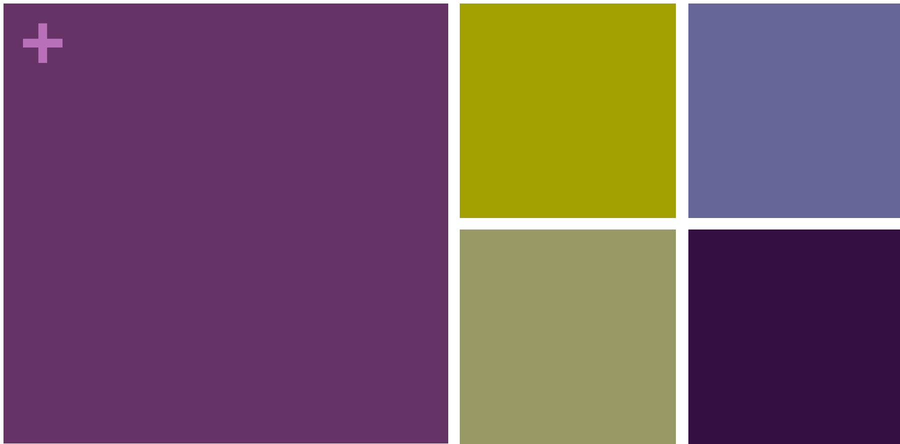

PTSD: past, present & future

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Psychiatrists and Psychologists

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Psychiatrists and Psychologists

- A psychiatrist studies diseases of the mind, whereas a psychologist writes crappy self-help books.
- Pete, Outnumbered.

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Psychiatrists and Psychologists

- A neurotic is a man who builds a castle in the air. A psychotic is the man who lives in it. A psychiatrist is the man who collects the rent
- Jerome Lawrence

Psychiatrists and Psychologists

- Psychiatrist
- Medical doctor
- Understanding of medical conditions
- Diagnose and Prescribe
- Less use of rating scales
- Don't deliver talking therapies
- Clinical lead of teams

- Psychologist
- Psychology degree then further training
- Don't prescribe
- Often don't diagnose
- Heavy use of rating scales
- Principally deliver talking therapies
- Important senior team members

PTSD - past

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Case 1

- 1,000,000 years ago
- Early man attacked by a sabre-toothed tiger near a waterhole
- Adrenaline response

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Case 1

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Case 1

- Chronic adaptive response
- Avoids waterhole
- Hypervigilant to sabre-toothed tigers
- Always ready for a fight
- Sleeps less
- Recurrent memories re-inforce the response

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Case 2 - Private Harry Farr

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Case 2 - Private Harry Farr

- First Battalion West Yorkshire Regt.
- 1914: Brief period AWOL
- 1915: Hospital admission for shell shock
- 1916: Battle of the Somme; did not advance to the front
- Medical officer determined no physical injury
- Remained in the rear despite orders and efforts
- Court martialed and shot
- Pardoned in 2006
- Ref: Prof S. Wessely, Journal of RSM, 2006.

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Emergence of PTSD

- WWI – Shell shock recognized
- DSM I – 1952 – Traumatic neurosis
- DSM II – 1968 – Transient situational neurosis
- DSM III – 1980 (post Vietnam) – PTSD
- Prevalence increasing; remains a degree of controversy.

PTSD - present

+ Case 3

+ Case 3

- 25 year old woman was driving home with 2 year old son in rear. A vehicle crosses the central line resulting in a head-on collision.
- Air bags deployed. Fears car is on fire. Needs to be cut out of by Fire Service.
- Physical injuries are facial bruising , fractured ribs, fractured collarbone, whiplash injuries to neck and shoulder
- Son is uninjured

Case 3

- Reliving nightmares and disturbed sleep
- Vivid flashbacks
- Anxiety when attempting to drive, resulting in avoidance
- Anxious and hypervigilant passenger
- Irritable, jumpy, poor concentration
- Anxious in crowds and very worried about risks generally
- Stops son from attending nursery and stops going to work
- Increases alcohol consumption
- Strain on relationship with partner

Case 3

- Talks to GP – is prescribed an antidepressant and referred for psychological therapy
- Still on waiting list when meets with solicitor
- Expert diagnoses PTSD
- Receives psychological therapy
  - Cognitive Behavioural Therapy (CBT)
  - Eye Movement Desensitisation & Reprocessing (EMDR)
  - Mindfulness
- Medication is less important
- Recovery with 16 sessions

Cognitive Behavioural Therapy

- Thoughts drive our emotions and behavior
- Behaviour can re-enforce thoughts
- Thoughts aren't facts

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Cognitive Behavioural Therapy

Thought	Emotion	Evidence for	Evidence against	Balanced thought	Emotion

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+ Cognitive Behavioural Therapy

Thought	Emotion	Evidence for	Evidence against	Balanced thought	Emotion
Cars are lethal	10/10 anxiety	I almost died Lots of RTAs	Never crashed before	RTAs are infrequent	4/10 anxiety

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+ Cognitive Behavioural Therapy

- Graded exposure

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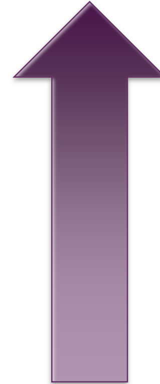
Cognitive Behavioural Therapy – Graded Exposure

- Driving with son in the car
- Driving on a main road
- Driving on a side road
- Sitting in the car with the engine running
- Sitting in the car on the drive way



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Cognitive Behavioural Therapy – Graded Exposure

- Listening to self talk about accident

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Eye Movement Desensitisation and Reprocessing (EMDR)

- History taking and planning
- Preparation
- Assessment
- Treatment
- Evaluate progress

Mindfulness based therapies

- Acceptance and Commitment Therapy (ACT)
- Don't fight it

+ NICE guidance – updated Dec 2018

- Trauma-focused CBT – 8 to 12 sessions but more if clinically indicated, e.g. multiple traumas; may need booster sessions.
- EMDR – 8 to 12 sessions.
- Computerised CBT – 8 to 10 sessions (less severe PTSD, and no risk to self or others)
- Medication – if patient preference, prescribe antidepressant medication. Prescribe antipsychotic medication is severe, disabling and not responded to other treatments.
- Not counselling

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+ Treatment provision

- Self-help guides
- Improving Access to Psychological Therapies (IAPT)
- Secondary mental healthcare
- Private provision

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+ NHS vs Private Treatment

- Issues of
  - Quality
  - Adherence to recommended plan
  - Waiting time
  - Responsiveness
  - Range of resources

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+ General epidemiology

- 7% lifetime prevalence (5% male, 10% female)
- 2-3% current PTSD
- 40-70% Western populations report one or more traumatic incident
- Onset usually within days
- Prognosis
  - High spontaneous recovery in initial months; 50% by 2 years (DSM5 indicates by 3 months)
  - Substantial chronicity; 30% at 3 years
  - Risk of relapse

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+ Comorbid conditions - 80% overall

- Depressive illness
- Substance misuse
- Anxiety generalizes
- Psychological overlay onto pain
- Somatisation

+ Diagnostic Manuals

- International Classification of Disease – 10 (ICD-10)
  - Used in NHS
  - Centrality of intrusive memories and reliving nightmares
- Diagnostic and Statistical Manual 5 (DSM5)
  - American
  - Operationalised
    - Exposure threshold
    - Intrusion symptoms
    - Avoidance
    - Negative alterations in cognitions and mood
    - Hyperarousal
    - More than a month
    - Causes clinically significant distress or impairment
- ICD-10 generally more favourable to the Claimant

+
Case 4

- 25 year old woman was driving home with 2 year old son in rear. Suffering post-natal depression and comorbid anxiety
- When stationary at traffic lights, a car drives into the rear, impact speed approximately 15 miles per hour
- Physical injuries are mild whiplash injuries to neck and shoulder
- Son is uninjured

+
Case 4

- Reliving nightmares and disturbed sleep
- Vivid flashbacks
- Anxiety when attempting to drive, resulting in avoidance
- Anxious and hypervigilant passenger
- Irritable, jumpy, poor concentration
- Anxious in crowds and very worried about risks generally
- Stops son from attending nursery and stops going to work
- Increases alcohol consumption
- Strain on relationship with partner

Diagnosis?

- ICD10: response to a stressful event or situation of an exceptionally threatening or catastrophic nature, which is is likely to cause pervasive distress in almost anyone
- DSM5 – Criteria A: Exposure to actual or threatened death, serious injury, or sexual violence
- BUT – ICD-10: Predisposing factors such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness may lower the threshold for the development of the syndrome.

Case 5

- 25 year old woman was driving home with 2 year old son in rear. A vehicle crosses the central line resulting in a head-on collision.
- Air bags deployed. Fears car is on fire. Needs to be cut out of by Fire Service.
- Physical injuries are facial bruising , fractured ribs, fractured collarbone, whiplash injuries to neck and shoulder
- Son is uninjured

Case 5

- Disturbed sleep
- No flashbacks; nightmares relate to RTA but not reliving
- Marked distress when discussing the accident
- Anxiety when attempting to drive, with panic attacks, resulting in avoidance
- Anxious and hypervigilant passenger
- Irritable, jumpy, poor concentration
- Anxious in crowds and very worried about risks generally
- Stops son from attending nursery and stops going to work

Diagnosis?

- ICD-10 PTSD not diagnosable as no reliving nightmares or flashbacks
- DSM5 PTSD is diagnosable because Criteria B (paraphrased):
  - Recurrent, involuntary and intrusive memories
  - Flashbacks in which it feels as if the trauma is recurring
  - Recurrent distressing dreams related to the trauma
  - Intense or prolonged psychological distress at exposure to cues
  - Marked physiological reaction to cues

+

Rating scales

- Validity is less than a semi-structured clinical interview
- IES-R most commonly used
  - PTSD considered likely if score is greater than 33 out of 88
  - Greatest use is monitoring response to treatment

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Revised - Impact of Events Scale

	Below is a list of difficulties people sometimes have after stressful life events. please read each item and then indicate how distressing each difficulty has been for you during the past 7 days or other agreed time:	0 = Not at all	1 = A little	2 = Moderately	A lot = 3	Extremely = 4
a	any reminder brought back feelings about it	0	1	2	3	4
b	I had trouble staying asleep	0	1	2	3	4
c	other things kept making me think about it	0	1	2	3	4
d	I felt irritable and angry	0	1	2	3	4
e	I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
f	I thought about it when I didn't mean to	0	1	2	3	4
g	I felt as if it hadn't happened or it wasn't real	0	1	2	3	4
h	I stayed away from reminders about it	0	1	2	3	4
i	pictures about it popped into my mind	0	1	2	3	4
j	I was jumpy and easily startled	0	1	2	3	4
k	I tried not to think about it	0	1	2	3	4
l	I was aware that I still had a lot of feelings about it, but I didn't deal with them	0	1	2	3	4
m	My feelings about it were kind of numb	0	1	2	3	4
n	I found myself acting or feeling like I was back at that time	0	1	2	3	4
o	I had trouble falling asleep	0	1	2	3	4
p	I had waves of strong feelings about it	0	1	2	3	4
q	I tried to remove it from my memory	0	1	2	3	4
r	I had trouble concentrating	0	1	2	3	4
s	reminders of it caused me to have physical reactions	0	1	2	3	4
t	I had dreams about it	0	1	2	3	4
u	I felt watchful and on-guard	0	1	2	3	4
v	I tried not to talk about it	0	1	2	3	4
	Totals					

avoidance subscale (total of e, g, h, k, l, m, q, v divided by 8) =
intrusion subscale (total of a, b, c, f, i, n, p, t divided by 8) =
hyperarousal subscale (total of d, j, o, r, s, u divided by 6) =

Weiss,D.S. & Marmar,C.R. *The impact of event scale-revised.* in Wilson,J.P. & Kean,T.M. (eds.) *Assessing psychcological trauma and PTSD: a practitioner's handbook (ch 15).* N.Y: Guildford, 1995.

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Case 6 – Complex PTSD

- 21 year old man
- Suffered physical and sexual abuse from step-father from age 9 to 15
- Subsequent promiscuous relationships with older men, so of whom were violent
- Misuse of stimulants and cocaine since age 17
- Frequent presentation at A&E with self-inflicted lacerations

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Case 6 – Complex PTSD

- Disturbed sleep, nightmares, flashbacks
- Mood swings
- Perceptual abnormalities – hears voices when very anxious
- Longest employment is 3 months
- Frequently homeless

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+ Complex PTSD

- Overlap with Borderline/Emotionally Unstable PD
- PTSD sx plus
  - Relational problems
  - Emotional dysregulation
  - Disturbance of Self-concept
- More debilitating that PTSD
- Higher comorbidity that PTSD

+ Case 6 – Complex PTSD

- Poor response to treatment – high rate of drop outs
- Therapy needs to be prolonged
- Treatment (difficult)
  - Stabilisation
  - Trauma processing
  - Rehabilitation

PTSD – the future

- Greater service provision – especially EMDR
- ICD-11
  - Exposure to extremely threatening or horrific event or series of events
  - 3 core elements: Re-experiencing, avoidance, hyperarousal.
  - Last several weeks and interfere with normal function
- Complex PTSD in ICD-11
  - As per PTSD but with persistent and pervasive impairments in affective function, self function, relational function.

Questions, comments and cases