Post-traumatic stress disorder

A brief overview

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BACKGROUND Post-traumatic stress disorder (PTSD) is an anxiety disorder which occurs following exposure to a traumatic, potentially life threatening event. It is frequently comorbid with other anxiety and mood disorders, substance misuse and physical symptoms that may cloud its presentation. In itself, PTSD is a frequently chronic disabling condition associated with a marked impact on social, occupational and family functioning that also carries an increased risk of suicide. Early intervention once the disorder is present, represents the most effective chance of reducing disability. Appropriate diagnosis and referral are among the key skills required by the general practitioner to deal with this condition.

OBJECTIVE This article aims to provide an overview of PTSD for GPs including clinical features, epidemiological aspects, approach to assessment and treatment, and specialist resources available.

DISCUSSION Recent world events including terrorist attacks, wars in Afghanistan and Iraq, and Middle East turmoil have raised community awareness of the impact of trauma. General practitioners are in a unique position to be involved in the early diagnosis and treatment of PTSD, which has been shown to improve outcome.

Recent world events have raised awareness in our community of the possible psychological sequelae of trauma, including post-traumatic stress disorder (PTSD). The terrorist attacks of September 11, the Bali bombings, wars in Afghanistan and Iraq, ongoing conflict in the Middle East and the plight of refugees who have headed for our shores have all demonstrated the potentially potent psychological effects that trauma can have on people, their families, loved ones and communities. With this in mind, it is important that general practitioners and mental health workers have a good working knowledge of PTSD and post-trauma responses, so that early identification of problems and early intervention can be facilitated.

Clinical features

The 1980 Diagnostic and Statistical Manual of Mental Disorders (DSM III) included for the first time the diagnosis 'post-traumatic stress disorder' which was included under the category of anxiety disorders.[1] This description included an exposure to a 'severe stressor outside the range of usual human experience' which led to the re-experiencing of the trauma, avoidance responses, psychological numbing and heightened physiological arousal.[1]

The DSM IV (1994) defines PTSD as an anxiety disorder characterised by four main groups of diagnostic criteria, with symptoms present for at least one month.[2] The first group involves the person having been exposed to an event involving 'actual or threatened death or serious injury, or a threat to the physical integrity of self or others' and their 'response involved intense fear, helplessness, or horror'.[2] To make the diagnosis the person must have experienced some, but not necessarily all of the symptoms from each of the symptom clusters listed in Table 1. Cases with PTSD-like symptoms of less than one month's duration are referred to as acute stress disorder.[2]

Table 1. PTSD symptoms

Intrusive symptoms

- recurrent distressing thoughts, images and dreams of the event
- feeling or acting as if the event were recurring
- psychological distress when reminded of the event
- physical symptoms of anxiety (eg. sweating, tachycardia) when reminded of the event

Avoidance symptoms

- trying to avoid thoughts, feelings conversations, activities places and people that remind them of the event
- difficulty remembering some aspects of the event
- reduced interest in usual activities
- feeling detached or cut off from others
- emotional numbing
- difficulty seeing a future for themselves

Hyperarousal symptoms

- insomnia
- irritability and anger outbursts
- having problems concentrating
- constantly on the look out for danger
- heightened startle response

Table 2. Resources

Websites providing information regarding PTSD

Australian Centre for Post-traumatic Mental Health: www.acpmh.unimelb.edu.au

Austin Health Veterans' Psychiatry Unit PTSD Program: www.ptsdarmc.com.au

National Centre for PTSD (USA): www.ncptsd.org

Trauma Pages (USA): www.trauma-pages.com

Clinical services

Veterans

Contact numbers for these services can be obtained from state branches of the Department of Veterans' Affairs

Veterans' hospital departments of psychiatry and PTSD treatment programs

Vietnam Veterans' Counselling Service

Survivors of Sexual Abuse

In each state there are counselling services for survivors of sexual assault. Consult local phone directories

Private practitioners

Royal Australian and New Zealand College of Psychiatrists (RANZCP): State branches can advise regarding psychiatrists with expertise and a particular interest in treating PTSD

Australian Psychological Society (APS): Toll free referral number: 1800 333 497 (for advice Australia wide regarding psychologists with expertise in the treatment of psychological trauma)

PTSD symptoms

The criteria shown in Table 1 are useful in helping us to make the diagnosis, however, it is important to remember the influence of factors within the individual on their presentation, in particular that of personality, personal history and social circumstances. Post-traumatic stress disorder is also commonly associated with particular feeling states including guilt, shame and a sense of humiliation and fear.

Course

Typically, symptoms begin fairly soon after exposure to a traumatic event. In around 50% of cases, PTSD-like symptoms dissipate over the ensuing three months, but in some instances the symptoms continue, and can do so for many months and not uncommonly, years.[2] The longitudinal course of PTSD is often fluctuant, with exacerbations and periods of lesser severity occurring over time without any particular identifiable external 'cause'. The symptoms of PTSD are also sensitive to external stressors and can flare up in times of stress or when the individual is exposed to external cues which evoke the original traumatic event.

Comorbidities

Comorbid disorders can also alter the expression of PTSD. For example depression can have an 'amplifying' effect on PTSD symptoms and this combination is a common reason for patients to finally seek help. Other common comorbidities include the other anxiety disorders, in particular panic disorder with or without agoraphobia, social phobia, and generalised anxiety disorder. Substance abuse/dependence including alcohol and the full range of illicit substances and prescription medications (eg. benzodiazepines) is also a common comorbidity. Post-traumatic stress disorder can also be associated with physical symptoms (eg. chronic pain).

Epidemiology

Research with Vietnam war veterans has provided much information on PTSD. This research has generated varying results, however, a major US study indicated that 15% of Vietnam veterans had current cases of PTSD, 30% had suffered from PTSD, and 50% had experienced some symptoms of PTSD during their lifetime.[3]

Studies regarding the prevalence of PTSD in the community have also had widely varying results.

The US National Comorbidity Survey (NCS) showed a lifetime prevalence of PTSD in 5–6% of men and 14% of women.[4] The risk of PTSD has been shown to be greater if there has been direct rather than indirect exposure to trauma.[2] Exposure to certain types of trauma has been associated with higher prevalence rates of PTSD. For example the NCS showed a prevalence of 55% for women who had been sexually assaulted.[4]

Assessment

Engagement and general approach

Engaging the patient is of central importance in assessment. It is often painful and distressing for patients to describe their traumatic experience and symptoms, in particular the re-experiencing phenomena and their content, and this process can be greatly facilitated when it occurs in the context of a trusting therapeutic alliance. With this in mind an assessment can be made in stages over a few sessions if necessary. If the patient appears very apprehensive about the process, the initial stages should involve establishing rapport and exploring the elements of the history that the patient finds least threatening, ie. describing the symptoms and not the content.

Assessment should also include a general psychiatric assessment including a medical history, enquiry regarding common comorbidities, risk assessment and a physical examination. As PTSD can cause difficulties not just for the sufferer, but also for their partners and children, it is important to meet with the partner to see how they and the rest of the family are coping; the partner is also an important source of support and collateral history.

Treatment

Treatment for PTSD needs to be broad with consideration given to the relevant issues for each patient within a biopsychosocial framework. Early intervention provides the best chance of successful treatment putting GPs in a unique position to identify the problem and commence treatment. When treated early, PTSD can go into clinical remission. However, once it has become a chronic disorder, the aims of treatment move toward those of symptom reduction, better coping and improvement in the quality of life. Early referral to a consultant psychiatrist or service specialising in the treatment of psychological trauma is recommended (Table 2).

Biological treatment

Antidepressant medication can be very useful in the treatment of PTSD. The selective serotonin reuptake inhibitors (SSRIs) should be considered first line pharmacotherapy.[5,6] Paroxetine is the only drug in Australia with PBS approval for the treatment of PTSD, although the other SSRIs have also been shown to be useful. As an example of typical drug dosages for the treatment of PTSD (in an otherwise healthy adult under 60 years of age) paroxetine can be commenced at a dose of 20 mg per day. If there has been little therapeutic response after approximately 3–4 weeks of treatment, the dose can be gradually titrated to response and within the limits of side effects up to a maximum dose of 50 mg per day. Higher doses may be of benefit, but should be initiated and managed by or in consultation with a psychiatrist.

Patients often describe that antidepressants are helpful in reducing the intensity of the hyperarousal symptoms. They may also lead to some reduction in the intensity and frequency of intrusions and can also assist in reducing avoidance behaviours.[5] Antidepressants are also useful in the treatment of comorbid depression and may help reduce substance abuse if substances have been used to self medicate depressive or hyperarousal symptoms.

Anxiolytics

Anxiolytics, in particular benzodiazepines, must be used with great caution, given the potential for abuse and dependence. They should be used only when other measures such as antidepressants and psychotherapy have failed to adequately control the patient's anxiety symptoms. They should be used sparingly and, if possible for short periods only. There are however, some patients with particularly debilitating anxiety symptoms who may benefit from their use in the longer term.

Other medications

In severe cases, major tranquillisers and mood stabilisers may be beneficial, however, research on their use is scant.[7] Such treatment should be initiated and managed in consultation with a psychiatrist.

Psychological treatment

Key components of the psychological treatment of PTSD include:

- education about the disorder and stress

Case history

David, aged 25 years, is a university student who stopped to assist a severely injured victim of a road accident. Five months later he presents requesting medication to help him sleep. He is experiencing recurrent frequent images and dreams of the crash and the victim's injuries. He wakes up sweating and his heart races. He avoids driving or watching the news. He has stopped visiting friends and is irritable with his partner. He is having difficulty concentrating on his study.

GPs who are registered with the HIC for level 1 of the BOMHI are able to use specific Medicare items for their consultations with patients on completion of a mental health assessment, plan and review cycle. A patient suffering from PTSD would be eligible, and the process involves the following steps:

Step 1: Perform a mental health assessment – undertaken over one or more consultations of at least 30 minutes (item 36 or 44 as appropriate).

In David's case this would involve making a thorough psychiatric assessment, including exploration of the symptoms, previous physical and psychological symptoms, supports, previous coping strategies, current or previous substance abuse and making a careful risk assessment. Use of a symptom screening tool such as HAD or K10 forms a baseline to check further progress. Involving his partner in this process is desirable. During the assessment phase the process of education commences.

Step 2: Devise a mental health plan – undertaken over one or more consultations of at least 30 minutes (item 36 or 44 as appropriate).

This is a plan of action tailored to and agreed on with the patient. In David's case this includes the following.

- education about PTSD and the stress response
- stress management techniques
- behavioural treatments, eg. slow breathing and relaxation techniques for anxiety, sleep-wake cycle management, activity planning (See the article 'Behavioural modification strategies' page 715 this issue)
- encouragement to reduce alcohol intake and other substance abuse (if present)
- give opportunity to talk about the event
- consider commencing paroxetine or other SSRI
- referral to a psychologist/psychiatrist with expertise in trauma counselling techniques.

(GPs registered as level 2 of the BOMHI may use specific item numbers if they deliver any of the focussed psychological strategies in the mental health plan).

Step 3: Review – at least one month and up to six months after the mental health plan. Item 2574 for a level C consultation, item 2577 for a level D consultation. This stage involves a review of progress and revision of the plan if required. A repeat of the HAD/K10 can form part of the assessment of progress.

Figure 1. Using the BOMHI in treating PTSD

responses
- learning skills to better manage anxiety and anger
- helping the patient reduce their substance use, and
- providing them with the opportunity to talk about and attempt to make sense of the traumatic event.

General practitioners can initiate treatment in these areas, and the Better Outcomes in Mental Health Initiative (BOMHI) can assist GPs in delivering these components (Figure 1).

Critical incident debriefing

Critical incident debriefing, a specific form of counselling that is offered to those exposed to a traumatic event as soon as practical after the event with the aim of reducing psychological morbidity, remains the subject of debate. This appears to be largely due to the difficulties involved in accurately researching outcomes in this area and to the existence of conflicting bodies of outcome research.[7] However, despite ongoing debate in our community, critical incident debriefing is routinely offered to those exposed to a traumatic event.

Individual psychotherapy

Individual psychotherapy should be provided by a clinician experienced in the treatment of psychological trauma. A variety of different paradigms exist, including exposure work (exposure to the details, memories and feelings of the trauma), cognitive behavioural therapy (CBT), eye movement desensitisation and reprocessing (EMDR), and psychodynamic approaches. The largest body of evidence exists for the efficacy of exposure work, however, CBT, EMDR and psychodynamic approaches have also been shown to be helpful.[7]

Group psychotherapy may be particularly helpful in the treatment of psychological trauma.[7] Different paradigms also exist for group treatment, ranging from educational sessions and skills based groups (eg. anger and anxiety management) to psychodynamic approaches.

Social interventions

Addressing the social issues relevant to the patient can involve assessing a range of support, relationship, family issues and occupational functioning. It is important if possible, to identify, mobilise and educate the patient's support network. The patient's partner should be seen as part of the assessment

which then provides the opportunity to offer the partner support and education. Consideration should be given to whether the partner or children need psychiatric or psychological assessment and treatment and whether a referral for family assessment and family therapy is indicated. The assessment of occupational functioning may be indicated in those who are less able or unable to work due to their psychological symptoms.

Conclusion

Post-traumatic stress disorder is an anxiety disorder that can follow exposure to a traumatic event. It is often associated with comorbid anxiety, mood disorders, substance misuse and physical symptoms and can cause considerable impairment in social and occupational functioning. Early diagnosis and treatment provide patients with the best chance of recovery, placing GPs in a unique position to be involved in this process. Assessment needs to be broad, approached with sensitivity and should include the patient's partner. Treatment can be initiated by GPs, although early referral to specialist practitioners and services is advisable.

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