RURAL PSYCHIATRY AND MENTAL HEALTH FORUM 2019

PTSD: INVISIBLE WOUNDS

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DOUBLE TREE BY HILTON PERTH

DEFINING POST-TRAUMATIC STRESS DISORDER (PTSD)

A failure to recover from experiencing a *Traumatic Event*

This implies the default position for humans is that we recover.

Post-traumatic stress disorder (PTSD) is a treatable anxiety disorder affecting around one million Australians each year.

DSM-V requires eight criteria to be met in order for the diagnosis of PTSD to be made.

- *Criterion A* defines the stressor, including features relating to the event itself and the response to the stressor.
- *Criterion B,* refer to re-experiencing, symptoms (One of five criteria required).
- *Criterion C,* refer to avoidance and numbing, (One of two).
- *Criterion D* refer to negative changes in cognitions and mood (two of seven).
- *Criterion E* refers to marked alterations in arousal and reactivity (two of six).
- *Criterion F* stipulates that the symptoms need to have been present for at least one month.
- *Criterion G* requires that the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- *Criterion H* requires that the disturbance is not attributed to the physiological effects of a substance or other medical condition.

Specify :

With Dissociative symptoms. Depersonalisation and or Derealisation.

With delayed onset. If full symptoms are not met until after six months following the event.

ICD-11 DIAGNOSTIC CRITERIA

PTSD	Complex PTSD
Exposure to an extremely threatening or horrific event or series of events	Exposure to an extremely threatening or horrific event or series of events, most commonly prolonged or repetitive events from which escape is difficult or impossible
Re-experiencing the traumatic event(s) in the present in the form of vivid intrusive memories, flashbacks or nightmares	Re-experiencing the traumatic event(s) in the present in the form of vivid intrusive memories, flashbacks or nightmares
Avoidance of thoughts and memories of the event(s), or avoidance of activities, situations or people reminiscent of the event(s)	Avoidance of thoughts and memories of the event(s), or avoidance of activities, situations or people reminiscent of the event(s)
Persistent perceptions of heightened current threat, e.g. as indicated by hypervigilance or enhanced startle reaction to stimuli such as unexpected noises	Persistent perceptions of heightened current threat, e.g. as indicated by hypervigilance or enhanced startle reaction to stimuli such as unexpected noises
	Problems in affect regulation
	Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event
	Difficulties in sustaining relationships and in feeling close to others
Significant impairment in personal, family, social, educational, occupational, or other important areas of functioning	Significant impairment in personal, family, social, educational, occupational, or other important areas of functioning

Recent research literature consistently reports three interesting findings:

1) Men experience traumatic events more often,
2) Women and men differ in the type of traumatic experiences they experience, and
3) Women more often develop PTSD after the experience of a traumatic event.

Some explanations for these differences.

The reported higher vulnerability of women for PTSD could be due to the methodology used, the higher prevalence of childhood sexual abuse, domestic violence and rape in women, the different coping styles of women and men, or the more limited socio-economic resources of women.

HISTORY OF PTSD

Lady Percy's soliloquy in Henry IV, Part 1 (act 2, scene 3), written around 1597, represents an unusually accurate description of the symptom constellation of PTSD.

Previous diagnoses now considered historical equivalents of PTSD include railway spine, stress syndrome, nostalgia, soldier's heart, shell shock, battle fatigue, combat stress reaction, or traumatic war neurosis

The term post-traumatic stress disorder (PTSD) was coined in the mid-1970s, in part through the efforts of anti–Vietnam War activists and the anti-war group Vietnam Veterans Against the War who coined the term post-Vietnam Syndrome; the condition was added to the DSM-III as posttraumatic stress disorder in 1980.

1.4 million Australians at any one time have Post Traumatic Stress Disorder (PTSD).
(Australian Bureau of Statistics)

Serious accidents are one of the leading causes of PTSD in Australia (ACPMH).

Australian military PTSD statistics.

56% of Australia's Vietnam War veterans
31% of Australia's Gulf War veterans

Compared to :

6.4% of Australians aged 16-85 years in general population (2007 ABS)

30-50% of a tsunami-affected population

75% of Bosnian refugee women

60% of US female rape survivors

50% of UK sexually abused children,

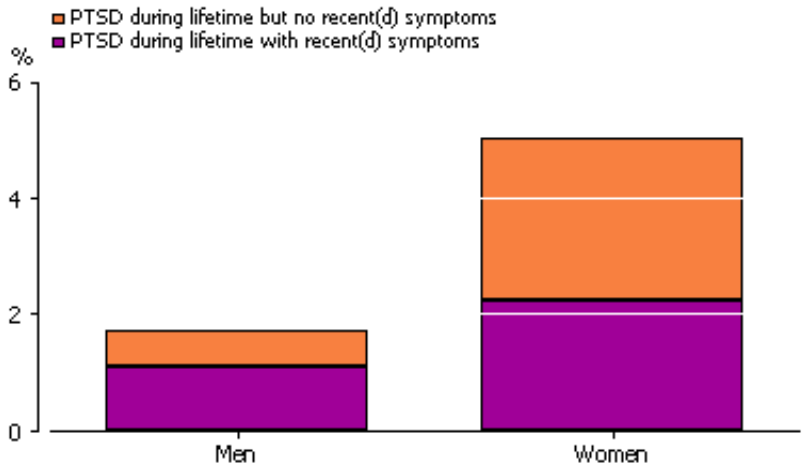
MENTAL HEALTH CONSEQUENCES OF EXPERIENCE OF VIOLENCE

In 2007, around one million people aged 18-85 years said that the most traumatic event in their lives was being beaten, held up or threatened with a weapon, or sexually assaulted.

Of these people, 521,000 (3.4% of all people in this age range) experienced symptoms such as flashbacks, nightmares or anxiety, that were sufficiently severe and long-lasting for a diagnosis of PTSD.

Around half of those diagnosed with PTSD (1.7% of all people aged 18-85 years) had experienced violent crime-related symptoms of PTSD during the 12 months prior to being surveyed. Women were around twice as likely as men to have had PTSD with recent symptoms, and around four times as likely to have had PTSD but with no recent symptoms.

People aged 18-54 years were around twice as likely as those aged 55-85 years to have recently experienced violent crime related PTSD (2.1% compared with 0.8%).



The 2007 National Survey of Mental Health and Wellbeing (SMHWB) was designed to provide lifetime prevalence estimates for mental disorders. Respondents were asked about experiences throughout their lifetime and the presence of symptoms in the 12 months prior to the survey interview.

PTSD was the most prevalent Anxiety disorders

- 6.4% of people aged 16-85 years

Women experienced higher rates of PTSD than men

- 8.3% compared with 4.6% respectively.

SPECIFIC POPULATIONS

2012 Indigenous population study of three towns, located in the Murchison Health District of the Central West Region of Western Australia.

As this was a population study, three Aboriginal communities were selected on the basis of observable level of traumatic events, accessibility, prior connection with the author and community leaders' indication of support for the study.

Inclusion criteria for an individual participant were: Aboriginality, being resident in these communities and aged 18 to 65 years. Aboriginality and residency status were established through Aboriginal Health Workers.

Exclusion criteria were those with a cognitive impairment, severe physical illness causing current symptoms, and intoxication at the time of interview.

Nadew GT. Exposure to traumatic events, prevalence of posttraumatic stress disorder and alcohol abuse in Aboriginal communities. Rural and Remote Health (Internet) 2012

Age group (years)	Frequency n (%)
18-25	53 (24)
26-35	82 (37)
36-45	44 (20)
46-55	30 (14)
56-65	12 (5.4)

Marital status	Frequency n (%)
Married	21 (9.5)
De facto	102 (46.2)
Single	52 (23.5)
Separated	9 (4.1)
Divorced	7 (3.2)
Widowed	30 (13.5)
Total	221 (100)

Figure 1: Participants' traumatic exposure, PTSD and alcohol abuse.

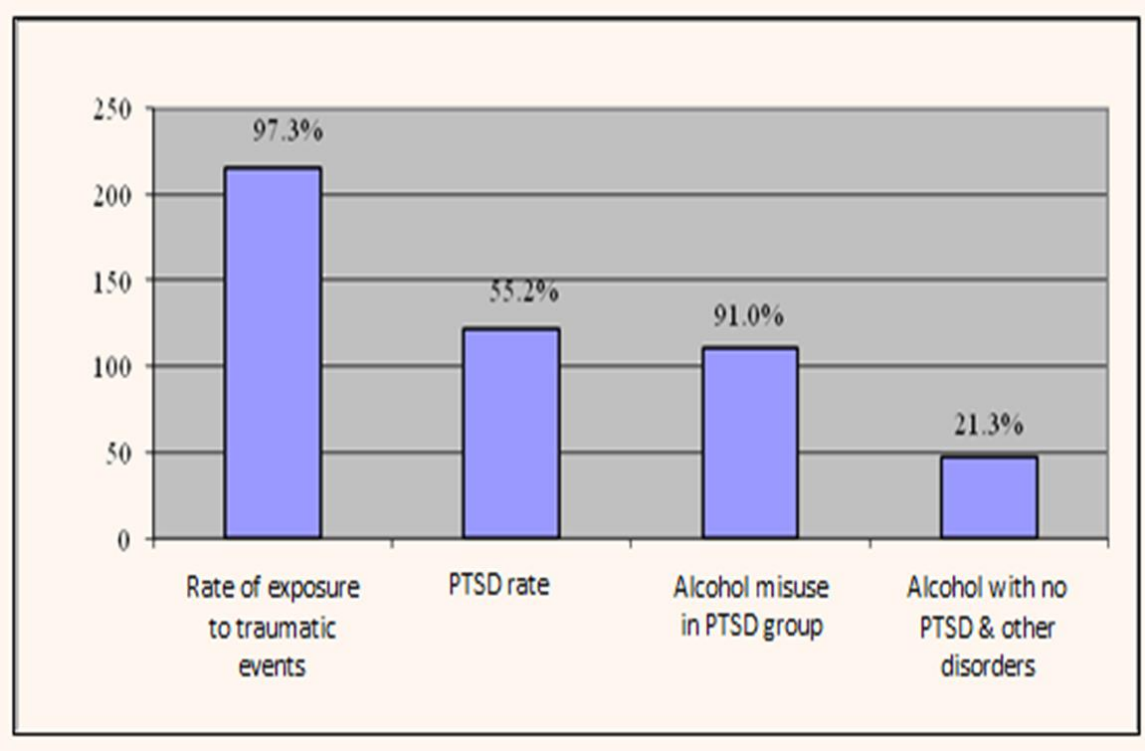
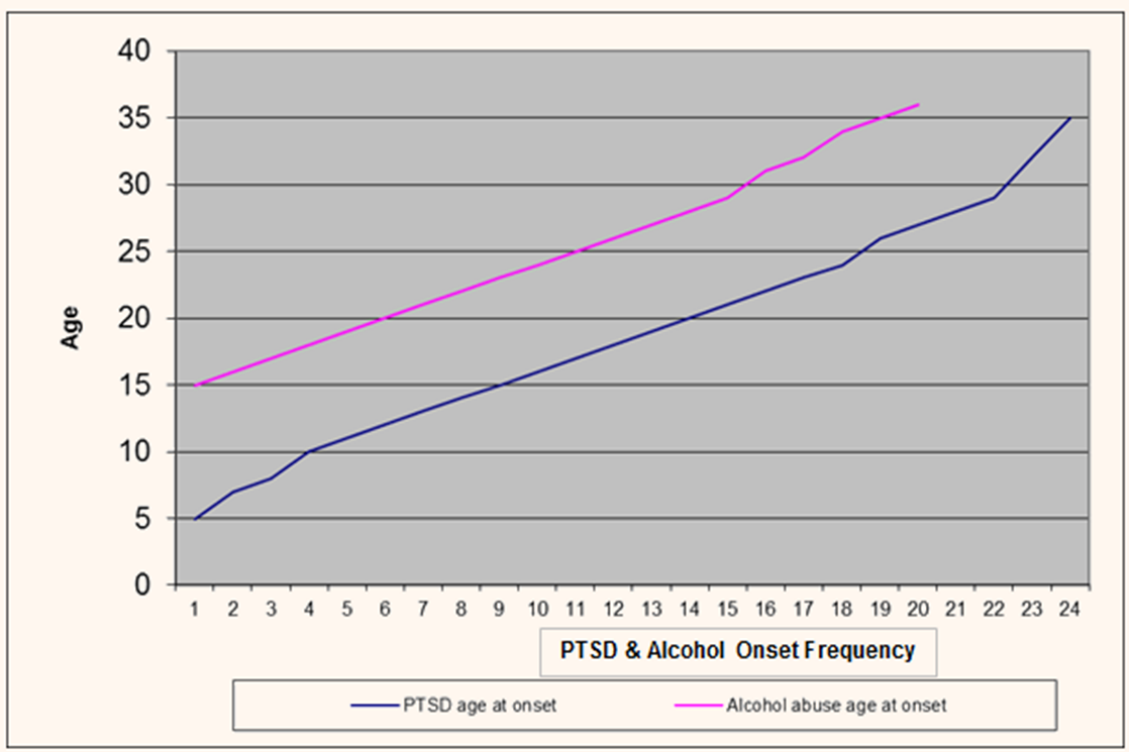
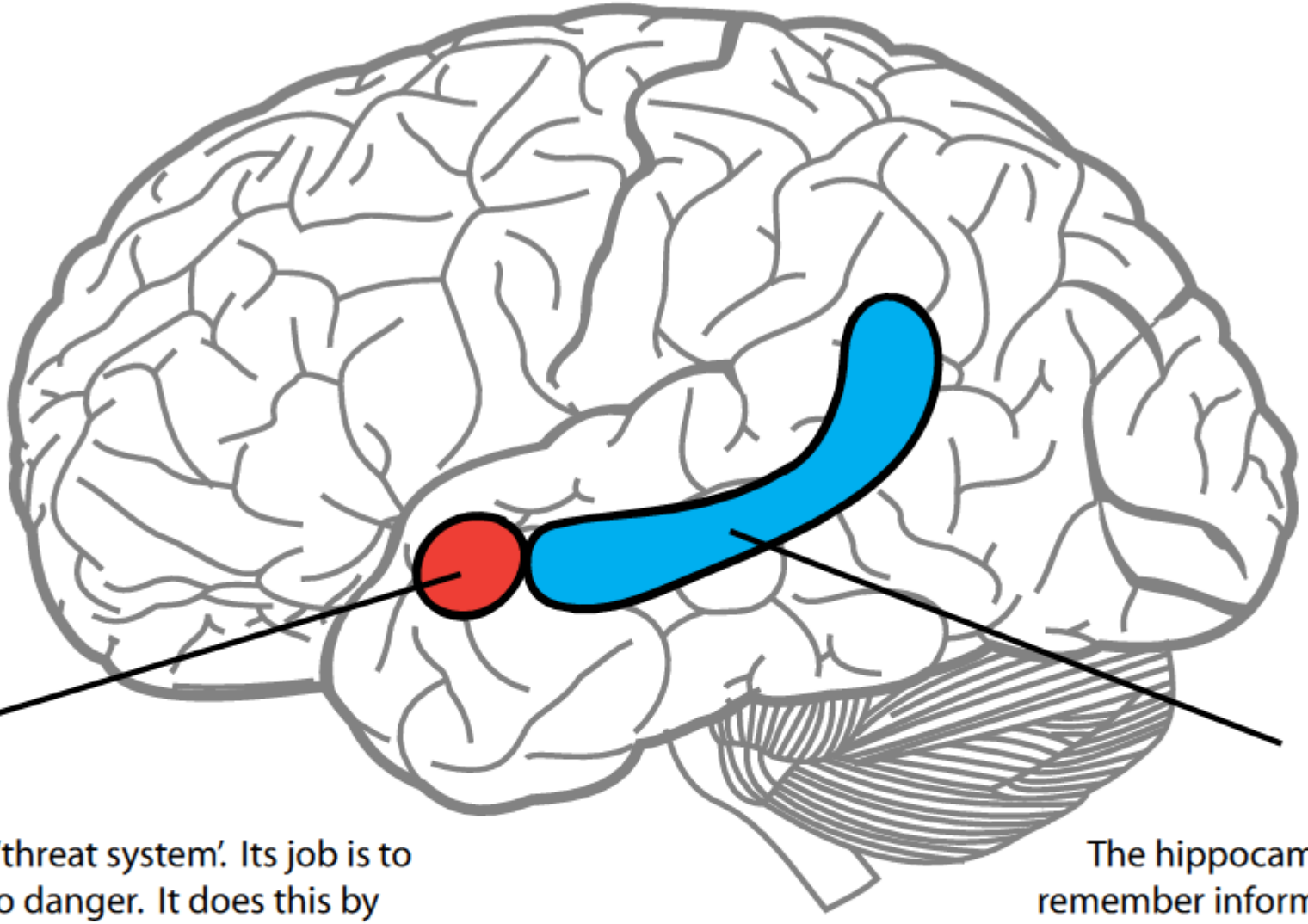


Figure 2: Age of onset for PTSD and alcohol abuse.





lala

la is part of our 'threat system'. Its job is to
by alerting us to danger. It does this by
n alarm in our body: by triggering the 'fight or flight'
gets us ready to act.

ly it isn't very good at discriminating between
'out there', or dangers that we are just thinking
ponds in the same way. This means that it
larm off when we are thinking about an

Hip

The hippocampus h
remember information.
and it 'tags' our memori
about where and w

When our 'threat system' is active
doesn't work so well. It can forget to tag
time and place information, which mea
get stored in the wrong place. When we

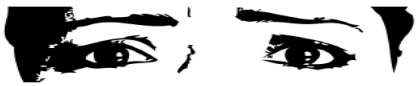
Understanding **Post-Traumatic Stress Disorder (PTSD)**

Traumatic event

Memories of the trauma
- vivid
- fragmented
- sensory
- 'nowness'

Changes beliefs about:
- your self
- the world
- other people

Current sense of threat
e.g. fear, shame, disgust



Avoidance means that the memories remain unchanged

Avoidance means that the beliefs go unchallenged

Coping strategies
e.g. avoidance

FACTORS INFLUENCING THE DEVELOPMENT AND MAINTENANCE OF PTSD

Before	During	After
History of Trauma Past Traumas (Frequency/Intensity) Childhood med. procedures Increased baseline stress Upbringing/Background Family/Friends/Culture = Belief System about Self/Others/World = Values/Norms/Expectations Biological Temperament (Anxious/Relaxed etc.) Family history of Mental Health Issues Social Support Network Relationships with family/friends Family Stress Sporting clubs/activities Other Sources of Life Stress	Nature of Traumatic Event Frequency (single/repeated) Duration (continuous/brief) Severity/Brutality Timing Proximity Context of Traumatic Event Relationship to victim/perpetrator Lack of Control/Helplessness Unexpected/Predictable Conflict between Event and Values/Beliefs Behaviour of Others Support or Reliability of Team/Others	Impact on Values and Beliefs Loss of Trust, Faith, Esteem in Self/Others/Society Response of Others (defence/society/family) Degree of Understanding Expectations Social Support Professional Support Debriefing/Lack of Debriefing Quality of Treatment Perceived Ability to Access Treatment (i.e., impact on career/reputation) Environment Safety of Environment (i.e., war zone) Similarity of Environment to Trauma (i.e., triggers) Relationships Marital/Family Relationship

Warning Signs:

Symptoms do not usually just pop up out of the blue. They are usually preceded by some warning signs. These can be many (sometimes minor) things, such as the experience of certain emotions, changes in thoughts, or changes in behaviour.

Changes in How You Think

"I don't care about going to therapy anymore."
"Nothing is working out for me. I am never going to get better."
"No one cares about me or what I do. What's the point of going on?"
"I'm feeling a little down. This must mean that I am going to fall into a deep depression again."

Changes in Your Mood

"Everyone is getting on my nerves lately."
"I just don't feel happy, even when I am around people that I know I love."
"I am beginning to feel really jumpy and on edge."
"My mood keeps changing rapidly. In minutes, I can go from feeling really happy to really down or terrified."

Changes in Your Behaviour

"I just don't have the energy to take care of myself in the morning. I haven't showered for days."
"I don't want to be around people anymore. I've been isolating myself."
"I've been drinking more, but just to take the edge off of my feelings a little."
"I've noticed that I am less talkative than I used to be."

TRIGGERS

Triggers are events or sensory perceptions that cause a person to reflect on a memory that relates to the trauma.

Triggers can fall into two categories:

Internal triggers are things that you feel or experience inside your body. Internal triggers include thoughts or memories, emotions, and bodily sensations (for example, your heart racing).

External triggers are situations, people, or places that you might encounter throughout your day (or things that happen outside your body).

FLASHBACKS

Flashbacks refers to the distress that comes from the fact that the brain is unable to recognise the ‘memory’ (that has been triggered) as it hasn’t been processed as stored in the episodic memory.

As such, the facts of what happened, the emotions associated with the trauma and the sensations touch, taste, sound, vision, movement, and smell can be presented by the mind as if they are happening right now – flashback.

PTSD AND DISSOCIATION

Dissociation is a mental health term used to describe an abnormal sense of psychological, emotional, or physical detachment.

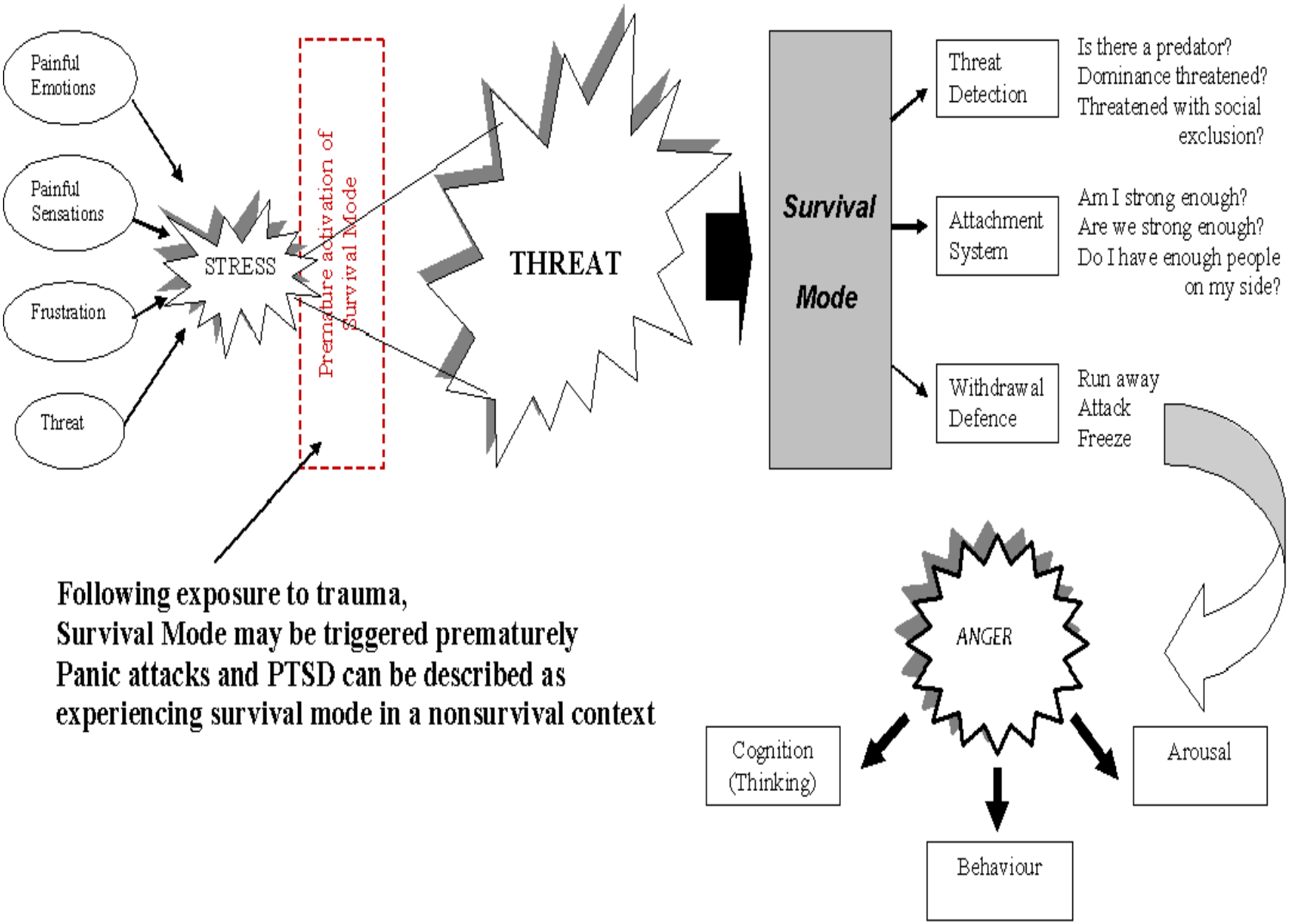
Prominent forms of this detachment include:

Depersonalisation-a sense of unusual separation from the body and

Derealisation- sense of unusual separation from the surrounding physical environment.

Generally speaking, people experience dissociation as part of a psychological defence mechanism against overwhelming events or circumstances.

ANGER and PTSD Stress Threat Survival mode model.



Following exposure to trauma,
Survival Mode may be triggered prematurely
Panic attacks and PTSD can be described as
experiencing survival mode in a nonsurvival context

TREATMENT OPTIONS FOR PTSD

Treatment for post-traumatic stress disorder (PTSD)

Treatment for PTSD relieves symptoms by helping you deal with the trauma you've experienced. Rather than avoiding the trauma and any reminder of it, treatment l encourages you to recall and process the emotions and sensations you felt during the original event. In addition to offering an outlet for emotions you've been bottling up, treatment for PTSD also helps to restore your sense of control and reduce the powerful hold the memory of the trauma has on your life.

Treatment for PTSD, includes:

- Exploring your thoughts and feelings about the trauma,
- Working through feelings of guilt, self-blame, and mistrust,
- Learning how to cope with and control intrusive memories,
- Address problems PTSD has caused in your life and relationships, and
- Learning to express anger assertively rather than aggressively.

Types of treatment for post-traumatic stress disorder (PTSD)

Trauma-focused cognitive-behavioural therapy. Cognitive-behavioural therapy for PTSD and trauma involves carefully and gradually "exposing" yourself to thoughts, feelings, and situations that remind you of the trauma. Therapy also involves identifying upsetting thoughts about the traumatic event–particularly thoughts that are distorted and irrational—and replacing them with more balanced picture.

Family therapy. Since PTSD affects both you and those close to you, family therapy can be especially productive. Family therapy can help your loved ones understand what you're going through. It can also help everyone in the family communicate better and work through relationship problems caused by PTSD symptoms.

Medication is sometimes prescribed to people with PTSD to relieve secondary symptoms of depression or anxiety. Antidepressants such as Prozac and Zoloft are the medications most commonly used for PTSD. While antidepressants may help you feel less sad, worried, or on edge, they do not treat the causes of PTSD.

EMDR (Eye Movement Desensitization and Reprocessing) incorporates elements of cognitive-behavioural therapy with eye movements or other forms of rhythmic, left-right stimulation, such as hand taps or sounds. Eye movements and other bilateral forms of stimulation are thought to work by "unfreezing" the brain's information processing system, which is interrupted in times of extreme stress.