Dealing with post-traumatic stress disorder in general practice

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Abstract
Traumatic experiences are prevalent in South Africa and may result in psychiatric disorders such as post-traumatic stress disorder (PTSD). PTSD is accompanied by a range of psychobiological alterations, including changes in brain structure and functioning. General practitioners have an important role to play in identifying and assisting those in need of help. Efficacious psychotherapies and pharmacotherapies are available for PTSD, i.e. cognitive behavioural therapy and selective serotonin reuptake inhibitors.

Introduction
The South African Stress and Health Study has estimated that 75% of adult South Africans have experienced a traumatic event, such as a physical or sexual assault, motor vehicle accident or disaster, i.e. fire or flood, at some point in their lives. Although responses to these events vary greatly and the majority of people recover on their own, some people develop longer-lasting problems, such as post-traumatic stress disorder (PTSD) or depression. Lifetime rates of PTSD have been estimated to be approximately 2.3% in South African community samples and prevalence may be higher in primary healthcare populations.

The Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR) diagnosis of PTSD requires that the event involves an actual or threatened death or serious injury (real or perceived) to self or others, and that the event evokes feelings of fear, helplessness or horror in the person (Criterion A). Other criteria include at least one symptom from the re-experiencing cluster (Criterion B: Distressing recollections of the event; upsetting dreams; acting or feeling as if the event is recurring and psychological reactivity on exposure to reminders of the event); three from the avoidance cluster (Criterion C: Efforts to avoid reminders of the event, i.e. thoughts, feelings, activities, places or people; inability to remember parts of the event; diminished interest in activities; feelings of detachment from others; restricted range of affect and a sense of a foreshortened future); and two from the hyperarousal cluster (Criterion D: Difficulty sleeping; increased anger or irritability; difficulty concentrating; hypervigilance and exaggerated startle response). Symptoms need to be present for at least one month, and cause significant distress or impairment in social, occupational or other important areas of functioning.

DSM-5 criteria have not yet been finalised, but will be slightly different. The response to stress includes numerous neurochemical changes. PTSD is characterised by disruptions in these processes, including concomitant alterations in cognitive-affective function, e.g. difficulties with memory and a startle response, and brain structure, e.g. decreased hippocampal volume. The precise molecular disruptions in PTSD remain to be fully characterised but include changes in hormones, e.g. glucocorticoids; neurotransmitters, e.g. monoamines; and neuroplasticity pathways, e.g. brain-derived neurotrophic factor. Given the brain’s plasticity, some of these changes may be reversible. Notably, while some molecular changes in PTSD may reflect the consequences of trauma, others may comprise pre-existing vulnerability factors.

Although some trauma survivors seek psychological or psychiatric treatment, usually the majority present to general practitioners with general health complaints. Traumatised patients have been noted to visit physicians four times as often as nontraumatised ones. Survivors of childhood sexual abuse report more somatic complaints and are more likely to have a mental health, pain disorder or general medical diagnosis.

As a result of the stigma and shame surrounding many traumatic events, e.g. sexual abuse, as well as that surrounding mental health problems, individuals with...
PTSD might not even mention the trauma exposure to their clinicians. As such PTSD and related conditions are often under-diagnosed, making it important for healthcare providers to ask routinely whether the patient has experienced a traumatic event, and if so, to screen for PTSD. Notably, healthcare providers who record more mental health diagnoses than their colleagues have reported decreased health expenditures and in-patient medical hospitalisations among their patients.

Co-morbidity

PTSD is associated with significant functional impairment. Often, it co-occurs with other psychiatric disorders, particularly depression and substance-use disorders. A USA community study found that significant depressive symptomatology affects almost 50% of persons diagnosed with PTSD, and that the prevalence of alcohol-use disorders in individuals with PTSD is 52% for men and 30% for women. The fact that a range of different conditions are associated with trauma has contributed to the proposal of a separate category of trauma- and stress-related disorders in DSM-5.

Management

Although debriefing and benzodiazepines have often been used in the acute aftermath of exposure to a trauma, current guidelines suggest that these interventions should be avoided. Acute interventions should focus on promoting a sense of safety, calm, self- and community efficacy, connectedness and hope. Once PTSD has been diagnosed, appropriate interventions should be made. Psycho-education is a critical step, as it helps to empower patients to understand PTSD, its development, perpetuation and consequences. It also offers tools that help with coping. The patient’s view of PTSD should be explored. A collaborative approach to choosing efficacious psychotherapy and pharmacotherapy options can then be adopted.

The psychological treatment with the best evidence for efficacy in PTSD is trauma-focused cognitive-behavioural therapy (CBT). Trauma-focused CBT involves gradual repeated exposure to memories and situations associated with the traumatic event (that although objectively safe, elicits anxiety or is avoided) through imagination, narrative or in vivo exposure, and gradually challenging maladaptive trauma-related appraisals. Although the underlying mechanisms for this have not been elucidated, eye movement desensitisation and reprocessing therapy has also shown some promise.

First-line drug treatments for PTSD include selective serotonin reuptake inhibitors and the selective norepinephrine reuptake inhibitor, venlafaxine. Second-line treatments include the newer antidepressants and tricyclic antidepressants. Third-line treatment is monoamine oxidase inhibitors. In treatment-resistant cases, atypical antipsychotics, in conjunction with antidepressants, have shown to be beneficial.

Summary

PTSD is a common mental disorder that is often associated with high levels of disability and co-morbid conditions. Numerous psychobiological alterations accompany PTSD. Primary healthcare providers are often the first and only source of advice and support for patients suffering from PTSD. Appropriate intervention by primary healthcare providers may improve treatment outcomes.

References

16. Rose S, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing
Post-traumatic stress disorder (PTSD) can result from experiencing or witnessing traumatic incidents, including hijackings, domestic violence or violent attacks, road accidents, robberies, and natural disasters. In Living with Post-traumatic Stress Disorder, Simon Pellatt shares his story, illustrating that treatment can effectively restore quality of life.