MWIA CASE STUDIES

LIFELONG IMPACT OF CHILDHOOD ABUSE

Case 30: Posttraumatic Stress Disorder (PTSD)

Objective

- To illustrate the long-term sequelae of childhood sexual abuse.

Narrative Case

** At the end of the case study you can find "Learning points" related to information presented in the narrative case, denoted by numbers in square brackets.*

Susan, age 55, came to the medical review panel as her long-term disability had been refused by her work disability insurance. The review panel had difficulty understanding the reason for her inability to work, as there was no clear-cut history in her medical record. She was working as a care aide at a long-term facility when she felt too anxious and depressed to work. The review panel had the opportunity to interview Susan and find out the details of her disability.

Susan had been attending her general practitioner for ten years but felt uncomfortable telling him about the sexual abuse she suffered as a child. [1] It was only when she was referred to a female psychiatrist that she was able to open up about her past. She had a brother who was having sexual intercourse with her since the age of 12 and although her mother knew about it, she did nothing to stop it. [2] Throughout her teenage years, she found herself partying and would overuse alcohol, smoke marijuana and occasionally use heroin. She was devastated to find she had contracted hepatitis C. She married young to get out of the house, but her husband was both verbally and physically abusive. She really could not leave him as she had three young children and no means of support. [3]

As the children grew older, she was able to get a job as a care aide and finally left her husband. She had a few boyfriends but they had drug and alcohol problems and were abusive towards her. [4] They blamed her for not being interested in sex but she found it difficult to enjoy intercourse without intrusive memories of her sexual abuse as a child. [5]

Work was becoming difficult. She felt anxious all the time. She was constantly tired due to nightmares and was surprised that the sexual abuse by her brother still turned up in these nightmares after all the years. At work, she had found it difficult to concentrate as thoughts kept swirling around her head. When the family of a patient complained about her care of their mother, she decided she could no longer work. She went to her doctor and was prescribed antidepressants but did not find them helpful. She found it difficult to complete the paperwork for the long-term disability and when this was turned down she did not know what she was going to do.

Learning Points

[1] Patients often present to their general practitioner but do not know how to bring up the topic of sexual abuse. Likewise, physicians are often not sure how to ask, for fear that they do not know the proper management.

[2] As a child she felt helpless and trapped. If her own mother would not stand up for her, what was she to do

[3] Getting out of the house and away from the toxic environment is so important, that the choice of a husband is often poor and the selection is of one who continues to abuse her.

[4] Due to low self-esteem, she chose partners who perpetuated her low self-esteem, treating her as if she was deserving of abuse.

[5] Due to her PTSD, she tried to avoid sexual activity as it brought back the childhood memories of abuse.

Background information on PTSD

- DSM-5 diagnostic criteria for PTSD can be found in the "Useful Resources" section on page 3.
- Criteria in the DSM-5 differs from the DSM-IV in several ways.[1]
    - More clearly details what constitutes a traumatic event
    - Specifically includes sexual assault and recurring exposure
    - Language describing the individual's response to a traumatic event (for example, "intense fear", "hopelessness" and "horror") has been deleted because it had no utility in predicting the onset of PTSD.
    - DSM-5 pays more attention to the behavioural symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three:
        1. The **Re-experiencing** covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress.
        2. **Avoidance** refers to distressing memories, thoughts, feelings or external reminders of the event.
        3. **Negative cognitions and mood** represents a myriad of feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.
        4. Arousal is marked by aggressive, reckless or self-destructive behaviour, sleep disturbances, hyper-vigilance or related problems.

Prevalence:

- Women's lifetime prevalence of developing PTSD is double that of men's, and this disparity is even larger when the traumatic event happens in childhood.[2]
- Approximately 30-50% of sexually abused children meet the diagnostic criteria for PTSD, and a much larger proportion experience at least some of the PTSD symptoms.[2]
- In a national study, 20% of adolescents, 40% of college women, and 27.2% of household-residing women who reported sexual revictimisation were currently experiencing PTSD. [3]
- Compared to non-victims, the likelihood of meeting the PTSD diagnostic criteria within the last six months was 4.3-8.2 times higher for revictimised respondents and 2.4-3.5 times higher for one-time victims of sexual abuse. [3]

Useful Resources

DSM-V Diagnostic Criteria for PTSD in Adults [4]

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).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

   Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

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).

   Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

   Note: In children, there may be frightening dreams without recognizable content.
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.)

   Note: In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Perisistent 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).
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).

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).
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”).
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.
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 behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

- **With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:
    1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
    2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

        Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

References

1. American Psychiatric Association (2013). *Highlights of Changes from DSM-IV to DSM-5.* Retrieved from: https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425596.changes
2. Maikovich, A. K., Koenen, K. C. & Jaffee, S. R. (2011). Posttraumatic Stress Symptoms and Trajectories in Child Sexual Abuse Victims: An Analysis of Sex Differences Using the National Survey of Child and Adolescent Well-Being. *Journal of Abnormal Child Psychology, 37*(5), 727-737. doi: 10.1007/s10802-009-9300-x
3. Walsh, K., Danielson, C. K., McCauley, J. L., Saunders, B. E., Kilpatrick, D. G. & Resnick, H. S. (2013). National Prevelnce of PTSD Among Sexually Revictimized Adolescent, College, and Adult Household-Residing Women. *Archives of General Psychiatry, 69*(9), 935-942. doi: 10.1001/archgenpsychiatry.2012.132
4. American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders. Fifth Edition.* Washington, D.C: Author.