

CASE FIVE

Short case number: 3_25_5

Category: Mental Health and Human Behaviour

Discipline: Psychiatry

Setting: General practice

Topic: Post-traumatic stress disorder

Case

A 23 year old man, Patrick Gasana, a student from Rwanda doing a business course, comes to see you complaining of difficulties sleeping, feeling constantly on edge and a lack of concentration in his studies since the convenience store where he was working at night was robbed 6 weeks ago. During the robbery he was threatened with a knife by two hooded young men. He felt completely helpless. He can't believe it happened to him. He thought he had left behind violence when he left Rwanda.

Patrick reports he has been feeling homesick since he came to Australia one year ago, and has found it very difficult to make close friends. Although he has acquaintances, there is no one he can really talk to about what has happened to him. Prior to the robbery he was doing very well in his course.

Questions

1. Outline your assessment of Patrick. Consider Adjustment Disorder, Post Traumatic Stress Disorder (PTSD) and normal responses to stress – what questions will you ask to clarify the symptoms?
2. Does Patrick have any risk factors for developing PTSD? Are there other risk factors?
3. When would you consider using an interpreter for your assessment of Patrick, and how would you use the interpreter?

Following your assessment you diagnose Patrick with PTSD. Patrick does not have symptoms of major depression or anxiety. He expresses a preference not to take medication and does not want to be considered as “a crazy person”.

4. What is your management plan for Patrick? Use an individualised biopsychosocial approach and discuss the evidence base for any specific treatments you are recommending.

During your assessment Patrick describes what happened after the robbery/assault. The police came and took his statement and he then had to clean up the damage on his own. He called the owner of the shop who offered him the next day off, but Patrick said he really needed the money so he went back the next day to work, but reported feeling constantly on edge.

5. On reflection, do you think anything could have been done differently to assist Patrick after the robbery? Would this have prevented him from developing PTSD?

- **Outline your assessment of Patrick. Consider Adjustment Disorder, Post Traumatic Stress Disorder (PTSD) and normal responses to stress – what questions will you ask to clarify the symptoms?**

The normal response to stress:

- Emotional Response (Anxiety or Depressive)
- Defence mechanism (depersonalisation, derealisation, denial)
- Coping Strategies
- Emotion Reducing Strategies (venting, evaluation & analysis of problem or event)

Adjustment Disorder - Symptoms last no longer than 6 months (he has been here for 1 year and symptoms started quickly after the robbery so probably not this). Key difference,

Acute Stress Disorder - Refer to initial reaction in first month after a stressor

PTSD - >1 Month

- Hyperarousal
- Intrusion / Re-experiencing (nightmares or flashbacks)
- Avoidance (do you avoid people or going to work)

- **Does Patrick have any risk factors for developing PTSD? Are there other risk factors?**
- **When would you consider using an interpreter for your assessment of Patrick, and how would you use the interpreter?**
- **What is your management plan for Patrick? Use an individualised biopsychosocial approach and discuss the evidence base for any specific treatments you are recommending**
- **On reflection, do you think anything could have been done differently to assist Patrick after the robbery? Would this have prevented him from developing PTSD?**

ANSWERS

1. Outline your assessment of Patrick. Consider Adjustment Disorder, Post Traumatic Stress Disorder (PTSD) and normal responses to stress – what questions will you ask to clarify the Tony's symptoms?

Build rapport

Consider if interpreter is needed - CALD background (see below)

History from Patrick to clarify what happened during the robbery – check in with him that he is feeling able to talk about what happened to him.

Physical health review – ask if Patrick was injured in the robbery, check in on his current self-care and if he has any medical issues / physical symptoms.

Ask about Patrick's functioning

Issues at work – how is his job going now, how is his relationship with his employer / co-workers.

Ask more specifically about his struggles with learning / studying

Ask about contact with family – is he able to easily speak with them, has he been able to talk to them about what happened.

Any social supports in Australia.

Living situation – does he feel safe at home, if he lives with others then how are they getting along.

Is he able to cook / clean for himself?

To clarify a diagnosis for Patrick:

Screen for major depression and psychotic symptoms.

PTSD is a specific diagnosis, and not all responses to trauma are classified as PTSD. Symptoms 1 month. Less than one month = Acute Stress Disorder.

For PTSD:

Here are some of the relevant DSM-5 Diagnostic Criteria Posttraumatic Stress Disorder for Patrick's case and *questions to about these issues added in italics*:

- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).

Ask Patrick how he felt at the time of the robbery, did he fear for his life or think he would be seriously harmed. Looking back on the event does he still feel this way?

- B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Ask Patrick if has thoughts coming into his mind about the robbery, which he can't stop and which make him feel very upset.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Ask Patrick if he has been having nightmares about the robbery or what happened in the aftermath.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

Ask about flashback, which can be considered framed as “dreams when you’re awake” about the robbery, where he feels like it could be happening to him again, and it feels outside of his control.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

How does Patrick feel if he sees or hears something that reminds him of the robbery? If he thinks about the robbery, how does he feel?

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Has Patrick experiences increased heart rate / sweating / shortness or breathing / GI upset etc?

- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Ask Patrick what he does when a memory about the robbery come back to him, does he immediately try to do something else, to put it out of his mind or use substances so he doesn’t have to think about it.

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Has Patrick been able to return to work? How does he feel when he was back at work? Has he changed anything about his work practices as a result of the robbery, for example is he avoiding going to specific parts of the shop, has he changed his usual routine.

- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Observe whether Patrick is able to remember the details robbery and whether there are elements of the event that seem to be missing.

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).

Ask Patrick how he feels following the event and listen out for him expressing a change in his world view. Does he now feel it is pointless to be studying? Does he feel his life is ruined? Does Patrick feel that he should never have moved to Australia?

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.

Do you feel like you no longer fit in with others, hat no one can understand you?

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behaviour.

Ask Patrick about driving recklessly, substance use, risky sexual behaviour etc.

3. Hypervigilance.

Does Patrick feel constantly on edge, how would he respond if he heard a loud noise, does he worry that all customers coming into the shop could be violent?

4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Adjustment disorders

In adjustment disorders, the stressor can be of any severity or type rather than that required by PTSD Criterion A. The diagnosis of an adjustment disorder is used when the response to a stressor that meets PTSD Criterion A does not meet all other PTSD criteria (or criteria for another mental disorder). An adjustment disorder is also diagnosed when the symptom pattern of PTSD occurs in response to a stressor that does not meet PTSD Criterion A (e.g., spouse leaving, being fired)

2. Does Patrick have any risk factors for developing PTSD? Are there other risk factors?

Risk and Prognostic Factors

Risk (and protective) factors are generally divided into pre-traumatic, peri-traumatic, and post-traumatic factors.

Risks for Patrick:

Lack of social support prior to event – struggled to make friends in Australia

Minority racial/ethnic status – from Rwanda

Young age

Perceived threat to life – threatened with a knife.

Negative appraisals, exposure to reminders, loss of ability

Exposure to reminders – quickly returned to work

Potential losses if he cannot study in Australia

Lack of social support – family likely overseas

Consider cultural factors

Culture-Related Diagnostic Issues to consider (from DSM-5)

The risk of onset and severity of PTSD may differ across cultural groups as a result of variation in the type of traumatic exposure (e.g., genocide), the impact on disorder severity of the meaning attributed to the traumatic event (e.g., inability to perform funerary rites after a mass killing), the ongoing sociocultural context (e.g., residing among unpunished perpetrators in post conflict settings), and other cultural factors (e.g., acculturative stress in immigrants). The relative risk for PTSD of particular exposures (e.g., religious persecution) may vary across cultural groups.

For Patrick consider the context of the 1994 Rwandan genocide and the potential for intergenerational trauma – although he was not yet born it is likely some of his relatives were

affected. Research has demonstrated long-lasting and intergenerational effects of mass violence on individuals, families and communities.

Risk factors for PTSD - From DSM-5

Pre-traumatic factors

Temperamental

These include childhood emotional problems by age 6 years (e.g., prior traumatic exposure, externalising or anxiety problems) and prior mental disorders (e.g., panic disorder, depressive disorder, PTSD, or obsessive-compulsive disorder [OCD]).

Environmental

Vulnerabilities include lower socioeconomic status; lower education; exposure to prior trauma (especially during childhood); childhood adversity (e.g., economic deprivation, family dysfunction, parental separation or death); cultural characteristics (e.g., fatalistic or self-blaming coping strategies); lower intelligence; minority racial/ethnic status; a family psychiatric history. Social support prior to event exposure is protective.

Genetic and physiological

Vulnerabilities include female gender, younger age at time of trauma exposure (for adults). Certain genotypes may either be protective or increase risk of PTSD after exposure to traumatic events.

Peri-traumatic factors

Environmental

Vulnerabilities include severity (dose) of trauma (the greater the magnitude, the greater the likelihood of PTSD), perceived life threat, personal injury, interpersonal violence (particularly trauma perpetrated by a caregiver or involving a witnessed threat to a caregiver in children), and, for military personnel, being a perpetrator, witnessing atrocities, or killing the enemy. Finally, dissociation that occurs during the trauma and persists afterward is a risk factor.

Post-traumatic factors

Temperamental

Vulnerabilities include negative appraisals, inappropriate coping strategies, and development of acute stress disorder.

Environmental

Vulnerabilities include subsequent exposure to repeated upsetting reminders, subsequent adverse life events, and financial or other trauma-related losses. Social support (including family stability, for children) is a protective factor that moderates outcome after trauma.

3. When would you consider using an interpreter for your assessment of Patrick, and how would you use the interpreter?

Background:

In most Australian States, there are legislative and policy requirements to ensure that people from culturally and linguistically diverse backgrounds are not prevented by barriers of communication or culture from making optimal use of health services. Health services staff should inform clients of their rights of access to interpreting services.

For Patrick:

The need for an interpreter should be assessed at the initial contact with Patrick and reviewed at key points in the service delivery process. Using incidental interpreters (e.g., children, relatives, cleaners...) is fraught with dangers and can lead to serious errors or ethical breaches.

Communication in any clinical relationship is of paramount importance. Inadequate communication with people who have limited English proficiency limits their ability to access services, and has a profound impact on the quality of treatment they receive.

Working with interpreters

- Ensure that you know which language (and dialect) Patrick speaks
- Check whether there may be an ethno-political divide between consumer and interpreter, which could be relevant as Patrick is from Rwanda.
- Ask Patrick if the gender of the interpreter is important to the interview
- Brief the interpreter. It is advisable that clinicians confer with the interpreter prior to the meeting in order to provide information about the purposes of the consultation and to establish the mode of interpreting (i.e. consecutive or simultaneous interpreting).

Technical language

- Interpreting consists of interpreting meaning as well as possible —some words or phrases often have no direct translation in another language— and the interpreter is not specially trained or educated in health issues or terminology. Therefore:
- Use clear and simple language to explain mental health terms and processes
- Avoid acronyms and jargon
- Check for understanding.

Confidentiality

It is important to stress to the patient (and interpreter) that all information is confidential. Although interpreters are bound by a Code of Ethics to ensure that they maintain confidentiality in their work, many service-users are unaware of this. Concern about what happens to information divulged in the presence of an interpreter may be based on past experience of, for example, stigma, or interpreting by unqualified staff. Failure to maintain confidentiality is a serious breach of ethics.

- When briefing the interpreter, reiterate the expectation of confidentiality
- When introducing the interpreter to the patient explain that everything discussed in the meeting is considered confidential (subject to the requirements of law) and that the interpreter, as well as staff, are bound to observe confidentiality.

4. What is your management plan for Patrick? Use an individualised biopsychosocial approach and discuss the evidence base for any specific treatments you are recommending.

Psychological intervention:

Provide psychoeducation to Patrick about PTSD.

The course of PTSD varies enormously from person to person; it can be delayed, intermittent, and chronic.

Mindfulness can be helpful

Patrick will need to be referred for appropriate therapy as soon as possible (referred for treatment with a psychologist or psychiatrist who has specific experience with trauma-focused interventions).

In practice, most treatment plans seek to:

- Dampen emotional arousal
- Deal with the meaning of the trauma
- Use exposure techniques to desensitise the patient from the disturbing memories

There are a number of psychological techniques used, evidence is for:

- Trauma focused cognitive behavioural therapy (CBT).
- Prolonged Exposure (PE)
- Cognitive Processing Therapy (CPT)
- Eye movement desensitisation and reprocessing (EMDR).

Evidence:

Cochrane Systematic Review - Psychological treatment of post-traumatic stress disorder (PTSD)
Intervention Version published: 18 July 2007

There was evidence individual TFCBT, EMDR, stress management and group TFCBT are effective in the treatment of PTSD. Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly.

Watkins et al. Treating PTSD: A Review of Evidence-Based Psychotherapy Interventions 2018.
In 2017 Veterans Health Administration and Department of Defense (VA/DoD) and the American Psychological Association (APA) each published treatment guidelines for PTSD, which are a set of recommendations for providers who treat individuals with PTSD. Both guidelines strongly recommended use of Prolonged Exposure (PE), Cognitive Processing Therapy (CPT) and trauma-focused Cognitive Behavioral Therapy (CBT).

Social

Support for return to work – consider other financial supports available in the short term if unable to continue work at present.

Promote social skills

Promote exercise for recovery.

Consider contact with trauma support groups

Multicultural mental health support – e.g. Embrace

Contact with family

Secure living situation

Support from university for Patrick for his studies – special consideration may be needed to ensure he does not fail, extra support, reduce course load etc.

Consider any legal or compensation issues

Bio:

Medications are second line treatment for PTSD

SSRIs are widely used to reduce arousal and distress and to treat comorbid conditions.

Cochrane review. Pharmacotherapy for PTSD

Medication treatments can be effective in treating PTSD, acting to reduce its core symptoms, as well as associated depression and disability. The findings of this review support the status of SSRIs as first line agents in the pharmacotherapy of PTSD, as well as their value in long-term treatment.

Treat Patrick for any comorbid conditions, if any (e.g., depression, drug use, physical health problems)

5. On reflection, do you think anything could have been done differently to assist Patrick after the robbery? Would this have prevented him from developing PTSD?

Trauma —and its consequences— is one of the most common mental health problems. For example, in Australia, half of the adult population has been exposed at some stage to a serious traumatic experience. Traumatic events are part and parcel of the work of some professions (e.g., military, police, and rescue services). Trauma in childhood is very prevalent (e.g., child abuse) and plays an etiological role in the development of almost all psychiatric disorders.

There is little evidence showing which interventions actually reduce PTSD and which do not.

Discuss the value of debriefing.

Debriefing has become very popular when seeking to prevent or reduce PTSD among people exposed to traumatic events, natural or manmade. However, there is no evidence that single session individual psychological debriefing is a useful treatment for the prevention of PTSD after traumatic incidents. A more appropriate response could involve a 'screen and treat' model.