Post-traumatic psychiatric disorders: PTSD is not the only diagnosis

Yann Auxéméry

Hôpital d’Instruction des Armées Percy, service médical de psychologie clinique appliquée à l’aéronautique [Medico-Psychological Service Applied to Aeronautics, Main Aeromedical Centre], 101, avenue Henri Barbusse, 92140 Clamart, France

Yann.auxemery@hotmail.fr

Key points

Traumatic events and their consequences are often hidden or minimised by patients for reasons linked to the post-traumatic stress disorder itself (inexpressibility, shame, depressive thoughts, fear of stigmatisation, etc.).

Although post-traumatic stress disorder (PTSD) remains the most widely known disorder, chronic post-traumatic psychiatric disorders are many and varied.

After a trauma, the practitioner has to check for the different clinical forms of post-traumatic psychological consequences: PTSD is not the only diagnosis.

Based on our own clinical experience compared to the international literature, we think necessary to build a didactic classification describing chronic post-traumatic symptoms and syndromes.

Post traumatic depressions and bereavement lead to high risk of suicidal crisis and self-harm behaviours.

Re-experiencing are felt with anxiety, hyper arousal increases anxious reactivity, and avoidance strategies increase anticipatory anxiety, indicating post-traumatic anxiety disorders (agoraphobia, specific phobia, obsessive compulsive disorder, separation anxiety, social phobia).

Characterising an often-severe clinical picture, the co-occurrence of post-traumatic and chronic psychotic symptoms is not unusual (post-traumatic schizophrenia, post-traumatic depression with mood-congruent psychotic features, non-schizophrenic post-traumatic psychotic disorder, and bipolar reaction to trauma).

A physical injury occurring at the same time as a traumatic exposure increases the risk of developing post-traumatic stress disorder later which, in turn, afflicts the subjective perception of the physical health (development of somatoform and psychosomatic disorders, comorbidity with a post-concussion syndrome).

The trauma may cause a rupture in the biography of a person, also in his/her internal physiological functioning as in his/her social activities (impacts of instinctive functions and behaviours, personality changes, and adjustment difficulties on professional and personal life).

Although a nomenclature is necessary for semiological descriptions, a thorough analysis of the patient’s general psychological functioning must also be conducted.
Introduction

Post-traumatic psychiatric disorders have existed since antiquity [1,2] and are still described in modern classifications [3,4]. Psychotraumatology has become a full-scale specialty with neurobiological, psychological, and societo-anthropological scopes. Although "post-traumatic stress disorder" (PTSD) remains the most widely known disorder, chronic post-traumatic psychiatric disorders are many and varied. Psychotherapeutic and pharmacological options must be adapted to each clinical entity, and the expert assessment of psychological damage requires a clear description of post-traumatic symptoms.

Through a short nosography, we suggest clinical descriptions for existing post-traumatic symptoms and syndromes, based on our own clinical experience and the international literature. After providing clinical descriptions of psychological trauma, the immediate clinical response, and the cardinal chronic symptoms, we describe post-traumatic psychotic, mood, and anxiety disorders. We then give an overview of the somatoform expressions, and psychosomatic and somatic sequelae (including brain injury consequences if associated), before describing the impact of trauma on instinctive functions, conduct disorders, personality changes, and adjustment difficulties on professional and personal life.

Points essentiels

Les troubles psychiques post-traumatiques : l’état de stress post-traumatique n’est pas le seul diagnostic

Du fait de l’expression clinique même de ces troubles (indicibilité, sentiment de honte, cognitions dépressives, crainte de stigmatisation...), la confrontation à un événement traumatique, comme ses conséquences médico-psychologiques, sont souvent tues ou minimisées par les patients.

Alors que le trouble de stress post-traumatique (TSPT) reste le diagnostic le plus connu, sans doute parce qu’il est le plus fréquemment posé, les troubles psychiques post-traumatiques chroniques sont en réalité divers et variés par leurs expressions cliniques.

Après un trauma, le praticien se doit de rechercher les différentes formes cliniques constituant les troubles psychiques post-traumatiques : le TSPT n’est pas le seul diagnostic.

D’après notre expérience clinique confrontée aux données de la littérature internationale, il nous ait apparu nécessaire de décrire les symptômes et syndromes post-traumatiques chroniques grâce à la présentation d’une classification construite sur un mode didactique.

Les dépressions et deuils post-traumatiques sont à risque élevé de crise suicidaire et de comportements auto-agressifs.

Les reviviscences sont souvent éprouvées dans l’angoisse, l’hyperactivité neurovégétative majeure la réactivité anxieuse tandis que les stratégies d’évitement pérennisent l’anxiété anticipatoire, impliquant la présence fréquente de troubles anxieux post-traumatiques (agoraphobie, phobies spécifiques, troubles obsessionnels et compulsifs, anxiété de séparation, anxiété sociale).

Longtemps négligés dans la littérature, les symptômes psychotiques post-traumatiques chroniques sont pourtant fréquents (schizophrénie post-traumatique, dépression post-traumatique avec caractéristiques psychotiques congruentes à l’humeur, réactions bipolaires, troubles psychotiques post-traumatiques non schizophréniques).

Une blesure physique contemporaine d’une exposition traumatisante augmente le risque de développer un syndrome de répétition ultérieur qui, réciproquement, grève la perception subjective de la santé physique, alors même que cette dernière est objectivement impactée (développement de troubles somatoformes et psychosomatiques, comorbidité avec un syndrome post-commotionnel).

Le vécu traumatique peut entraîner une rupture dans la trajectoire d’un sujet, autant pour son fonctionnement psychophysiologique individuel que dans ses liens sociaux (modifications des fonctions instinctuelles et des conduites, mise en tension des traits de personnalité, désadaptations dans les espaces professionnels et privés).

Une nomenclature reste indispensable aux descriptions séméiologiques, mais, dans tous les cas, une analyse globale de la situation psychique singulière du patient est également nécessaire.
Traumatic event, immediate clinical response, latency period, cardinal symptoms and other post-traumatic symptoms

From the traumatic event to the latency period

Although one person can face several traumas throughout his/her life, we focus here on the clinical consequences of a single psychological trauma in adulthood (repeated assaults and child traumas are clinically specific). A potentially traumatic event is defined as a sudden and direct confrontation with death or its equivalents (such as serious injury, assault, or witnessing a cataclysmic event) [4–6]. The DSM-5 also defines the possibility of “indirect exposure”, caused by the announcement, from afar, of the death or serious injury of relatives or closed friends [4,7]. The term “remote trauma” can be used to describe specific circumstances, such as those witnessed by surveillance camera operators or drone pilots [8]. A traumatic event, as such, is defined by an immediate subjective feeling of traumatic and peritraumatic distress, characterised by the negative emotions of fear, helplessness, revulsion and/or horror [3,4]. Resulting from the traumatic event, traumatic and peritraumatic dissociation manifests as a reduction in consciousness, changes in temporal/spatial perception (such as the slowing of time, perception of a long silence), derealisation (feeling as if the surroundings are unreal, altered sensory perceptions), depersonalisation (out-of-body experience, sensation of body fragmentation), automatic motor behaviours (adaptive or otherwise), and partial or complete dissociative amnesia [9,10]. Other immediate clinical signs are characterised by restlessness, panicky flight, or shock and stupor. After a few minutes, anxiety often predominates, but a confused state and psychotic disturbances are also possible. Although flashbacks are frequent in the hours and days following the trauma, they usually disappear for a latency period lasting several days to several weeks [11,12]. Clinically characterised by mild symptoms, this period terminates with the return of flashbacks, triggered by implicit environmental perceptions or conscious thoughts evoking the trauma. Less commonly, a stressor linked to a happy event, apparently far removed from the initial traumatic circumstances, may also be the trigger. A chronic symptomatology can then wax and wane between periods of partial remission and active post-traumatic symptoms [13–16].

Chronic cardinal symptoms: re-experiencing, hyper-arousal, avoidance, dissociation

The pathognomonic sign of PTSD is re-experiencing the traumatic scene with the same distress, perceptions, emotions and dissociation that were originally experienced. Internal feelings of anxiety and negative thoughts are also recalled. These episodes can occur during sleep – as traumatic nightmares, and during waking periods – as flashbacks. Other manifestations are possible: intrusive memories perceived as distinct from the original event; mental ruminations about the event; delusions of re-experiencing the event by recognising elements of it in the environment; elementary motor phenomena replicating the motor response from the time of the event; and repetitive behaviours (fugue, crying, self-harm or aggression) [4,17]. Resulting from the fear of a new trauma, or from flashbacks during a reduction in awareness, the two other cardinal symptoms are autonomic hyperactivity (hypervigilance, irritability, startle response, restlessness) and, cognitive and behavioural strategies for avoiding stimuli that might re-awaken the traumatic memory (places, activities, persons, objects, internal perceptions). Another major symptom, dissociation, is found in the peritraumatic and post-traumatic continuity [18]: traumatised people tend to manifest dissociative phenomena (traumatic amnesia, dissociative fugue, depersonalisation, derealisation, nonepileptic psychogenic seizures) [4,19]. Finally, negative thoughts or feelings that began or worsened after the trauma have been included in the DSM-5 definition of PTSD.

Links between PTSD and other chronic post-traumatic symptoms

Although PTSD remains the most widely known pathological state, many other post-traumatic symptoms are associated with re-experiencing. Varying degrees of the following should be considered: mood disorders (especially depressive), pathological bereavement, anxiety disorders (primarily agoraphobia and obsessive compulsive disorders), psychotic disorders, psychoactive substance misuse (particularly alcohol and drug misuse), somatoform expressions, psychosomatic and somatic symptoms (including brain injury sequelae if associated), disturbances in instinctive behaviours, conduct disorders, personality changes, and adjustment difficulties on professional and personal life. These disorders, or symptoms of them, have sometimes been called “nonspecific” because they are also found in psychiatric disorders other than PTSD. However, hyper-arousal, avoidance strategies, and other many symptoms, maintain a strong clinical connection to the traumatic circumstances that gave rise to them, meaning they are not only “comorbidities” or “complications” [13,14], but authentic post-traumatic clinical entities. Cardinal and other post-traumatic symptoms do not necessarily occur together, but may fluctuate qualitatively and quantitatively between periods of remission and relapse. Re-experiencing can fade or even disappear over time, whereas other clinical manifestations can appear or worsen. Without treatment, the post-traumatic disorder may become disabling as symptoms accumulate, with negative somatic impacts and bad social consequences.

Post-traumatic clinical forms of disorders elsewhere described

Without attempting to redefine every disorder listed in the literature, we present definitions and examples of post-traumatic clinical forms.
Post-traumatic depression, bereavement, and suicidal risk
Depressive symptoms are newly-addressed in the DSM-5 as a PTSD criterion: negative thoughts or feelings about oneself or the world, decreased interest in activities, feelings of isolation, and difficulty experiencing positive affect.

Post-traumatic depression
Morbid ruminations, often fatalistic, are focused on the causes and consequences of the trauma, and are dominated by feelings of shame, abandonment and guilt [20,21]. Culpability is particularly felt by survivors who had to run away from danger or who blame themselves for their responsibility during the trauma. Links to the world and to others are often marred by pessimistic reflections: the impossibility of controlling one’s own destiny, the lack of meaning in life, etc. A loss of confidence in human nature persists, with the impression that others cannot understand traumatic suffering. A withdrawal into oneself and restricted social activities is common [22,23].

Post-traumatic bereavement
Post-traumatic bereavement arises when the traumatic event relates to the loss of relatives or closed friends (discovering the corpse of a relative who has committed suicide, watching family members dying, soldier seeing his/her partner killing in action). Flashbacks keep the deceased close to the bereaved, and make it more difficult to progress through the stages of bereavement. Blocking is frequent during the depressive stage.

Suicidal risk
Post-traumatic depression and bereavement lead to a high risk of self-harm and suicide [27-29].

Post-traumatic phobic and anxiety disorders
Intense anxiety is often present during, and immediately after the traumatic event. Later, re-experiencing episodes are concomitant with anxiety, the hyper-arousal intensifies anxious reactivity, and avoidance strategies increase anticipatory anxiety. Moreover, generalised post-traumatic anxiety is often associated with panic attacks [30].

Agoraphobia
Agoraphobia is more frequent when the traumatic event occurs in a public place such as a market or on public transport – places in which an individual could also experience specific phobias [31].

Specific phobias
Specific phobias linked to perceptions of a traumatic event are common (darkness, sharp objects, entering a lift, seeing someone with a similar physical appearance to an attacker, etc.) [32,33].

Obsessive compulsive disorder
Obsessive compulsive disorder may be closely related to the traumatic event (locking doors after an intrusion into the home, checking the gas after a fire, and repeated washing after an assault, etc.) [34].

Separation anxiety
The fear of losing someone close during a trauma often generates separation anxiety [35].

Social phobia
Social phobia is also common, arising from a fear of having to recall the trauma and/or its consequences at the request of others [33,36,37].

Post-traumatic psychotic and bipolar disorders
Characteristic of an often-severe clinical picture, the co-occurrence of chronic post-traumatic and chronic psychotic symptoms is common [38]. Several authors have described the trauma as an important element revealing a pre-existing vulnerability [39,40]. Especially, interacting with several genes belonging to several different biological pathways, childhood traumatic events are risk factors for developing bipolar disorders, in addition to a more severe clinical presentation over time [39,40]. From another angle, schizophrenic patients report more trauma and abuse than the general population and the prevalence of PTSD in patients with a severe mental disorder is between 30% and 40% [41,42]. Although the accuracy of trauma reports is difficult to precisely evaluate in patients suffering from distortions of thought and memory difficulties, trauma exposure in patients with schizophrenia tends to be underreported [43]. Nevertheless, it appears difficult in many cases to differentiate clinically between psychotic hallucinations and intrusive memories.

Non-schizophrenic post-traumatic psychotic disorder
The post traumatic stress disorder with secondary psychotic symptoms (PTSD-SP) is a PTSD complicated by additional psychotic features that are not related to another nosographic framework than PTSD itself. That is to say that PTSD-SP is a severe form of PTSD that is marked by severe pathological perceptions and dissociative symptoms [44-46]. Hallucinatory and delirious phenomena can arise, based on themes related to the trauma and its consequences [47,48]. In the absence of disorganised thoughts and ambivalence, these symptoms do not belong to the schizophrenia spectrum. However, paranoid reactions are possible [49].

Post-traumatic depression with mood-congruent psychotic features
A feeling of incurability dominates this clinical entity in which the subject blames him/herself for the traumatic event and its consequences [20,50,51]. Symptoms of identity denial are sometimes found: confined to intense depersonalisation, the subject feels he/she is “no longer him/herself” and that his/her mind “no longer functions”. Psychotic visions of ruin may coincide with re-experiencing scenes of destruction.
Bipolar reaction to trauma
An attack of mania can be triggered by a traumatic confrontation that can reveal or sensitize underlying bipolarity [20,39,40,52].

Post-traumatic schizophrenia
Latent schizophrenia may be triggered by several elements of the psychological trauma: fragmentation anxiety after witnessing amputation, anxiety of being devoured after witnessing anthropophagy, and annihilation anxiety after witnessing total destruction [23,53]. Delusions often integrate, into its paralogical system, traumatic circumstances and/or its consequences.

Somatoform, psychosomatic and somatic consequences of psychological trauma
A physical injury occurring at the same time as a traumatic exposure increases the risk of developing PTSD; this, in turn, affects the subjective perception of physical health [54,55]. Physical lesions from a traumatic event may have major consequences comprising functional deficits, aesthetic sequelae, pains and dysesthesia [56].

Somatoform expressions
Post-traumatic pain syndrome
When a psychological trauma is combined with a physical injury, this physical pain is a reminder of the tragedy, equivalent to physically re-experiencing the event. These bodily perceptions may also trigger other re-experiencing (proprioception in case of physically re-experiencing the event. These bodily perceptions may also trigger other re-experiencing (proprioception in case of assault; visual and olfactory reminders of the initial injury) [57].

Post-traumatic conversion
There is a concordance between the physiological function affected by the trauma and the location of the post-traumatic conversion (blindness when facing an approaching object, aphonia after being unable to avert the traumatic event, paralysis after a fall) [58-60]. Fixing the immediate post-traumatic behavioural reaction, the conversion could sometimes be considered equivalent to re-experiencing the event.

Post-traumatic somatisations
Anxious somatisations manifest in several areas (cardiac, neurological, rheumatological, and gastrointestinal, etc.) [61]. Perceptions of anxiety, often felt periodically since the trauma, may return with re-experiencing episodes, or may become continuous.

Post-traumatic psychosomatic and somatic consequences
Psychosomatic disorders may result from the stress sustained in PTSD, leading to cutaneous (psoriasis, eczema, hair whitening, hair loss), digestive (gastritis, inflammatory bowel disease), cardiovascular (arterial hypertension, atheromatosis), endocrine and auto-immune diseases (diabetes, dysthyroidism) [61-63]. The traumatised person may also suffer physical damage due to risky post-traumatic behaviours (misuse of psychoactive substances, self-harm, dangerous driving, and sexual promiscuity).

Comorbidity between PTSD and post-concussion syndrome
Several psychological and neuropsychiatric symptoms have been described after varying degrees of cranial trauma [64-69]. The combination of psychological trauma and mild traumatic brain injury increases the risk of post-concussion syndrome [68]. Appearing a few days or weeks after the trauma, post-concussion syndrome is characterised by a lack of consistency between the multiple subjective complaints from the patient, and, confirmation based on clinical examinations or routine explorations (neurobiological markers start to be used for research). Post-concussion syndrome may consist of general symptoms (fatigue, sleep problems), somatic symptoms (headaches, dizziness), cognitive symptoms (memory and concentration problems), and affective symptoms (irritability, emotional lability, depression, apathy, anxiety) [70,71].

Impact of trauma on cognitions, behaviours, personality, and adjustment capacities
Trauma may disrupt a person’s physiology as well as his/her social functioning.

Cognitive difficulties
Cognitive difficulties frequently involve impairments to attention, memorising (especially verbal and working memories) and executive functions (decreasing flexibility and inhibition).

Effects on instinctive behaviours
Parasomnias
Non-recurring nightmares, terrors, panic attacks and sleepwalking are frequent [72,73].

Eating disorders
Alterations in eating behaviour such as anorexia, bulimia, snacking, and hyperphagia are possible [74,75].

Sexual dysfunction
A decline in sexual desire often occurs, in addition to sexual pain [76,77].

Conduct disorders
Problematic use of psychoactive substances, behavioural addictions
The use of licit or illicit psychoactive substances is frequent, notably to reduce anxiety and to increase sleep. Tobacco and alcohol addictions are frequent, but dependences on other drugs, primarily benzodiazepines and opioids, are often comorbid in cases of polydrug use [78-80]. Repetitive behaviours such as compulsions or addictions are possible (addiction to games mimicking the trauma, risk-taking behaviours, and self-injury).

Self-harming and aggressive behaviours
Traumatised individuals often endanger themselves with suicidal equivalents or other confrontations with death, such as aggressive behaviours towards themselves or others, dangerous driving, risky sexual behaviours, or drugs taking [27-29].
Post-traumatic personality changes

Traumatic events, exposure to prolonged distressing situations, and physical injuries (amputations, the presence of foreign bodies such as bullets or shrapnel, and various other sequelae) are all likely to cause personality changes [17,81,82]. These manifestations reflect a split from the previous way of life, whatever form it may have taken [83,84]. Whatever the type of response caused by activating defence mechanisms, people suffering from re-experiencing episodes and other post-traumatic symptoms regularly isolate themselves from others.

Professional and personal adjustment difficulties

When an individual has been injured during his/her job (a bus driver attacked, a bank cashier robbed, or a soldier wounded in action), the motivation for pursuing his/her profession is tested and, it may be difficult to go back to his/her former activities [85,86]. More generally, returning to "normal life" is often complex. Hobbies may be impossible to continue, and, familial and social difficulties and financial problems are frequent [87].

References


Disclosure of interest: the author declares that he has no competing interest. The positions expressed in this article are only the views of the author and should not be considered as the official point of view of the French Army Health Service.
Post-traumatic psychiatric disorders: PTSD is not the only diagnosis


