Presentation

ACTDGP Mental Health Evening Seminar


Activity Code: 410358

28/11/01

Dr Jeannie Higgins
Overview

• What are traumatic stress reactions (including PTSD, complex PTSD and other comorbid conditions)?
• Causes of traumatic stress reactions including PTSD?
• Assessment criteria (formal and informal tools)
• Treatment issues
• What can the GP do?
• Resource material
• Case discussion
DIAGNOSTIC CRITERIA for 309.81 POSTTRAUMATIC STRESS DISORDER (1)

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

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

(2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganised or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognisable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event

(5) physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event
DIAGNOSTIC CRITERIA for 309.81 POSTTRAUMATIC STRESS DISORDER (2)

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect (e.g. unable to have loving feelings)
   (7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:
   Acute: if duration of symptoms is less than 3 months
   Chronic: if duration of symptoms is 3 months or more
   With Delayed Onset: if onset of symptoms is at least 6 months after the stressor
Complex PTSD and Co-morbid Conditions

• associated with repeated and severe trauma exposure
• physiological sequelae
• cognitive sequelae
• sequelae on self
• emotional sequelae
• sequelae for relationships
• behavioural sequelae
Physiological Sequelae of Repeated Traumatisation

- hypervigilance, heightened baseline levels of anxiety, sleep disturbance
- intense startle reactions, headaches, gastrointestinal disturbances, chronic pain, respiratory disturbances, cardiovascular difficulties, neuromuscular problems
- urinary tract difficulties, skin disorders
- long term effects on the neurochemical response to stress e.g. magnitude of the catecholamine response, the duration and extent of the cortisol response, serotonin and endogenous opioid system
- alterations in immune competency, decreased hippocampal volume
- extreme autonomic responses to stimuli reminiscent of traumatic events, nonhabituation to startle stimuli
- amnesias and hypermnesias, traumatic memories stimulated by physiological arousal, sensorimotor rather than semantic memories
Cognitive Sequelae of Repeated Traumatisation

- dissociation
- avoidance and minimisation of trauma-related information
- disorientation in place and time
- memory dysfunction and concentration problems
- problems in decision-making
- selective attention to threat-related cues problems discriminating between neutral and threat-related cues
- learning difficulties
- cognitive distortions
Sequelae of Repeated Traumatisation on Sense of Self

- annihilation of the meaning structure
- lack of a sense of individual autonomy
- loss of a sense of self
- construing self as evil contaminated or tainted
- lack of an internal sense of worth
- perception of current reality as unsafe
- continually waiting for unpredictable and uncontrollable catastrophic consequences lack of a sense of personal power to influence the outcome of events
- perception of current reality as horrible, unchangeable, and inevitably catastrophic
Emotional Sequelae of Repeated Traumatisation

- chronic depression
- feelings of emptiness and numbness, hopelessness, powerlessness, rage, fear, shame, guilt,
- chronic irritability and outbursts of rage
- inability to connect feelings to bodily sensations and to thoughts
- difficulty in regulating overwhelming feelings
- intense self-hatred
- extreme fear of making mistakes and evaluation
Sequelae of Repeated Traumatisation on Relationships

- lack of a sense of a separate personal identity in relation to others
- traumatic bonding with perpetrators
- social withdrawal and constriction
- patterns of revictimisation and re-enactment of the dynamics of relationships formed in traumatic environments
- difficulty in establishing and maintaining healthy intimate relationships
- pattern of abusive behaviour towards others
- fear of intimacy yet intolerance for being alone
Behavioural Sequelae of Repeated Traumatisation

- constriction in initiative, future planning and active engagement in the world
- chronic suicidal behaviour
- repeated self-injury & sabotage
- impulsive behaviours, substance abuse
- overwork, overachievement, perfectionism
- patterns of revictimisation
- excessive risk-taking
- substance abuse
- eating disorders
Context for trauma exposure

- Families e.g. motor vehicle and other accidents, criminal assault, personal disasters, child abuse, domestic violence, rape, sadistic organised torture and entrapment, internment and captivity

- Communities e.g. natural or person created disasters, repeated physical and emotional deprivation and abuse, criminal assault, rape

- Societies e.g. war, political torture and trauma, internment and captivity, rape

- Occupations e.g. soldiers, nurses, police, fire fighters, ambulance service, medical practitioners, prisoner officers, bank tellers
Causes of Traumatic Stress reactions including PTSD & comorbid conditions

- Single exposure or repeated exposure to traumatic stressors i.e. events involving actual or threatened death, serious injury, sexual or other physical assault and a personal response of intense fear, helplessness, or horror.

- Numerous major schools of thought provide explanations for the aetiology of PTSD and other traumatic stress reactions e.g. psychodynamic, cognitive/behavioural and information processing, biological and socio-cultural

- Scientific and clinical evidence unequivocally supports a complex and reciprocal biopsychosocial meta-theoretical approach to understanding the causes, the unique individual manifestation, the severity and the maintenance of traumatic stress reactions.

- Health outcome is best predicted by a complex interaction between person, trauma and recovery variables. Helps to explain individual differences in emotional and physical health following exposure to traumatic events (see risk factors for PTSD)
Risk Assessment for Enduring Psychological Distress
Following Exposure to Traumatic Life events

Personal Factors

• pre-existing family of origin dysfunction
• personal or family history of psychological distress
• history of childhood abuse or prior history of other trauma exposure
• neuroticism
• external locus of control
• lower resiliency
• less hardiness
• younger age
Risk Assessment for Enduring Psychological Distress
Following Exposure to Traumatic Life events

Trauma Characteristics

• magnitude and severity of trauma exposure
• multiple versus single exposure
• perception of life threat or of serious injury
• identification with the victim or the situation
• the psychological proximity of the event
• the receipt of intentional injury or harm
• exposure to grotesque sights
• the violent or sudden death of a loved one
• learning of exposure to a noxious agent
• causing death or severe harm to another
• bereavement and loss
• the non-accidental death of children
• perceived uncontrollability and unpredictability
Risk Assessment for Enduring Psychological Distress Following Exposure to Traumatic Life events

Recovery factors

• ongoing exposure to traumatic stressors
• perceived lack of consistent and quality social support

Practical Assistance

Information

Emotional Support

• limited range of safe and effective strategies to deal with overwhelming feelings, thoughts and heightened physiological arousal
• the experience of personally significant concurrent life stressors
• inability to make realistic sense out of the traumatic event and of personal reactions
Assessment (1)

- Dangers of both over and under-diagnosis i.e. concluding that just because someone has been exposed to a potentially traumatising event that this necessarily means that they have a disorder OR alternatively missing the connection between symptoms across many sources of the person's functioning and their origin in unresolved traumatic stress reactions.

- Over 90% of the general population DO NOT develop PTSD following exposure to traumatic stressors but this varies greatly according to the severity and nature of the traumatic event. For instance,

- Australian Vietnam veterans have lifetime prevalence rates of PTSD ranging from 17% to 25.7% and current prevalence rate of 6.8% to 17.3%
Assessment (2)

- About a quarter to well over half people of the people exposed to individualised traumatic violence have diagnosable PTSD at sometime during their life i.e.
  - between 80% to 94% of rape survivors develop diagnosable PTSD
  - PTSD rates of over 40% are common among female survivors of domestic violence
  - 72% of adult survivors of child sexual assault meet diagnostic criteria for PTSD
  - Between 1 in 12 to 1 in 16 NSW Police have diagnosable PTSD after one year of operational policing compared to 1 in 33 new recruits. Baseline trauma symptoms do not predict trauma symptoms after 1 year (Higgins, 1995; 1997)
  - At six month follow-up 25.5% of patients hospitalised with mild to moderate (not severe) physical injuries following exposure a traumatic event had diagnosable PTSD
  - There is a 15% overall prevalence rate for PTSD among emergency personnel i.e. fire, police, ambulance and emergency hospital staff
Assessment (3)

- Physical and psychological safety issues are the first priority in cases involving traumatic stressors.
- Structural and psychological interventions concerning physical and psychological safety. E.g. change of accommodation or removal of perpetrator in cases of domestic or organised sadistic violence.
- Screen and identify any untreated physical condition, which may reciprocally interact with the intensity of psychological distress experienced by the traumatised person.
- Identify triggers to intense psychological or physiological reactions.
- Collaboratively develop immediate and personalised strategies to deal constructively with overwhelming feelings.
- Discuss creative alternatives to self-injury, develop suicidal and homicidal contracts. People with PTSD commit suicide eight times more frequently than those without PTSD even after the influence of depression is statistically controlled.
- Identify and discuss the advantages and disadvantages of hospitalisation.
- Explore and monitor the range and type of viable work duties, assist the traumatised person to negotiate compensation and return to work plans, where relevant.
Assessment (4)

• encourage patients to leave most major life decisions (except those concerned with immediate safety) until they are past the immediate presenting crisis

• assist the traumatised person to provide time and space for their own healing process whilst minimising current day losses and maintaining current strengths

• meet with safe and supportive family members or friends with the informed permission of the patient and explain therapeutic plan

• Assess and arrange assistance for other family members to help ensure they can meet their own psychological and social needs.

• Determine the ability and commitment of safe family or close friends to help provide a favourable recovery environment for the traumatised person

• Review financial considerations and organise referral to public or private mental health professional (see criteria for selecting a mental health professional)
Detailed Psychological Assessment (1)

- thorough identification of presenting difficulties and strengths across the major areas of functioning,
- generational psychosocial history
- generational and personal history of trauma,
- substance use and medical history,
- occupational history,
- relationship history,
- previous therapeutic history,
- current social networks and their perceived quality,
- concurrent life stressors,
- rationale and feelings associated with the traumatised person seeking help,
- the traumatised person’s account of precipitating events leading up to this current presentation,
Detailed Psychological Assessment (2)

- current personal attempts to heal and restraints to progress.
- Process may include both structured interviews and formal psychometric testing depending on the needs and priorities of the particular traumatised person.
- Such a process may uncover various comorbid problems which are commonly associated with traumatisation e.g. depression, substance abuse, social phobias, panic disorders, obsessive-compulsive problems, PTSD, borderline personality characteristics and DID.
Potential Therapeutic Benefits of Assessment Process

• Can enable the traumatised person to begin to take some very early fledgling steps towards making links between past, present, and future behavioural options and to begin to understand the survival value of their trauma symptoms within traumatising environments

e.g. the good sense but terrible isolation of shutting down emotionally when there was no-one to provide safe nurturance, the wisdom but concurrent pain of replaying the traumatic event until the traumatised person can predict when or if such an event might happen again, the ingenuity but enormous physical and psychological strain of remaining very wound up when the traumatised person did not know when or if they might have to fight, run away, or simply be trapped and endure another traumatising event., the absolute brilliance but devastating confusion of disassociating the feelings or even the entire content of life events that are completely overwhelming

• The professional can provide well timed and highly personalised additional information during this early stage so that the traumatised person can begin to consider alternative ways of making meaning out of their traumatic experiences.
Treatment Considerations (1)

• Evidence-based treatment is proposed as best practice in the PTSD field (see ISTSS Guidelines for Treatment of PTSD, 2000).

• Evidence-based treatment has helped to stop some harm to traumatised people and randomised controlled trials can challenge our conventional wisdom.

• Such studies have identified a multitude of interrelated predictor variables and complex consequences following exposure to potentially traumatising events. They have also demonstrated some alleviation in suffering that is maintained at follow-up.

• Evidence based treatment studies have also helped to identify the common elements of successful treatments i.e. emotional and cognitive processing of the traumatising experience, gradual re-exposure to the event/s and reformulation of its meaning (Higgins, 2001; Valent 1999)

• However, there are significant limitations to the evidence base itself, as follows:

• The traumatised populations studied are often highly selected and they frequently have different presentations to the more complex cases seen in clinical practice.

• The most distressed people generally do not volunteer or drop out of these studies

Treatment Considerations (2)
• Particular traumatic incidents may precipitate consequences associated with unresolved but different traumatic experiences, amplify distress and distort our understanding of outcomes.

• Unique characteristics of the therapist and the therapeutic relationship are largely ignored even in cases of interpersonal trauma.

• There is a real risk of effectively filtering the traumatised person's world to fit within preconceptions, a restricted knowledge base, group differences and the forced choices of standardised outcome measures. Indulgence in logical fallacies is not an unusual occurrence. For example, a psychiatric drug appears to help this condition therefore the condition must be caused by biology (Sturdee, 2001).
Pharmacological treatments for Traumatic Stress Reactions

• See ISTSS Guidelines for Treatment of PTSD, 2000 for a recent comprehensive review.

• Medications might be selectively and temporarily useful. Minor and major tranquillisers, sedatives, barbiturates, alcohol or any other drugs with addictive potential can be extremely dangerous for traumatised people.

• The SSRI group of anti-depressant drugs can have some very useful short-term benefits for the treatment of traumatic stress reactions. They may temporarily assist in lowering heightened arousal levels, modulating intrusive memories and thoughts of traumatising events and in alleviating some of the emotional numbing and depressive symptoms (Friedman, Davidson, Mellman & Southwick, 2000).
Pharmacological treatments for Traumatic Stress Reactions

(2)

• However, controlled drug studies are in their infancy in the treatment of traumatic stress reactions and there is a risk of side effects that may exacerbate the agitation, sleep, digestive and sexual disturbances that are so common following traumatisation (Friedman et al., 2000; Valent, 1999).

• Traumatised people may also be at risk of attributing any positive changes to the tablets or to the doctor that prescribed them and less likely to reconstrue themselves as being capable of constructively intervening in their own symptoms and recovery.
Psychological Treatments for Traumatic Stress reactions

• See ISTSS Guidelines for Treatment of PTSD, 2000 for a recent comprehensive review.

• Exposure Therapy, Stress Inoculation training, Cognitive processing therapy and Cognitive therapy are best supported by the available controlled outcome studies (Rothbaum, Meadows, Resick & Foy, 2000)

• Effective therapy is understood to act as a significant catalyst to enable traumatised people to re-formulate more complex meanings about their identity, personal power, reality, value and fundamental social roles that incorporates but is no longer entirely informed or dominated by their traumatising experiences.

• Therapeutic techniques do not exist independently of the way they are understood by the traumatised person

• Therapy assists traumatised people to enact these new meanings in the ways they think, feel, behave, relate and experience their bodies. This process is not linear and sequential but circular and interactive (Higgins, 1994; 1995; 2000; Mahoney 1991; Neimeyer and Mahoney, 1995; Schore, 1994; 2001).
Therapeutic process in the Reconstruction of Trauma (1)

- process issues rather than techniques critical to outcome
- Perceived safety and therapeutic dynamics are crucial
- confirms a sense of personal power, unique identity, personal value and a reality that can make meaning out of traumatising experiences
- safe to express of powerful emotions, trying on new personal meanings, behaviours and social roles
- personalised and culturally relevant strategies
- identify and challenge unhelpful ways of thinking that may have been appropriate in traumatic environments
- experiment with alternative ways of being in and acting upon the world.
Therapeutic process in the Reconstruction of Trauma (2)

- a sense of continuity between the past, present and the future and consider the timing of trauma work
- development of individual and social resources and vary the focus on current life events and traumatic material
- purpose of techniques and their construction by individuals is vital
- collaborative planning for termination and healing continues beyond therapy
- technically eclectic and theoretically integrated
- excellent clinical results
What can the GP do? (1)

- see ISTSS paper entitled "Psychological Trauma and the Primary Care Provider" (2001)
- Embed questions about trauma exposure within standardised medical assessment e.g. child abuse, domestic violence, occupational trauma, combat exposure
- Ask directly if you suspect unresolved traumatisation when alone with the patient
- Use accurate reflective and empathic listening skills. Do not judge, patronise or try to rescue.
- Assess suicidal and homicidal risk and negotiate and document contracts
- Repeatedly emphasise strengths or signs of initiative and autonomy in the traumatised person including the courageous act of self-disclosure to you.
- Strongly encourage the patient to take personal responsibility to seek and follow up on appropriate treatment with your guidance
- Provide information and pamphlets about traumatic stress reactions and helpful treatments (see resources)
What can the GP do? (2)

- Emphasise the resources available in the community to assist e.g. police, domestic violence crisis team, refuges, protection orders, experienced and well-qualified mental health professionals, relevant self-help books

- Provide information on selecting a mental health professional whom is experienced and skilled in treating the complex consequences of traumatic stress reactions

- Do not judge or abandon the traumatised person. You may be the only support person involved. Be a firm yet gentle anchor providing unconditional regard and ongoing strong encouragement to seek skilled mental health support

- Screen and identify any untreated physical condition, which may reciprocally interact with the intensity of psychological distress experienced by the traumatised person.

- Maintain ongoing collaborative professional involvement with the treating mental health professional
Resource Material

- Managing Traumatic Stress Symptoms and Stressful Events (Australian Psychological Society, APS)
- Selecting a Mental Health Professional (Higgins 2001)
- Psychological Trauma and the Primary care provider (ISTSS draft pamphlet)
- Indirect trauma (ISTSS draft pamphlet)
- Responding to Crisis (ISTSS draft pamphlet)
- Sudden Traumatic Loss (ISTSS draft pamphlet)
- Physical health and Traumatic Stress (ISTSS draft pamphlet)
- How trauma can effect your relationships (ISTSS draft pamphlet)
- Traumatic Stress and Substance Abuse (ISTSS draft pamphlet)