Posttraumatic Stress Disorder

Operational Definition

A. The person was exposed to one or more of the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:
   - Experiencing the event(s) him/herself
   - Witnessing, in person, the event(s) as they occurred to others
   - Learning that the event(s) occurred to a close relative or close friend; in such cases, the actual or threatened death must have been violent or accidental
   - Experiencing repeated or extreme exposure to aversive details of the event(s)

Operational Definition

B. Intrusion symptoms that are associated with the traumatic event(s) (that began after the traumatic event(s)), as evidenced by 1 or more of the following:
   - Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the event(s).
   - Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s).
   - Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the event(s) were recurring
   - Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the event(s)
   - Marked physiological reactions to reminders of the event(s)

Operational Definition

C. Persistent avoidance of stimuli associated with the traumatic event(s) (that began after the traumatic event(s)), as evidenced by efforts to avoid 1 or more of the following:
   - Avoids internal reminders (thoughts, feelings, or physical sensations) that arouse recollections of the traumatic event(s)
   - Avoids external reminders (people, places, conversations, activities, objects, situations) that arouse recollections of the traumatic event(s).

Operational Definition

D. Negative alterations in cognitions and mood that are associated with the traumatic event(s), as evidenced by 3 or more of the following:
   - Inability to remember an important aspect of the traumatic event(s)
   - Persistent and exaggerated negative expectations about one's self, others, or the
   - Persistent distorted blame of self or others about the cause or consequences of the traumatic event(s)
   - Pervasive negative emotional state
   - Markedly diminished interest or participation in significant activities.
   - Feeling of detachment or estrangement from others.
   - Persistent inability to experience positive emotions

Operational Definition

E. Alterations in arousal and reactivity that are associated with the traumatic event(s), as evidenced by 3 or more of the following:
   - Irritable or aggressive behavior
   - Reckless or self-destructive behavior
   - Hypervigilance
   - Exaggerated startle response
   - Problems with concentration
   - Sleep disturbance

Operational Definition

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

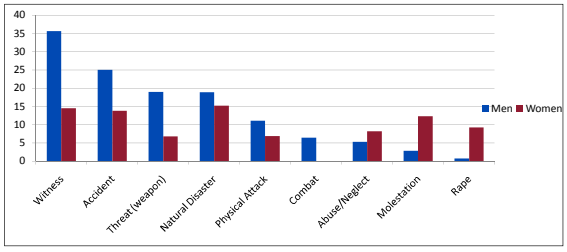
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not due to the direct physiological effects of a substance or GMC

PTSD Prevalence

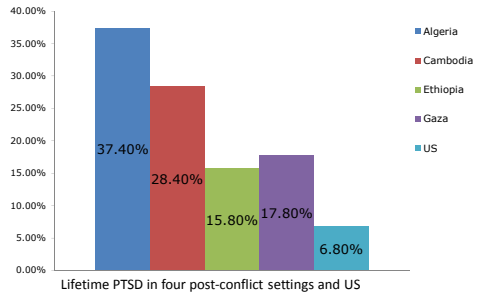
- 61% of men and 51% of women experience a trauma in their lifetime
- More than 25% experience multiple traumas
- Lifetime rate 6.8%, current rate 3.6%

Kessler et al., (1995, 2005)



(Kessler et al., 1995)

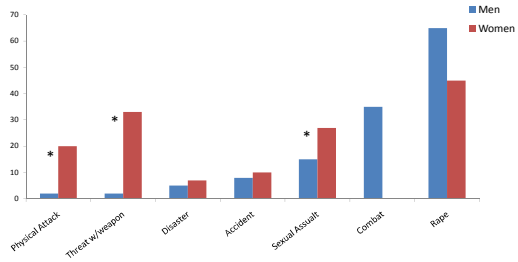
PTSD Prevalence is Higher in Populations with More Trauma Exposure



Lifetime PTSD in four post-conflict settings and US

De Jong et al., 2001

PTSD Varies as a Function of Type of Trauma



* Significant gender difference in prevalence

Kessler et al., 1995, 1999

PTSD Prevalence in Vets

- Lifetime prevalence of PTSD is **39%** among male combat veterans
- Male combat vs. all other male trauma
  - Higher lifetime PTSD prevalence
  - Greater likelihood of delayed onset
  - Greater likelihood of unresolved symptoms

Slide 10

JCN1 Ideally you'd spell out "four" in the label "Lifetime PTSD in Four Post-Conflict Settings and US"
Jill, 7/14/2010

PTSD Course

- Course is highly variable
- Onset usually occurs within 1-2 years of trauma, but can be long-delayed
- Median duration was three years in people who received treatment, five years in people who did not

PTSD Course

- Symptom exacerbation is common in chronic PTSD
- New trauma or life events can reactivate symptoms

PTSD Risk Factors

- Pretraumatic event:
  - Female gender
  - Some genetic factors
  - Childhood trauma
  - Previous psychiatric problems
  - Lower level of education
  - Lower socioeconomic status
  - Minority race

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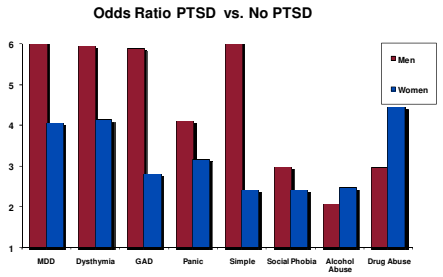
PTSD Risk Factors

- Peritraumatic event:
  - Greater perceived threat or danger, and helplessness increases risk
  - Unpredictability and uncontrollability of traumatic event also increases risk
- Posttraumatic event:
  - Lack of social support, life stress, attributions

Gender Differences

- Much higher rates in females in civilian populations
- Equal rates seen in military populations, although some controversy over this

Comorbidity



Impact of PTSD

- Elevated risk of mood, other anxiety, and substance abuse disorders
- Greater functional impairment
- Reduced quality of life
- Elevated risk of poor physical health

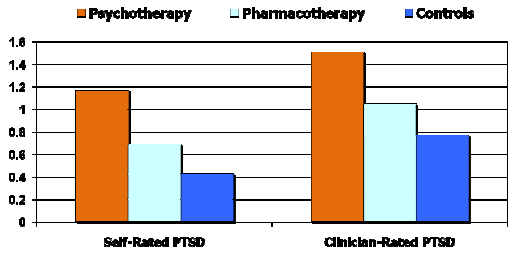
Etiology

- It is adaptive to have strong reactions when your life is threatened
- But, these reactions should decrease when the threat is no longer present
- This does not occur in people with PTSD, it can be seen as a failure to adapt

Treatment

- CBT, particularly Prolonged Exposure, is much more effective than medications
- Medication, however, is more readily available and useful for treating comorbid problems

Meta-Analysis of PTSD Treatments



Van Etten & Taylor, 1998

Pharmacology for PTSD

- SSRIs are the most well studied and most often prescribed
  - Outperform placebos significantly, in both civilian and military populations
- Venlafaxine (Effexor) slightly outperforms SSRIs in both populations

CBT for PTSD

- Prolonged exposure (PE) and cognitive processing therapy (CPT) are consistently shown to be effective treatments for PTSD
- General components shared are
  - Psycho-education
  - Anxiety management
  - Exposure
  - Cognitive restructuring

Prolonged Exposure (PE)

1. Psycho-education: Patient learns about trauma and PTSD
2. Breathing skills: Learns to manage anxiety
3. In vivo exposure: Confronts feared stimuli in real life
4. Imaginal exposure: Involves mental exposure to trauma by repeated telling of memories

Cognitive Processing Therapy (CPT)

1. Education about PTSD, thoughts and emotions
2. Processing trauma (with or without account)
3. Challenging thoughts
4. Cognitive restructuring

PE or CPT?

- Not a lot is known about treatment matching
- Most important is to use evidence-based therapy
  - Dropout rates are similar
  - Therapist comfort
  - Patient preference