

Post traumatic stress disorder in the primary care setting

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Posttraumatic stress disorder (PTSD) is a serious and disabling disorder that is commonly seen in primary care settings. Primary care practitioners can be instrumental in recognising, diagnosing, and treating PTSD. Unless trauma histories are specifically obtained, the disorder is easily missed because of the substantial symptom overlap with depression and other anxiety disorders, the significant medical and psychiatric comorbidity, and the stigma, shame and secrecy that are often associated with the diagnosis.

Introduction

Events that give rise to PTSD typically involve interpersonal violence (e.g. rape, assault, hijacking) or exposure to life-threatening accidents (e.g. motor vehicle accidents) or disasters (e.g. fires, floods). These events are characterised by their capacity to evoke fear, helplessness, or horror in response to the threat of injury or death. Although PTSD has been studied most rigorously in combat veterans, the type of trauma most likely to provoke PTSD is assaultive violence, particularly rape, which contributes to the high prevalence of the disorder in women (women are twice as likely to develop PTSD as men). Of note, the vast majority of survivors of trauma do not develop PTSD. In fact, epidemiological studies indicate that while 40-90% of the general population are exposed to a traumatic event in their lifetime, only 1-9% develop PTSD. The following factors may make it more likely that a person will develop PTSD: (i) the more severe and long-lasting the trauma, (ii) the closer the person was to it, (iii) the more dangerous it seemed, (iv) the more times the person has been traumatised, and (v) negative reactions from relatives and friends.

The biologic alterations observed

in PTSD do not typically resemble those associated with other types of stress. Studies of the neurobiologic mechanisms in PTSD have delineated alterations in brain regions, such as the amygdala and hippocampus, that are associated with fear and memory, as well as changes in physiological, hormonal, and neurochemical systems. These biologic alterations explain many of the emotional and behavioural manifestations of the disorder. Three types of symptom clusters characterise PTSD: (i) re-experiencing the traumatic event, which refers to unwanted recollections in the form of distressing images, nightmares, or flashbacks, (ii) avoidance of reminders of the event, including places, persons or even thoughts and emotions associated with the incident, and (iii) hyperarousal experiences, such as insomnia, irritability, increased startle reactions, and impaired concentration.

Within the first month of a traumatic event, traumatised individuals may meet the diagnostic criteria for acute stress disorder. While acute stress disorder does not always lead to PTSD, the presence of severe symptoms during this period should alert the clinician that the patient is at an increased risk for PTSD. A number

of other psychiatric problems can occur in association with PTSD. The most common comorbid disorders are depressive disorders, substance use disorders, and other anxiety disorders.

Treatment

Primary care physicians can play an important role in educating patients and their families about the symptoms of, and various treatments for, PTSD. Many traumatised patients are reluctant to seek help for their symptoms, especially from mental health professionals. Patients should be made to understand that anyone may develop PTSD symptoms in response to extreme trauma and that the diagnosis is not reflective of a character flaw or a personal weakness. Education, supportive counselling, and providing a safe and supportive environment for discussing fears and concerns, should ideally be provided to all patients with PTSD. Patients can be treated with medication, psychotherapy or a combination of these modalities. Psychotherapy alone may be the best option in patients with only mild symptoms, providing that the clinician can provide such treatment or resources are available in the area

to do so. If psychotherapy is not an option, the clinician should offer the patient medication from the beginning. Medication should also be prescribed to patients who prefer medication, whose symptoms are severe and persistent, who have comorbid depression or anxiety, or whose daily functioning is severely disrupted.

Medications

The selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, and monoamine oxidase inhibitors have been shown in randomised clinical trials to be effective in treating PTSD symptoms and improving the quality of life of these patients. SSRIs should be considered as a first-line option because they are safer and better tolerated than the older antidepressants. They are also effective in treating associated anxiety or depression. Currently, sertraline (Zoloft) and paroxetine (Aropax) are the only medications that are approved by the Food and Drug Administration (FDA) in the United States for the treatment of PTSD. A trial of at least 6-8 weeks is needed to see if medication will help. Patients who have experienced some improvement in this time are likely to continue improving for several weeks or months thereafter. The Expert Consensus guidelines on the treatment of PTSD (based on the results of a survey of expert physicians in the field) recommend that if there is no response to an 8-week trial of an SSRI, treatment should be switched to venlafaxine (Effexor), a different SSRI, a tricyclic antidepressant, or nefazodone (Serzone). If there is a partial response, a mood stabiliser such as divalproex (Depakote) can be added. Benzodiazepines should be avoided or used with caution in patients with PTSD as double-blind, placebo-controlled trials have not shown them to be significantly superior to placebo. For

acute PTSD (when symptoms have lasted less than 3 months), the experts recommend continuing medication for at least 6-12 months; for chronic PTSD (when symptoms have lasted longer than 3 months), medication should be continued for at least 12-24 months.

Psychotherapy

Three specialised types of psychotherapy, used alone or in combination with medication, are effective in helping patients confront their fears by reducing psychological and physiological distress associated with memories of the traumatic event: (i) exposure therapy – helping patients confront the specific situations that remind them of their terrifying experience (e.g. driving a car again after being involved in an accident). Repeated exposures helps the patient to realise that the feared situation is no longer dangerous and they can handle it, (ii) cognitive therapy – helping patients change irrational beliefs, e.g. unrealistic guilt, and (iii) anxiety management – teaching patients skills such as relaxation training and positive thinking. Group therapy may also be helpful in some patients in reducing isolation. Primary care physicians may themselves be able to provide psychotherapy or may wish to refer to a clinician with expertise in this area.✚

See CPD Questionnaire p.47

References

1. Foa EB, Davidson JRT and Frances A. The Expert Consensus Guidelines Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999; 60 (suppl 16): 1-76.
2. Yehuda R. Post-traumatic Stress Disorder (review). *N Eng J Med* 2002; 346(2): 108-114.

Note:

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