Posttraumatic Stress Disorder: Review Questions

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QUESTIONS

Choose the single best answer for each question.

Questions 1 to 4 refer to the following case.

A 47-year-old pawn shop worker was shot while at work 1 year ago. He was severely wounded and was left bleeding by the assailant. The patient reports to his physician that he has had high levels of anxiety since his attack. He has nightmares about the event and feels as if he is reliving the experience. He gets very anxious when he talks about the shooting. He feels fearful and is reluctant to leave his home, especially at night. He has stopped working. The physician suspects posttraumatic stress disorder (PTSD).

1. To meet diagnostic criteria for PTSD, which additional symptom must be present in this patient?
(A) Avolition
(B) Crying spells
(C) Increased arousal
(D) Loss of appetite

2. Which of the following would be considered first-line treatment for this patient's symptoms if the diagnosis of PTSD is confirmed?
(A) Alprazolam
(B) Amitriptyline
(C) Divalproex
(D) Risperidone
(E) Sertraline

3. The patient meets criteria for PTSD and begins first-line treatment. If psychotherapy is also considered, which of the following would most likely benefit this patient?
(A) Brief counseling for trauma
(B) Cognitive behavioral therapy
(C) Psychological debriefing
(D) Trauma-focused psychodynamic therapy

4. Six months after treatment and psychotherapy, the patient continues to have nightmares. He often wakes up at night in cold sweats and has difficulty falling to sleep. What is the next best step in the management of this patient?
(A) Add a β blocker to the treatment regimen
(B) Add prazosin or clonidine to the treatment regimen
(C) Increase the dose of the current medication
(D) Increase the frequency of therapy sessions from once every 2 weeks to once weekly

5. A 23-year-old man returned home about 3 weeks ago after being in a war zone for 6 months. During combat, he witnessed the death of one of his best friends. He is unable to recall specific details of how his friend died. Since returning home, he complains of poor sleep, both in quality and quantity. He also has lost his appetite, feels restless, becomes anxious easily, and is startled at the slightest noise. He reports a long history of feeling uncomfortable in new environments. Prior to being in combat, the patient states that he felt anxious when meeting new people and would isolate himself most of the time. Which of the following is the most likely diagnosis?
(A) Acute stress disorder
(B) Generalized anxiety disorder
(C) PTSD
(D) Social anxiety disorder

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6. **Which of the following is most likely to be comorbid with PTSD?**
   (A) Depressive disorder
   (B) Obsessive compulsive disorder
   (C) Schizophrenia
   (D) Substance abuse disorder

ANSWERS AND EXPLANATIONS

1. **(C) Increased arousal.** Many patients with PTSD relive traumatic events through recurrent images, flashbacks (sudden, clear recollection of a traumatic event), nightmares, and increased arousal. A sense of reliving a terrifying experience may cause patients to avoid any stimulus that reminds them of the event. To meet diagnostic criteria for PTSD, patients should have 2 or more persistent symptoms of increased arousal not present before the traumatic event, including difficulty falling asleep or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, or an exaggerated startle response. Additionally, patients with PTSD also can develop dissociative symptoms including derealization (ie, the feeling that the external environment seems unreal or strange), depersonalization (ie, subjective feeling of unreality or strangeness or being disconnected from one's body or environment), and dissociative amnesia (ie, the inability to recall extensive and important personal information that is usually connected with a traumatic event).[1] In PTSD, dissociative amnesia is more extensive than ordinary forgetfulness.[1] These dissociative symptoms may also be seen in the context of other illnesses (eg, dissociative fugue, depersonalization disorder).[1] Avolition (the lack of interest or desire to pursue goals) is commonly seen in patients with schizophrenia.[1] Loss of appetite and crying spells are more commonly present in mood disorders, such as depression and bipolar disorder.[1]

2. **(E) Sertraline.** Sertraline is a selective serotonin reuptake inhibitor (SSRI). SSRIs are considered first-line treatment for PTSD because of their effectiveness against all 3 symptoms of PTSD (ie, sense of reliving a traumatic experience, avoidance, and increased arousal).[2] SSRIs are also appropriate treatment for patients with acute stress disorder.[2] Alprazolam is a benzodiazepine used for treating symptoms of anxiety but has not been proven effective in treating PTSD.[3] Amitriptyline, a tricyclic antidepressant medication, can be used to treat PTSD but is not considered first-line treatment.[4] Risperidone is an antipsychotic medication that can be used to augment SSRIs if first-line treatment options are ineffective.[5,6] Divalproex is an anticonvulsant medication with mood-stabilizing effects used for treating mania associated with bipolar disorder, epilepsy, and as prophylaxis for migraine. It has been shown to reduce intrusion and hyperarousal symptoms but has no significant effect on avoidance/numbing symptoms.[7]

3. **(B) Cognitive behavioral therapy.** Of the potential answers, cognitive behavioral therapy has been studied to the greatest extent and has proven efficacy in treating PTSD and acute stress disorder.[8] It ideally should be initiated within a month after a traumatic event.[8] Although the case patient has had symptoms for a year, cognitive behavioral therapy would still be effective, but earlier treatment is better. Trauma-focused psychodynamic therapy would also help this patient but is less effective for reducing PTSD symptoms as compared with cognitive behavioral therapy.[9,10] Although brief counseling may be helpful, more intense counseling services are generally needed in patients with PTSD.[9,10] Psychological debriefing may augment symptoms and is ineffective in preventing PTSD and in improving social functioning.[9,10]

4. **(B) Add prazosin or clonidine to the treatment regimen.** Adding prazosin (an α-adrenergic blocker) or clonidine (a centrally acting α-agonist) to an SSRI has been shown to reduce sleep disturbances (eg, nightmares) in patients with PTSD.[11,12] The dose of SSRIs should be optimized to therapeutic level before adding another medication. If patients still experience nightmares, the addition of prazosin or clonidine may improve sleep and reduce the nightmares. Increasing the frequency of therapy sessions has not been shown to improve outcomes.[9,10] Adding a β blocker is helpful when hyperarousal symptoms such as tremors, sweating, and increased startle response are present.[13]

5. **(C) PTSD.** Because this patient's symptoms have persisted for more than 1 month, he meets criteria for PTSD. Acute stress disorder is differentiated from PTSD based on duration of symptoms. In acute stress disorder, symptoms must occur within 4 weeks of the traumatic event and resolve within the 4-week period.[1] Patients with social anxiety disorder, or social phobia, tend to avoid situations (eg, being in a new environment, meeting new people) that would provoke anxiety. As a result, they often decline invitations to social events. However, patients with social anxiety disorder do not show changes in

sleep patterns and appetite and do not have amnesia associated with a traumatic event, as seen in the case patient.[1] Patients with generalized anxiety disorder have difficulty controlling apprehension and anxiety, but the focus of the anxiety and worry is not related to other Axis I disorders (eg, panic attacks in panic disorder, being easily embarrassed in public as in social phobia, being contaminated as in obsessive-compulsive disorder).[1]

6. **(D) Substance abuse disorder.** Comorbid conditions are present in approximately two thirds of patients with PTSD.[14,15] Substance abuse disorder is the most likely comorbid condition associated with PTSD, followed by depressive disorders. The prevalence of comorbid substance abuse disorders in patients with PTSD is approximately 65.9% as compared with a prevalence of 62.2% for comorbid depressive disorders.[14,15] Personality disorders (eg, borderline, paranoid, dependent, antisocial disorders) are also prevalent comorbidities of PTSD.[14,15]

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