Post Traumatic Stress Disorder (PTSD)

Karen Elmore MD
Robert K. Schneider MD
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Definition and Criteria
PTSD is unlike any other anxiety disorder. It requires that the patient experience or witness a traumatic event and have a response that involves intense fear, helplessness or horror. Symptoms of PTSD fall into three categories: re-experiencing the traumatic event, avoidance or emotional numbing, and increased arousal (DSM-IV). Many people experience anxiety, flashbacks, disturbed sleep and irritability after a traumatic event. If these symptoms abate before four weeks time, the appropriate diagnosis is acute stress disorder. However, if symptoms persist longer, the clinician should strongly consider the diagnosis of PTSD.

Traumatic events include rape, natural disaster, sexual molestation, physical assault, combat, displacement as a refugee, motor vehicle accidents and even diagnosis with a life threatening illness. The death of a loved one can be especially traumatic. In one community survey, the trauma most frequently reported as the precipitating event for PTSD was sudden and unexpected death of a loved one (Breslau 1998). This is in counterdistiction to less frequent but severe traumas that are most likely to precipitate PTSD (i.e. rape, combat).

Severity and duration of the trauma, as well as the vulnerability of the individual, influence whether PTSD develops. The experience of trauma has a cumulative effect, and it is believed that most people will develop the disorder if exposed to enough. The trauma most strongly associated with PTSD in women is rape or sexual molestation, and in men is combat exposure (Kessler 1995). Victims of repetitive abuse during childhood or ongoing trauma make up a subgroup of
patients with PTSD called complex PTSD. This is not a DSM-IV diagnosis, but a collection of symptoms including standard PTSD criteria plus somatization, character pathology, affective symptoms and dissociative symptoms (Herman 1992). This severe form of PTSD is not restricted to the mental health specialty sector, but is frequently seen in primary care especially in somatizing patients (Dickinson 1998).

A study done after the Oklahoma City bombing found that while all victims had symptoms of re-experiencing and increased arousal in the first two weeks after the event, the more unusual symptoms of avoidance and numbing were strongly correlated with the eventual development of PTSD (100% sensitivity and 94% specificity). Asking about these symptoms allows primary care providers to recognize women who are at high risk, especially if seen shortly after the traumatic event (North 1999).

**Epidemiology and Impact on Society**

Women are twice as likely as men to develop PTSD. Other risk factors include co-morbid psychiatric diagnosis, previous trauma, and an unsupportive recovery environment. In one community study, 9.2% of women met criteria for PTSD after exposure to any trauma. More specifically, PTSD developed in 20.9% of those assaulted, 14.3% of people after sudden and unexpected death of a loved one, and 2.2% after learning about traumatic events happening to others (Breslau 1998). The median time to remission for a single episode is three years with treatment and greater than five years without (Kessler 1995). This has an enormous impact on society when one considers that 10-12% of women have a lifetime history of this disorder (Breslau 1991, Kessler 1995, Resnick 1993). PTSD leads to 3.6 days per month of work days lost and work cutback days, leading to $3 billion annual productivity loss per year in the United States (Kessler 1997). Despite these alarming statistics, PTSD is under recognized. According to the National Comorbidity Study, approximately 60% of people with PTSD go untreated. The most common reason sited in this study for not seeking
treatment was that the individuals did not think she had a problem (Kessler 2000).

Women with PTSD are at increased risk of developing mood, anxiety, and substance abuse disorders. Interestingly, this risk disappears when PTSD is successfully treated (Kessler 2000). Depression is an especially common co-morbid diagnosis. Physicians should note that PTSD has a stronger association with suicide than any of the other anxiety disorders. Patients are six times more likely than the general population to attempt suicide (Kessler 1999).

**Treatment**

Treatment for PTSD involves three parts: education, psychosocial support (including psychotherapy), and pharmacologic therapy. Primary care physicians can provide psychosocial support during the first several weeks after a trauma (Lange 2000). One or two appointments may be enough to improve feelings of safety. Patients should be encouraged to talk about their feelings with trusted family and friends. The physician should also make the patient aware that feelings of anxiety, depression, and flashbacks are a normal reaction immediately post trauma, but the persistence of them is not.

If a patient does develop PTSD, several treatment options are available. Psychotherapy, particularly cognitive behavioral therapy, has been widely studied and been found effective (Foa 2000). SSRIs are considered the first-line medication treatment of choice. As with panic disorder, the starting dose should be half the starting dose for depression and should be increased slowly. If the therapy is successful, medication should be continued for at least one year (Ballenger 2000). Benzodiazepines are not beneficial in the treatment of PTSD, and there is some evidence to suggest that they have a negative impact (Ballenger 2000). Sleep disturbance, especially due to nightmares, may be particularly disturbing. Nonbenzodiazepine hypnotics, such as trazadone, may be very useful.
Bibliography


DSM IV


Kessler RC, Frank RG. The impact of psychiatric disorders on work loss days. Psychol Med 1997;27:861-73
