

COMORBIDITY – A TROUBLESOME FACTOR IN PTSD TREATMENT

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SUMMARY

Posttraumatic stress syndrome (PTSD) is a disorder which emerges after the patient has experienced one or more psychotraumatic events, which equally include neurobiological deregulation and psychological dysfunction. Comorbidity is present in more than 80% of the diagnosed cases of PTSD, which makes treatment of the primary disorder very difficult.

It has been identified that PTSD can be found in comorbidity with other psychiatric disorders as well as with physical illnesses.

This study presents aged 42, who has been psychiatrically treated for the past 12 years, with a diagnose of chronic PTSD and who subsequently developed depression. The patient has been treated for psoriasis for the past seven years, and two years ago, had to undergo surgery due to bladder carcinoma, followed by a radiotherapy course. Multiple comorbidity significantly makes the treatment of the primary illness very difficult and it limits the choice of pharmacotherapy in ambulatory conditions.

Key words: PTSD – comorbidity-depression – psoriasis - bladder carcinoma

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INTRODUCTION

Posttraumatic stress syndrome (PTSD) was recognised as an unique diagnostic category in 1978, in the Diagnostic and statistical manual (DSM-III) following the emergence of the clinical picture in Vietnamese war veterans, after the experienced war turmoil.

According to DSM-IV (1994) the main diagnostic PTSD feature is the emergence of symptoms after exposure to extreme traumatic events in which the physical integrity of the individual was in direct or indirect threat; those who witnessed death, wounding or threatening of the physical integrity of another, a member of the family or someone close. The reaction to the event has to include an intense fear, a sense of helplessness and horror (APA 1994).

The disorder is characterised by a sequence of experiences of traumatic events. There is a difference between a traumatic and a stress event, in that the first causes suffering to a large number of individuals, regardless of their psychophysical condition before the occurrence of the event.

Reactions to a traumatic experience are considered to be unavoidable and universal. War is a catastrophe of enormous proportions which strikes whole populations everywhere. PTSD is a consequence of an outright threat to someone's life or his or her physical integrity, immediate threat to the family, a sudden destruction of someone's home or community, and witnessing heavy wounding, death or torturing of the other. The nature of a traumatic event as such is extremely horrifying for everyone who experiences it, usually accompanied by fear, horror and a sense of helplessness. The disorder can appear any time in someone's life, including in children (APA 1994).

The psychological symptoms of PTSD are categorized within 3 separate groups of symptoms: (1) recurrent experiencing of the traumatic event (e.g. recalling the event, disturbing dreams about the event), (2) constant avoidance of the stimuli in connection to the trauma and general reactivity numbness, and (3) permanently increased arousal (e.g. difficulty to fall asleep, irritability or anger outbursts, hypervigility). The symptoms within the clinical picture need to be present for at least a

month, together with the appearance of the following:(4) clinically significant disturbance or impairments in social, working and other modes of functioning (APA 1994).

In terms of the experienced trauma, if the symptoms develop within a period of six months and persist for a period of up to six months after the event, this is an indication of acute PTSD. If the disorder lasts longer, that is an indication of a diagnosis of chronic PTSD. The prognosis of chronic PTSD is quite adverse, and could result in permanent personality damage (APA 1994).

Posttraumatic Stress Disorder (PTSD) frequently appears accompanied by other psychiatric disorders such as: Alcohol and Drug abuse, Personality Disorder, General Anxiety Disorder, Obsessive Compulsive Disorder, Schizophrenia etc. Occasionally it might create a problem for clinicians to distinguish PTSD symptoms from symptoms of coexisting psychic disorders (Licanin & Redzic 2002)

Post-traumatic stress disorder (PTSD), depression and metabolic syndromes are increasing public health problems in post-war countries. Comprehending the comorbidity among PTSD, depression and metabolic syndrome has an essential clinical and theoretical issue (Jakovljević 2008), and raises questions about efficiency and effectiveness of resource application in attaining successful outcomes in public mental health services for patients with co-morbid PTSD. (Howgego et al. 2005)

Although commonly in comorbidity, representing a requirement for a more demanding treatment, successful PTSD treatment can also be obtained and conducted in ambulatory conditions.

CASE REPORT

A 42-year old man, married, highly educated, has been in psychiatric treatment for the past 12 years. The patient was a war volunteer in Croatia's War of Independence (1991-1995), and was a member of the elite troops fighting on the first lines of defence for nearly five years. His younger and the only brother died as a soldier soon after the war's outbreak. The patient's family (his wife, parents and two children) lived in a village which was heavily damaged by the havoc of war and are still live there today. Shortly after the war, he demilitarized at his own request.

He tried to get employment in vain for two years, due to which he was threatened existentially.

The patient noted his own tendency towards conflicts and quarrels within the family, which was the motive of his visit to a psychiatrist. He used to negate or diminish his own disturbances, attend check-ups irregularly, take his prescribed psychopharmaceuticals only occasionally at his own discretion. He was hospitalized twice and was discharged at his request. Predominant features of his clinical picture were repeated experiencing, avoidance, lower frustration threshold and sleep disturbances.

Social functioning was aggravated drastically. His existential dependence on his wife and parents led to the emergence of a depressive symptomatology, in terms of weakened self-respect, loss of interests and motives. During a phase of depression which was diagnosed seven years ago, paroxetine (40 mg) and diazepam (10 mg in the evening) were introduced. Skin changes appeared in terms of scaling on the elbows, knees and scalp. Sexual dysfunction and weight gain were seen as paroxetine side-effects. Differential dermatological testing revealed the presence of psoriasis of a progressive course (which spread to the whole body in a year). The patient refused any further psychiatric treatments and continued using alternative methods. All the above mentioned led to the worsening of his clinical PTSD picture as well as depression and psoriasis.

Alternative methods resulted in an uncared for and generalized psoriasis which made the family insist he should continue with his medical treatments. Three years ago the patient visited our psychiatric outpatient clinic for the first time. He rejected psychopharmaceuticals at his first medical examination but agreed to a supportive therapy in which he persistently limited the therapist's interventions and refused trauma elaboration. Lack of memory and somatic difficulties appeared to be fundamental in his reporting. His mental disturbances were persistently negated. Six months after the supportive therapy in 2-month-intervals, the patient accepted trauma elaboration and psychopharmacology (fluoxetine 20 mg). His psoriasis improved thanks to the effectiveness of corticosteroids. The patient became quite compliant in his treatment and agreed to psychodiagnostic analysis.

Four months after the introduction of psychopharmaceuticals, his mental state was on the verge of a partial remission when macrohematuria emerged. The diagnostics conducted, revealed and confirmed bladder carcinoma which was removed surgically, after which a course of radiotherapy

was commenced. Radioactive treatment lasted four months during which his psoriasis worsened (corticosteroids are contraindicated during radioactive therapy).

Mentally, he was struck with PTSD symptoms again (profound and repeated experiencing of the events, avoidance, nightmares), alongside depressive symptomatology (loss of interests, motives, willpower, reflections about the meaning of life).

During the deterioration of his condition, the psychotherapy intensity was increased and the patient accepted it. New psychopharmacotherapy was introduced (sertraline 150 mg, alprazolam 1,5 mg, fluzepam 30 mg) following further psychological testing. Six months later, alprazolam was gradually reduced and discontinued in the end. Psychotherapy initiated the strengthening of the patient's defence mechanisms as well as the patient's ability to confront the illnesses. The patient became motivated and an opportunity to accept retirement arose, which he managed to obtain.

PSYCHODIAGNOSTICS AND EVALUATION

The patient was submitted to psychological testing on two occasions. The first testing (Measurement 1.) was performed on 28/09/07 and the second testing (Measurement 2.) on 20/11/08. In both instances, the patient complained about various physical difficulties (bladder carcinoma removal surgery, large intestine diverticular inflammation, psoriasis). He verbalised his emotional difficulties which he brought into connection with the traumatic experiences he had experienced in the war. The loss of his brother was the key feature among the traumatic experiences. Alongside the PTSD symptoms, he reported lethargy, anxiety, tension, and the feeling of being worn out. Subjectively, the patient mentioned deterioration of his memory ability, without significant shifts on the emotional level.

Table 1. Results of the psychodiagnostic analyses of the mnestic abilities and sensomotor functions

Mnestic abilities	Measurement 1.	Measurement 2.
Memory quotient	average (92)	average (109)
Concentration interference	++	+
Sensomotor function	tremor	in order

Results of the mnestic abilities' analysis revealed a significant improvement of the memory and concentration functions. In both instances, mnestic abilities functioned on an average level but with a significant difference. The first measurement revealed mnestic ability functioning on a lower boundary towards bellow-average values. However, the second measurement showed mnestic ability functioning on a higher boundary

towards above-average values. The first measurement disclosed profound disturbances in concentration which brought on reduced effectiveness in all functions. The second measurement revealed less observable and isolated concentration disturbances. The first measurement of the sensomotor functions showed functional tremor, whereas the second measurement showed functions being in order.

Table 2. Results gained on a personality level (MMPI, Harvard trauma questionnaire, BDI)

Personality	Measurement 1.	Measurement 2.
Personality (characteristics)	tendency towards anxiety somatisation	
Affect	depressive	
Self-harm	pronounced	mild- present through thoughts
PTSP	high intensity	

On a personality level, no significant shifts are evident. In both instances, PTSD symptoms of high intensity with a depressive affect and a tendency towards somatisation of anxiety are recorded on the self-evaluation scales. Discrepancies are not significant. The significance of the discrepancies is noted in the evaluation of self-harm which was

pronounced in the first measurement and which became less pronounced in the second measurement and was present through suicidal thoughts (Table 3).

On the emotional level, a change is evident in the self-evaluation in comparison to the environment. In the second measurement, the patient

evaluates himself as being socially isolated and yet, he perceives himself as being sceptical towards his environment. Oppositionality towards the same environment is lowered. Although other dimensions remained in the same category, they

show a tendency towards a decrease (aggressiveness, depressiveness) or towards an increase (exploration, self-protection, uncontrollability, BIAS) which manifest a lowered pathological intensity of the emotional response.

Table 3. Results gained on the emotional level (Plutchik 2000)

Emotions	Measurement 1.	Measurement 2.
Aggressiveness	high (99)	high(89)
Depression	high (99)	high (86)
Exploration	low (17)	low (22)
Self-protection	low (19)	low (23)
Uncontrollability	low (28)	low (36)
BIAS	low (10)	low (22)
Oppositionality	moderate (57)	low (25)
Reproduction	moderate(40)	low(20)
Incorporation	moderate (43)	low (25)

Table 4. Results received on a Lifestyle and Defence mechanisms questionnaire (Lamovec et al. 1990)

Defence mechanisms	Measurement 1.	Measurement 2.
Projection		high
Intellectualization		high
Negation		high
Compensation	low 10	low 30

Defence mechanisms use: moderate in both measurements

The use of defence mechanisms shows the dominance of three mechanisms of defence: projections, negations and intellectualisation. The patient enables his negative impulses and assigns them to the environment. He tries to isolate the affect. An increase of the compensatory mechanisms is evident (which is still quite low; it usually arises with the ending of depression and self-respect increases, enabling a process of restitution in terms of the establishment of " the object which was lost".

DISCUSSION

PTSD comorbidity is explained by many authors (Licanin & Redzic 2002, Beck et al. 2009). The intertwining of the mental and physical illnesses was quite challenging in the treatment which subsequently turned out to be complex and demanding. First of all, PTSD was diagnosed which wasn't treated adequately due to the patient's non compliance, so as a result, depression emerged. Research demonstrates a common comorbidity between depression and PTSD (Beck et al. 2009, Burris et al. 2008). Apart from the mental comorbidity, the patient developed a physical comorbidity. In the very beginning, psoriasis was not recognised as an illness but a

side-effect of an antidepressant. At the antidepressant discontinuation, the skin illness developed, and further examination revealed psoriasis. Psoriasis is a psychosomatic illness, which significantly worsens after each mental distress. Emotional stresses represent significant triggering factors in psoriasis patients (Griffiths & Richards 2001)

The clinical picture of psoriasis usually correlates with a state of depression. Skin changes are visible and consequently, a sense of shame appears, withdrawal, lack of self-confidence, the individual isolates from the environment, which intensifies the depressive symptomatology. (Gotovac 2005)

PTSD symptoms, such as repeated experiencing, avoidance and increased arousal, accompanied by symptoms of depression, induce the development of psoriasis, whereas in the case of remission of the mental illnesses (PTSD and depression) a significant improvement of psoriasis becomes evident.

The bladder carcinoma diagnosis provoked re-traumatization of a patient's already frail self and secondarily, the worsening of PTSD. At the completion of radiotherapy which was of a high priority due to the patient's critical state, he accepted a psychopharmacological treatment.

Although it may seemed paradoxal at the time, this patient finally accepted a psychiatric treatment at once, soon after facing a possible fatal outcome.

The emergence of a “fatal illness” reactivated his defensive mechanisms on thought, emotional and expressive level. He agreed to a supportive psychotherapeutic treatment (confrontation by emotions) which helped by relieving and expressing the emotions. Therefore, he reversed from a passive way of facing the illness (avoidance) to the active models of confrontation.

For the majority of patients, the first association of a carcinoma diagnosis is a fatal outcome of the illness. The patient must confront the fear of the treatment and the outcome of the illness, dreading suffering and death, while his family is facing the physical threat of the ill member and a threatening loss. The SSRI introduction, combined with psychotherapy, reduced and overcame the fears.

At the completion of the radiotherapy course, the condition was cured, and with a regular psychopharmacotherapy, remission of the mental illnesses was achieved (PTSD and depression). Psoriasis was regularly treated with corticosteroids although the introduced SSRI (sertraline) exhibited an indirect effect on the dermatological illness (Gupta & Guptat 2001).

Psychological distress within the structure of depression and PTSD represents a high risk for the emergence of carcinoma. The presence of the mentioned mental disorders is generally a negative prognostic factor due to which it is of crucial importance to bring the mental disorders to a phase of remission, with all the medical methods available (Hamer et al. 2009).

CONCLUSION

Due to the comorbidity of mental disturbances, a dedicated involvement of the psychiatrists is needed. In case of comorbidity of mental disturbances and physical illnesses, interdisciplinary teamwork is required. The priority in medical treatment is reserved for the illnesses with a possible fatal outcome. A systematic and thorough

psychiatric treatment led to the remission of the mental disorders, which resulted in the improvement of the psychosomatic illness.

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