



*Figure 4.* Percentage of participants who chose each time option.

### **Difference in PTSD knowledge by demographic groups**

An independent sample t-test indicated that PTSD knowledge did not differ by gender, males ( $M = 33.74$ ,  $SD = 4.45$ ) and females ( $M = 33.86$ ,  $SD = 4.58$ ;  $t(180) = -0.13$ ,  $p = 0.894$ ). An independent sample t-test also indicated that those with a university degree ( $M = 34.23$ ,  $SD = 4.58$ ) knew a little more about PTSD numerically, than those without a university degree ( $M = 33.64$ ,  $SD = 4.58$ ;  $t(166) = -0.73$ ,  $p = 0.466$ ). As well as those who have had some sort of PTSD education before ( $M = 36.28$ ,  $SD = 4.21$ ) had numerically better PTSD knowledge than those who had never had any PTSD education ( $M = 32.69$ ,  $SD = 4.25$ ;  $t(179) = -3.50$ ,  $p < 0.001$ ). An independent sample t-test also indicated that those who know someone with PTSD ( $M = 34.51$ ,  $SD = 4.71$ ) knew a little more about PTSD numerically, than those who did not know anyone with PTSD ( $M = 33.05$ ,  $SD = 4.23$ ;  $t(180) = -2.19$ ,  $p = 0.030$ ).

Participants 18-29 years of age had the highest mean level on PTSD knowledge ( $M = 34.03$ ,  $SD = 4.34$ ), those 30-47 years old had a mean level of 33.74 ( $SD = 4.78$ ) and those 48-

60+ years old had a mean level of 33.21 ( $SD = 4.96$ ). However, a one-way ANOVA did not indicate a significant difference in PTSD knowledge by age ( $F(2, 179) = 0.33, p = 0.717$ ).

A Spearman's rank-order correlation indicated that there was a positive correlation between one's own assessment of PTSD knowledge and actual PTSD knowledge ( $r(181) = 0.33, p < 0.001$ ). Which indicated that those who thought they had a higher PTSD knowledge actually did have a higher PTSD knowledge.

### **Discussion**

The purpose of the study was to examine lay knowledge about PTSD in Iceland. The first hypothesis was that the sample would have insufficient knowledge about PTSD. This hypothesis was supported, none of the participants answered all of the questions correctly and on average participants answered less than half of the questions correctly. The fact that people do not have adequate knowledge about PTSD shows that there is need for better PTSD education for the general public. The second hypothesis was that participants would have poor knowledge about effective PTSD treatments. This hypothesis was also supported, most of the participants correctly identify cognitive therapies as effective PTSD treatments, however, they were not able to correctly identify exposure therapies, antidepressants, eye-movement desensitisation (EMDR) and reprocessing and stress inoculation training (SIT) as effective treatments. Also, participants wrongly identified other treatment options (distractor items) as effective PTSD treatments, for example anxiety medication, supportive groups, and yoga. Cognitive therapies are often used as treatments for all sorts of disorders in Iceland, therefore it is not surprising that most of the participants correctly identified that as being an effective PTSD treatment. Participants might have chosen anxiety medication as effective PTSD treatment because PTSD is an anxiety disorder. Yoga is very popular in Iceland and is supposed to help reduce anxiety, which might be the reason why participants chose yoga as an effective PTSD treatment. The third hypothesis was that

those with a university degree would have better knowledge about PTSD than those without a university degree. This hypothesis was not supported, there was not a significant difference between education and PTSD knowledge. However, those with a university degree had a slightly higher mean score than those without a university degree. The reason why there was not a difference between education might be because psychology is taught in high schools as well as in universities. The fourth hypothesis was that females would have better PTSD knowledge than males. This hypothesis was not supported, there was not a significant difference between gender and PTSD knowledge. The fifth hypothesis was that those who have had some sort of PTSD education before would have a better knowledge of PTSD than those who had never had any PTSD education. This hypothesis was supported and most of the participants that had gotten some sort of PTSD education before reported having learned about PTSD in school, in many cases as psychology students or in psychology courses in high school. The sixth hypothesis was that those who know someone who has PTSD would have a better PTSD knowledge than those who do not know anyone with the disorder. This hypothesis was also supported, this is probably because participants have learned about the disorder by associating with the person that has PTSD. The seventh hypothesis was that those younger would have better PTSD knowledge than those who are older. This hypothesis was not supported although those 18-29 years old had the highest PTSD knowledge mean score.

Most of the participants recognised PTSD as an anxiety disorder, rather than anger, depression, or phobia disorder. More than half of the sample correctly identified females as more likely to develop PTSD than males. A large proportion of participants were able to identify bedwetting as a PTSD symptom in children, rather than hives, hearing loss or delayed growth spurt. A little more than half of the sample were able to recognise that not everyone who goes through dangerous events develops PTSD. Surprisingly many thought that PTSD can be preventable. This confirms that there are some misconceptions about PTSD

amongst the general public. Half of the sample correctly identified PTSD as being diagnosed after having symptoms for at least one month, rather than one week, two weeks, or three weeks.

One surprising finding was that more than half of the sample knew someone with PTSD and knowing someone who has PTSD did significantly predict PTSD knowledge. This also tells us that PTSD is more common than people think and more people are being diagnosed with it. Most of the participants believed that they neither had good nor little PTSD knowledge. Participants belief of their own PTSD knowledge was correlated with actual PTSD knowledge, meaning those who identified higher PTSD knowledge actually had a higher PTSD knowledge than those who identified a lower PTSD knowledge.

Participants knew most about events that could lead to PTSD, this is in line with previous findings (e.g., Harik et al., 2017). Being raped or sexually assaulted was the most recognised traumatic event. However, more than half of the sample incorrectly identified getting divorced and learning that your spouse had an affair as events that could lead to PTSD. These are events that can cause mental problems, however, they cannot lead to PTSD. Combat was the most recognised traumatic event in Hariks findings and getting divorced was the most incorrect identification (Harik et al., 2017). Participants also did well on recognising PTSD symptoms which is also in line with previous findings (e.g., Harik et al., 2017). Although more than half of the sample wrongly identified alcohol or drug addiction, decreased appetite, and sleeping too much as PTSD symptoms. However, it is not surprising that participants confused those as PTSD symptoms, alcohol or drug addiction is not a PTSD symptom although it can follow the disorder. Many of those who have PTSD take drugs or drink alcohol to cope with the trauma. Also decreased appetite or sleeping too much might follow the disorder. The most recognising symptom was nightmares about the traumatic event as well as in Hariks findings. The sample in the current study knew least about PTSD

treatments which is also in line with previous finding (e.g., Harik et al., 2017; Tsai et al., 2018). In Hariks findings cognitive therapies were the most recognised treatments as well as in the current study and eye-movement desensitisation was the least recognising treatment (Harik et al., 2017). In the current study exposure therapies were the least recognising treatments. Not knowing about effective PTSD treatments can cause people to seek inefficient and potentially harmful treatments.

There were some limitations to the study that should be mentioned. The first one was that the sample was small, there were only 182 participants that took part in the study and it was a snowball sample, therefore it might not adequately represent the general Icelandic public. Gender imbalance could also be a factor, there were only 35 male participants and 147 female participants. Another limitation was that most of the questions from the study have not been used before and the questions from Hariks PTSD knowledge survey have only been used once, therefore it is difficult to determine validity and reliability. Finally, the COVID-19 pandemic might have influenced the writing of this report.

Despite these limitations, the study also had some strengths. First, this study was the first of its kind in Iceland and contributes to the literature on PTSD knowledge. As well as giving information about the relation between demographic groups and PTSD knowledge, which previous studies have not specifically studied.

In future studies, it would be interesting to compare PTSD knowledge with those who are diagnosed with PTSD and those who are not on an Icelandic sample, as well as having a random sample and a bigger sample size. It would also be interesting to compare PTSD knowledge scores between countries or continents and examine the reasoning for differences in PTSD scores.

In conclusion, the findings give important information about what the Icelandic public knows about PTSD. The findings indicate that there is need for further PTSD education for

the general public, especially about PTSD treatments, so that people know that if they suffer from the disorder they know about effective treatments. It is also important to educate the public about how common PTSD is so that people might view the disorder as less stigmatising.

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## Appendix A

## Questions from the PTSD Quiz on MedicieNet

1. Áfallastreituröskun er tegund \_\_\_\_\_ röskunar?
  - a) Reiði
  - b) Þunglyndis
  - c) Kvíða
  - d) Fælni
2. Hvort kynið er líklegra til að þróa með sér áfallastreiturösku?
  - a) Karlar
  - b) Konur
3. Hugtakið „ofurárverkni“ þýðir að vera óhóflega vakandi fyrir ógnum eða hættu.
  - a) Satt
  - b) Ósatt
4. Hvaða einkenni geta börn með áfallastreituröskun sýnt?
  - a) Seinkaðan vaxtarkipp
  - b) Ofsakláða
  - c) Pissa undir (undirmiga)
  - d) Heyrnartap
5. Flestir sem hafa upplifað hættulega atburði þróa með sér áfallastreituröskun.
  - a) Satt
  - b) Ósatt
6. Öfgafullt tilfinningalegt eða sálrænt uppnám eftir harmleik eða hörmung er einnig kallað\_\_\_\_\_.
  - a) Afneitun
  - b) Sjökk

- c) Forðun
  - d) Ótti
7. Hægt er að koma í veg fyrir áfallastreituröskun.
- a) Satt
  - b) Ósatt
8. Áfallastreituröskun var áður þekkt sem „bardagapreyta“.
- a) Satt
  - b) Ósatt
9. Einstaklingur sem hefur lent í áfalli er líklegur til að greinast með áfallastreituröskun eftir að hafa haft einkenni í að minnsta kosti \_\_\_\_.
- a) Einn mánuð
  - b) Tvær vikur
  - c) Þrjár vikur
  - d) Eina viku

## Appendix B

## Hariks PTSD knowledge survey

1. Vinsamlegast tilgreindu hverjir af eftirfarandi atburðum gætu leitt til áfallastreituröskunar?
  - a) Taka þátt í stríðsátökum
  - b) Skilnaður
  - c) Líkamlegt ofbeldi
  - d) Vera rekinn úr vinnu
  - e) Vera vitni að manndrápi
  - f) Verða fyrir nauðgun eða kynferðislegu ofbeldi
  - g) Horfa á umfjöllun um náttúruhamfarir í sjónvarpinu
  - h) Missa ömmu eða afa af náttúrulegum orsökum
  - i) Lenda í alvarlegu bílslysi
  - j) Heyra að ástvinur slasaðist alvarlega í slysi
  - k) Komast að því að makinn þinn hélt framhjá
  - l) Eiga mjög erfitt fjárhagslega
2. Vinsamlegast tilgreindu hvað af eftirfarandi er einkenni áfallastreituröskunar
  - a) Martraðir um áfallið
  - b) Minni matarlyst
  - c) Áfengis- eða eiturefnafíkn
  - d) Líða mjög illa við minningar um áfallið
  - e) Forðast það að hugsa eða tala um áfallið
  - f) Vera ofvirkur í marga daga eftir áfallið
  - g) Langvarandi brjóstverkur
  - h) Sofa of mikið

- i) Vera pirraður eða reiður
  - j) Heyra raddir sem segja þér að skaða aðra
  - k) Vera mjög vakandi eða á varðbergi
  - l) Neikvæðar tilfinningar um áfallið eins og t.d. reiði eða skömm
  - m) Forðast staði eða fólk sem minnir þig á áfallið
  - n) Þvo hendurnar aftur og aftur
3. Vinsamlegast tilgreindu hvert af eftirfarandi þú telur að séu árangursríkar meðferðir við áfallastreituröskun
- a) Langvinn berskjöldun
  - b) Þunglyndislyf
  - c) Augnhreyfinga ónæmismeðferð (EMDR meðferð)
  - d) Tónlistarmeðferð
  - e) Hugræn atferlismeðferð
  - f) Reiðistjórnun
  - g) Geðrofslyf
  - h) Fjölskyldumeðferð
  - i) Hópmeðferð
  - j) Marijúana
  - k) Streituónæmingarþjálfun
  - l) Meðferð með aðstoð hunda
  - m) Meðferð með aðstoð hesta
  - n) Kvíðalyf
  - o) Yoga
  - p) Sjálfhjálparforrit á netinu