DELAYED EMERGENCE OF POST-TRAUMATIC STRESS DISORDER

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ABSTRACT

Post-traumatic Stress Disorder (PTSD) is the development of characteristic symptoms following a psychologically distressing event that is outside the range of usual human experience. A Chinese male with a delayed onset, non-combat post-traumatic stress disorder is described and discussed. This is an unusual case because the symptoms were reexperienced four years after a life threatening vehicular accident. The patient responded to a combination of antidepressant treatment and individual psychotherapy. He remained well on follow up one year later.

Keywords: Post traumatic stress disorder, delayed onset, non-combat PTSD.

SINGAPORE MED J 1991; Vol 32: 92-93

INTRODUCTION

Psychological reaction to catastrophic trauma was first designated as post-traumatic stress disorder (PTSD) in 1980. This disorder, as defined in the new DSM-III-R[1], is characterized by five criteria: 1) a history of exposure to severe stress; 2) reexperiencing the trauma through intrusive recollections, nightmares, or flashbacks; 3) persistent avoidance of emotionally-charged stimuli through numbing of responsiveness, avoidance of charged stimuli or psychogenic amnesia; 4) persistent hyperarousal as indicated by insomnia, irritability, hypervigilance and increased startle response; 5) the symptoms must be of at least one month duration. If the symptoms occur six months after the trauma, it is known as the delayed onset PTSD.

Despite the many articles on this syndrome, there were only two reports of war-related PTSD in Asians. Kinzie et al[2] described 13 survivors of Cambodian concentration camps who met the DSM-III criteria for PTSD. Mollica et al[3] reported this disorder in 26 Southeast Asian refugees who had experienced multiple war traumas. Both studies were carried out in patients who had attended the Indochinese refugee clinics in the United States. To the best of the author's knowledge, there has been no report of non-combat PTSD in the Asian population. This is a case of PTSD in a Chinese man which developed four years after a life-threatening accident.

CASE REPORT

A 30-year old married, army vehicle mechanic instructor was referred by his counsellor with a one-month history of insomnia and fear of darkness. The patient, the youngest of eight siblings, was born after an uneventful pregnancy. Although he gave a childhood history of being fearful of heights, the problem was not severe enough for him to seek medical help. He left school at 14 and worked in a factory prior to his enlistment twelve years ago. His wife described him as an athletic but reserved individual with few friends.

In 1985, while he was driving an armoured vehicle during a night exercise, the vehicle skidded, overtumed and hung at the edge of a cliff. He kept very still as he was fearful that any movement would tip the vehicle down the cliff. The patient waited to be rescued but the position of the vehicle prevented his colleagues from helping him. It was after ten minutes before he could free himself and climb out of the vehicle. He received outpatient treatment for his facial lacerations and multiple bruises. He felt dazed and numb for a few days but these symptoms resolved and he reported for work after a week of medical leave.

Upon his return, he requested for a transfer to the workshop to avoid going back to the site of the accident. He felt apprehensive whenever he had to drive on undulating terrain. The patient experienced similar anxiety when the bus he travelled in swayed to the right or left because it reminded him of the sensation just before the armoured vehicle overturned. Reports on his performance were otherwise good.

One month prior to his consultation, he witnessed an accident in which his trainee's finger was amputated by the machine gun mounting of an identical armoured vehicle. He started having insomnia, recurrent nightmares and intrusive thoughts of his own accident. He experienced helplessness, poor concentration and irritability whenever he had any reminders of the accident. He expressed anger towards his colleagues for not helping him at that time. The patient startled easily and became so fearful of darkness that he requested to be relieved from guard duty. He ruminated frequently about death and felt sorry for his wife because he realized that he had become less caring towards her. The unfounded fear of being sent back to the field was so overwhelming that he wanted to resign from his job. During mental state examination, he was tremulous, tearful, apologetic and depressed. He had poor concentration and he was preoccupied with intrusive thoughts of the accident. He startled easily when exposed to noise. A diagnosis of delayed onset post-traumatic stress disorder was made.

The patient was treated for a period of six months and a total of 12 sessions. He was initially reluctant to take medication and was seen weekly for relaxation therapy. This was of limited benefits and he was prescribed Clomipramine 50mg orally on his third visit. The dose was increased to 75mg at night. He showed symptomatic improvement three months after his consultation. In the subsequent sessions, the patient was encouraged to talk about his trauma and his resentment towards his colleagues. The antidepressant was gradually tailed off and he resumed normal duty at the end of the fifth month. At one year follow-up, he was free of symptoms and continued to perform satisfactorily at work.

DISCUSSION

This patient met the criteria for delayed onset post-traumatic stress disorder as he reexperienced the symptoms after a latent

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period of four years[1]. Non-combat PTSD may arise as a result of natural disaster, accident or a deliberately caused disaster such as torture.

Was the stress experienced by this patient outside the range of usual human experiences? In DSM-III-R, trauma that are usually considered as outside the range of usual human experiences involve either a serious threat to one's life or physical and psychological integrity such as being involved in a road traffic accident. It can also be a serious threat or harm to one's loved ones, a sudden destruction of one's home or even seeing another person who has been seriously injured or killed. Furthermore, the trauma can either be experienced alone or it may be in the company of others. Although the accident in 1985 was not fatal, it involved a serious threat to the patients's life and physical and psychological integrity. The event which was experienced with intense fear, terror and helplessness, would have been distressing to most.

In PTSD, the reexperienceing symptoms may develop months or years after the traumatic event though the avoidance symptoms have usually been present during the latent phase of this disorder[1]. Following the initial symptoms four years ago, the patient appeared to have recovered from his original trauma. In the interim period, he exhibited phobic avoidance behaviour as evidenced by his request for a transfer to the workshop to avoid being sent back to the accident site. He also avoided thoughts that reminded him of the accident. The patient had told no one of the discomfort he experienced when travelling in a bus or driving on uneven terrain.

The amputation of his trainee's finger in an identical armoured vehicle was a symbolic event that triggered off the intense emotional response. Our patient reexperienced the trauma through intrusive thoughts and recurrent nightmares of the original accident. This breakthrough phenomenon, albeit uncommon, has been described in one of the victims of the Australian Ash Wednesday bushfire[4]. The patient had numbing of responsiveness and he was clearly aware of a change in his attitude towards his wife. However, he did not experience flashbacks or psychogenic amnesia.

Insomnia, irritability, poor concentration, fear of darkness and increased startle response were hyperarousal symptoms experienced by the patient. He had recurrent thoughts of resentment towards his colleagues because of their inactivity at the time of the accident. Excessive preoccupation with a particular grievance or injustice as seen in this patient was reported by 44% of cases in a study involving 327 civil accident subjects[5].

Introversion, neuroticism, a past history and family history of psychiatric disorder were significant premorbid factors associated with the development of PTSD[6]. In our patient, his introverted personality and his fear of heights which was suggestive of some neurotic traits might have predisposed him to the development of this disorder. His initial unwillingness to talk about the trauma was a culturally determined behaviour. This reluctance was similarly observed in the Indochinese refugees[2,3]. The therapist must be aware of this cultural characteristic in order to help the patient effectively.

However, there has been no consensus with regards to treatment. Drugs such as clonidine, tricyclic antidepressants, monoamine oxidase inhibitors, propranolol, lithium and benzodiazepine have all been reported to be useful in dampening hyperarousal but ineffective against avoidant symptoms[7,8]. Neuroleptic medication has a limited role in the treatment of PTSD. It is only prescribed if the patient exhibits aggressive psychotic symptoms, self-destructive behaviour and frequent flashback episodes characterized by visual or auditory hallucination of traumatic events. Clomipramine, a tricyclic antidepressant, was used successfully in this patient. It is postulated that tricyclics dampen hyperarousal through their antipanic action[8] and its antidepressant effect is also useful in patients with concomitant depression. Pharmacotherapy provided symptom relief and facilitated the patient's participation in psychotherapy. The focus of therapy was to help him work through the feelings of resentment about the accident.

Treatment of PTSD is important because of its profound disruptive effect on the psyche of these individuals. It is important for health care professionals to recognise this syndrome in accident victims because they may otherwise be misdiagnosed or wrongly labelled as malingerers. Effective clinical intervention which aims at restoring patient to their previous functioning can only be instituted if the problem is correctly identified.

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