Post-Traumatic Stress Disorder 20

An educational service of NetCE

Ask Your Patients...

"Have you been experiencing symptoms as a result of a trauma?"

If Your Patient Asks...

"Is it normal to still feel this way?"

UNDERSTAND the problem

Post-traumatic stress disorder (PTSD) is a severe, potentially chronic and disabling disorder that develops in some persons following exposure to a traumatic event involving actual or threatened death, serious injury, or sexual assault.[1] The prevalence of PTSD in the U.S. population is approximately 8%, with incidence as high as 17% in primary care patients and possibly greater than 50% in mental health treatment-seeking populations.[2, 3] PTSD can become chronic in as many as 40% of cases.[4]

Roughly 60% of men and 50% of women in the United States have experienced a traumatic event, with the majority reporting trauma exposure also reporting two or more traumatic events.[5] However, PTSD only develops in 10% to 20% of those exposed to trauma, a finding that has prompted intense research efforts in identifying risk factors and early intervention to prevent or reduce the development of PTSD.[5]

WHAT are the diagnostic criteria

To understand the origin of presenting problems, providers should routinely ask about recent or remote stressful or traumatic experiences and, if suspected, use a traumatic events checklist.[6]

WHO is at risk

Populations at risk for PTSD include refugee victims of torture, combat veterans, persons released from incarceration, victims of sexual assault, survivors of natural disasters, and adults who endured repeated sexual or physical abuse as children.[6]

While higher PTSD rates have been found in individuals who are black or Hispanic, this is primarily attributable to greater exposure to traumatic stressors. Otherwise, little to no racial or ethnic differences have been found in PTSD prevalence.

The type of trauma experienced may increase the likelihood of developing PTSD. Compared to PTSD prevalence following single-trauma exposure, adult PTSD prevalence following sustained trauma exposure from childhood sexual abuse is likely substantially higher. One study found 39% of women and 29% of men who reported sustained childhood sexual abuse developed PTSD in adulthood.[7]

As noted, PTSD has long been observed to develop in only a minority of persons exposed to traumatic experience, suggesting that individual differences largely account for variation in PTSD rates that are independent of trauma event factors.

In addition to specific PTSD symptoms, the time of onset, frequency, course, severity, distress level, and degree of functional impairment require consideration. Persistence of several symptoms over the initial 30-day postexposure period indicates a developing trauma-related stress disorder, including:[8]

- Recurring thoughts, mental images, or nightmares of the trauma event
- Disrupted sleep
- Changes in appetite
- Anxiety and fear, especially when exposed to trauma-associated events or situations
- Feeling on edge, easily startled, or overly alert
- Feeling depressed or sad or having diminished energy
- Memory problems, including difficulty recalling aspects of the trauma
- Feeling "scattered" and unable to focus on work or activities
- Difficulty making decisions

- Feeling irritable, easily agitated, angry, and resentful
- Feeling emotionally numb, withdrawn, disconnected, or different from others
- Spontaneous crying or feeling a sense of despair and hopelessness
- Feeling extremely protective of, or fearful for, the safety of loved ones

HOW to treat PTSD

When initiating PTSD treatment, patients should be provided with education about the disorder, the common symptoms, and the range of available and effective pharmacologic and nonpharmacologic treatments.

Psychosocial rehabilitation interventions are strongly supported across a broad range of mental disorders, and a growing evidence base confirms the beneficial effect in patients with PTSD. Specific interventions include family psychoeducation, supported education, housing and employment, intensive case management, peer counseling, and "vet to vet" services. Their implementation is associated with positive outcomes in several dimensions, such as symptom reduction, decreased risk of relapse, increased housing stability, improved social and work functioning, reduced stress in families, and enhanced quality of life.

Selection of the initial pharmacologic approach is based on clinician and patient choice and guided by the manifesting symptoms of PTSD, other disorders, and patient preference, with polypharmacy choice dictated by clinical presentation and co-occurring psychiatric disorders. Selective serotonin reuptake inhibitors are widely recommended as first-line agents in the treatment of PTSD, with demonstrated efficacy in reducing the global, re-experiencing, avoidance/numbing, and hyperarousal symptoms of PTSD.[8]

WHERE to find resources

National Center for PTSD
http://www.ptsd.va.gov

National Institute of Mental Health
http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd

National Alliance on Mental Illness
http://www.nami.org

Anxiety and Depression Association of America
http://www.adaa.org/understanding-anxiety/posttraumatic-stress-disorder-ptsd

Post-Traumatic Stress Disorder (PTSD) Alliance
http://www.ptsdalliance.org

International Society for Traumatic Stress Studies
https://www.istss.org

1 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: American Psychiatric Association Press; 2013.

2 Meredith LS, Eisenman DP, Green BL, Basurto-Davila R, Cassells A, Tobin J. System factors affect the recognition and management of post-traumatic stress disorder by primary care clinicians. *Med Care*. 2009;47(6):686-694.

3 Schnurr PP, Spiro A, Vielhauer MJ, Findler MN, Hamblen JL. Trauma in the lives of older men: findings from the Normative Aging Study. *J Clin Geropsychol*. 2002;8(3):175-187.

4 Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry*. 1995;52(12):1048-1060.

5 National Center for PTSD. Understanding and Coping with PTSD. Available at http://www2.nami.org/TextTemplate.cfm?Section=Family_to_Family&Template=/ContentManagement/ContentDisplay.cfm&ContentID=124250. Last accessed August 11, 2015.

6 Australian Centre for Posttraumatic Mental Health. Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder. Available at https://www.nhmrc.gov.au/guidelines-publications/mh13-mh14-mh15-mh16. Last accessed August 11, 2015.

7 Molnar BE, Buka SL, Kessler RC. Child sexual abuse and subsequent psychopathology: results from the national comorbidity survey. *Am J Public Health*. 2001;91(5):753-760.

8 U.S. Department of Veterans Affairs, Department of Defense. Clinical Practice Guideline for Management of Post-Traumatic Stress. Available at http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf. Last accessed August 11, 2015.

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