Post- traumatic stress disorder

DR FAIZ NOORE MBBS, MM (PSYCHOTHERAPY), FRANZCP, FFPMANZCA

CONSULTANT PSYCHIATRIST & SPECIALIST PAIN MEDICINE PHYSICIAN

Summary

- Psychiatric disorder following exposure to an extremely traumatic event
- Consist 4 symptom groups: intrusion, avoidance, negative mood & thinking and altered arousal and reactivity
- Comorbid conditions include depression, anxiety, anger and substance misuse
- Assessment includes attention to physical, psychological, social needs and an assessment of risk
- Trauma focused psychological treatment is first-line Rx, medication is second-line Rx

Definition

- Exposure to trauma
- 4 symptom types
- Impairment of function

Trauma types

- Violence
- Physical and sexual abuse
- Severe accidents
- Disasters
- War
- Threat to life in medical care
  - Anaesthesia
  - Childbirth complications
  - Medical negligence

4 Symptom Clusters (1)

1. Intrusion symptoms
   - Flashbacks
   - Intrusive images
   - Sensory impressions
   - Dreams and nightmares
2. Avoidance
   - Avoiding people
   - Avoiding situations or circumstances resembling traumatic event
   - Avoiding situations or circumstances associated with the trauma

4 symptom clusters (2)

3. Negative mood and thinking
   - Feeling alienated
   - Constricted affect or emotional numbing
   - Diminished interest
   - Negative beliefs about the world & oneself
   - Inability to remember here aspects of the trauma
4. Altered arousal and reactivity
   - Hypervigilance for threat
   - Exaggerated startle response
   - Irritability, Impaired concentration, insomnia

Epidemiology

- Lifetime prevalence 6.8% in US 1.9% in six European countries
- 12 months prevalence 3.6% in US and 1.3% in Australia

Aetiology

- Affects people with sound personalities & without mental illness
- Vulnerability factors
  - Past psychiatric history
  - Low intelligence
  - Female gender
  - Past exposure to trauma
- Psychological theories
  - Emotional processing theory
  - Dual representation theory
  - Cognitive model of PTSD

Emotional processing theory

- Complex fear structures embedded in memory
- Pathological
- Activation cause cognitive behavioural and physiological reactions
- Problems with trauma information processing
  - misinterpreting - benign stimuli as dangerous and
  - the self is incompetent

Dual rrepresentation theory

- Memory consists of verbally accessible memory and situationally accessible memory
- Verbal memory easily recalled
- Situational accessible memory unconscious and triggered by situations and events resembling trauma -> reexperiencing of trauma with original intensity

Cognitive model of PTSD

- Negative appraisal of the trauma

  ->Developing the schema that the world is dangerous and the self is incompetent

  -> Constant sense of threat and situations are misinterpreted as threatening

PTSD Maintaining Factors

1. Unhelpful coping strategies
   - Conscious suppression trauma memory
   - Elimination about the trauma
   - Disassociation / Avoidance
   - Social withdrawal
   - Substance use
2. Poor social support which is made wore by
   - Alienation
   - Social Withdrawal
3. Drawn out litigation – makes it difficult to put the event in the past

Pathophysiology 1

- Brain regions involved include
  - Amygdala
  - Hippocampus
  - Medial prefrontal cortex
  - Anterior cingulate gyrus

Pathophysiology 2

- Reduced hippocampal size
- Failure of mPFC & anterior cingulate gyrus to regulate amygdala activity ->Hyper-reactivity to threat
- Fear -> amygdala -> hypothalamus -> Cortisol. But in PTSD
  - low cortisol levels inhibit ACTH production from anterior pituitary &
  - there is reduced sensitivity to CRF
  - Suboptimal cortisol
  - Elevated CRF->increased noradrenaline release by locus coeruleus -> failure to contain sympathetic response ->consolidation of traumatic memories
- Other neurotransmitters 5HT, GABA, Glutamate, neuropeptide Y, BDNF

Classification

- Acute stress disorder < 1/12
- PTSD >1/12
- PTSD
  - Dissociative subtype depersonalisation (outside observer) derealisation (unreality, distance or distortion)
  - Delayed expression – after 6/12
  - Mild / Moderate / Severe

Screening

- Brief screening instrument for
  - people subjected to trauma
  - repeated primary care presentations with medically unexplained symptoms
  - Impact of life event scale
  - PTSD checklist for DSM 5
  - Davidson trauma scale

Secondary prevention

- Immediate, practical, social and emotional support by non-mental health professionals
- Watchful waiting and psychological first aid when required (information, emotional support, practical support)
- People wish to discuss the experience should be supported provided they are strong enough to cope with the distress
- People with severe ongoing symptoms require formal assessment and intervention if the disorder is not improving
- Individual trauma focused cognitive behaviour therapy within three months
- Beta-blockers not better than placebo

Diagnosis

- Exposure & response to trauma
- Intrusion symptoms
- Avoidance symptoms
- Negative and distorted thinking and mood
- Hyperarousal
- Depression
- Alcoholism or substance use
- Anxiety

Dx Tests

- PTSD checklist
- PCL-5
- Impact of event scale

DDx

- Depression
- Specific phobias
- Panic disorder
- Adjustment disorders
- Dissociative disorders
- OCD
- Psychosis

Rx

Rx goals

1. Reduce symptom severity
2. Treat trauma -related comorbid conditions
3. Improve functioning and the store sense of safety and trust
4. Relapse prevention
5. Limit generalisation of danger experience following trauma

General principles of treatment

1. Respect, trust and understanding and empathy
2. Psychological education about trauma reactions, symptoms of PTSD its course and treatment
3. Don't delay treatment because of litigation issues
4. Support the family– Self-help groups
5. Appropriate practical support in the aftermath of trauma
6. Mass trauma is assisted by

-Sense of safety / Calming / Sense of self & community safety / Connectedness / Hope

Watchful waiting

- Mild – Moderate Symptoms
- Less than 3/12

Psychological therapies

- Severe symptoms <3/12 – Trauma focused CBT (TFCBT)
- Any severity of symptoms >3/12 TFCBT or EMDR
- No or limited improvement – pharmacological Rx

- Number of sessions 5-12
- More than 12 sessions when there are multiple problems –disability, comorbid disorders,
- Weekly sessions
- 60-90 mins

Pharmacotherapy

- Antidepressants help with core PTSD
- Small effect size
- Use after psychological therapies have started

OR

1. If patient prefers not to have psychological therapy
2. Failure to respond to psychological therapy
3. Inability to tolerate psychological therapy
4. Adjunctive to psychological Rx

Pharmacotherapy

- SSRI – effect size small
- All SSRI's aren't equal in PTSD
- Best evidence is for
  - Paroxetine
  - Sertraline
  - Venlafaxine

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