PTSD, nytt och gammalt

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Posttraumatiskt stressyndrom PTSD

- Vanlig sjukdom, livstidsprevalens
  - Män ca 5%
  - Kvinnor ca 10%

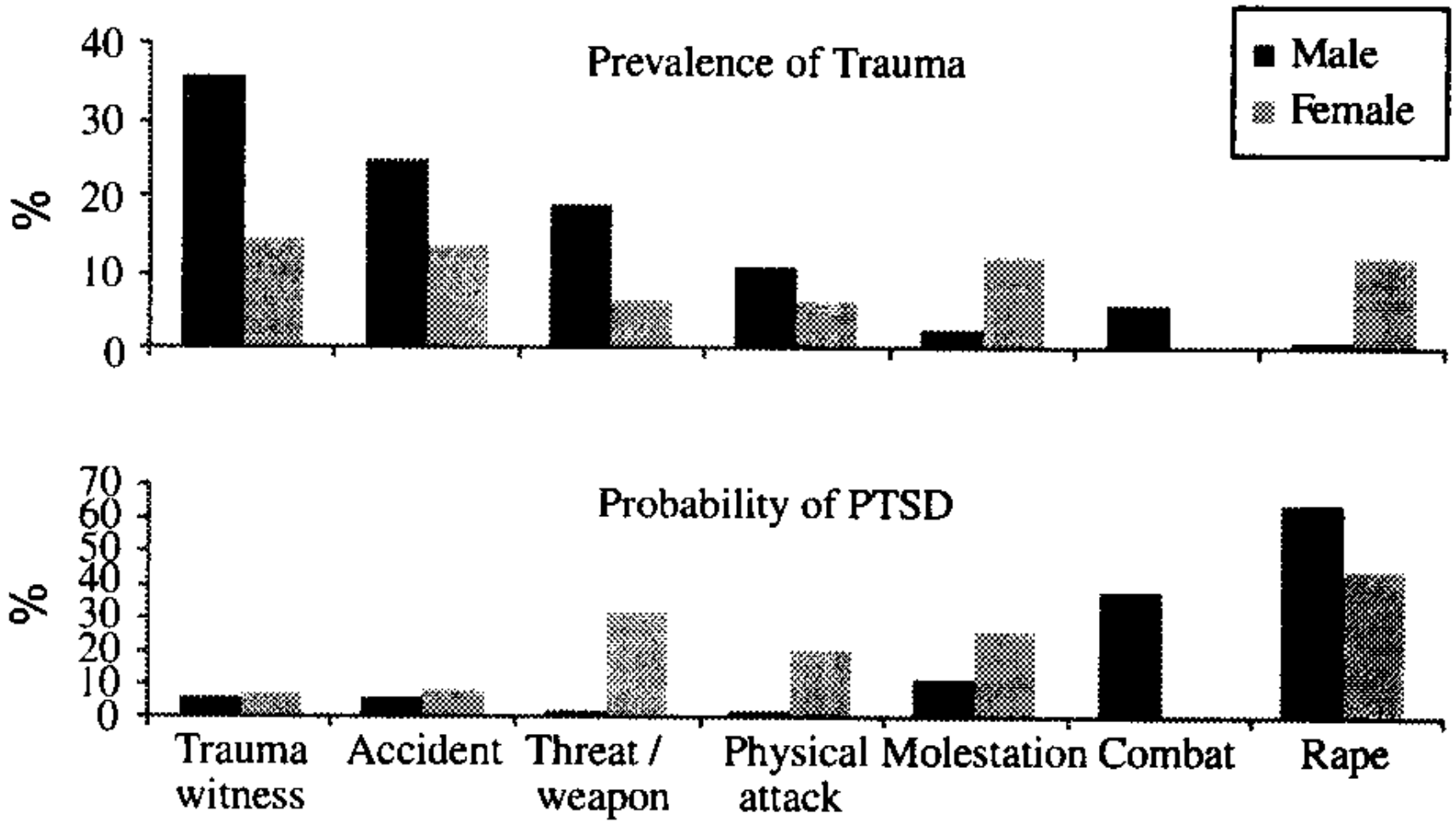

Fig. 1. Prevalence of trauma and probability of PTSD (Kessler RC et al. J Clin Psychiatry 2000;61(Suppl 5):4–12. Kessler RC et al. Arch Gen Psychiatry 1995;52:1048–60.)

Specific Symptoms of PTSD, DSM-IV:

The person has been exposed to **a traumatic event** in which 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 **and the person's response** involved intense fear, helplessness, or horror.

- Recurrent and **intrusive distressing recollections of the event**, including images, thoughts, or perceptions.
- Recurrent **distressing dreams** of the event.
- Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative **flashback episodes**, including those that occur on awakening or when intoxicated).
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

The individual also has **persistent avoidance of stimuli** associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by 3 or more of the following:

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

Persistent symptoms of increased arousal (not present before the trauma), as indicated by 2 or more of the following:

- **Difficulty falling or staying asleep**
- **Irritability or outbursts of anger**
- **Difficulty concentrating**
- **Hypervigilance**
- **Exaggerated startle response**

Complex post-traumatic stress

The National Center for PTSD has describes C-PTSD as being the result of the **individual experiencing a prolonged period (months to years) of total control by another**. The other criteria are symptoms that tend to result from chronic victimization

Complex post-traumatic stress

- Difficulties regulating emotions, including symptoms such as persistent sadness, suicidal thoughts, explosive anger, or inhibited anger
- Variations in consciousness, such as forgetting traumatic events, reliving traumatic events, or having episodes of dissociation (during which one feels detached from one's mental processes or body)
- Changes in self-perception, such as a sense of helplessness, shame, guilt, stigma, and a sense of being completely different than other human beings
- Varied changes in the perception of the perpetrator, such as attributing total power to the perpetrator or becoming preoccupied with the relationship to the perpetrator, including a preoccupation with revenge
- Alterations in relations with others, including isolation, distrust, or a repeated search for a rescuer
- Loss of, or changes in, one's system of meanings, which may include a loss of sustaining faith or a sense of hopelessness and

Tänk på svårighetsgrad vid PTSD-diagnos

- Subklinisk
- Lätt
- Måttlig
- Svår (Complex post-traumatic stress)

Depression och ångest vanliga symptom vid PTSD

- Ångest ofta i form av panik-syndrom
- Depressiva symptom uppfyller ofta kriterier för egentlig depression

Problem att hitta diagnos

- Symptom kommer inte fram spontant
- Ofta visas bara ångest och/eller depression och kan i sig förklara sjukdom

Panikattacker vid PTSD kommer ofta i samband med mardrömmar eller återupplevanden

Stämningsläget vid PTSD med depressiva symptom inte så homogent som vid primär depressiv sjukdom

Hur hitta PTSD?

- Diagnos fordrar direkta frågor om specifika symptom
- Grad av sömnstörning ger en god indikation
  - 4-6 timmars sömn indikerar lätt/mättlig PTSD
  - 1-3 timmars sömn indikerar svår PTSD

”Klinisk bild vid PTSD”

- Färgad av återupplevanden/mardrömmar
- Färgad av depression
- Inaktiv bild, drar sig undan, ensam med tankar (oftast i återupplevanden)
- Överaktiv bild, ständigt sysselsatt, kan inte sitta still

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Neurocognitive Functioning in Posttraumatic Stress Disorder

Michael David Horner[1,2,3] **and Mark B. Hamner**[1,2]

This paper reviews the literature on performance on standard neuropsychological tests among individuals with posttraumatic stress disorder (PTSD). Of 19 studies, 16 reported impairment of attention or immediate memory (or both); however, most of these studies included PTSD patients with significant psychiatric comorbidity, so that the extent to which the observed deficits are specifically attributable to PTSD remains unclear. Other potential confounds, including medical illness, substance abuse, and motivational factors, further preclude definitive conclusions at present. Results of structural and functional neuroimaging studies of PTSD are also summarized. Two studies have reported correlations between hippocampal volume and cognitive findings in PTSD patients; functional studies have indicated specific findings in limbic regions, although the relationship of these results to neuropsychological performance remains to be explored.

KEY WORDS: neuropsychology; cognition; posttraumatic stress disorder.

Kognitiv störning vid PTSD

Av 19 studier raporterade 16 nedsatt kognitiv funktion, vanligaste symptom:

- Nedsatt minne
- Nedsatt uppmärksamhet (exekutiv störning)

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Original article

Executive function and memory in posttraumatic stress disorder: a study of Bosnian war veterans

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Abstract

The present study assessed neuropsychological functions related to attention, executive function and everyday memory in a group of men with a diagnosis of combat-related posttraumatic stress disorder (PTSD). Twenty Bosnian male combat veterans with a diagnosis of PTSD were tested using the Sustained Attention to Response Task, the Hayling Sentence Completion Test, the Trail Making Test, Rivermead Behavioral Memory Test and Wechsler Adult Intelligence Scale (verbal scales). Their performance was compared with age- and IQ-matched male war veterans with no PTSD. The study disclosed pervasive cognitive impairments with large effect sizes pertaining to attention, working memory, executive function, and memory. The effects did not appear to be attributable to alcohol abuse, loss of consciousness, or educational level. We speculate that, in the present group of combat veterans, PTSD was associated with dysfunction of a higher-level attentional resource which in turn affected the activity in other systems concerned with memory and thought.

Bakgrund till kognitiv störning vid PTSD

MR: Atrofi av hippokampus

SPECT/PET: öka aktivering av

nukleus amygdala efter provokation, minskad aktivitet av Brokas area

Hull 2002

Skador i frontallob svåra att avbilda men sannolikt det viktigaste

2 studier har visat korrelation mellan hippokampusdegeneration och kognitiv störning

Kan kortisolhypotes förklara atrofi?:

PTSD har

- lågt basalkortisol
- låg aktivering under morgonen
- lågt svar vid postdexametsontest
- högre täthet av glycocotrikoidreceptorer

Bremner et al 2003: Kortisonökning efter efter stress kraftigt ökad vid PTSD

Elzinga et al 2003: Kortisolsvar vid PTSD kraftigt ökad vid provokation

Är PTSD en kronisk sjukdom?

- Symptom kan återuppväckas efter lång tids frånvaro
- Hjärnan får andra reaktions- och aktivitetsmönster som tycks bli bestående

Skapar PTSD kroniska kognitiva skador?

- Inga vetenskapliga evidens
- Många kliniska exempel

Hur kan kognitiva skador upptäckas?

- Mycket lite framkommer i ett vanligt samtal
- På direkta frågor brukar minnesproblem finnas
- Enkel testning kan ge svar
  - Minnestest
  - 100 – 7 upprepat (klarar inte 93-7)

Vilka problem ger kognitiv störning?

- Missar i vanliga vardagssituationer
- Klarar inte stressade eller komplicerade situationer
  - Svårt planera och organisera
  - Svårt föreställa sig annan situation
  - För många intryck eller problem leder till kaos i tankarna med risk för impulshandlingar

Behandling av PTSD

- Sociala faktorer
- Psykoterapi
- Läkemedel

Trygghet och social stimulans är grunden för behandling

Utan en grundläggande trygghet är det mycket svårt att påverka sjukdomsbilden.

Trygghet är en förutsättning, men inte tillräckligt

Social gemenskap och aktivitet ger en grund för normala mentala funktioner

Två olika situationer:

- ”Flykt in i friskhet” med överaktivitet
- Inaktivitet, vänder in i sin sjukdom

Cochrane-rapport: psykoterapi vid PTSD, 2005

- Traumainriktad kognitiv terapi effektiv
- Stresshantering ger viss effekt

Cochranerapport: läkemedelsbehandling vid PTSD, 2006

- SSRI-preparat (citalopram, paroxetine, sertraline m.m.) ger positiva effekter

- I övrigt liten kunskap

Effekter av SSRI på kortisol vid PTSD

- SSRI sänker höga kortisolnivåer vid PTSD

Andra läkemedel vid PTSD

- Undvik lugnande medel, risk för beroende stor
- Topimax kan påverka (öppna studier och klinisk erfarenhet), dos 100 – 400 mg/dag
- Lyrica??

A Follow-Up Study of Mental Health and Health-Related Quality of Life in Tortured Refugees in Multidisciplinary Treatment

Jessica Mariana Carlsson, MD, Erik Lykke Mortensen, CandPsych,† and Marianne Kastrup, MD, LicMed‡*

Abstract: Longitudinal studies of traumatized refugees are needed to study changes in mental health over time and to improve health-related and social interventions. The aim of this study was to examine changes in symptoms of PTSD, depression, and anxiety, and in health-related quality of life during treatment in traumatized refugees. The study group comprises 55 persons admitted to the Rehabilitation and Research Centre for Torture Victims in 2001 and 2002. Data on background, trauma, present social situation, mental symptoms (Hopkins Symptom Checklist-25, Hamilton Depression Scale, Harvard Trauma Questionnaire), and health-related quality of life (WHO Quality of Life-Bref) were collected before treatment and after 9 months. No change in mental symptoms or health-related quality of life was observed. In spite of the treatment, emotional distress seems to be chronic for the majority of this population. Future studies are needed to explore which health-related and social interventions are most useful to traumatized refugees.

Key Words: Torture, posttraumatic stress disorder, quality of life, depression, anxiety.

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on mental health (Amir and Lev-Wiesel, 2003; Eaton et al., 1982). Another study, however, by Joffe et al. (2003), indicated normal social and daily functioning (Joffe et al., 2003).

Several longitudinal studies of traumatized refugees in community settings have also shown that the mental symptoms (PTSD, depression, and anxiety) persist over time (Hauff and Vaglum, 1995; Lie, 2002; Mollica et al., 2001; Sabin et al., 2003), while only few studies have suggested improvement (Beiser and Hou, 2001; Steel et al., 2002; Westermeyer et al., 1989).

Because of the evidence of persisting mental symptoms, there is an obvious need to develop interventions that may improve mental health and quality of life in traumatized refugees. Published clinical studies within this field vary with respect to the origin of the population, the traumatic background, and the study design (Allodi, 1991; McIvor and Turner, 1995). No randomized controlled trials are described in the literature, and much of the published material on clinical interventions is descriptive reports on the experiences of the clinicians, case stories (Basoglu, 1998; Moore and Boehnlein, 1991; Morris et al., 1993), or small cohort studies without control groups. Cohort studies can examine changes during or after treatment but do not provide evidence on the

Trots allt, behandling fungerar men ha långt tidsperspektiv