The Management of Post Traumatic Stress Disorder In Adults

June 2003

These guidelines have been published by the Clinical Resource Efficiency Support Team (CREST), which is a small team of health care professionals established under the auspices of the Central Medical Advisory Committee in 1988. The aims of CREST are to promote clinical efficiency in the Health Service in Northern Ireland, while ensuring the highest possible standard of clinical practice is maintained.

These guidelines have been produced by a small Sub-Group of Psychiatrists, Clinical Psychologists, Psychiatric Nurses and Social Workers. CREST wishes to thank them and all those who contributed in any way to the development of these guidelines.

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CLINICAL RESOURCE EFFICIENCY SUPPORT TEAM

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1 INTRODUCTION

For 25 years, leading up to the paramilitary cease-fires of the mid-1990s, Northern Ireland experienced civil unrest and paramilitary campaigns resulting in death and injury to thousands. Tragically, despite these paramilitary cease-fires, violent incidents are still commonplace in certain parts of the Province. Few who have lived through this period of our history have not been personally affected by the violence. In this part of the world, the term "Post Traumatic Stress Disorder" (PTSD) has become associated with "The Troubles". However, it must be emphasised that violent incidents are not the only cause of trauma.

The definition of a traumatic stressor is problematic. According to the DSM-IV classification, for a diagnosis of post traumatic stress disorder, the traumatic event must be one in which "both of the following were present:

1) The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others;
2) the person's response involved intense fear, helplessness or horror".

The full DSM-IV definition of PTSD is outlined in Appendix 1.

An early study in Northern Ireland[(1)] indicated that 75 per cent of untreated individuals with PTSD will recover within 18 months. However, this can be delayed if the correct conditions for psychological re-adjustment are not present. Those individuals suffering from less severe psychological reactions to trauma rarely seek professional help. Indeed it is probably not appropriate that they should do so. Instead they seek the support of family, friends, religion and the local community. Those individuals who go on to develop severe post traumatic stress disorder, however, can be incapacitated by their psychological injury and can benefit from the help of mental health professionals.

Exposure to a traumatic stressor can lead to a variety of different psychological sequelae. Such difficulties can include generalized anxiety states, phobic states, depressive illness, adjustment disorders, somatization disorders, substance abuse and post traumatic stress disorder. Indeed, many people subject to traumatic stressors can suffer co-morbidity, having more than one of the conditions listed above. In addition, there are often psychosocial sequelae of trauma including

isolation and detachment, increased interpersonal conflicts and poorer familial and occupational functioning.

This guideline specifically focuses on the assessment, treatment and care of post traumatic stress disorder in adults.

The US National Co-morbidity[2] study found the lifetime prevalence of post traumatic stress disorder to be around 8%. A number of predisposing factors have been identified including female sex, prolonged childhood separation from parents, family history of anxiety, family history of antisocial behaviour, pre-existing anxiety or depression, neuroticism, being older and being socially isolated. Over 80% of those with PTSD have been found to have a co-morbid condition.

The US National Co-morbidity study found that the median time to remission in post traumatic stress disorder was 36 months for those treated and 64 months for those not treated. Clinical improvement was most marked in the first 12 months and reportedly continued for another 5 years. Even following treatment, symptoms failed to remit in over one third of those with the condition. Whilst it is normal to experience at least some symptoms of PTSD after traumatic exposure[3], a number of studies have observed that very few trauma survivors are fully asymptomatic at 1 year post traumatic event, irrespective of whether the traumatic event is for example, rape, torture[4] or a natural disaster[5]. With regard to Northern Ireland there has been no equivalent research carried out and there is no robust epidemiological evidence regarding post traumatic stress disorder in the Province.

2 ASSESSMENT

The nature, duration, intensity and meaning of an individual's experiences of trauma vary greatly. There is no simple cause and effect relationship between the event and subsequent psychological symptoms. If a group of people witness any given event, each person's experience of that event will be unique and probably very different from that of other members of the group.

A significant difficulty in accurately assessing trauma responses arises out of the overlap between symptoms of trauma per se and of those of other disorders. For example, problems with concentration and sleep need careful, differential diagnosis to be distinguished from symptoms of anxiety and depression not directly connected to a traumatic experience. Diagnosis is further compounded when trauma-related symptoms occur simultaneously with other psychiatric disorders.

Such intricacies of assessment mean that exclusive reliance upon general standardised inventories and global psychological measures result in criterial information being missed and referrals and/or treatment interventions being misdirected. The purpose of the assessment (whether clinical, research or forensic) will direct the use of different measures and interview methods. The guidance offered herein will focus on assessment for clinical purposes.

The usual concern of clinicians is for qualitative rather than quantitative information. However, standards of good practice suggest information from scientifically validated measures should be considered together with qualitative information, in order to achieve a thorough and comprehensive assessment.

Diagnostic interviews accompanied by standardised inventories will increase the accuracy of diagnostic formulation. There are clear advantages to using self-report inventories in conjunction with structured interviews as part of an assessment:

- They are readily available;
- they require little or no training to administer;
- they provide reliable and valid information;
- when people are inhibited by face-to-face interviews, self-report inventories can enable more worthwhile and reliable disclosure;
- treatment efficacy and outcome can be reviewed by examining a person's responses to an inventory on different occasions (for example, before, during and after treatment).[6]

The self-report measures identified in this document (Appendix 3) measure a significant range of PTSD symptoms as identified in DSM-IV and can be used to assess responses to any type of trauma which falls within this classification.

As with any psychological distress, good clinical assessment is required before formulation of any management plan. The clinical history should include information about an individual's family history, personal history, personality, past history of illness including previous exposure to traumatic stressors, social supports, coping abilities and indices of social and occupational functioning. Given the high incidence of co-morbidity, the identification of such co-morbid conditions should be an integral component of any assessment protocol.

Consideration should also be given to interviewing a spouse or family member to establish their view on symptoms and functional difficulties.

It is important to appreciate that individuals might have very differing needs and treatment goals which may/may not be realistic. For some, complete recovery is the goal. For others, reduction in the intensity of certain symptoms i.e. intrusive imagery/flashbacks might be the priority while yet others will view social and occupational functioning or interpersonal relationships as of paramount importance. Assessment should address these issues so that an agreed treatment plan can be devised.

3 EARLY INTERVENTIONS

Initial anxiety and distress is very common after a traumatic incident and should not be viewed as pathological. The majority of those exposed to traumatic stressors cope with the support of family and friends and do not develop a clinically significant illness. Therefore, in the first instance, support for those involved in traumatic incidents and their friends or relatives should be along practical lines. Crisis Support Teams are available and each Board has set up a Trauma Advisory Panel to develop a support network. Those exposed to traumatic stressors may also find considerable help available through other professional and trained volunteer services such as Victim Support, Red Cross, WAVE and CRUSE - bereavement care. There is some evidence to suggest that such practical assistance may reduce the frequency of both avoidance and intrusive symptoms (Evidence Grade III - refer to Appendix 2 for definition of Evidence Base.

There is now good evidence that psychological debriefing, in the form of single session individual debriefing is not helpful and may well be harmful (Evidence Grade IA). There is, however, no similar evidence regarding the efficacy of group debriefing, one way or the other. Recent studies have demonstrated the benefits of brief programmes of cognitive behavioural intervention for those individuals identified, usually by the diagnosis of acute stress disorder, as at risk of developing post traumatic stress disorder (Evidence Grade IB). The aims of such interventions are to enhance the individual's coping abilities.

At present there is no good evidence to support the use of routine medications in the early aftermath of trauma but clinical expediency may mean that targeting specific symptoms if they are very disturbing or troublesome, such as agitation, marked arousal or severe sleep disturbance, may be necessary (Evidence Grade IV).

4 MANAGEMENT AND TREATMENT

In recent years there has been increasing evidence about the effectiveness of certain psychological and pharmacological treatments for post traumatic stress disorder. Irrespective of the treatment chosen, the therapist should first form and maintain a therapeutic alliance, special attention being given to issues of trust and safety. There should be concern for the patient's physical safety, and education and reassurance regarding the individual's psychological symptoms should be provided. The patient's symptoms and general functioning should be monitored over time and the issue of co-morbidity addressed. It may be important to involve other health professionals and the patient's family members and trusted friends. Treatment may have to continue for a considerable period of time and be flexible in response to the often fluctuating course of symptoms and the individual's reaction to other life stresses that may occur, e.g. inquests, anniversary reactions, bereavements, medical retirement, unemployment etc.

A comprehensive management plan may involve a combination of psychological therapy, pharmacotherapy, and social interventions, particularly in those individuals whose condition is chronic. When complete recovery may be an unrealistic goal, rehabilitation can lead to a significant improvement in quality of life. Treatment plans should be individually tailored as no therapy has a documented successful outcome in all cases of post traumatic stress disorder.

4.1 Psychotherapeutic Treatments

Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) have been clearly shown to be effective in treating post traumatic stress disorder, the exposure and cognitive re-structuring elements of treatment probably being the most important (Evidence Grade 1A). Psychological treatment interventions should be grounded in an appropriate psychological model applied to the individual's needs. It is important to acknowledge that some trauma survivors are reluctant to approach reminders of the trauma. They may experience difficulty tolerating the high anxiety and temporary increase in symptoms; therefore, care should be taken in the use of exposure based therapies. Psychological therapies tend to have significantly lower dropouts from treatment than do pharamacological interventions (Evidence Grade 1A).

Psychosocial rehabilitation and marital/family therapy are not, of themselves, proven treatments for post traumatic stress disorder. However, as part of an overall management plan, it will often be necessary to include aspects of these treatments. There is little current empirical evidence for the efficacy of hypnosis, psychodynamic therapy or creative arts therapies. The issue of counselling and accreditation of counselling has been addressed by the Social Services Inspectorate (NI). However there is no available evidence to support generic counselling.

Supportive group therapy, psychodynamic group therapy and cognitive behavioural group therapy have all proved promising in research, however, the available evidence does not presently favour one type over another (Evidence Grade IIB). The specific indications and contra-indications for group therapy are similar to those with regard to group therapy for other anxiety based conditions. Of particular importance is that individuals have shared similar traumatic experiences and that due consideration is given to gender, sexual orientation, ethnicity, culture and religion. The latter requirements would suggest that group therapy might present intrinsic difficulties in Northern Ireland, except with specific populations such as security personnel, whether still serving or retired.

4.2 Pharmacological Treatments

Selective serotonin reuptake inhibitors (SSRIs) can be recommended as a first line drug treatment for individuals with post traumatic stress disorder (Evidence Grade IB). The medication should be prescribed at the maximum tolerated dosage for a minimum of a 12 week period before evaluating effectiveness. If there is a clinical response, the SSRI should be continued for approximately 12 months.

Unlike other drugs tested so far, the SSRIs have effectively reduced all clusters (re-experiencing, avoidance/numbing and hyperarousal) of PTSD symptoms. SSRIs may also be clinically useful because a number of symptoms associated with PTSD may be mediated by serotoninergic mechanisms such as rage, impulsivity, suicidal intent, depressed mood, panic symptoms, obsessional thinking and behaviours associated with alcohol or drug abuse/dependency.

Other antidepressants such as monoamine-oxidase inhibitors (MAOIs) (Evidence Grade IIA) and tricyclic antidepressants (TCAs) (Evidence Grade IB) can be used as second line drug treatment for post traumatic stress disorder. MAOIs are less effective against the avoidance/numbing symptoms than are SSRIs. Tricyclic antidepressants have a similar spectrum of action as MAOIs but are less effective again.

Evidence supporting the use of anti-adrenergic (Evidence Grade III) and anti-convulsant (Evidence Grade III) agents is weak. Benzodiazepines may be considered for short term treatment of sleep disturbance and agitation but neither they nor antipsychotic agents could be recommended for routine use in patients with post traumatic stress disorder.

4.3 The Treatment of Chronic PTSD

Some patients with chronic PTSD develop a severe disabling mental disorder which becomes entrenched and damages personal, recreational and occupational relationships. Case management and psycho-social interventions may be more beneficial in these circumstances. Chronic PTSD is associated with a higher incidence of co-morbidity, thus, combined treatment modalities should be available involving psychotherapy or a combination of medication and psychotherapy. The expert consensus guidelines (Evidence Grade IV)[(8)] recommend the commencement of psychotherapy and medication from the start, when a co-morbid psychiatric disorder is present. For example, when PTSD presents co-morbidly with depression, an SSRI should be considered with CBT. At present, CBT has the strongest evidence base of the psychological therapies for efficacy in treating chronic PTSD [(7), (9)] . Tarrier et al (1999) [(10)] found that both exposure and cognitive restructuring are equally effective in treating chronic PTSD although many patients who received either treatment exclusively continued to experience symptoms and distress, prompting the authors to recommend a combination of both treatments. One important limitation of exposure therapy is the capacity of patients to tolerate large amounts of high affect associated with exposure treatment. An audit of the Omagh programme found that co-morbidity was not associated with poor outcome, perhaps because co-morbid patients received more therapy sessions [(11)] .

5 SUMMARY AND RECOMMENDATIONS

1. Further guidelines are required to bridge the gap between research and practice to enable clinical audit of services and best practice to be implemented.

2. Psychological distress caused by traumatic incidents is considerable. Health Boards and DHSSPS need to recognize that post traumatic stress disorder is a significant public health issue.

3. There is a need for epidemiological data on the incidence and prevalence of post traumatic stress disorder in Northern Ireland to more clearly establish the size of the problem.

4. On the basis of current research it is recommended that SSRIs are the first line pharmacological treatment to be followed by MAOIs and TCAs. The psychological treatment(s) of choice are CBT and EMDR unless reasons exist for ruling them out. Other family and social interventions should be applied as appropriate in individual cases. The efficacy of treatment interventions should be monitored closely.

5. Single session individual psychological debriefing should not be routinely administered.

6. There is an urgent need for local outcome research, which includes robust longer term follow up to address whether the findings from mainly American based research, can be applied to the population in Northern Ireland.

7. Further guidelines in the management of other reactions to trauma are required.

8. Local experience would strongly suggest that there is a relative shortfall of appropriately trained therapists to meet current service demand.

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APPENDIX 1

POST TRAUMATIC STRESS DISORDER DSM-IV

In Northern Ireland clinical practice, the International Classification of Diseases, 10th revision (ICD10) is used for clinical coding purposes. With regard to post traumatic stress disorder, it is widely acknowledged that the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV)[12] are much superior to ICD10. Both clinicians and researchers working in the field tend to use DSM-IV in preference almost exclusively and this is the rationale behind the use of the DSM-IV criteria in this guideline.

A The person has been exposed to a traumatic event in which both of the following were present:

1 The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

2 The person's response involved intense fear, helplessness or horror.

B The traumatic event is persistently re-experienced in one (or more) of the following ways:

1 Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions.

2 Recurrent distressing dreams of the event.

3 Acting or feeling as if the traumatic event was recurring (includes a sense of reliving the experience, illusions, hallucinations and disassociative flashback episodes, including those that occur on awakening or when intoxicated).

4 Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

5 Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect (e.g. unable to have loving feelings).
7. A sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

D Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilence.
5. Exaggerated startle response.

E Duration of the disturbance (symptoms in criteria B, C and D) is more than one month.

F The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

APPENDIX 2

EVIDENCE BASE/STRENGTH OF EVIDENCE

In line with the Department of Health's recently published guidelines for Treatment Choice in Psychological Therapies and Counselling, the following classification of grading the strength of evidence has been adopted:

IA - Evidence from meta-analysis of randomised controlled trials.

IB - Evidence from at least one randomised controlled trial.

IIA - Evidence from at least one controlled study without randomisation.

IIB - Evidence from at least one other type of quasi-experimental study.

III - Evidence from descriptive studies, such as comparative studies, correlational studies and case-control studies.

IV - Evidence from expert committee reports or opinions, or clinical experience of respected authority or both.

APPENDIX 3

ASSESSMENT INSTRUMENTS

Structured Interview Measures

There are a number of well-developed, semi-structured interviews that assess the symptoms of PTSD in adults. The following have been found to be reliable and valid measures.

1. The Clinician-Administered Post-Traumatic Stress Disorder Scale (CAPS)

Authors: Blake, D.D., Weathers, F.W., Nary, L.M., Kaloupek, D.G., Charney, D.S., & Keane, T.M. (1996) [(13)].

- This questionnaire has been designed for clinicians who have a working knowledge of PTSD.
- It identifies different traumatic events by means of the symptoms revealed by responses to structured questions.
- It comprises 30 items.
- It takes 30-60 minutes to administer.
- It assesses DSM-IV criteria (A-F) for PTSD.
- It also measures the impact of symptoms on occupational and social functioning and provides an indication of overall PTSD severity.

2. PTSD Symptom Scale - Interview (PSS-I)

Author: Foa, Edna,
[Standardisation Study: Foa, E.B., Riggs, D.S., Dancu, C.V., & Rothbaum, B.O., (1993)] [(14)]

- The questionnaire is designed to assess DSM-IV (B, C & D) symptoms of PTSD relating to a single traumatic event.
- It has 17 items.
- It takes approximately 20 minutes to administer.
- It provides severity scores that reflect the frequency of the symptoms.

Self-report Measures

1. Trauma Symptom Inventory (TSI)

Author: Briere J. (1996)[15]

- This measure has 10 clinical scales that assess a range of trauma related symptoms. The assessment also includes three additional validity scales useful in identifying response tendencies that would invalidate the results, e.g. inconsistent responses.
- The measure consists of 100 items and takes approximately 20 minutes to complete. It does not specifically assess DSM-IV criteria but contains items that correspond to criteria B, C & D. The clinical scales are converted to T scores and the validity scales are based on a normative sample.

2. Modified PTSD Symptom Scale: Self-report Version (MPSS-SR)

Authors: Falsetti, S., Reisck, P., Resnick, H., & Kilpatrick D (1993) [16]

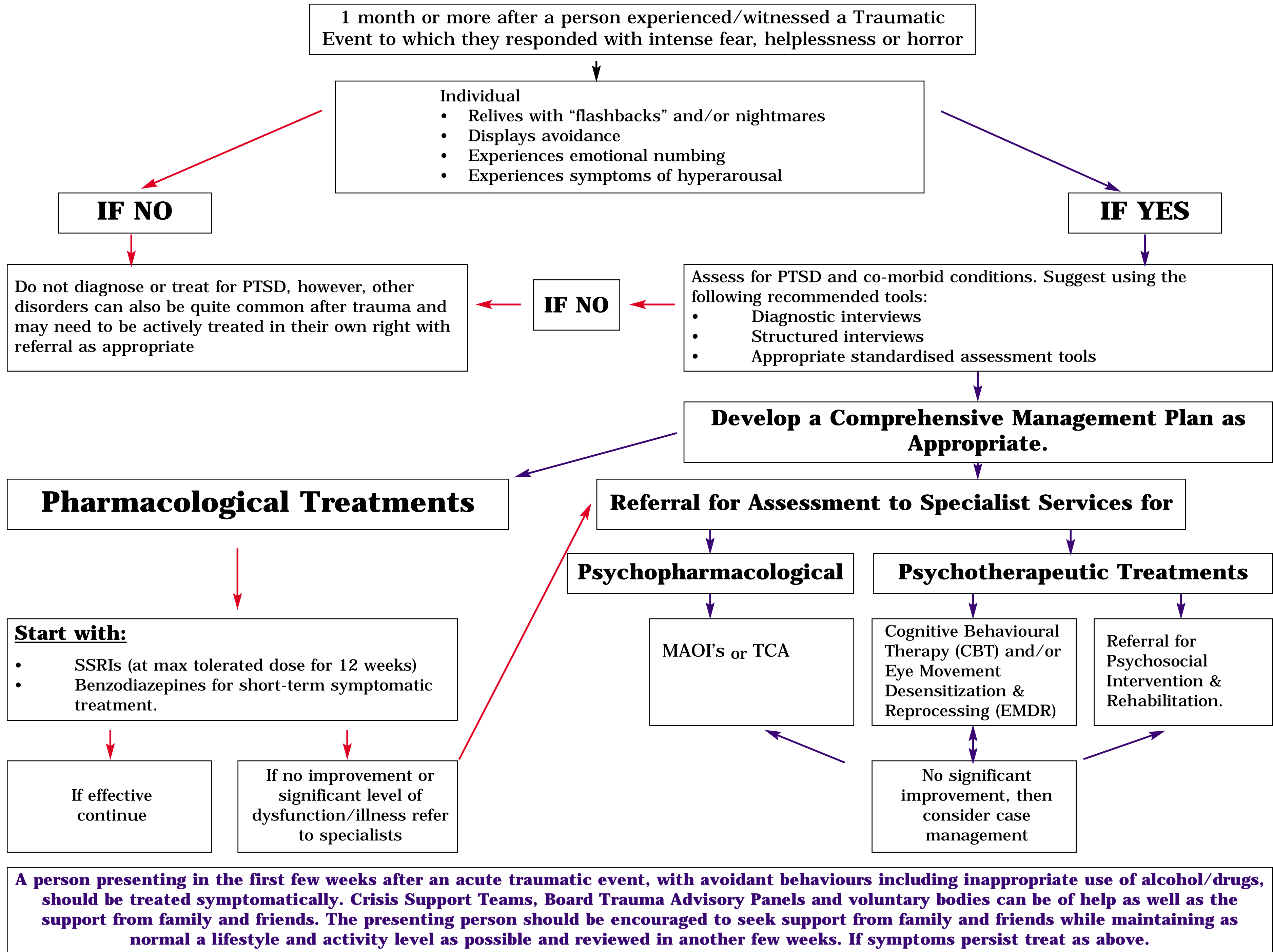
- Measures PTSD symptoms B, C & D of DSM-IV criteria.
- Useful where the trauma history is unknown or there are multiple traumas.
- The scale has 17 items.
- It takes approximately 15 minutes to complete.
- The scales provide frequency and severity scores for symptoms.

3. Impact of Event Scale - Revised (IES-R)

Authors: Weiss, D., & Marmar, C. (1996)[17]

- Brief and easy to use.
- Measures PTSD symptoms related to a single traumatic event.
- Assesses 14 out of 17 DSM-IV symptom criteria B, C, & D for post traumatic stress disorder.
- The scale has 22 items and requires approximately 5 minutes to complete.

ASSESSMENT & TREATMENT OF POST TRAUMATIC STRESS DISORDER IN ADULTS



A person presenting in the first few weeks after an acute traumatic event, with avoidant behaviours including inappropriate use of alcohol/drugs, should be treated symptomatically. Crisis Support Teams, Board Trauma Advisory Panels and voluntary bodies can be of help as well as the support from family and friends. The presenting person should be encouraged to seek support from family and friends while maintaining as normal a lifestyle and activity level as possible and reviewed in another few weeks. If symptoms persist treat as above.

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APPENDIX 5

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