Medicine for Managers

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Post Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a mental and behavioural disorder syndrome associated with multiple symptoms arising from exposure to a real or threatened serious injury, such as domestic violence, assault, warfare or accidents, or sexual assault. The signs and symptoms are complex and are associated with changes in multiple areas of the brain. It was first identified as 'shell shock' during the first world war.

The ancient Greeks first documented mental disorders which developed following trauma. The recognition of such symptoms occurred in literature of the seventeenth and eighteenth centuries, and Samuel Pepys, in his diary in 1666, documented distressing reactions to the horrors of the Great Fire of London.

During the eighteenth century, men involved in military actions and civilians involved in such traumas as railway accidents, who were affected mentally by the horrors they encountered, were often dismissed as suffering from lethargy or melancholia, exhaustion or 'irritable heart'.

Soldiers who were unable to fight through mental disability were regarded by medical professionals as struggling with the heavy packs they carried, or homesickness. During World War I, the term ***Shell Shock*** was introduced as a diagnosis in veterans who experienced symptoms such as tremors, nightmares, memory loss, insomnia and poor concentration and was also known as 'combat neurosis' or 'old-sergeant syndrome'.

It was recognised as developing as a result of the constant threat of exposure to death or serious injury. The diagnosis was expanded during the Second World War and also became known as 'war neurosis' or 'psychoneurosis'.

During the Vietnam War, more detailed and documented research resulted in the recognition in veterans of chronic psychological problems resulting in medical, social and occupational problems.

The term ***Post Traumatic Stress Disorder*** came into use in the 1970s and was accepted by psychiatrists in Europe and the USA in around 1980. Diagnostic criteria were refined and recognition beyond the militia was established.

Causes. Essentially it is caused by a serious threat of physical injury, death or sexual assault. Failure to recover results in chronic PTSD symptoms. Factors believed to increase the risk of PTSD include:

- Being a woman
- Having previous traumatic exposure
- Lower socio-economic group
- Poor education
- IQ level
- Pre-existing mental illness

The risk of the appearance of PTSD may be aggravated by concomitant stresses such as financial problems, adverse life events, poor personal relationships and lack of social support.

Symptoms of PTSD may be diverse. They include:

- Persistent re-experiencing of an event
- Intrusive thoughts associated with trauma
- Insomnia and nightmares
- Intense negative emotional reactions to exposure reminders

Sufferers struggle with acquisition and processing of information and mood negativity. They try to avoid the triggers associated with particular events and develop negative beliefs, sometimes blaming themselves for traumatic events or their consequences. They may feel alienated from others.

PTSD cannot be diagnosed until ***one month or more*** has passed since the traumatic incident. During the first month, symptoms arising from a traumatic event is diagnosed as ***Acute Stress Disorder***.

Diagnosis of the disorder in adults, adolescents and older children depends on the nature and severity of a traumatic event, together with the presentation of a range of symptoms.

1. ***The actual event(s)*** may be an actual or threatened death, serious injury or sexual violence, directly experienced or witnessed
2. ***Experience***. Flashbacks, nightmares and repeated thoughts about traumatic events cause emotional distress or adverse reactions
3. ***Avoidance*** of thoughts or feelings associated with an event or of people, places or events that trigger recollections of events
4. ***Negative changes*** in mood or function which may include memory loss, negative self-beliefs, blaming oneself or others for the consequences of the event, loss of interest in activities or people and inability to experience positive emotions
5. ***Over-reaction*** including angry outbursts, reckless or self-destructive behaviour, difficulty concentrating and insomnia.
6. ***Functional distress or impairment*** as a result of the disturbance
7. ***Symptoms are unrelated*** to the use of alcohol, illicit drugs or other agents

Overall, the response to events in PTSD may be one of dissociation or depersonalisation.

Children as young as six may develop symptoms after reaction to trauma. They may become withdrawn and disruptive at school, as well as suffering nightmares, irrational fears, anger and

fighting. Schoolwork often suffers, and there may be features of depression or anxiety.

How Common is PTSD?

Exposure to traumatic events is common and it has been estimated that 50-70% of adults have experienced a traumatic event during their life. Most people do not develop PTSD, a third of people may go on to do so following the event. Up to one in 10 people may develop PTSD at some point in their life and data suggests that 4% of the population have symptoms at any one time. Women aged 16-24 are most likely to screen positive for PTSD.

It has been estimated that the risk of developing PTSD following traumatic events is as follows:

- Rape 49%
- Severe beating/assault 32%
- Sexual assault 23.5%
- Serious injury due to accident 17%
- Shooting or stabbing 15.5%
- Sudden death of family or friend 14%
- Child serious illness 10.5%
- Witness to killing or serious injury 7%
- Natural disaster 4%

Patients referred with a possible diagnosis of PTSD will undergo a physical and mental status examination.

The ***General Physical Examination*** will exclude physical causes of symptoms. Patients may show physical arousal (e.g. sweating, agitation, tremor) when giving their history of trauma.

Any person who suffered head trauma should be assessed for any neurological impairment.

The ***Mental Status Examination*** may identify:

- ***Behavioural factors*** such as difficulty engaging, increased vigilance, and distress when discussing the trauma
- ***Cognitive Factors*** including distorted thoughts of self, others and the world, difficulty concentrating and partial amnesia concerning the trauma
- ***Emotional factors,*** largely marked negative emotions and diminished positive emotions.

Diagnosis may be complicated by substance abuse. Up to 50% of men have been found in studies to have a concomitant problem with alcohol abuse. The figure is lower for women. The use of opiate and non-opiates is raised amongst individuals with PTSD.

Differential Diagnosis

In many cases, the diagnosis of PTSD is clear from the history and findings. However, in some cases, the features may be blurred because of other exogenous factors or pre-existing incidence or susceptibility to other mental illnesses. In such cases it may be necessary in particular to distinguish PTSD from:

- Anxiety
- Schizophrenia
- Obsessive-Compulsive Disorder

Treatment. There have been many different approaches to the treatment of PTSD.

There is variable evidence to support some of the methods employed.

Psychological First Aid following such events as major natural disasters *may* help. Emotional support and reassurance that a strong post-event emotional reaction is normal may decrease the risk of PTSD. Attempts to prevent PTSD by 'debriefing' individuals or groups following a disaster have not proved to be successful.

Cognitive Behavioural Therapy (CBT) started within weeks of an event may reduce the rate of subsequent PTSD.
Trauma-focused CBT has been shown to be effective in treating PTSD. One study has shown that even a single CBT session for sleep abnormalities may improve daytime PTSD symptoms.

Medication has been of variable value. Many drugs have been tried with little or no success. In particular trials of escitalopram (*Cipralex*), temazepam and gabapentin have failed to prevent PTSD and benzodiazepines appear to be harmful.
It does appear that ***trauma-focused psychotherapy*** may be effective against PTSD. A review of over 50 clinical trials suggested that it was the most effective treatment.

Undoubtedly, some people suffering from PTSD feel that there is a stigma associated with the diagnosis.

There have been at least one limited study to explore the difficulty associated with the diagnosis. In the study military veterans with combat-related PTSD were investigated. Common perceptions of treatment-seeking veterans included labelling as 'dangerous', 'violent' or 'crazy' and that in some way veterans with PTSD have somehow brought it on themselves.

Most participants avoided early treatment to avoid a label of mental illness. Unsurprisingly, they recognised that fellow veterans involved in combat best understood their PTSD symptoms.

The result of the review was that treatment will be sought earlier and will be more effective only by understanding of the disorder to enable early engagement and resistance of stigma

I personally find that PTSD is something that is difficult to fully understand, even as a medical professional, not only because I have never experienced it but because, for someone with a general practice background, it can be so difficult to identify.

It should not be so.

When I was young, my beloved grandfather, who had been gassed during World War I, was still traumatised by his experience forty years later.

My wonderful father, who was captured by, and escaped from the Japanese in Burma in World War 2, would have nightmares during my youth.

Neither was ever diagnosed as having PTSD or

received any care or support, a situation which was, I suspect, the fate of hundreds of thousands of troops across those and other wars.

Diagnosis was, and remains a challenge and separating those severely traumatised from those without true post-traumatic symptoms is amongst the greatest difficulties for those on front-line medicine.

Perhaps, like so many identified more modern medical problems, more training is the solution, or easier referral to triage facilities in an extended primary care environment.

At least now, I think most people understand the terrible consequences that severe trauma of whatever cause may generate.

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