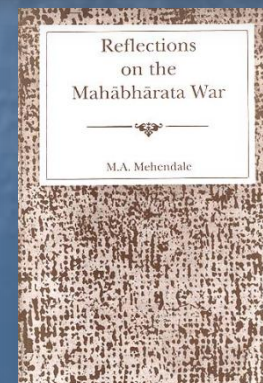
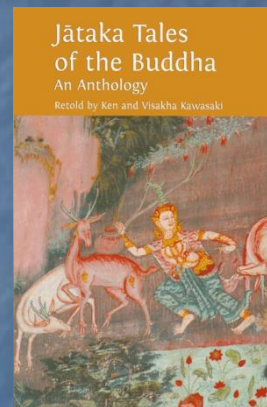
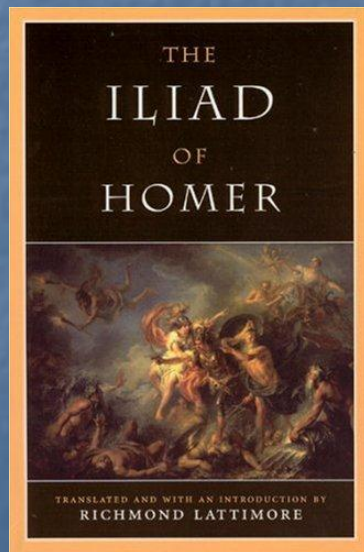
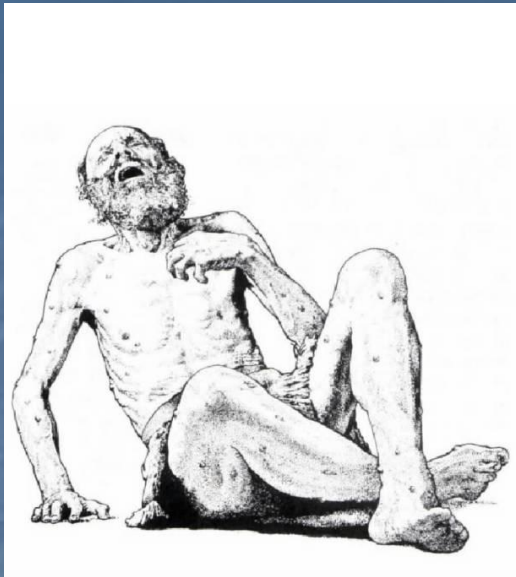


Taking the Mystery out of Post Traumatic Stress Disorder

PTSD

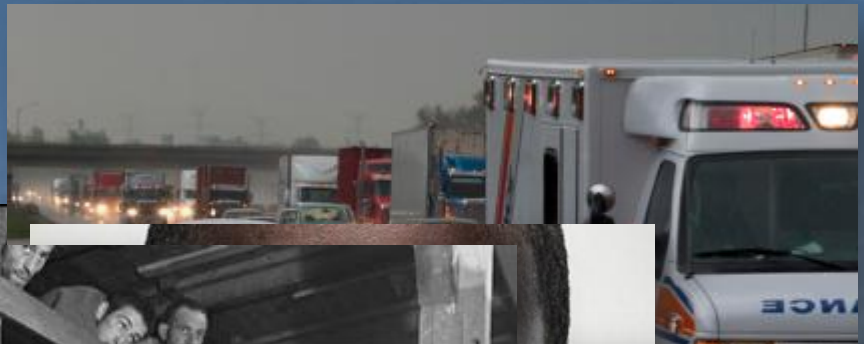
Rob Shieff

The disorder that follows
traumatic stress





Korean War
DSM I : Gross Stress Reaction



we need to start talking about it

stop!!
we are present

Freephone
0808 1000 900

Insolence source: NPS/US, 2010. Civil Malwareware in the United Kingdom. Stop a Hate UK & Insolence is a project of the Lucy Hamilton Foundation. Registered Charity 1011000.

In a nutshell

George Vaillant : The Harvard Class of '42

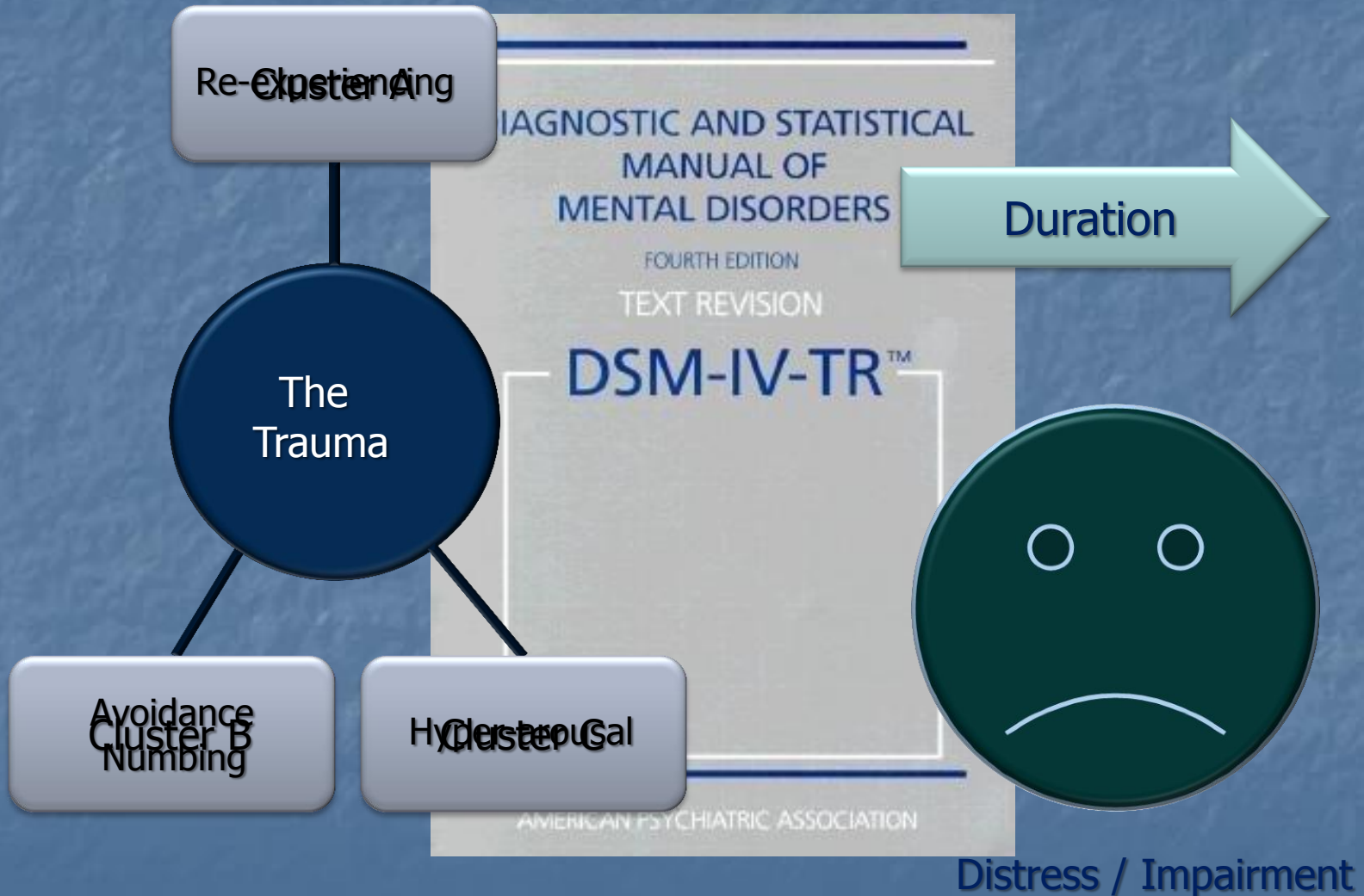
Nearly all went to war. 70% had combat exposure

40-50 years later – all had memories / nightmares. Most highly functional, and opposed to notion that they were ill, placed value on their experience, stating that it gave them pride / colour

4% of the cohort were traumatised - all identified as struggling to cope by 1945. Of that group of 6 men:

- 3 suicided
- 2 suffering long term mental disorder
- 1 missing presumed murdered

Making the diagnosis



The Trauma

■ Criteria A :

- 1. Experiencing, witnessing, or hearing about an event involving actual or threatened death or serious injury to self or others
- 2. Responds to that event with intense fear, helplessness or horror

Re-experiencing

- 1 or more of the following :
 - (1) distressing memories of the event
 - (2) distressing dreams of the event.
 - (3) flash-backs : acting or feeling as if the traumatic event were recurring
 - (4) intense distress
arousal
on exposure to internal or external cues to the traumatic event

Avoidance / Numbing

- 3 or more of the following :
 - (1) avoid thoughts, feelings, or conversations associated with the trauma
 - (2) avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) diminished interest or participation in significant activities
 - (5) detachment or estrangement from others
 - (6) restricted range of affect
 - (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Hyper-arousal

- 2 or more of the following :
 - (1) difficulty falling or staying asleep
 - (2) irritability
 - (3) difficulty concentrating
 - (4) hypervigilance
 - (5) exaggerated startle response

Duration

- More than 1 month

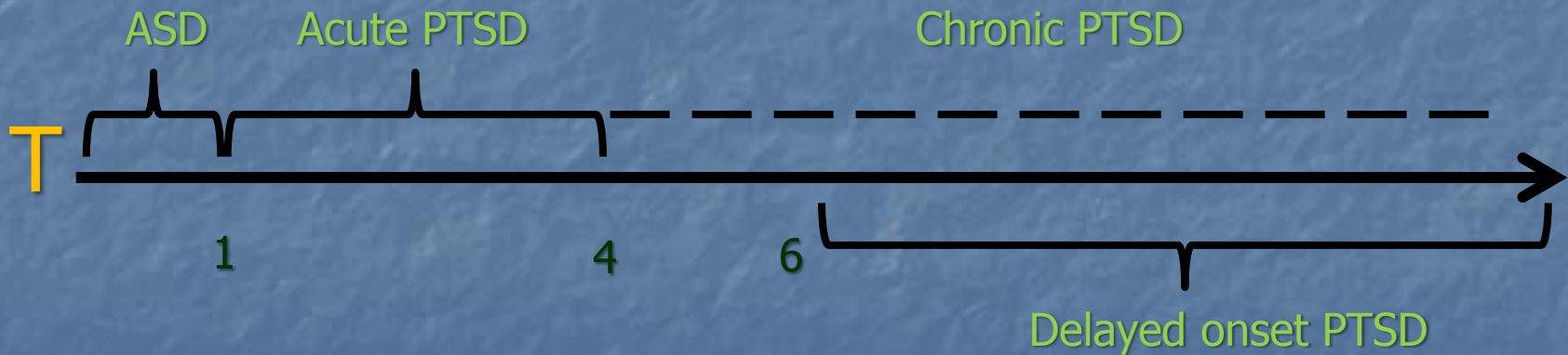
Acute Stress Disorder

13-33% adults 17-21% children

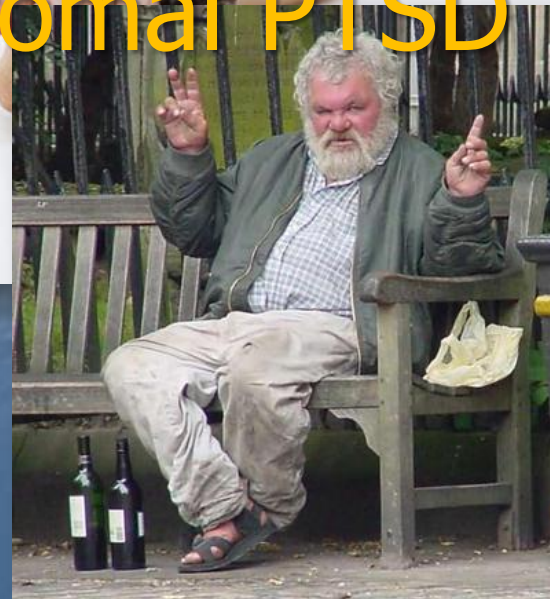
Dissociation (acute ?adaptive / ongoing = Sx)

75-80 % with ASD → PTSD

BUT : many develop PTSD without initial ASD



Distress / Impairment



Sub – syndromal PTSD

Different points of view

ICD

WHO / Great Britain

Does not include :

A2

Numbing
Sense of forshortening
Impairment

DSM V

Fear Circuit Disorders
(PTSD / Panic / Social + Specific Phobias)

No A2 criteria

4 symptom clusters :

1. Intrusions
2. Avoidance (≥ 1 only + no numbing)
3. Negative alteration in cognitions or moods (includes disinterest / detached)
4. Alteration in arousal

Assessing PTSD

Screening and Tracking

PTSD Checklist

Self-report

Robust psychometrics

Takes 5 minutes for patient to complete

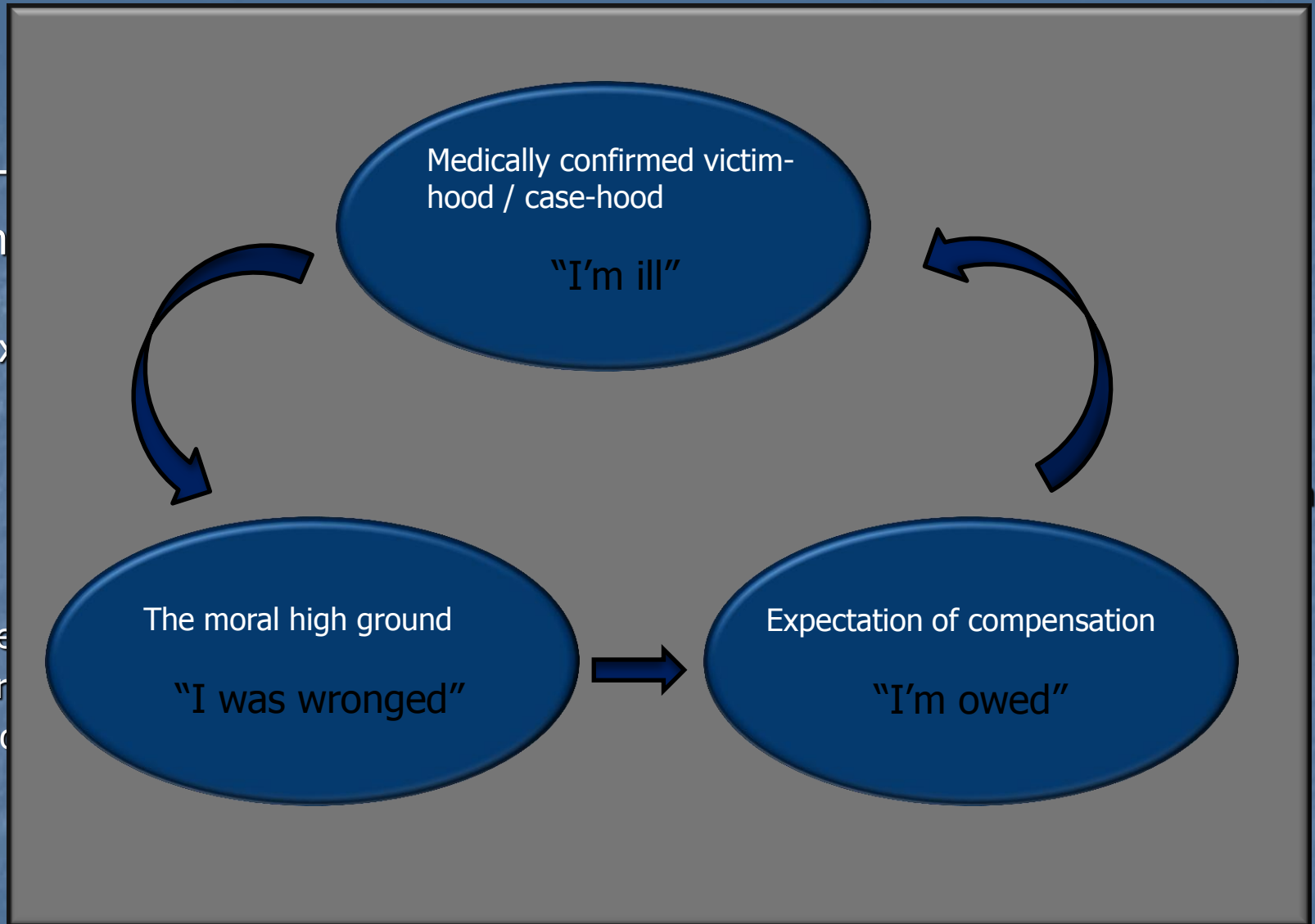
Easy to score

www.acpmh.unimelb.edu.au/.../PTSD%20Checklist%20_PCL_.pdf

■ Is PTSD
normal

■ Ex

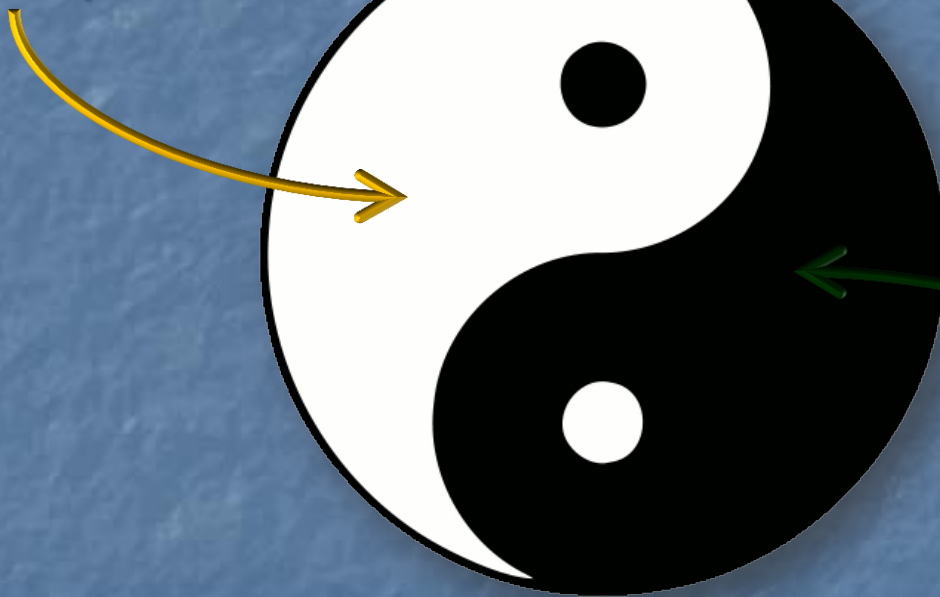
■ Se
■ Pr
■ De



Simon Wessely

Epidemiology

Epidemiology of
Trauma Exposure



Epidemiology
of
PTSD

Epidemiology of Trauma Exposure

■ M=61% F=51%

- Multiple trauma more common than single
- Most common trauma is some kind of injury
- Most trauma is sexual attack (10%)
- Inner city stress points are
- Some occupations carry high risk : paramedics / fire-fighters / police
- Peak age of trauma risk = 16-20

Trauma exposure in past 12 months : 18-39 = 27% 40-59 = 21% >60 =14%

- Inner city Ethnic trends : USA – white rate very similar to non-white rate
- Developing countries : post-conflict / low income trauma rate very high

BUT : Risk of trauma exposure > Risk of PTSD
val from rates massive (Mandorian refugees : report 12-14 events
nearly 100% exposed to some sort of atrocity)

- A2 Criteria : 77% who report trauma meet A2 for that event

NB : A1 criteria $M > F$

A2 criteria $F > M$

Epidemiology of PTSD

Western World Life-time Prevalence : 7-9%

Conditional Risk

Armed Services

M=5% Ethnicity

20% F exposed to trauma → PTSD 8% M → PTSD

Why ? High toxicity trauma / Greater A2 experience

Life-time prevalence of PTSD = non-white F = 27%

Post-conflict countries : Gaza 18%
 Highest risk trauma for PTSD development is rape :
 higher if entered in black Vietnam Vets 28%
 (age / education / firing line placement rather than ethnicity)
 M = 65% F = 46% Algeria 37%

Children

USA : age 2-17 : past 1 year
>50% physically assaulted



PTSD prevalence age 12 – 17:
M = 3.7% F = 6.3%

Older adults

Little studied.

PTSD = 70% in CA in hospital



Early milder stressor → ↓ PTSD
Early severe stressor → ↑ PTSD

Co-morbidity

- PTSD is THE MOST commonly co-morbid mental illness
- 92% have $\geq$ 1 additional Axis 1 disorder :
 - MDD (77%)

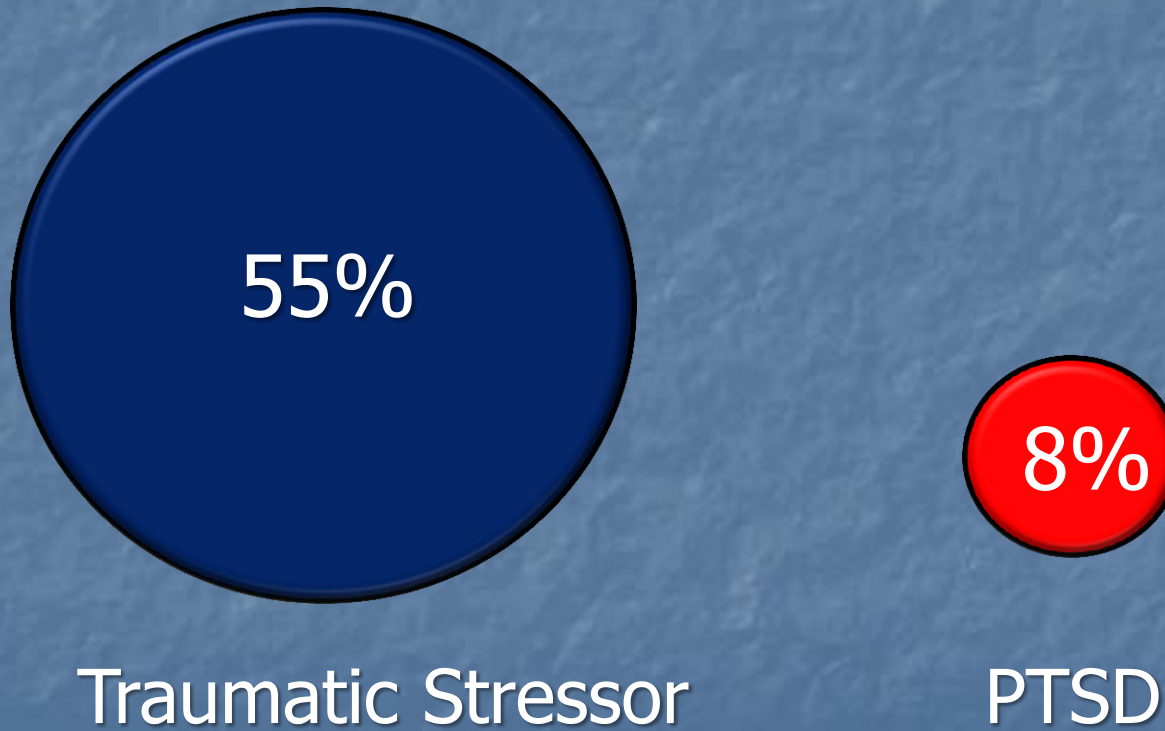
Bottom Line

If you diagnose PTSD, look hard for the other diagnoses

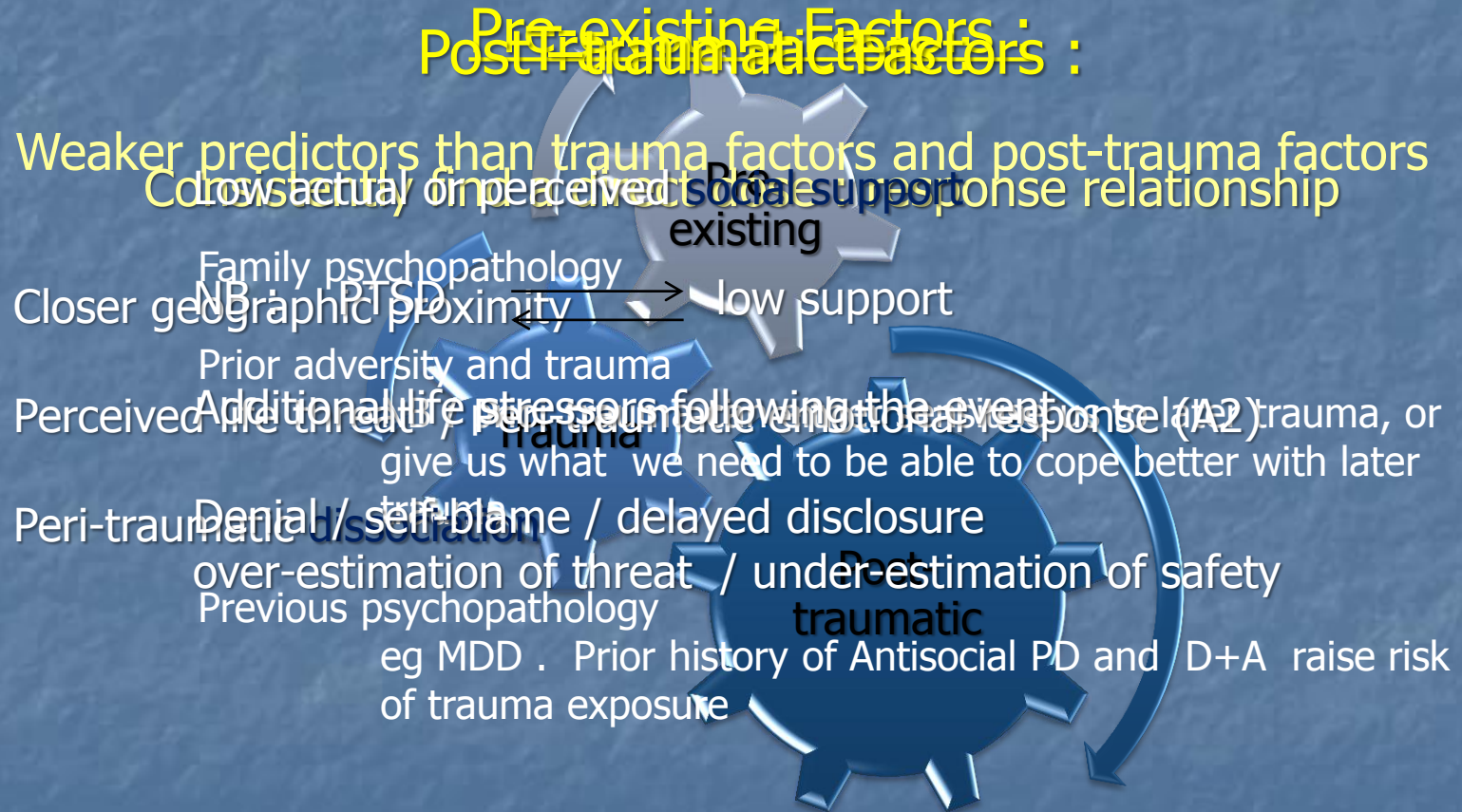
- impairment
- difficulty to
- suicide
- Usually PTSD comes first
- Note the cluster of CSA + PTSD + BPD = 'complex' PTSD

Risk Factors

Trauma is necessary but not sufficient for the generation of PTSD

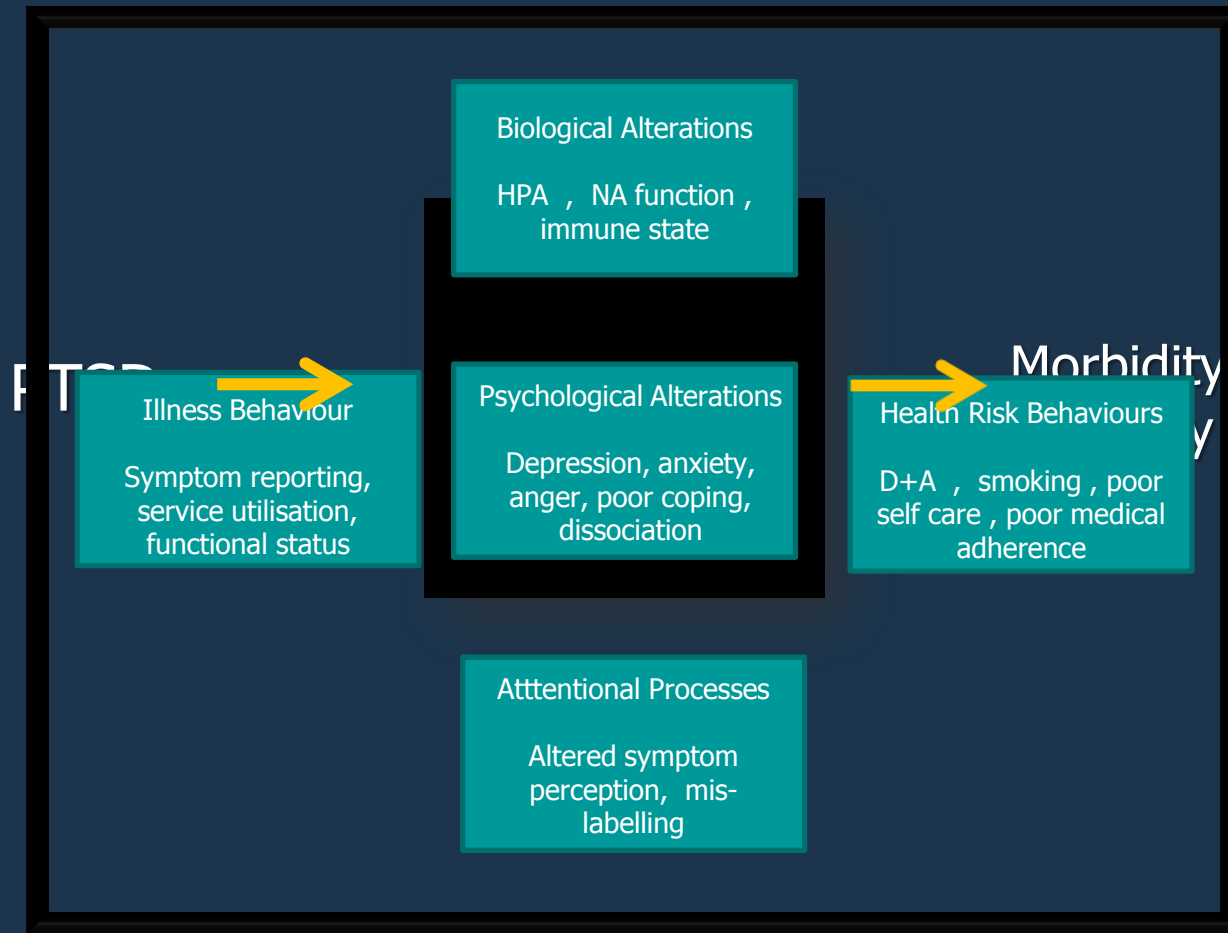


What else contributes to the risk ?



Trauma exposure and physical health

Most



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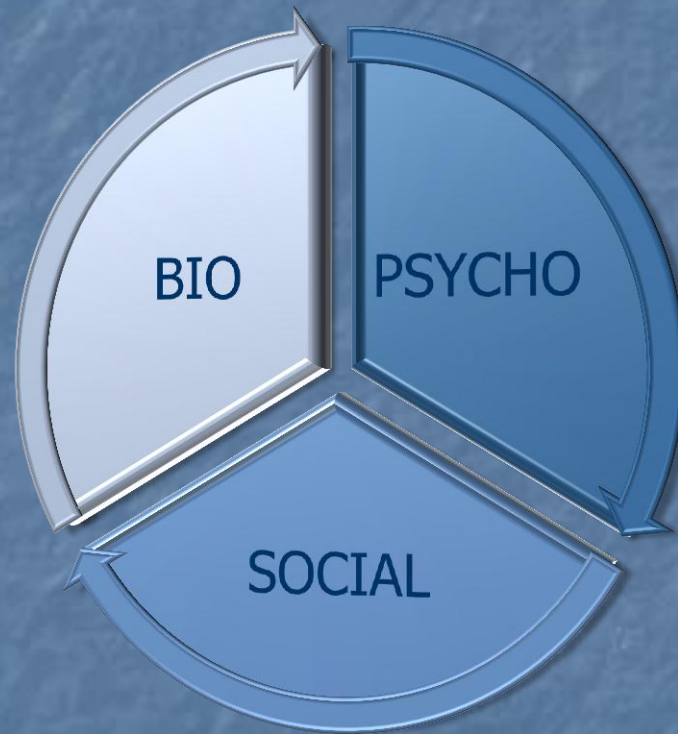
ns

d

etting
TSD

outcome
(higher)

What causes PTSD ?



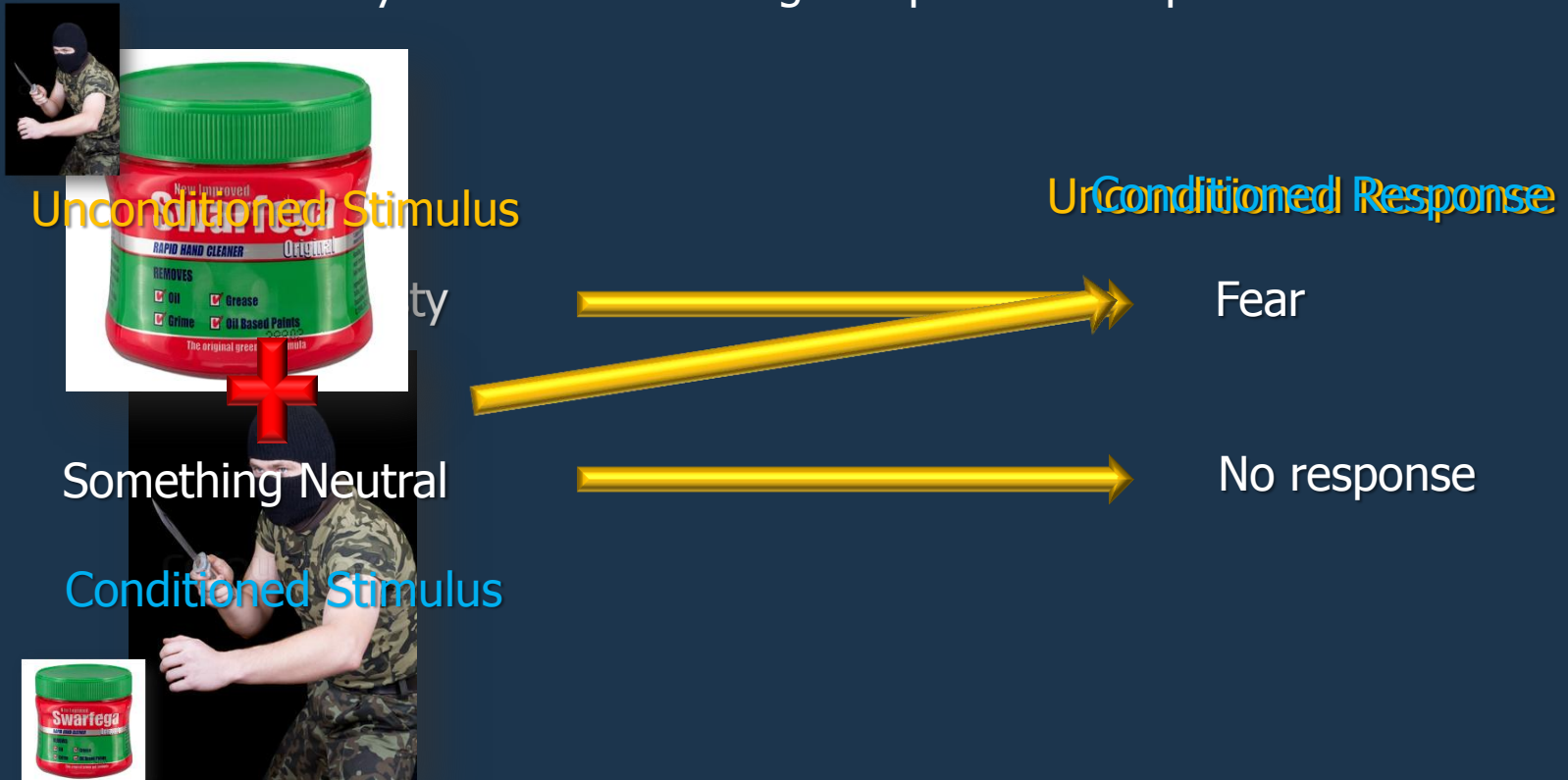
Psychological Models

- Learning / Conditioning
- Cognitive

Learning / Conditioning

Classical

We learn by association : Might explain the acquisition of fear



Undoing the connection

Repeated exposure to the Conditioned Stimulus

In the absence of the Unconditioned Stimulus

Results in the **extinction** of the Conditioned Response

This occurs by the formation of a new association



Operant

We learn by consequences. We are likely to repeat something if it might explain maintenance of fear.

- We get something nice
 - Working hard → praise : so we keep on working hard
- We don't get something nasty
 - The dentist makes me anxious, and anxiety feels nasty
 - If I avoid the dentist I don't feel anxious so I keep on avoiding the dentist

Because avoidance reduces anxiety we keep on avoiding situations that cause anxiety

Consequence



ety is
re ne



ve information

Cognitive

Cognitive Theory : 101

1. $\text{Experience} = \text{Event} + \text{Meaning}$
2. $\text{Anxiety} = \text{fearful anticipation of future events}$
3. $\text{Anxiety} = \frac{\text{overestimation of threat}}{\text{underestimation of ability to cope}}$

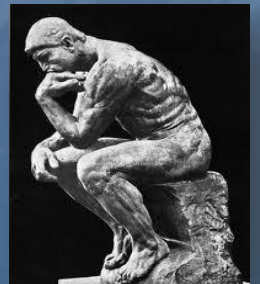
The PTSD Paradox

Anxiety relates to future threat **BUT** PTSD relates to a past event

In PTSD this means that :

Patients experience their past trauma in a way that creates a sense of current threat

HOW DOES THIS OCCUR ?



TRAUMA

Centres on the Just World View:

"Good things happen to good people, bad things happen to bad people"

Trauma can impact on this in 2 ways :

- 1) Reinforces negative beliefs : eg "I'm bad"
"I brought it on myself because of the clothes I wore"
- 2) Forces a change in the belief to fit the events :
"The world is a dangerous place" / "No-one can be trusted"

Plus :

Suppression / Avoidance / Hypervigilance to threat / D+A

The Neurobiology of PTSD

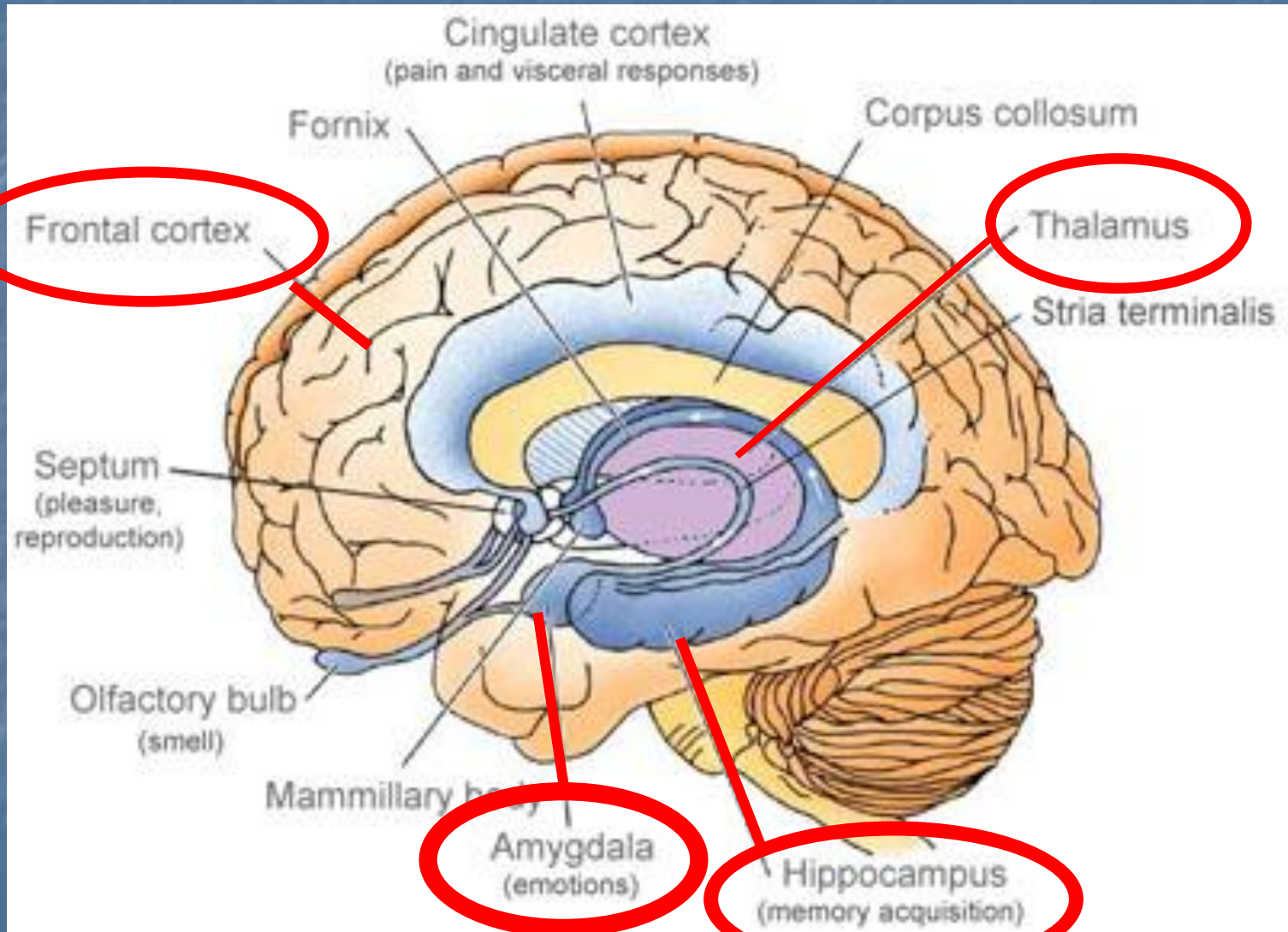
Neuro-anatomy

of fear
of PTSD

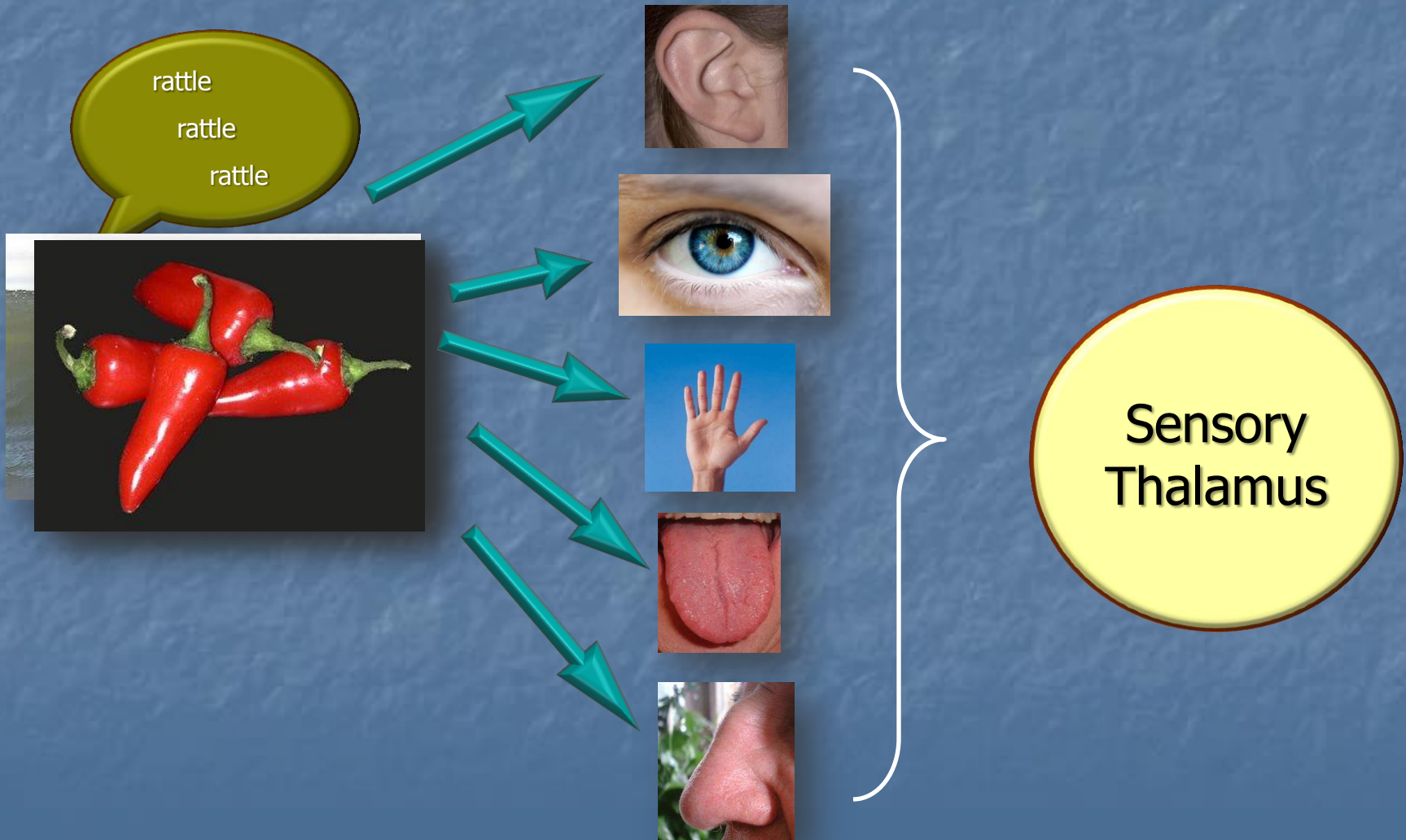
Neuro-chemistry



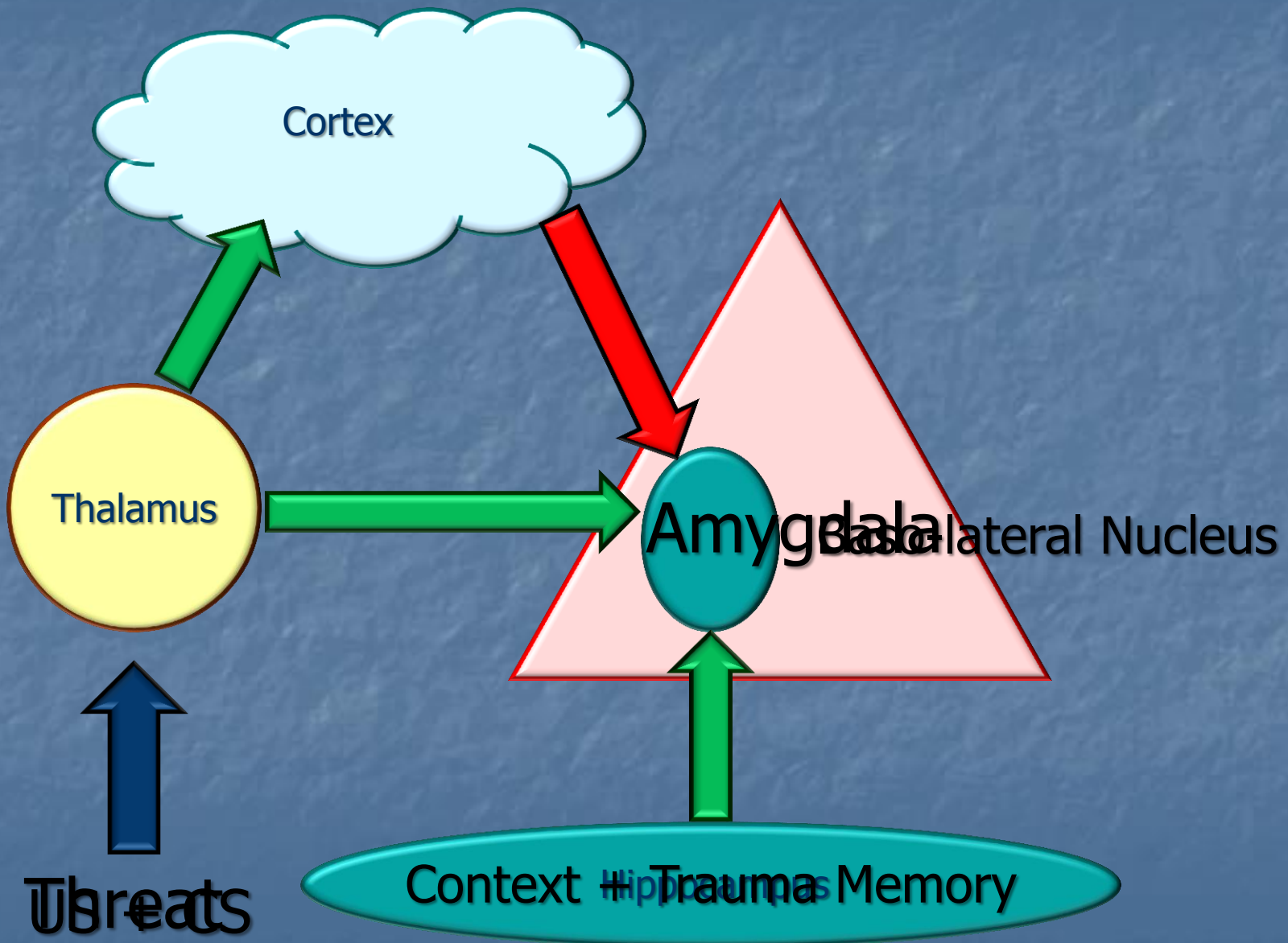
Neuro-anatomy of Fear



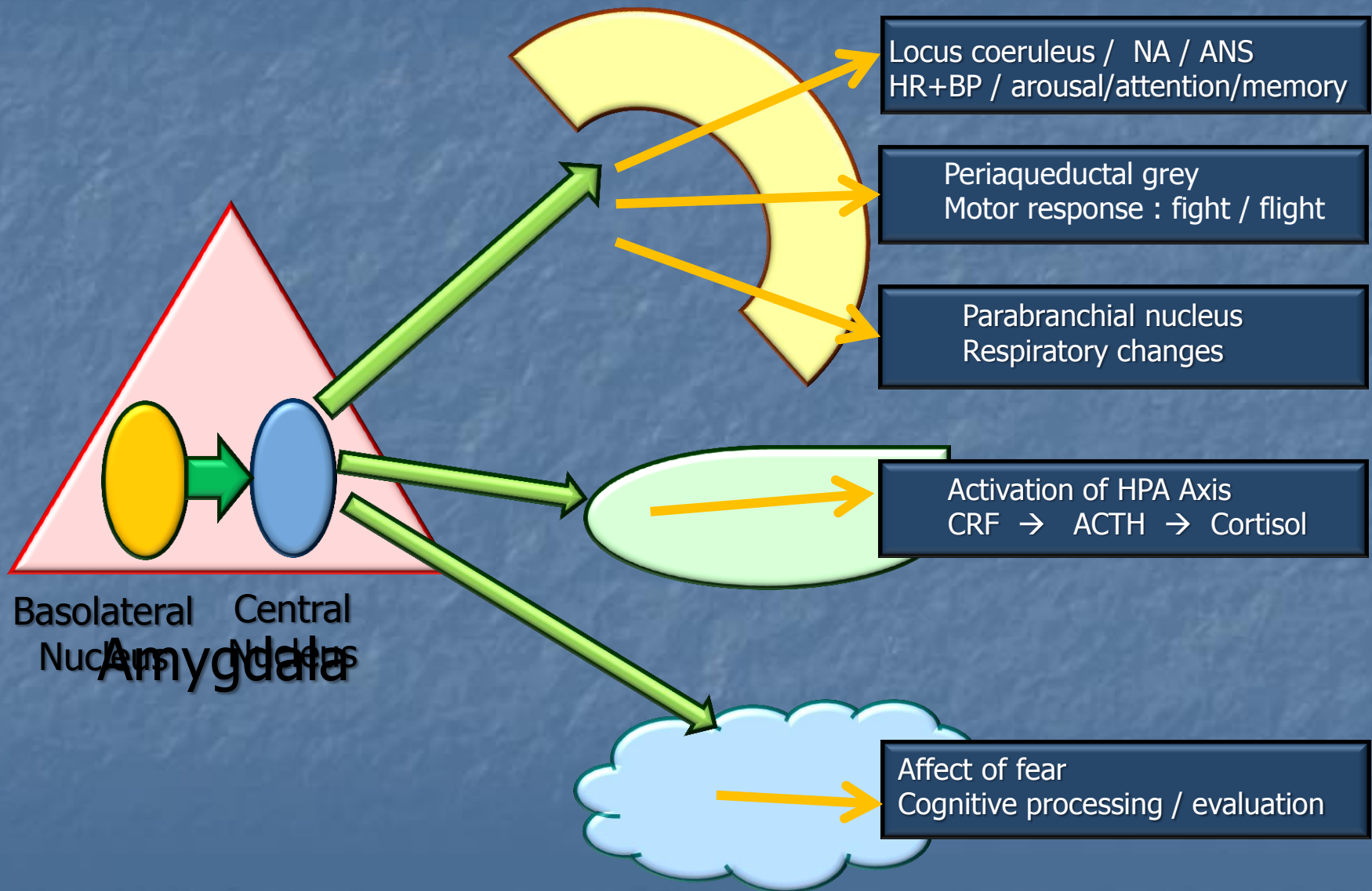
The Input Circuit



Input



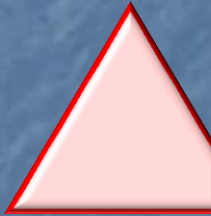
Output Circuit



Fear Circuit changes in PTSD

Hyperactive Amygdala

Underactive PFC



Evidence

Animal modelling

Functional Imaging
PET / fMRI

Hyper-responsivity to trauma
hyperarousal

Repetitious stimulation of
re-experiencing

NA / ANS stimulation
raised HR / BP
over-consolidation

feed-forward activation of Am

HPA abnormality

failure of normal suppression of ANS

in
function
of trauma related fear

Neuro-chemistry of PTSD

HPA System

CRF / Cortisol

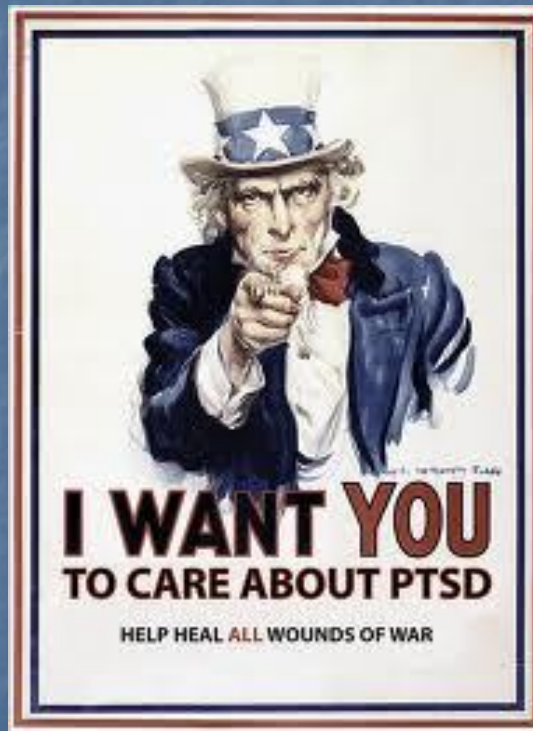
Stress → paraventricular nucleus of Hypothalamus release of CRF → anterior Pituitary release of ACTH → adrenal release of glucocorticoids (including cortisol)

Cortisol : mobilises energy stores / suppresses Noradrenergic response

In PTSD : relative reduction in [cortisol]

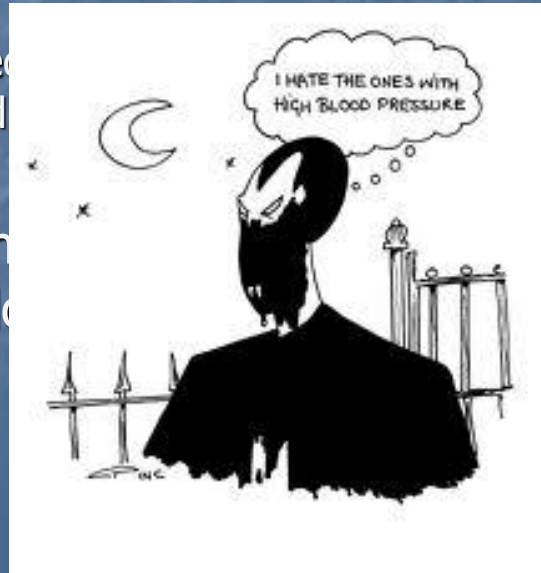
Suggests place for : Hydrocortisone provision to boost endogenous cortisol

Treatment of PTSD



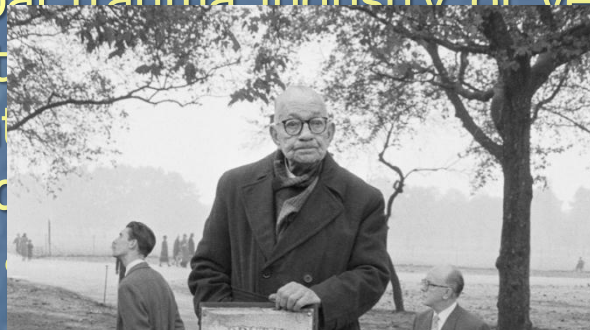
An ideal starting premise

- When terrible things happen we're meant to feel terrible
- Distress after trauma is like Blood Pressure
 - We all have it, but in some it is too high, and it needs to be carefully treated
 - The border between normal and abnormal is hard to define
- We are resilient
 - Most traumatised people cope using time honoured cultural (mour/alcohol)
- A sub-population of people who are resilient, most of whom do not use coping technology when stressed,



The Predicament

There is a large global trauma industry of very well meaning, but not necessarily well trained professionals offering a large volume of aid to a significant number of people who really need it, while many of those who could benefit from it have their problems identified, diagnosed and treated by professionals.



**WE NEED TO
RIGHT TREAT
PEOPLE**

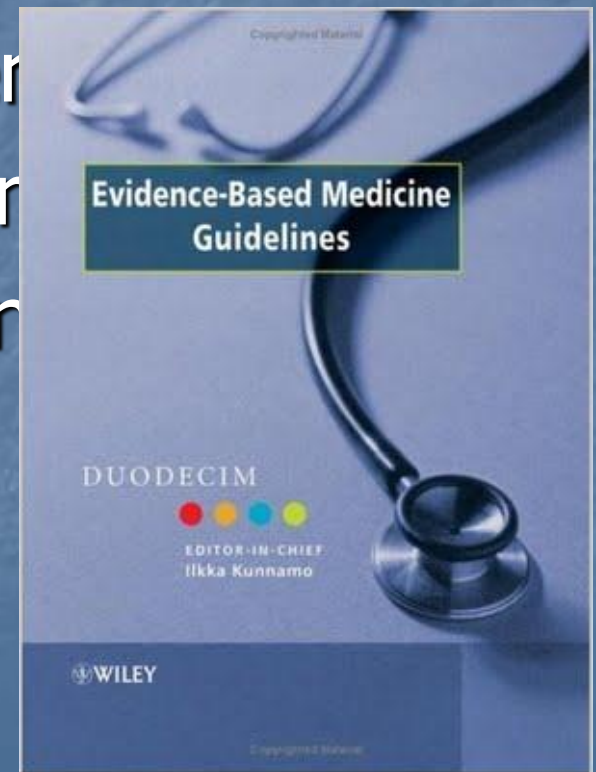


"Hard to tell from here. Could be buzzards. Could be grief counsellors."

**WE GET THE
THE RIGHT
PLE**

What are the right treatments?

- Psychological Treatment
- Pharmacological Treatment
- Public Mental Health Interventions



Psychological Treatment

- 2 keys : 1) extinction of responses to aversive stimuli (cues or memories) through exposure
- 2) cognitive re-appraisal of trauma

- 2 main forms

- Other forms

- Other modalities



virtual Reality Exposure

Cog)



Evidence

- Exposure / CBT > W/L
> non-specific treatment eg supportive counselling
- Exposure vs CBT : short-term - equally effective (50-79% recover)
long-term - CBT > Exposure
- EMDR : NICE endorsement but : mixed head-to-head findings
eye movements give no extra benefit
- Standard treatment modified to effectively treat PTSD plus :
anger / panic / D+A / Axis II (including complex PTSD)



Predicting response



Poor Outcome

History of childhood trauma

Physical injury from trauma

Co-morbid GAD

Low functionality (GAF)

Using BZDs during treatment

High EE at home or living alone

High depression/pain/anger

Favourable Outcome

Female

Low suicidality

Able to form relationships

Pharmacological Treatment

Cutting straight to the chase



SSRIs

In closer detail - The RCTs

- Anti-depressants
 - SSRIs
 - Venlafaxine / Mirtazapine
- Anti-adrenergics
- Anti-convulsants
- Atypical Anti-psychotics
- Steroids
- NMDA agonists



Antidepressants

SSRIs Venlafaxine

Treatment of choice in all guidelines – reasonable support for all available SSRIs
Rats > placebo
(effective, tolerable, safe, cheap)
Need long term treatment to secure remission

Most benefit on daytime symptoms (little effect on sleep/dreams)

Effective in acute treatment and for prevention of relapse

Mirtazapine

Improvement tends to accumulate over a long time

extending 12 weeks of treatment to 24 converted 55% non - responders to

responders
May offer particular benefit for nightmares, or memory of nightmares on
wakening

BE PATIENT and provide MAINTENANCE to prevent relapse

Others

■ Antiadrenergics

■ Propranolol :

reduces intrusions and reactivity to cues
may have a prophylactic role following trauma
(? By blocking memory consolidation)

■ Prazosin (α_1 antagonist) :

single night-time dose reduces nightmares / improves sleep
start low to avoid hypotension (1mg before bed)
mean maintenance dose = 10mg

■ Anticonvulsants

■ Mixed results : Carbamazepine / Valproate / Lamotrigine

■ Overall : adjunctive role in co-morbid PTSD + BPAD

More others

■ Atypical Antipsychotics

- Non-addictive sedatives / $\alpha 1$ blockers so may reduce intrusions
- Beware the metabolic syndrome
- Primarily used in combination with SSRIs
- Evidence for Risperidone / Olanzapine / Quetiapine

■ Steroids

- May impede trauma memory recall and so reduce re-experiencing
- Cortisol 10mg used as 'morning after pill'

■ NMDA agonist (D – cycloserine)

- Enhances neurogenesis and so facilitates new learning
- Used as adjunct to enhance effect of exposure therapy

Early Intervention for Trauma



A stitch in time

- The aim of Early Intervention is the prevention of chronic PTSD
- We need to understand the course of recovery from trauma
 - Help offered too early it is likely to be intrusive and inappropriate for most
 - Help offered too late, for those who need it, may increase PTSD risk
- 3 time periods follow trauma :
 - **Immediate** (0 – 48 hours) : dazed / anguished : Basic physiological / safety needs
 - **Acute** (2 days – 1 month) : best placed for early intervention
 - **Chronic** : developed maladaptive coping strategies / persistent PTSD
- May be prudent to focus attention on :
 - Those with severe immediate trauma reactions (high arousal / depression / dissociation)
 - Those with past psychiatric history / past trauma history
 - Those who face severe isolation / continued adversity



Psychological First Aid

What helps

#1 : contact + engage / safety + comfort / calm + orientate

Be supportive

Allow disclosure if initiated (but don't force it if it's not)

Provide information : what to expect : normalise / de-stigmatise
what support services are available and when to use them

Encourage positive coping strategies and healthy behaviours

Increase social support

Consider medication for symptom containment : anxiety / insomnia

The ABCs of PTSD and the ACC



The Accident Compensation Act 2001

Definition

Personal Injury



Mental injury

Definition : a clinically significant behavioural, cognitive, or psychological dysfunction

Entitlements

A person has cover for a work-related mental injury if

- the mental injury is caused by a single event that :
 - the person experiences, sees, or hears **directly**
 - is an event that could reasonably be expected to cause mental injury to people generally

A work-related personal injury is a personal injury that a person suffers

- while at any place for the purposes of their employment

21B : Cover for work-related mental injury



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Post-Traumatic Stress Disorder (PTSD) Guide - How do I know if I have PTSD?

Post-Traumatic Stress Disorder (PTSD)

What is PTSD?

What are the symptoms of PTSD?

What causes PTSD?

Who is at risk for PTSD?

How do I know if I have PTSD?

What treatments are available for PTSD?

How can I prevent PTSD?

When should I seek medical care?

More information about PTSD

About this Guide

A doctor or [mental health](#) professional diagnoses [PTSD](#) based on the symptoms described by the patient. Your doctor or mental health professional will perform a thorough psychological evaluation, asking you to describe the symptoms you are experiencing, when and how often they occur, and how intense they are. He or she may also ask you about the traumatic event that triggered your symptoms. You may also be given a [physical examination](#) to rule out other medical problems.



Advertisements

In order to be officially diagnosed with PTSD, you must meet certain criteria laid out in [Diagnostic and Statistical Manual of Mental Disorders](#) (DSM) published by the [American Psychiatric Association](#). The criteria for diagnosis with PTSD are:

- You experienced or witnessed a traumatic event which involved death or serious injury (or the threat of same), or a threat to the physical integrity of oneself or others
- Your response to the event involved intense fear, helplessness, or horror (or in children: disorganized or [agitated](#) behavior).
- You persistently re-experience the event in one of the following ways:
 - recurrent distressing thoughts, perceptions, or images of the event
 - recurrent distressing dreams of the event
 - Feeling as if the event were happening again through [hallucinations](#) or dissociate episodes (flashbacks)
 - Intense psychological distress or physical stress reaction upon exposure to things that remind you of the event

Ads by Google

[DSM-IV-TR Manual Online](#)

DSM-IV codes, diagnoses, decision trees and criteria sets online
www.appi.org/PsychiatryOnline

[NZ Health Insurance Quote](#)

Get quotes & advice - and choose value for money NZ Health Insurance
www.inform.co.nz

... that's all from me

