Posttraumatic Stress Disorder (PTSD)

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Overview

- Posttraumatic stress disorder (PTSD) is an anxiety disorder that a person may develop after experiencing or witnessing an extreme, overwhelming traumatic event during which they felt intense fear, helplessness, or horror.

- The dominant features of posttraumatic stress disorder are emotional numbing (i.e., emotional nonresponsiveness), hyperarousal (e.g., irritability, on constant alert for danger), and reexperiencing of the trauma (e.g., flashbacks, intrusive emotions).

- PTSD is as an anxiety disorder. Anxiety disorders cover several different forms of abnormal, pathological anxiety, fears, phobias and nervous conditions that may come on suddenly or gradually over a period of several years, and may impair or prevent the pursuing of normal daily routines.

Overview Continued

Some of the disorders that must be ruled out when diagnosing PTSD include the following:

- Acute stress disorder (duration of up to 4 weeks)
- Adjustment disorder (less severe stressor or different symptom pattern)
- Mood disorder or other anxiety disorder (symptoms of avoidance, numbing, or hyperarousal are present before exposure to the stressor)
- Other disorders with intrusive thoughts or perceptual disturbances (obsessive compulsive disorder, schizophrenia, other psychotic disorder)
- Substance abuse or dependence disorder
- Furthermore, malingerers — that is, people who falsely claim to be traumatized—sometimes feign PTSD symptoms in order to win money in a court case as compensation for "emotional suffering."

Criterion for PTSD

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

2. The person's response involved intense fear, helplessness, or horror.

   Note: in children, it may be expressed instead by disorganized or agitated behavior.

Symptoms of PTSD are grouped into 3 Categories

Intrusive elements:

- Recurrent and intrusive distressing recollections of the event.
- Recurrent dreams of the event
- Sudden acting or feeling as if the traumatic event were recurring
- Intense psychological distress at exposure to things that symbolizes or resembles an aspect of the trauma, including anniversaries thereof.
- Physiological reactivity when exposed to internal or external cues of the event.
- At least one of these symptoms to be diagnosed with Post Traumatic Stress Disorder

Avoidance Features

- Efforts to avoid the thought or feelings associated with the trauma
- Efforts to avoid activities, places, people or situations that arouse recollection of the trauma.
- Inability to recall an important aspect of the trauma (psychological amnesia)
- Markedly diminish interest in significant activities
- Feelings of detachment or estrangement from others
- Restricted range of affect-unable to have loving feelings
- Sense of foreshortened future- does not expect to have career, marriage, children or normal life span.

At least three of these symptoms to be diagnosed with PTSD

Persistent symptoms of increased arousal (not present before trauma)

- Difficulty falling asleep or staying asleep
- Irritability or outburst of anger-irritability can progress to rage
- Difficulty concentrating
- Hypervigilence- resembles frank paranoia
- Exaggerated startled response

At least two of these symptoms to be diagnosed with PTSD

Recap…

- 1 or more Re-experiencing symptom
- 3 or more Avoidance symptoms
- 2 or more Increased arousal symptoms
- All of which must be present for a duration of more than 1 month and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Types of PTSD

- Acute PTSD - symptoms less than three months
- Chronic PTSD - symptoms more than three months
- Although symptoms usually begin within 3 months of exposure, a delayed onset is possible months or even years after the event has occurred.

[Can J Psychiatry, Vol 51, Suppl 2, July 2006]

Diagnosis of PTSD

- There are no laboratory tests to detect PTSD. To diagnose PTSD, a healthcare provider will consider the above symptoms together with history of trauma. He or she will likely also use psychological assessment tools to confirm the diagnosis and involve an appropriately trained specialist

- Although it may be tempting to diagnosis yourself, the diagnosis should be made by a mental health professional. This usually involves a a formal evaluation.

Age of Onset and Cultural Features

- Can occur at any age, including childhood, and can affect anyone.
- Individuals who have recently immigrated from areas of considerable social unrest and civil conflict may have elevated rates of PTSD.
- No clear evidence that members of different ethnic or minority groups are more or less susceptible than others.

Onset

- Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear.

Immediate Onset

- Better response to treatment
- Better prognosis (i.e., less severe symptoms)
- Fewer associated symptoms or complications
- Symptoms are resolved within 6 months

Delayed Onset

- Characterized by an onset of symptoms at least 6 months after the stressor
- Associated symptoms and conditions develop
- Condition more likely to become chronic
- Possible repressed memories
- Worse prognosis

Course

- The symptoms and the relative predominance of re-experiencing, avoidance, and increased arousal symptoms may vary over time.
- Duration of symptoms also varies: Complete recovery occurs within 3 months after the trauma in approximately half of the cases. Others can have persisting symptoms for longer than 12 months after the trauma.
- Symptom reactivation may occur in response to reminders of the original trauma, life stressors, or new traumatic events.

Course Continued

- The severity, duration, and proximity of an individual's exposure to a traumatic event are the most important factors affecting the likelihood of developing PTSD.
- Social supports, family history, childhood experiences, personality variables, and pre-existing mental disorders may influence the development of PTSD.
- PTSD can also develop in individuals without any predisposing conditions, particularly if the stressor is extreme.
- The disorder may be especially severe or long lasting when the stressor is of human design (torture, rape).

Possible Causes

A person develops PTSD in response to exposure to an extreme traumatic stressor involving direct personal experience of an event.

This includes:

- actual or threatened death or serious injury
- threat to one's physical integrity
- witnessing an event that involves death, injury, or a threat to the physical integrity of another person
- learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate

Examples of Traumatic Events Experienced Directly

- Military combat
- Violent personal assault (sexual assault, physical attack, robbery, mugging)
- Being kidnapped
- Being taken hostage
- Terrorist attack
- Torture
- Incarceration as a prisoner of war or in a concentration camp
- Natural or manmade disasters
- Severe automobile accidents
- Being diagnosed with a life-threatening illness

Examples of Witnessed Traumatic Events

- Observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster
- Unexpectedly witnessing a dead body or body parts

Examples of Events Experienced by Others that are Learned About

- Learning of a violent personal assault, serious accident, or serious injury experienced by a family member or a close friend
- Learning of a sudden, unexpected death of a family member or a close friend
- Learning that one's child has a life-threatening disease

Chance of Developing PTSD

- Likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressors increase.

- There is evidence of a heritable component to the transmission of PTSD
  - A history of depression in relatives has been related to an increased vulnerability to developing PTSD.

Prevalence

- Approximately 70% of adults in the United States have experienced a traumatic event at least once in their lifetime. Up to 20% of these people will go on to develop PTSD.
- An estimated 5.2 million American adults ages 18-54 have PTSD (or approximately 3.6%).
- Women are about twice as likely as men to develop PTSD.
- Approximately 30% of Vietnam veterans developed PTSD at some point after the war and 8% after the Persian Gulf War.

Estimated Risk for Developing PTSD Based on Event

- Rape (49%)
- Severe beating or physical assault (31.9%)
- Other sexual assault (23.7%)
- Serious accident or injury (i.e. car or train accident) (16.8%)
- Shooting or stabbing (15.4%)
- Sudden, unexpected death of family member or friend (14.3%)
- Child's life-threatening illness (10.4%)
- Witness to killing of serious injury (7.3%)
- Natural Disaster (3.8%)

www.ptsdalliance.org
www.nimh.nih.gov/pulicat/reliving.cfm

The Evaluation

- The nature of the evaluation for PTSD can vary widely depending on how the evaluation will be used and the training of the professional evaluator. An interviewer may take anywhere from 15 minutes to eight or more 1 hour sessions when the information is needed for legal or disability claims. Regardless of the length of the evaluation, it will include in-depth questioning of the traumatic event and symptoms being experienced as a result of these experiences.

www. ncptsd.va.gov

Evaluation Continued

More thorough assessments are likely to include:

- Detailed structured interviews and psychological tests on which you record your thoughts and feelings

- Close family member may be asked to provide more information

- Client may undergo a procedure that examines your physiological reactions (heart rate, blood pressure, plasma NE measurements) to mild reminders of your trauma.

Assessment Tools

- Two main categories of PTSD evaluations are structured interviews and self report questionnaires.
- Interviews
- Clinician Administered PTSD Scale (CAPS) developed by National Center for PTSD
- It has a format that requests information about the frequency and intensity of the core PTSD symptoms and common associated symptoms which may have implications on treatment and recovery. The CAPS-1 yields both continuous and dichotomous scores for current and lifetime PTSD symptoms.

www.ncptsd.va.gov

Treatment Outcome PTSD Scale (TOP-8)

- It is shorter, is easier to use, and is highly correlated with the CAPS, which is more time-consuming and less practical for use in clinical practice

- Scores:
  - 5 or less reflects no or minimal PTSD symptoms
  - 7 equals mild symptoms
  - 15 moderate symptoms
  - 21 indicates severe symptoms

- Remission in PTSD should be defined as no longer meeting the diagnostic criteria for the disorder, full functionality, and no or minimal anxiety and depression symptoms.

Can J Psychiatry, Vol 51, Suppl 2 July 2006

Other Interviews

- Structured Clinical interview for DSM (SCID) used in assessment of a range of psychiatric disorder including PTSD
- Anxiety Disorder Interview Schedule revised (ADIS)
- Structured Interview for PTSD (SI-PTSD)
- PTSD Symptom Scale Interview (PSS-I)
- Each has unique features

Self Report Questionnaires

- Several self-report measures have been developed as a cost and time efficient way of obtaining information about PTSD distress.
- These measures provide a single score representing the amount of distress an individual is experiencing.
- PTSD Checklist-- This measure comes in two versions. One is for civilians and another specifically designed for military personnel and veterans.
- Impact of Event Scale-Revised (IES-R)
- Kean PTSD Scale of the MMPI-2
- Mississippi Scale for Combat Related PTSD and the Mississippi Scale for Civilians
- The Post traumatic Diagnostic Scale (PDS)
- And many more…

Assessment Specific to Children

- As current diagnostic criteria are not developmentally sensitive (Tierney, 2000), diagnosis of PTSD in children and adolescents depends on the psychologist's careful integration of knowledge regarding child development and symptom expression.

- Generally, symptoms become increasingly similar to that explicated by the adult criteria as children age.

Preschoolers

- For the verbally developing preschooler, symptoms are expressed in nonverbal channels. This age-specific, developmental feature creates diagnostic difficulties because more than one-half of the DSM-IV criteria for PTSD require a verbal description of a subjective state *(Scheeringa, Peebles, Cook, & Zeanah, 2001).*

Preschoolers Continued

Symptomatic expression may include:

- acting out or internalized behaviors
- nightmare and disturbed sleep patterns
- developmental regression and clinging behavior *(Pullis, 1998; Yule, 2001)*

Re-experiencing trauma may be expressed as:

- generalized nightmares of monsters, rescuing others, or threats to self or others *(APA, 2000; Yule, 2001)*
- Traumatic play is often linked to themes of the traumatic events, is compulsive and repetitive in nature, and fails to relieve any of the accompanying anxiety (Cohen et al., 2000; Yule, 2001).

School-Age Children

At school-age, cognitive development presents with increasing verbal ability and difficulty with abstract conceptualization.

To a notable degree, symptoms continue to be expressed behaviorally and may include:

- regressions (e.g., bed wetting, clinging behavior or anxious attachment, school refusal) *(Terr et al., 1999; Webb, 1994; Yule, 2001)*

- less emotional regulation, and increases in externalizing or internalizing behavioral expression (e.g., fighting with peers, withdrawal from friends, poor attention, declining academic performance) *(Cook-Cottone, 2000; Yule, 2001)*

School-Age Children Continued

- In addition, school-age children may not yet be capable of abstractly interpreting somatic, affective experiences inherent in PTSD symptomatology (e.g., anxiety, reexperiencing) and consequently describes these experiences by listing concrete physiological complaints (e.g., stomach aches and headaches). (*Cook-Cottone, 2000)*

- Fears of going to sleep or being alone, sleep disturbance, clinging to others, and event-specific fears have also been reported.

(Cohen et al., 2000; Terr et al., 1999; Webb, 1994; Yule, 2001)

Symptoms in Preadolescents and Adolescents

- With age, symptoms become increasingly similar to adult manifestations *(Cohen et al., 2000).*
- However, for adolescents, abstract conceptions of identity, future, safety, and connection are vulnerable to alterations. *(Cook-Cottone, 2000; Johnson, 1998)*
- For example—a sense of foreshortened future (e.g., diminished expectations of getting married, establishing a career, and experiencing a normal life span).
- Those with chronic PTSD may present with self-injurious behaviors, suicidal ideation, conduct problems, dissociation, derealization, depersonalization, and/or substance abuse, which can mask the posttraumatic etiology of the disorder. *(Cohen et al., 2000; Johnson, 1998)*

Childhood Posttraumatic Stress Disorder: Diagnosis, Treatment, and School Reintegration., By: Cook-Cottone, Catherine, School Psychology Review, 02796015, 2004, Vol. 33, Issue 1

Post-trauma Assessment

- Post-trauma assessment involves a complete review of the child's pre- and post-trauma presentation based on multiple sources of input and using multiple formats (i.e., direct observation, oral-report, test, interview, and questionnaire data; and reports of those familiar with the child)

- To assess the complete spectrum of trauma, comprehensive structured and/or semi-structured interviews as well as trauma-specific measures are recommended

Finalized reports should include:

- academic functioning (i.e., review of records; cognitive and academic assessments; and parent, child, and teacher reports)

- behavioral functioning (i.e., behavioral assessments, observations, PTSD measures; and parent, child, and teacher reports)

Post-trauma Assessment Continued

- symptom severity (i.e., PTSD measures)
- diagnosis (i.e., comparison of child's presentation to age-specific diagnostic features, DSM-IV-TR criteria, and PTSD measures)
- developmentally sensitive recommendations including referral and/or in-school supports

Childhood Posttraumatic Stress Disorder: Diagnosis, Treatment, and Reintegration., By: Cook-Cottone, Catherine, School Psychology Review, 02796015, 2004, Vol. 33, Issue 1

PTSD and General Symptom Measures

- Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA)
- The Child PTSD Symptom Scale (CPSS)
- The CPTS-RI Revision 2
- Trauma Symptom Checklist for Children (TSCC)
- Trauma Symptom Checklist for Young Children (TSCYC)
- Child Posttraumatic Stress Reaction Index (CPTS-RI)
- Children's Impact of Traumatic Events Scale-Revised (CITES-2)
- Parent Report of Child's Reaction to Stress

http://www.ncptsd.va.gov/ncmain/assessment/childmeas.jsp

Differential Diagnosis

Differential diagnosis of the disorder or problem; that is, what other disorders or problems may account for some or all of the symptoms or features.

PTSD is frequently co-morbid with other psychiatric disorders including:

- Anxiety disorders
- Acute Stress Disorder
- Obsessive compulsive disorder
- Adjustment disorder
- Depressive disorders
- Substance Abuse disorders

PTSD Compared to Other Disorders

While the symptoms of posttraumatic stress disorder (PTSD) may seem similar to those of other disorders, there are differences.

- Acute stress disorder
- Obsessive-compulsive disorder
- Adjustment disorder

Differences between Acute Stress Disorder

- In general, the symptoms of acute stress disorder must occur within four weeks of a traumatic event and come to an end within that four-week time period.

- If symptoms last longer than one month and follow other patterns common to PTSD, a person's diagnosis may change from acute stress disorder to PTSD.

http://psychcentral.com/lib/2006/differential-diagnosis-of-ptsd-symptoms/

Differences between PTSD and Obsessive-Compulsive Disorder

- Both have recurrent, intrusive thoughts as a symptom, but the types of thoughts are one way to distinguish these disorders. Thoughts present in obsessive-compulsive disorder do not usually relate to a past traumatic event. With PTSD, the thoughts are invariably connected to a past traumatic event.

http://psychcentral.com/lib/2006/differential-diagnosis-of-ptsd-symptoms/

Differences Between PTSD and Adjustment Disorder

- PTSD symptoms can also seem similar to adjustment disorder because both are linked with anxiety that develops after exposure to a stressor. With PTSD, this stressor is a traumatic event. With adjustment disorder, the stressor does not have to be severe or outside the “normal” human experience.

http://psychcentral.com/lib/2006/differential-diagnosis-of-ptsd-symptoms/

Differences Between PTSD and Depression

- Depression after trauma and PTSD both may present numbing and avoidance features, but depression would not induce hyperarousal or intrusive symptoms

(FoCUS journal of lifelong learning in psychiatry summer 2003 vol1. no. 3)

PTSD Information

- It is important to ask all patients with mental health symptoms about trauma, particularly women suffering from treatment –resistant depression and those with general medical complaints, since patients with PTSD often present with somatic symptoms.

Can J Psychiatry, Vol 51, Sppl 2 July 2006

NOTE:

- Although many who experience severe trauma will develop symptoms of PTSD, most individuals exposed to a traumatic event do not develop a psychiatric illness.

J Clin Psychiatry. Volume: 67Suppl2, Issue: 2006,
Date: 2006 04 10, Pages: 26-33

Why PTSD Victims Might Be Resistant to Getting Help

- Sometimes hard because people expect to be able to handle a traumatic even on their own
- People may blame themselves
- Traumatic experience might be too painful to discuss
- Some people avoid the event all together
- PTSD can make some people feel isolated making it hard for them to get help
- People don’t always make the connection between the traumatic event and the symptoms; anxiety, anger, and possible physical symptoms
- People often have more than one anxiety disorder or may suffer from depression or substance abuse

During a Traumatic Event

- Norepinephrine- Mobilizing fear, the flight response, sympathetic activation, consolidating memory
- Too much = hypervigalence, autonomic arousal, flashbacks, and intrusive memories
- Serotonin- self- defense, rage and attenuation of fear
- Too little = aggression, violence, impulsivity, depression, anxiety
- PTSD victims – switch is stuck on

Causal Attributions

- “PTSD is typified by both automatic, involuntary symptoms, (e.g. flashbacks, intrusive thoughts, autonomic hyperarousal) and consciously mediated attempts to make meaning of the trauma experience. The automatic and involuntary symptoms appear to represent conditioned responding to environmental triggers associated with the trauma.”

- However, much less is known about the origins and consequences of victims’ efforts to understand their traumas or about how best to treat the symptoms associated with personal beliefs about traumas. The most comprehensive and widely cited guidelines for treating PTSD include using variants of cognitive therapy (including attribution retraining and cognitive restructuring).”

Massas., Phillip M and Hulsey, Timothy L. (2006)Causal Attributions in Posttraumatic Stress Disorder: Implications for Clinical Research and Practice, *Psychotherapy: Theory, Research, Practice, Training* 43, 201-215.

Treatment

- Individual Therapy
- Group Support (especially for Chronic PTSD)
- Medication

Treatment Continued

- Acute PTSD - Stress debriefing and psychotherapy
- Severe Acute PTSD - Stress debriefing, medication, group and individual psychotherapy
- Chronic PTSD - Stress debriefing, medication, group and individual psychotherapy
- For PTSD in children, adolescents, and geriatrics the preferred treatment is psychotherapy

Treatment Continued

- Exposure Therapy- Education about common reactions to trauma, breathing retraining, and repeated exposure to the past trauma in graduated doses. The goal is for the traumatic event to be remembered without anxiety or panic resulting.

- Cognitive Therapy- Separating the intrusive thoughts from the associated anxiety that they produce.

- Stress inoculation training- variant of exposure training teaches client to relax. Helps the client relax when thinking about traumatic event exposure by providing client a script.

Treatment Continued

- “Cognitive Restructuring involved teaching and reinforcing self-monitoring or thoughts and emotions, identifying automatic thoughts that accompany distressing emotions, learning about different types of cognitive distortions, and working to dispute the distress-enhancing cognitions, with a particular focus on abuse-related cognitions, for which the therapist remained alert during the personal experience work.”

- “In summary for women who did not drop out, CBT treatment was highly effective for achieving remission of PTSD diagnosis, ameliorating PTSD symptom severity, and reducing trauma-related cognitive distortions, compared with a WL control Group.”

(McDonagh, A., McHugo, G., Sengupta, A, Demment C.C., et al., (2005) Randomized Trial of Cognitive-Behavioral Therapy for Chronic Posttraumatic Stress Disorder in Adult Female Survivors of Childhood Sexual Abuse. *Journal of Consulting and Clinical Psychology*, 73, 515-524.)

Medications

- SSRIs – Sertraline (Zoloft), Paroxetine (Paxil), Escitalorpram (Lexapro), Fluvoxamine (Luvox), Fluxetine (Prozac)
- Affects the concentration and activity of the neurotransmitter serotonin
- May reduce depression, intrusive and avoidant symptoms, anger, explosive outbursts, hyperarousal symptoms, and numbing
- FDA approved for the treatment of Anxiety Disorders including PTSD

Medications Continued

- Tricyclic Antidepressants- Clomiprimine (Anafranil), Doxepin (Sinequan) Nortriptyline (Aventyl), Amitriptyline (Elavil), Maprotiline (Ludiomil) Desipramine (Norpramin)

- Affects concentration and activity of neurotransmitters serotonin and norepinephrine

- Have been shown to reduce insomnia, dream disturbance, anxiety, guild, flashbacks, and depression

Treatment for Children

- FDA approved Prozac for depression in children
- FDA approved Zoloft for OCD in children
- Cognitive-Behavioral therapy- exposure, anxiety management, Cognitive restructuring
- Play Therapy
- Parental influence and involvement in very important

Treatment

- With treatment, symptoms should improve after 3 months
- In Chronic PTSD cases, 1-2 years

Future Direction of Treatment

- Noradrenergic Agents
- Beta Blockers – Propranolol

Future Direction of Treatment Continued

- “Early Diagnosis and intervention- either psychotherapeutic or pharmacological- following trauma may some day reduce symptoms of posttraumatic stress disorder.”

- “Cognitive models- how the victim understands and appraises the stressful experience- are influential, and cognitive style also helps predict the occurrence of PTSD.”

(Levin, Aaron, Experts Seek Best Way To Treat Trauma Reactions, *Psychiatric News*, 2006, 41)

Treatment in Schools

- Primary – Anxiety/Stress management education
- Secondary- Stress debriefings
- Tertiary- Referral for psychotherapy and medical treatment

PTSD Myths

PTSD is a complex disorder that often is misunderstood. Not everyone who experiences a traumatic event will develop PTSD, but many people do.

MYTH:

PTSD only affects war veterans.

FACT:

Although PTSD does affect war veterans, PTSD can affect anyone. Almost 70 percent of Americans will be exposed to a traumatic event in their lifetime. Of those people, up to 20 percent will go on to develop PTSD. An estimated one out of 10 women will develop PTSD at sometime in their lives.

Victims of trauma related to physical and sexual assault face the greatest risk of developing PTSD. Women are about twice as likely to develop PTSD as men, perhaps because women are more likely to experience trauma that involves these types of interpersonal violence, including rape and severe beatings. Victims of domestic violence and childhood abuse also are at tremendous risk for PTSD.

PTSD Myths Continued

MYTH:

People should be able to move on with their lives after a traumatic event. Those who can't cope are weak.

FACT:

Many people who experience an extremely traumatic event go through an adjustment period following the experience. Most of these people are able to return to leading a normal life. However, the stress caused by trauma can affect all aspects of a person's life, including mental, emotional and physical well-being. Research suggests that prolonged trauma may disrupt and alter brain chemistry. For some people, a traumatic event changes their views about themselves and the world around them. This may lead to the development of PTSD.

PTSD Myths Continued

MYTH:

People suffer from PTSD right after they experience a traumatic event.

FACT:

PTSD symptoms usually develop within the first three months after trauma but may not appear until months or years have passed. These symptoms may continue for years following the trauma or, in some cases, symptoms may subside and reoccur later in life, which often is the case with victims of childhood abuse.

Some people don't recognize that they have PTSD because they may not associate their current symptoms with past trauma. In domestic violence situations, the victim may not realize that their prolonged, constant exposure to abuse puts them at risk.