Post Traumatic Stress Disorder (PTSD)

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Purpose

The purpose of this course is to describe post-traumatic stress disorder (PTSD), the symptoms, causes, co-morbid conditions, and treatment options.

Goals

Upon completion of this course, one should be able to do the following:

- List 4 criteria for post-traumatic stress syndrome (PTSD).
- Describe symptoms of PTSD for both adults and children.
- Differentiate among acute stress disorder, PTSD, and complex PTSD.
- Describe at least 4 risk factors for development of PTSD.
- Describe the types of symptoms exhibited by children with PTSD.
- Explain procedures for diagnosis of PTSD.
- List and describe 4 different types of treatment for PTSD.

Introduction

What is the face of post-traumatic stress disorder (PTSD)?

- Is it Doug, who sits restlessly twisting his hands together, every conversation ending with the war? What it was like, what he ate, how he slept, what he did—his mind in an endless loop beginning and ending in Vietnam—for 40 years.
- Is it Jason, the 11-year boy who is withdrawn, failing his classes, and explodes in anger when confronted, 2 years after his father died?
- Is it Teri, the 30-year old woman who lives in a house with every curtain drawn, every window and door locked, 10 years after being raped?
- Or, is it the 60-year old woman who can't bear to look at her body 4 years after a mastectomy?

The truth is, there isn't one face of PTSD. The news about PTSD in soldiers returning from Iraq has brought PTSD into public consciousness, but PTSD is more prevalent than most healthcare providers realize, and it is frequently overlooked as a diagnosis.

What is post-traumatic stress disorder (PTSD)?

First recognized as a psychiatric disorder in 1980, post-traumatic stress disorder (PTSD) is an anxiety disorder that can occur as the result of severe frightening, violent, or life-threatening trauma. Despite the fairly recent recognition as a

formal diagnosis, this disorder has a long history. During the Civil War, soldier's traumatized by battle were said to have "soldier's heart" and in later wars "battle fatigue" or "shell shock" and, after Vietnam, "post-Vietnam syndrome." It is estimated that about 5 million people in the United States suffer from PTSD, with females (10.4%) twice as likely to have PTSD as males (5%). Studies have shown that males are exposed to more violence but women develop PTSD after trauma at a higher rate than males although the reason for that is not clear. There are sets of criteria that must be met for a diagnosis of PTSD with symptoms persisting for at least a month and resulting in functional impairment:

- **Experiencing or witnessing** a traumatic event and feeling intense fear, horror, or helplessness,
- **Reliving experiences** *(At least one of these symptoms):*
    - Recurring flashbacks.
    - Memories.
    - Dissociative episodes.
    - Hallucinations.
    - Illusions.
    - Nightmares related to the traumatizing event.
    - Repetitive play or actions (children).
- **Avoidance behavior** *(At least 3 of these symptoms):*
    - Decreased emotional responsiveness and affect.
    - Detachment from others.
    - Avoidance/phobia of people, places, or experiences that remind the person of the trauma,
    - Inability to remember events related to the trauma.
- **Chronic hyperarousal** *(At least 2 of these symptoms):*
    - Insomnia.
    - Poor concentration.
    - Irritability.
    - Anger.
    - Blackouts (no memory of events or behavior).
    - Poor memory.
    - Increased startle response.
    - Hypervigilance.

Symptoms usually begin within 3 months of a traumatic event although in some people there is a delay of many months or even years before symptoms become obvious.

Acute stress disorder has similar symptoms to PTSD, but the duration of symptoms is much shorter, lasting only a few days to about 2 weeks. Patients may present with a wide range of symptoms related to PTSD and the severity of symptoms often relates to the developmental phase in which the trauma occurred and the degree of repetitiveness in the trauma. Those who experience early repetitive trauma (such as children) may develop a variant—**complex post-traumatic stress disorder (C-PTSD).** Complex post-traumatic stress disorder is characterized by long-lasting problems with many aspects of emotional and social dysfunction, including lack of self-control, suicidal thoughts, dissociation,

feelings of helplessness, guilt, and shame. People with complex PTSD may become preoccupied with thoughts of revenge or even allegiance with the perpetrator of abuse.

What are risk factors for development of PTSD?

There are many different events that can trigger PTSD, but the common thread is that the event has a profoundly disturbing effect on the individual. It can occur as the result of natural disasters, such as earthquakes or tsunamis. It can occur as a response to the death of a parent, child, or partner. Abuse, including child abuse, sexual abuse, and intimate partner abuse are both frequent causes of PTSD. Sexual assault, especially rape, is a frequent cause of PTSD in females whereas combat is more commonly a cause in males. Victims of torture frequently suffer severe PTSD, especially if the torture was prolonged. The death of a parent is especially traumatic for children with some degree of PTSD evident in almost 100% of children.

Studies have indicated that people who are diagnosed with life-threatening diseases, such as cancer, experience symptoms related to PTSD, with symptoms correlating with younger age or prior history of traumatic experiences. Researchers estimate that 4-5% of those who complete cancer treatment have PTSD, with higher rates in some groups, such as those undergoing bone marrow transplantation (12-19%).

In some cases, direct involvement in a traumatic situation is not necessary. For example, a cross-sectional random study of school children in New York City showed that about 18% of children (ages 6-17) suffered from severe to very severe PTSD after the 9/11 terrorist attack on the city, and 66% suffered from moderate PTSD. Adults in New York City also suffered increased rates of PTSD of associated with decreased productivity at the workplace and increased rates of binge drinking and alcoholism. Similar reports of increases in PTSD have occurred after such natural disasters as Hurricane Andrew and Hurricane Katrina.

What co-morbid conditions are associated with PTSD?

One of the problems with diagnosing PTSD is that it is often associated with co-morbid conditions and thus may be overlooked as a causative factor in other psychological or psychiatric disorders. A national study showed very high rates of co-morbidity with 88% of those with PTSD having one or more psychiatric diagnoses. Compared to those without PTSD, males were 14 times more likely and females 8 times more likely to have a second diagnosis. Alcoholism and depression each occur as co-morbid conditions in about half of people with PTSD. Commonly found co-morbid conditions include:

- Substance/alcohol abuse.
- Depression.
- Obsessive-compulsive disorder.
- Affective disorders, such as eating disorders.
- Bi-polar disorder.
- Generalized anxiety disorders.
- Panic disorder.

- Borderline personality disorder.

Additionally, studies indicate that the majority of affective disorders in both males and females occurred after development of PTSD. More than half of those with PTSD have thoughts of suicide or attempt suicide. There is also evidence from longitudinal studies that indicate that many of those with severe chronic diseases have suffered multiple traumatic experiences over their lifetimes, suggesting that PTSD affects general health.

How does PTSD affect children and adolescents?

For many years, it was believed that children who suffered trauma were protected from long term effects because of immaturity and that, over time, they would "forget" what happened to them, but there is clear evidence that this is not true. Child abuse, sexual abuse, loss of a parent or other trauma can have serious long-lasting effects. It is not really clear why some children develop PTSD and others do not, but about 20% of children exposed to trauma eventually develop PTSD. There are some risk factors that increase the likelihood of children's developing PTSD:

- *Perception of personal threat:* Higher rates of violence and fear increase risk of developing PTSD.
- *Abuse of trusted:* When the person causing harm/fear/violence is a trusted person, this increases the likelihood of developing PTSD.
- *Repetitive/ongoing abuse:* When a child is in a situation where there appears to be no escape from repeated abuse and is lacking in adequate family support, PTSD is more likely.
- *Guilt:* When a child feels to blame for the trauma, this child is more likely to develop depression and PTSD.
- *Early symptoms:* Children who withdraw and show signs of PTSD or exhibit hyperarousal with elevated heart rate soon after a traumatic event are at increased risk for long term PTSD.

Very young children may not be able to comprehend traumatic experiences that would be frightening for an older child and may have fewer residual problems. Additionally, some children appear to simply have more resilience and are able to develop an understanding that allows them to cope.

Children with PTSD may react differently from adults. Small children (≤5 years old) often exhibit severe anxiety on being separated from a parent or caregiver and are very clinging. They may appear extremely frightened and trembling. Some children may have episodes of screaming, whimpering, or crying. Some may become almost immobile because of anxiety while others may move about aimlessly. Typical symptoms include:

- *Behavioral problems:* Children who have been abused often become aggressive to other children, essentially re-enacting their own abuse. Children who have been sexually abused may exhibit sexual behavior at a young age or avoid touching others. Some children may become very inhibited, fearful, and shy.
- *Repetitive play:* They may use play to demonstrate the trauma over and over again, such as crashing cars together if they were involved in a car accident.

- *Avoidance:* Children often avoid thinking about trauma and may not even acknowledge that it happened.
- *Sleep disturbances:* Children may have trouble sleeping because of nightmares or fear of the dark.
- *Dissociative episodes:* Children appear to "blank out" in order to avoid dealing with the trauma or memories of it.
- *Hyperarousal*: Children may be constantly on alert, watching those around for signs of danger.
- *Developmental delay:* Young children who experience trauma may not go through normal developmental stages and may exhibit learning disabilities.

Children ages 6-11 may often exhibit regressive behavior typical of younger children. Children over 11 and teenagers usually exhibit symptoms that are similar to those of adults and frequently have trouble sleeping. Children may suffer from guilt or emotional numbing and may experience a number of somatic complaints, such as stomachaches or headaches, for which a medical cause cannot be identified.

How is the diagnosis for PTSD made?

Sometimes people who seek medical assistance have obvious bruising or evidence of healed fractures that might suggest a history of abuse, arousing suspicion of PTSD, but often people have vague somatic complaints, psychiatric or psychological problems, or fail to report any symptoms. There is no specific test for PTSD and the diagnosis is usually made on the basis of history and symptoms that meet the criteria for PTSD. A thorough history can sometimes help to identify potential causes of PTSD although initial diagnosis may be related to a co-morbid condition, such as depression. Diagnosis includes:

- Laboratory findings: Research has indicated that cortisol levels may be decreased and norepinephrine and epinephrine levels elevated (possibly related to hypervigilance and hyperarousal), but these tests are not routinely done for diagnostic purposes. There is some evidence that people with low cortisol levels are more likely to develop PTSD as the result of trauma.
- Mental status exams:
    - Davidson Trauma Scale.
    - SPAN (Startle, **P**hysiological arousal, **A**nger, **N**umbness).
    - Primary Care PTSD Screen (PC-PTSD).

The 4-item PC-PTSD screening is a simple screening device that can be used by healthcare practitioners. A positive finding for possible PTSD includes answering yes to 3 or the 4 questions posed if patients admit to having a "frightening, horrible, or upsetting" experience during their lifetime and in the previous month:

1. Had nightmares about it or thought about it when you did not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
3. Were constantly on guard, watchful or easily startled?
4. Felt numb or detached from others, activities, or your surroundings?

Diagnosis in children can be more difficult because caregivers may be the perpetrators of abuse, and children are often reluctant to admit or discuss trauma. A careful history must be taken if there is suspicion of PTSD to identify the traumatic experience, especially when a child has reported symptoms or exhibits symptoms during an examination, such as evidence of physical abuse and/or fear of being touched. Referral for psychological or psychiatric examination may be indicated. Mental status tests that are frequently used with children include:

- Child Post Traumatic Stress Reaction Index: 20-item measure.
- Impact of Event's Scale
- PTSD Scale
- Child PTSD Symptom Scale.

What treatments are available for PTSD?

One of the biggest problems with PTSD is that studies have consistently shown that almost half of the people with PTSD receive no therapy for it, often because physicians fail to recognize the disorder or do not recommend treatment. There are a number of different treatments available:

- **Exposure-based therapies:** This type of treatment uses cognitive therapy to help people confront their trauma through psychoeducation, breathing, imaginary reliving, and writing about the trauma. People are taught to recognize trauma-related thoughts and use practical approaches to adjust thought processes as a coping mechanism.
- **Eye-movement desensitization and reprocessing (EMDR):** This is a type of cognitive therapy during which the person talks about the experience of trauma while keeping the eyes and attention focused on the therapist's rapidly moving finger. Evidence is insufficient to determine if this is more effective than cognitive therapy alone.
- **Family counseling:** This may include counseling or classes in anger management, parenting, and conflict resolution
- **Sleep therapy:** This includes ways of coping with nightmares, such as imagery rehearsal therapy, relaxation techniques.
- **Mediations:** Antidepressant therapy usually needs to be continued for at least a year to avoid relapse of symptoms. Benzodiazepines have not been shown to be a useful treatment. Mediations prescribed may depend on co-morbid conditions, and include:
    - *SSRIs,* such as Prozac®, Zoloft®, and Paxil® help to reduce aggression and impulsive behavior as well as decreasing suicidal thoughts.
    - *Mood stabilizers,* such as Lamictal, Gabitril, and Depakote may help to control symptoms.
    - *Antipsychotics,* such as Risperdal®, Zyprexa®, and Seroquel® are especially helpful for those with hypervigilance, paranoia, and agitation.

Summary

Post-traumatic stress disorder (PTSD) is an anxiety disorder that occurs as the result of severe, violent, or life-threatening trauma. Four criteria for PTSD include:

- Experiencing or witnessing a frightening traumatic event.
- Reliving experiences.
- Avoidance behavior.
- Chronic hyperarousal.

Acute stress disorder has symptoms similar to PTSD but the duration rarely extends beyond 2 weeks while complex post-traumatic stress disorder, usually related to repetitive trauma, is characterized by long-lasting problems with many aspects of emotional and social dysfunction. There are many risk factors for PTSD, especially events that have a profoundly disturbing effect on the individual, such as natural disasters, death of a family member or partner, abuse, violence, sexual assault, torture, life-threatening illness or treatment, and combat. Co-morbid conditions occur in about 88% of those with PTSD and may include depression, and substance abuse, affective disorders, panic disorder, and suicidal tendencies. About 20% of children exposed to trauma eventually develop PTSD, and they may react differently from adults. Symptoms of PTSD in children include behavioral problems, repetitive play, avoidance, sleep disturbances, hyperarousal, and developmental delay. There is no definitive test for PTSD but a thorough history and mental status screening may assist with diagnosis. Treatment options include:

- Exposure-based therapies, such as cognitive therapy.
- Eye-movement desensitization and reprocessing (EMDR).
- Family counselling.
- Sleep therapy.
- Medications, such as SSRIs, mood stabilizers, and anti-psychotics.

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