UFCSPA

Trauma: quando tratar e como

Carolina Blaya

Junho 2013

Aspectos Históricos

- “Neurose traumática” (Oppenheim 1889)
- “Neurose de Guerra” (Kardiner, 1941): hipervigilância, sensibilidade à ameaça, forma crônica.
- Grupos com veteranos da guerra do Vietnã: Shatan e Lifton - DSM III (1980)
- DSM-III-R (1987): re-experimentação, evitação, excitabilidade aumentada
- DSM-IV (1994): TEPT e TEA entre os transtornos de ansiedade
- DSM 5 (2013): transtorno ligado ao estresse

Schestatsky et al, 2003
DSM 5

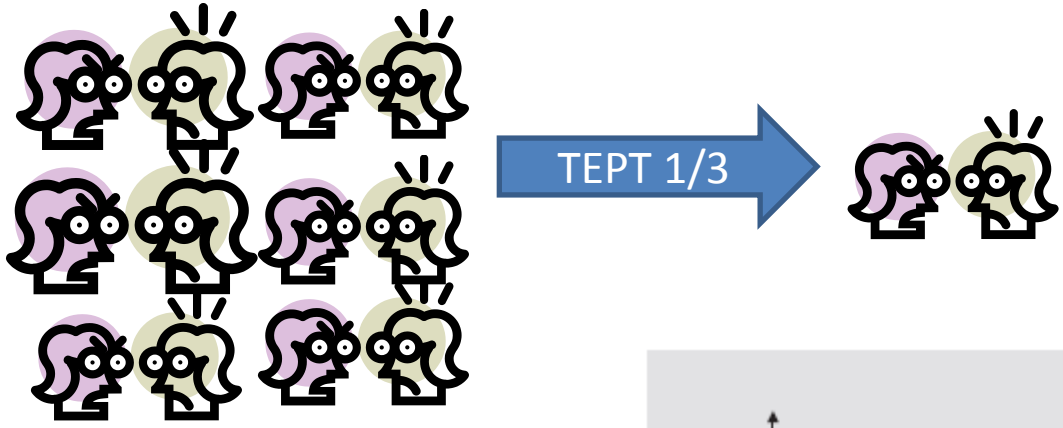
Reação aguda ao estresse vs. Transtorno de estresse agudo vs. TEPT

0-2 dias
Reação aguda ao estresse (Reação de ajustamento)

3-30 dias
Transtorno de estresse agudo

> 1mês
Transtorno de estresse pós-traumático

TEPT



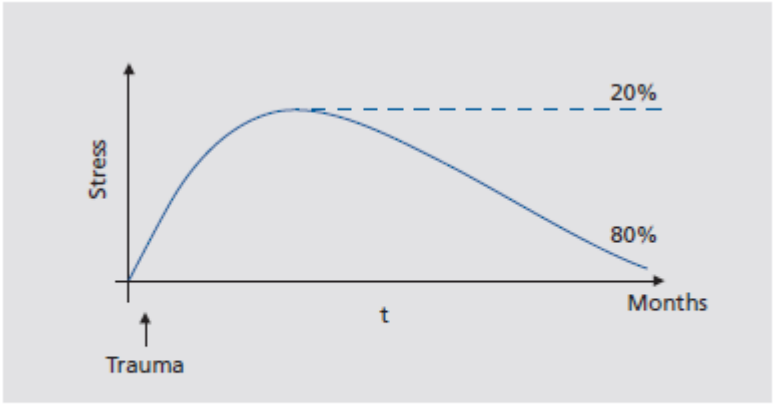


Figure 3. Most people exposed to trauma do not develop post-traumatic stress disorder.

Transtorno de estresse agudo

- Introduzido pelo DSM-IV para descrever manifestação que pode preceder o TEPT
- Manifestação no 1º mês após o trauma
- Identifica sujeitos com alta probabilidade de desenvolver o TEPT

Sensibilidade e especificidade do TEA para TEPT

Sensitivity, specificity, and positive and negative predictive power of ASD and subsyndromal ASD predicting diagnoses.

Variable	Sensitivity		Specificity		PPP		NPP	
	ASD	Subsyndromal ASD	ASD	Subsyndromal ASD	ASD	Subsyndromal ASD	ASD	Subsyndromal ASD
PTSD	.34 (.33)	.42 (.46)	.94 (.95)	.93 (.90)	.36 (.42)	.30 (.35)	.93 (.92)	.93 (.93)
MDD	.23 (.16)	.35 (.26)	.93 (93)	.87 (.89)	.40 (.35)	.30 (.35)	.86 (.83)	.89 (.85)
Panic disorder	.37 (.33)	.45 (.39)	.96 (.93)	.96 (.88)	.22 (.23)	.19 (.16)	.92 (.96)	.88 (.96)
Agoraphobia	.33 (.31)	.41 (.46)	.93 (.95)	.94 (.90)	.32 (.42)	.28 (.37)	.93 (.92)	.89 (.93)
Social phobia	.35 (.30)	.47 (.48)	.92 (.93)	.96 (.89)	.25 (.27)	.23 (.26)	.95 (.94)	.86 (.96)
Specific phobia	.32 (.24)	.44 (.41)	.92 (.93)	.96 (.88)	.20 (.15)	.19 (.16)	.96 (.96)	.88 (.96)
OCD	.48 (.39)	.57 (.54)	.92 (93)	.98 (.88)	.17 (19)	.14 (.16)	.98 (.97)	.58 (.98)
GAD	.33 (.26)	.41 (.36)	.94 (.94)	.92 (.89)	.40 (.39)	.33 (.33)	.92 (.90)	.90 (.91)
Substance use	.13 (.18)	.19 (.25)	.91 (.93)	.91 (.87)	.14 (.19)	.13 (.16)	.91 (92)	.87 (.92)
Any diagnosis	.19 (.18)	.25 (.27)	.95 (.97)	.95 (.93)	.65 (.73)	.59 (.67)	.72 (.70)	.72 (.71)

Note. Sensitivity = the probability that someone diagnosed with a disorder at 12 months had acute (or subsyndromal) stress disorder. Specificity = probability that someone who did develop a disorder at 12 months did not have acute (or subsyndromal) stress disorder. Positive predictive power = probability that someone with acute (or subsyndromal) stress disorder subsequently develops a disorder. Negative predictive power = probability that someone without acute (or subsyndromal) stress disorder subsequently does not develop a disorder. Data in parentheses refer to predictive functions of participants with no prior psychiatric disorder.

Bryant 2012

Transtorno de Estresse Agudo (DSM-5)

A. Exposição ou ameaça de morte, ferimento grave, violação sexual de uma das seguintes formas:

1. Exposição direta ao evento traumático

2. Testemunhou o evento

3. Soube do evento através de um familiar ou amigo próximo (evento violento ou acidental)

4. Foi extremamente exposto a muitos detalhes do evento (ex. Bombeiros, policial)

Não inclui eventos exposto somente através de mídia eletrônica e TV.

Transtorno de Estresse Agudo (DSM-5)

B. Nove (9/14) dos seguintes sintomas:

- Sintomas intrusivos (memórias intrusivas e invasivas, sonhos recorrentes, reações dissociativas como flash-back, intenso desconforto ou sintomas físicos marcados secundário a indícios internos ou externos ligados ao evento)
- Humor negativo (inabilidade de experienciar emoções positivas)
- Sintomas dissociativos (alterações da percepção da realidade ou de si próprio, inabilidade de lembrar de fatos importantes ligados ao trauma)
- Sintomas evitativos (esforços para evitar lembrar do trauma, esforços para evitar indícios externos que lembre o trauma)
- Sintomas de hiperexcitabilidade (Alteração do sono, irritabilidade ou agressividade, hipervigilância, problemas de concentração, reações de sobressalto)

C. Duração >3 dias e <1 mês

DSM-5 (2013)

Sintomas dissociativos

Table 2. Hierarchical Multiple Regression Analyses of Factors Related to Intrusions and Avoidance Reactions 18 Months and Almost 4 Years Postdisaster

	18-months postdisaster				4-years postdisaster			
	ΔR^2	*B*	*SE B*	β	ΔR^2	*B*	*SE B*	β
Step 1: Demographic characteristics and disaster experiences								
Gender (female)	.15***	4.32	1.38	.12**	.20***	2.15	1.27	.06
Age		0.26	0.05	.22***		0.31	0.05	.27***
Education level		−1.75	0.83	−.09*		−2.32	0.75	−.13**
Damage home		5.30	1.78	.12**		4.51	1.63	.11**
Disaster exposure		0.84	0.14	.24***		0.90	0.13	.27***
Step 2: Initial posttraumatic stress symptoms and psychological distress								
Gender (female)	.22***	−0.42	1.25	−.01	.16***	−1.71	1.19	−.05
Age		0.19	0.05	.16***		0.24	0.04	.21***
Education level		−1.04	0.72	−.05		−1.67	0.69	−.09*
Damage home		2.04	1.56	.05		2.00	1.49	.05
Disaster exposure		0.37	0.13	.10**		0.51	0.12	.15***
T1 IES		0.24	0.05	.22***		0.22	0.05	.22***
T1 SCL-90-R		0.13	0.02	.35***		0.10	0.02	.27***
Step 3: Peritraumatic dissociation								
Gender (female)	.008*	−0.03	1.25	−.00	.00	−1.65	1.20	−.05
Age		0.19	0.05	.16***		0.24	0.04	.21***
Education level		−1.04	0.71	−.05		−1.68	0.69	−.09*
Damage home		2.54	1.57	.06		2.08	1.50	.05
Disaster exposure		0.43	0.13	.12**		0.52	0.12	.16***
T1 IES		0.29	0.05	.28***		0.22	0.05	.23***
T1 SCL-90-R		0.15	0.02	.38***		0.10	0.02	.28***
PDEQ		−0.24	0.09	−.13**		−0.04	0.08	−.02

Note. T1 = 2–3 weeks postdisaster. IES = Impact of Event Scale; SCL-90-R = Psychological distress, total score on the SCL-90-R; PDEQ = Peritraumatic Dissociative Experiences Questionnaire (PDEQ); SRS-PTSD = Self Rating Scale for Posttraumatic Stress Disorders.
*$p < .05$. **$p < .01$. ***$p < .001$.

Van der Velden 2006

TEPT

- Geralmente nos primeiros 3 meses após o trauma
- Remissão espontânea em ½ dos casos em 3 meses
- Risco de suicídio indireto
- Incapacitação funcional, custos econômicos e alta utilização de serviços médicos
- 80% comorbidade

(DSM 5 2013, Krysinska 2010)

Transtorno de Estresse Pós-Traumático (DSM-5)

A. Exposição ou ameaça de morte, ferimento grave, violação sexual de uma das seguintes formas:

   1. Exposição direta ao evento traumático

   2. Testemunhou o evento

   3. Soube do evento através de um familiar ou amigo próximo (evento violento ou acidental)

   4. Foi extremamente exposto a muitos detalhes do evento (ex. Bombeiros, policial)

   Não inclui eventos exposto somente através de mídia eletrônica e TV.

B. Pelo menos 1 sintoma intrusivo (1/3) (Memória intrusiva e recorrente do trauma, sonhos recorrentes, reações dissociativas tipo flashback)

C. Pelo menos 1 sintoma de evitação (1/2) (evitação de lembranças, evitação de indícios externos que lembrem o trauma)

Transtorno de Estresse Pós-Traumático (DSM-5)

D. Duas ou mais alterações de humor e cognições (2/7) (incapacidade de recordar aspectos do trauma, crenças persistentes e exageradas quanto a si mesmo, os outros ou o mundo, Cognições distorcidas quanto às causas ou às consequências do trauma, estado emocional negativo persistente, redução de interesse e participação em atividades relevantes, sensação de distanciamento e afastamento de outras pessoas, incapacidade persistente de sentir emoções positivas)

E. Dois ou mais sintomas de excitabilidade aumentada (2/5) (irritabilidade ou surtos de raiva, comportamento auto-destrutivo, hipervigilância, resposta de sobressalto exagerada, dificuldade de concentração, dificuldade em conciliar ou manter o sono)

F. Duração superior a um mês

G. Sofrimento significativo ou prejuízo funcional

H. Não é secundário a efeito de substância ou condição médica

TEPT ao longo do mundo

Alemanha	1,3%
EUA	7,8%
Etiópia	15,8%
Faixa de Gaza	28,4%
Camboja	28,4%
Argélia	37,4%

(De Jong 2001, Kessler 1995, Perkoning 2000)

Prevalência de trauma e TEPT (NCS- DSM-III-R)

N=5877	Mulheres expostas	TEPT	Homens expostos	TEPT
Estupro	9,2%	45,9%	0,7%	65%
Agressão Física	6,9%	21,3%	11,1%	1,8%
Acidente	13,8%	8,8%	25,0%	6,3%
Desastre Natural	15,2%	5,4%	18,9%	3,7%
Ameaça com Arma	6,8%	32,6%	19,0%	1,9%
Guerra	0%	-	11,1%	38,8%
Total	51,2%	20,4%	60,7%	8,1%

(Kessler 1995)

Prevalência TEPT (DSM-IV)

- Ataque de 11/setembro (9%)
- Acidente com veículo (13–25%)
- Testemunhar um tiroteio (33%)

(Galea 2002, Bryant 2003, Classen 1998)

Table 3. Exposure to Traumatic Events in Sao Paulo (SP) and Rio de Janeiro (RJ), 2007–2008*.

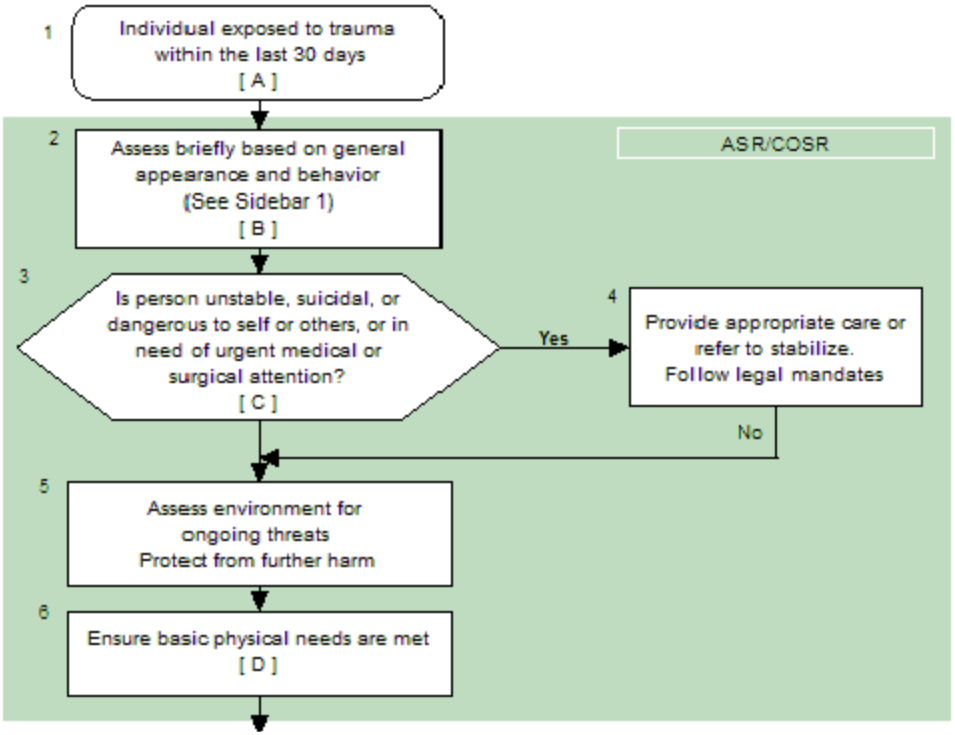
Traumatic events	Lifetime prevalence			12-month prevalence		
	SP	RJ		SP	RJ	
	% (95%CI)	% (95%CI)	P value	% (95%CI)	% (95%CI)	P value
Assaultive violence	***59.4 (57.0–61.8)***	***63.8 (60.8–66.90***	***0.024***	***9.5 (8.0–11.0)***	***11.4 (9.5–13.3)***	***0.115***
War experience	0.5 (0.01–8.9)	1.1 (0.5–1.7)	0.104	0	0.08 (0.0–2.4)	0.114
Being attacked without weapon	21.8 (19.7–23.8)	24.6 (22.0–27.3)	0.093	1.0 (0.5–1.5)	2.5 (1.5–3.4)	0.005
Being attacked with weapon	28.8 (26.6–31.0)	33.1 (30.2–36.1)	0.020	2.5 (1.7–3.2)	2.4 (1.5–3.3)	0.946
Being kidnapped, or held captive	0.7 (0.4–1.1)	1.5 (0.8–2.3)	0.048	0.1 (0.0–0.3)	0.08 (0.0–0.2)	0.840
Fast kidnap†	2.0 (1.2–2.8)	0.7 (0.2–1.2)	0.010	0.02 (0.0–0.6)	0	0.528
Torture/terrorism	0.8 (0.3–1.2)	2.2 (1.3–3.1)	0.003	0.1 (0.0–0.3)	0.2 (0.0–0.4)	0.814
Death threats	12.1 (10.5–13.7)	11.9 (9.8–13.9)	0.857	2.3 (1.5–3.1)	2.3 (1.4–3.2)	0.939
Conflict between gangs/drug dealers‡	1.2 (0.7–1.8)	3.0 (1.9–4.0)	0.002	0.3 (0.0–0.7)	0.6 (0.1–1.1)	0.324
Rape	1.3 (0.8–1.8)	2.3 (1.4–3.3)	0.044	0	0.008 (0.0–0.2)	0.114
Sexual molestation	2.5 (1.8–3.3)	4.9 (3.5–6.2)	0.001	0.004 (0.0–0.1)	0.02 (0.0–0.4)	0.219
Being beaten-up by parents/relatives	7.3 (6.1–8.6)	9.1 (7.2–10.8)	0.107	0.06 (0.2–1.0)	0.4 (0.1–0.7)	0.459
Being beaten-up by an intimate partner	6.8 (5.6–8.0)	6.8 (5.3–8.4)	0.992	0.9 (0.5–1.4)	0.9 (0.4–1.4)	0.885
Being beaten-up by anyone else than family/partner	3.7 (2.8–4.6)	4.2 (3.0–5.3)	0.523	0.2 (0.0 −1–0.4)	0.3 (0.02–0.6)	0.595
Having one's house broken into while at home	9.0 (7.6–10.5)	7.3 (5.7–8.9)	0.128	1.2 (0.7–1.8)	0.8 (0.2–1.3)	0.242
Blackmailing telephone calls	8.7 (7.2–10.1)	12.0 (10.0–14.0)	0.006	3.0 (2.1–3.8)	3.4 (2.3–4.4)	0.584
Other injury or shocking events	***72.7 (70/7–75.0)***	***79.0 (75.9–81.9)***	***<0.001***	***12.8 (11.1–14.4)***	***23.7 (21.0–26.4)***	***<0.001***
Car/motorcycle accident	18.1 (16.2–20.0)	17.4 (15.0–19.7)	0.645	1.3 (0.7–1.8)	1.5 (0.7–2.3)	0.625
Accidents other than car/motorcycle	5.3 (4.2–6.4)	7.1 (5.4–8.7)	0.070	0.4 (0.1–0.8)	0.5 (0.04–1.0)	0.836
Fire, flood, natural disaster	7.5 (6.2–8.9)	10.3 (8.4–12.3)	0.016	0.9 (0.3–1.4)	0.6 (0.1–1.0)	0.375
Witnessing someone being killing or injured	27.1 (24.9–29.3)	28.2 (25.4–31.1)	0.524	3.4 (2.5–4.3)	4.4 (3.1–5.7)	0.222
Witnessing bank robbery	7.0 (5.6–8.3)	7.1 (5.5–8.8)	0.875	0.8 (0.3–1.3)	0.8 (0.2–1.4)	0.973
Witnessing a shoot-out or being victim of stray bullet	16.1 (14.3–17.9)	29.4 (26.5–32.2)	<0.001	2.0 (1,3–2.7)	11.7 (9.6–13.8)	<0.001
Witnessing domestic violence during childhood¥	16.2 (14.5–18.0)	17.5 (15.1–19.8)	0.404	0.3 (0.0–0.6)	0.0	0.223
Having one's house broken into while not at home	14.2 (12.4–15.9)	10.4 (8.5–12.3)	0.006	1.2 (0.6–1.7)	1.5 (0.7–2.3)	0.486
Seeing or touching a corpse	31.0 (28.7–33.3)	37.5 (34.4–40.5)	0.001	4.6 (3.6–5.6)	10.3 (8.4–12.3)	<0.001
Witnessing atrocities, slaughter, massacre	7.7 (6.4–9.0)	11.5 (9.6–13.4)	0.001	1.0 (0.5–1.5)	2.2 (1.3–3.1)	0.014
Human-made disaster	2.2 (1.5–3.0)	4.3 (3.0–5.6)	0.004	0.4 (0.02–0.7)	0.4 (0.0–0.9)	0.782
Witnessing crime organizations' attacks^Δ	25.2 (23.1–27.4)	26.7 (23.9–29.5)	0.417	0.4 (0.2–0.5)	1.1 (0.4–1.7)	0.003
Sudden death/life-threatening illness of a dose person	***47.1 (44.6–50.0)***	***49.7 (46.6–52.9)***	***0.194***	***4.7 (3.7–5.7)***	***7.4 (5.7–9.0)***	0.004
Sudden unexpected death of a close person	42.2 (39.8–44.6)	45.1 (42.0–48.2)	0.150	3.8 (2.8–4.7)	6.8 (5.2–8.2)	<0.001
Child with life-threatening illness or injury	9.6 (8.2–11.0)	9.1 (7.3–11.0)	0.702	1.0 (0.5–1.5)	0.8 (0.2–1.3)	0.579
Any traumatic event	***86.0 (84.4–87.7)***	***88.7 (86.7–90.6)***	***0.055***	***21.7 (19.6–23.7)***	***35.1 (32.1–38.1)***	***<0.001***

*Prevalence estimates presented are weighted estimates.
†In the fast kidnap the person is kidnaped and held captive for several hours to withdraw cash form ATMs.
‡Conflicts between gangs/drug dealers refer to fights between rival groups, usually to control drug traffic areas in the slams.
¥This includes events that occurred up to 12 years of age.
^ΔIn 2006 and 2007, crime organizations perpetrated a series of random gunshots, depredations and bus-burnings in the two cities.
doi:10.1371/journal.pone.0063545.t003

(Ribeiro 2013)

VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress
Module A - Acute Stress Reaction/Disorder Prevention of PTSD

A



Sidebar 1. ASSESSMENT

- Symptoms
- Trauma
- Risk factors
- Medical status
- Mental status
- Functional status
- Psychosocial status
- Dangerousness
- Unit disruption

Sidebar 2. IMMEDIATE NEEDS

- Survival
- Safety & Security
- Food, hydration
- Shelter, clothing
- Sleep
- Medical care (first aid)
- Stabilization (if needed)
- Orientation
- Communication with unit/family friends and community

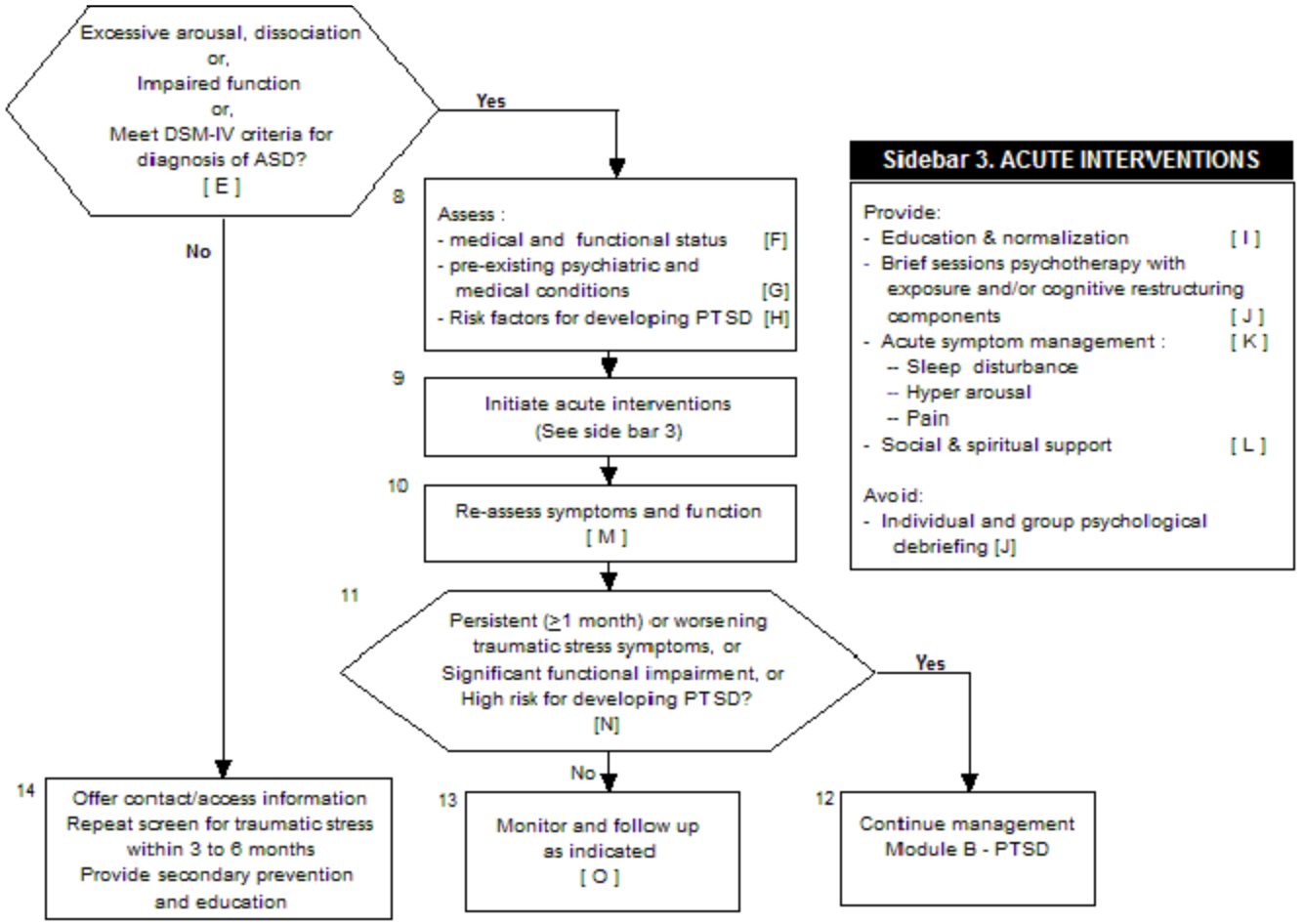

Excessive arousal, dissociation
or,
Impaired function
or,
Meet DSM-IV criteria for
diagnosis of ASD?
[E]
Yes
No
8
Assess :
- medical and functional status [F]
- pre-existing psychiatric and
medical conditions [G]
- Risk factors for developing PTSD [H]
9
Initiate acute interventions
(See side bar 3)
10
Re-assess symptoms and function
[M]
11
Persistent (≥1 month) or worsening
traumatic stress symptoms, or
Significant functional impairment, or
High risk for developing PTSD?
[N]
Yes
No
14
Offer contact/access information
Repeat screen for traumatic stress
within 3 to 6 months
Provide secondary prevention
and education
13
Monitor and follow up
as indicated
[O]
12
Continue management
Module B - PTSD
Sidebar 3. ACUTE INTERVENTIONS
Provide:
- Education & normalization [I]
- Brief sessions psychotherapy with
exposure and/or cognitive restructuring
components [J]
- Acute symptom management : [K]
-- Sleep disturbance
-- Hyper arousal
-- Pain
- Social & spiritual support [L]
Avoid:
- Individual and group psychological
debriefing [J]

Table A - 1 Early Intervention after Exposure to Trauma (<4 days after exposure)

	Balance of Benefit and Harm			
SR	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit Potential Harm
I	--	Psychological First Aid Psychoeducation and normalization Social support	Spiritual support	--
D				Psychological debriefing

SR = Strength of recommendation (see Appendix A)

Primeiros socorros psicológicos

1. *Contact and Engagement* - Respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate, and helpful manner
2. *Safety and Comfort* - Enhance immediate and ongoing safety, and provide physical and emotional comfort
3. *Stabilization (if needed)* - Calm and orient emotionally overwhelmed or distraught survivors
4. *Information Gathering - Current Needs and Concerns* - Identify immediate needs and concerns, gather additional information, and tailor PFA interventions
5. *Practical Assistance* - Offer practical help to the survivor in addressing immediate needs and concerns
6. *Connection with Social Supports* - Help establish opportunities for brief or ongoing contacts with primary support persons or other sources of support, including family members, friends, and community helping resources
7. *Information on Coping* - Provide information (about stress reactions and coping) to reduce distress and promote adaptive functioning
8. *Linkage to Collaborative Services* - Link survivors with needed services and inform them about available services that may be needed in the future.

These core goals of PFA constitute the basic objectives of providing early assistance (e.g., within days or weeks following an event). The amount of time spent on each goal will vary from person to person and with different circumstances, according to need.

The complete document describing PFA components can be found at: http://www.vdh.state.va.us/EPR/pdf/PFA9-6-05Final.pdf

VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress


The New York Times
MORSI DECLARES EMERGENCY RULE IN 3 EGYPT CITIES
SENATORS OFFER A NEW BLUEPRINT FOR IMMIGRATION
Frenzied Scene As Toll Tops 200 In Brazil Blaze
G.O.P.'s Cantor, Looking Past Politics of Debt
TRAGEDIA EN BRASIL: 233 M
SANTA MARIA, 27/01/2013
JUSTIÇA
30
Ganância
The Washington Post
Nightclub tragedy in Brazil
Senators to unveil immigration plan
ZERO HORA
SANTA MARIA, 27/01/2013

Tratamento do TEA

- Identificar vítimas em risco de desenvolver psicopatologia
- Tratamento de pacientes com TEPT com TCC nos primeiros meses pós-trauma previne outras complicações
- Os estudos positivos são focados em ansiedade, não há evidência em outras reações emocionais (raiva, depressão, culpa,...)

Bryant 2011

Table A-4 Early Interventions after Exposure to Trauma (4 to 30 days after exposure)

	Balance of Benefit and Harm			
SR	**Significant Benefit**	**Some Benefit**	**Unknown Benefit**	**No Benefit**
A	- Brief Cognitive Behavioral Therapy (4-5 sessions)			
B				
C		- Social support		
D				- Individual psychological debriefing ⊘ - Formal psychotherapy for asymptomatic survivors ⊘ - Benzodiazepines ⊘ - Typical Antipsychotics ⊘
I		- Psychoeducation and normalization	- Imipramine - Propranolol - Prazosin - Other Antidepressants - Anticonvulsants - Atypical Antipsychotics - Spiritual support - Psychological First Aid	- Group psychological debriefing

⊘= *Potential harm; SR = Strength of recommendation (see Appendix A)*

Debriefing

1. Introdução
2. Os fatos
3. Pensamentos e impressões
4. Emoções
5. Normalização
6. Planejamento do futuro
7. Desligamento

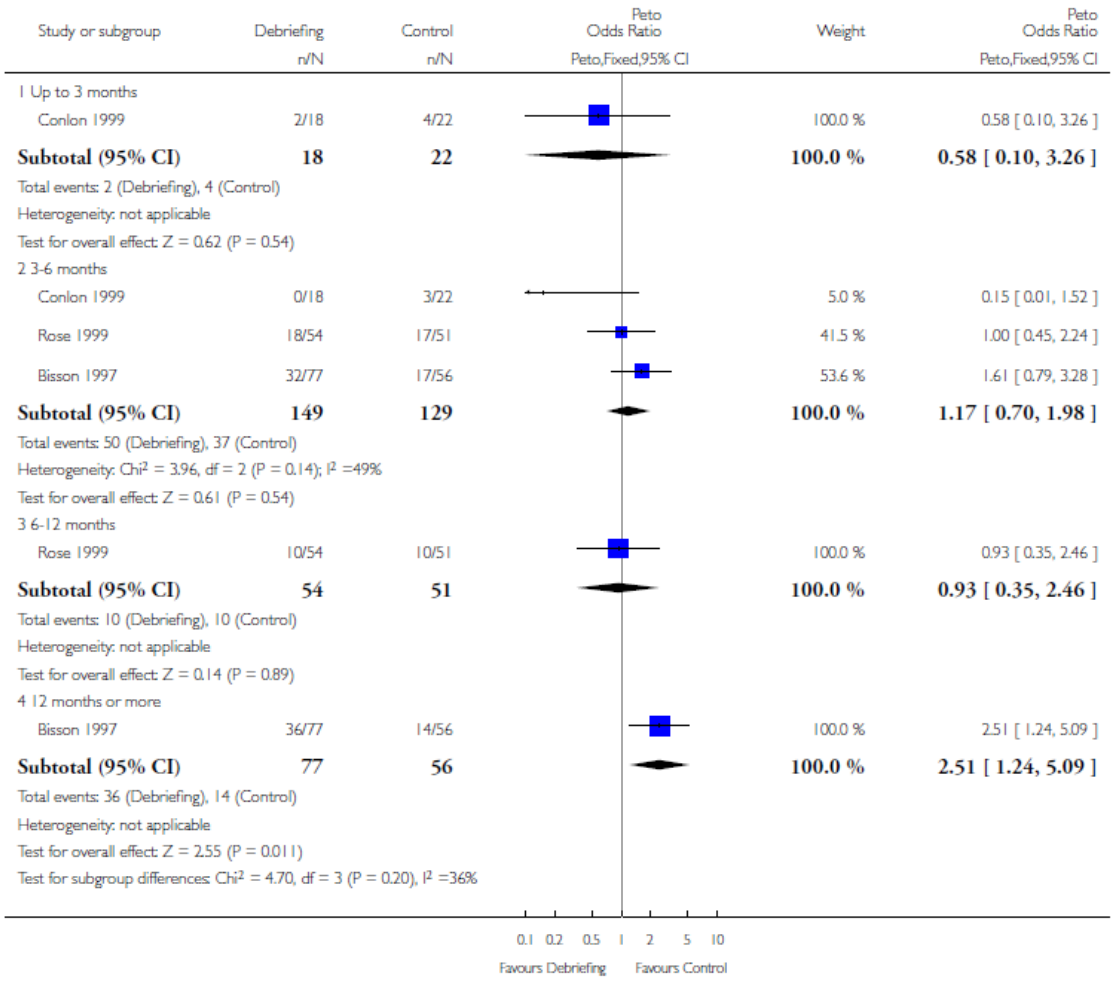
Mitchell 1983 and Dysegow 1989

Analysis 1.1. Comparison 1 Debriefing versus Control, Outcome 1 PTSD diagnosis - ITT data.

Review: Psychological debriefing for preventing post traumatic stress disorder (PTSD)

Comparison: 1 Debriefing versus Control

Outcome: 1 PTSD diagnosis - ITT data



Rose 2009

Display Settings: Abstract

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J Clin Psychiatry. 1996 Sep;57(9):390-4.

Treatment of recent trauma survivors with benzodiazepines: a prospective study.

Gelpin E, Bonne O, Peri T, Brandes D, Shalev AY.

The Center for Traumatic Stress, Department of Psychiatry, Hadassah University Hospital, Jerusalem, Israel.

Abstract

BACKGROUND: Most types of psychotropic drugs have been tried in the treatment of chronic posttraumatic stress disorder (PTSD), but have yielded limited results. Theory and retrospective research predict that early treatment may be more efficacious. Specifically, high-potency benzodiazepines have been recommended for the treatment of acute responses to trauma and for prevention of PTSD. This study prospectively evaluates the effect of early administration of benzodiazepines on the course of PTSD and PTSD symptoms.

METHOD: Thirteen trauma survivors (the benzodiazepine group) were treated within 6.7 +/- 5.8 days after the trauma (range, 2-18) with either clonazepam (N = 10, 2.7 +/- 0.8 mg/day) or alprazolam (N = 3, 2.5 mg/day). Thirteen other trauma survivors, pair-matched with subjects in the active treatment group for gender and symptom severity in the first week after the trauma, constitute the control group. Both groups were reevaluated 1 and 6 months after the trauma for PTSD symptoms (Horowitz Impact of Event Scale; Mississippi Rating Scale for Combat-Related PTSD-civilian trauma version), PTSD status (Clinician Administered PTSD Scale), state anxiety, depression, and resting heart rate.

RESULTS: Subjects in the benzodiazepine group did not differ from controls in 1-month and 6-month PTSD and anxiety scores. Repeated measures ANOVA showed no group or group-by-time effect on psychometric measures. A trend toward group-by-time interaction in resting heart rate was noted (progressive decrease in the benzodiazepine group). Nine benzodiazepine subjects and 3 controls met PTSD diagnostic criteria 6 months after the trauma.

CONCLUSION: Contrary to expectations, the early administration of benzodiazepines to trauma survivors with high levels of initial distress did not have a salient beneficial effect on the course of their illness, while reducing physiologic expression of arousal.

PMID: 9746445 [PubMed - indexed for MEDLINE]

European Neuropsychopharmacology (2009) 19, 283–295

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Alprazolam treatment immediately after stress exposure interferes with the normal HPA-stress response and increases vulnerability to subsequent stress in an animal model of PTSD

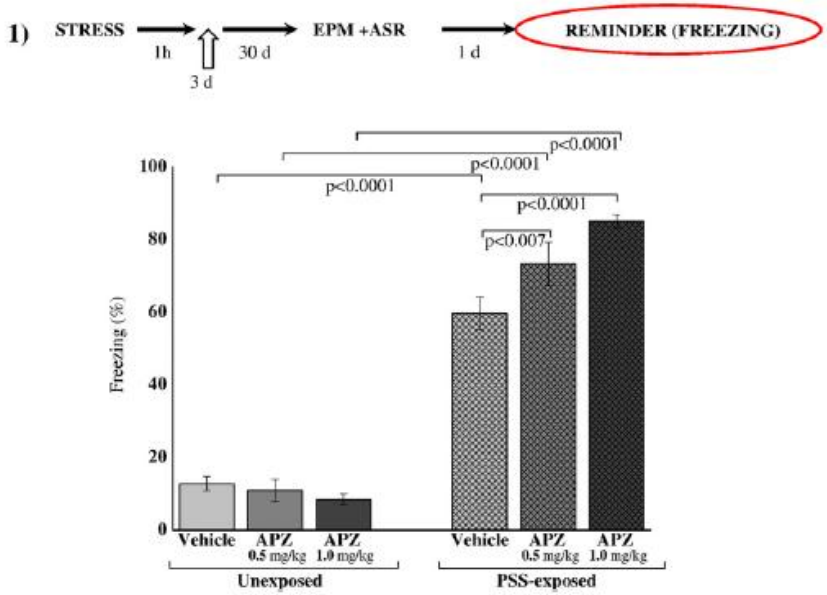


Figure 2 Effect of exposure to the situational reminder on freezing behavior at day 31: 1) The behavioral procedure used for the unexposed and PSS-exposed rats. Vertical open arrows represent intraperitoneal injection (alprazolam or vehicle). Freezing response (%) The situational reminder elicited significantly longer periods of immobility during exposure in Alprazolam treated rats, than in exposed rats treated with vehicle. All data represent group mean ± S.E.M.

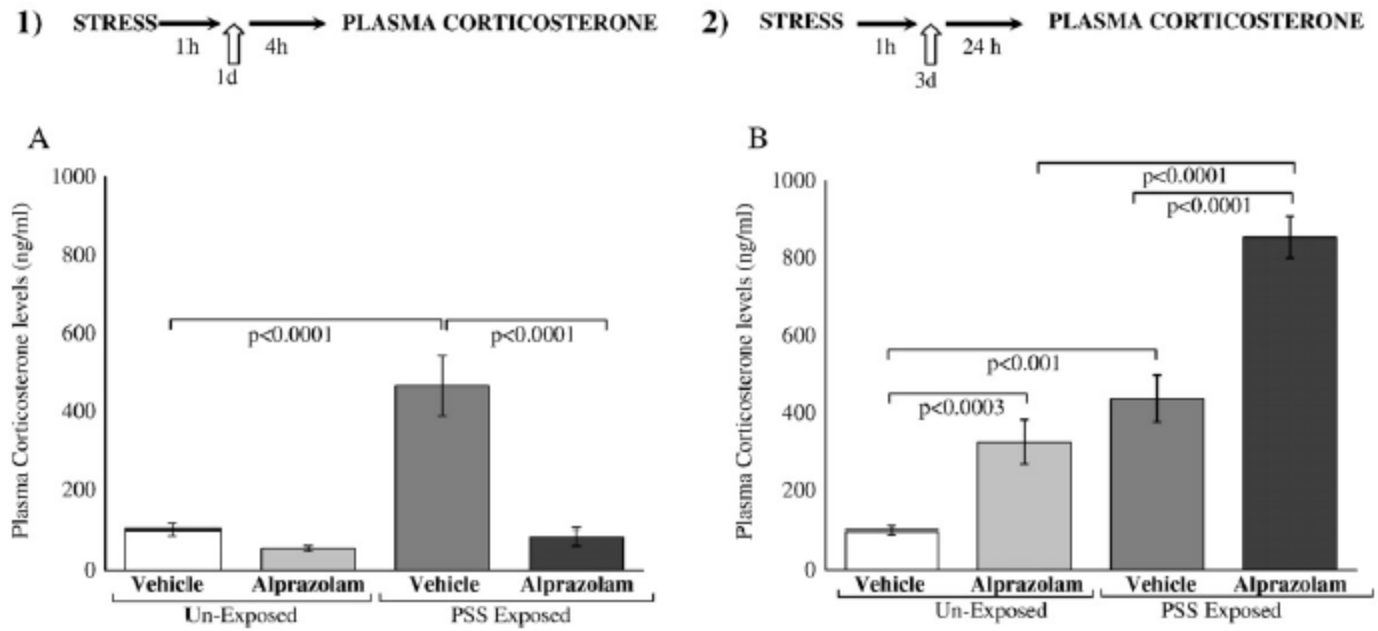
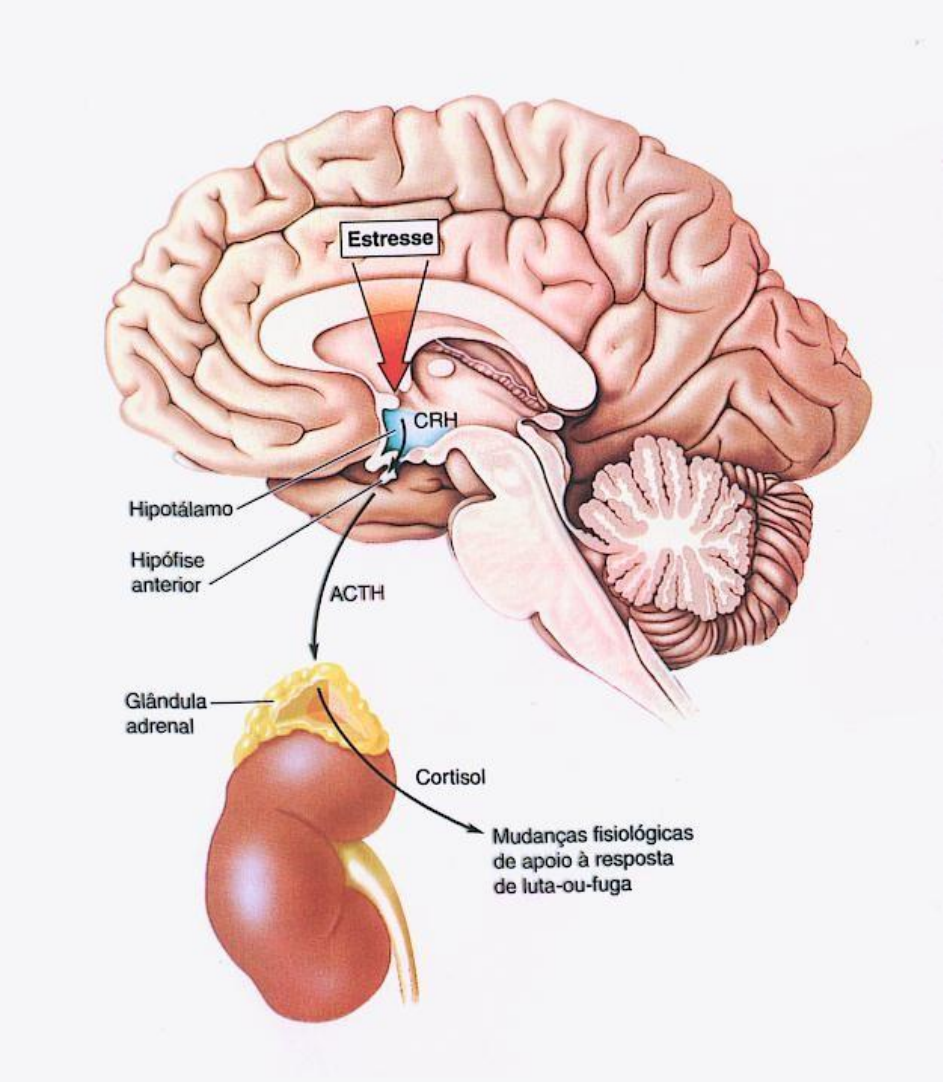


Figure 6 Effects of alprazolam immediately after PSS-exposure on circulating corticosterone levels: 1-2) The behavioral procedure used for the unexposed and PSS-exposed rats. Vertical open arrows represent intraperitoneal injection (alprazolam or vehicle). All data represent group mean ± S.E.M.

Eixo HHA


Estresse
CRH
Hipotálamo
Hipófise
anterior
ACTH
Glândula
adrenal
Cortisol
Mudanças fisiológicas
de apoio à resposta
de luta-ou-fuga

European Neuropsychopharmacology (2011) 21, 796–809

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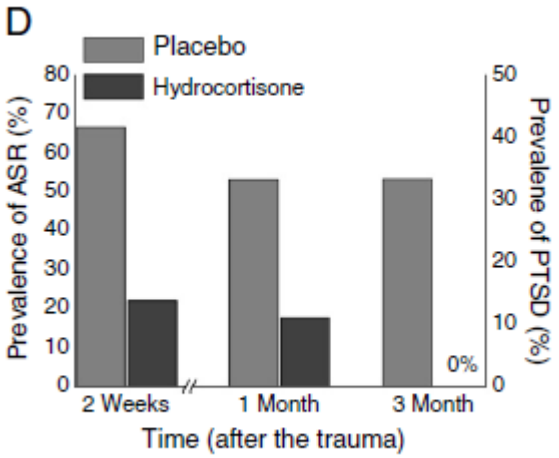
High dose hydrocortisone immediately after trauma may alter the trajectory of PTSD: Interplay between clinical and animal studies ☆

Joseph Zohar [a], Hila Yahalom [a], Nitsan Kozlovsky [b], Shlomit Cwikel-Hamzany [a], Michael A. Matar [b], Zeev Kaplan [b], Rachel Yehuda [c], Hagit Cohen [b,*]



Propranolol vs. TEPT

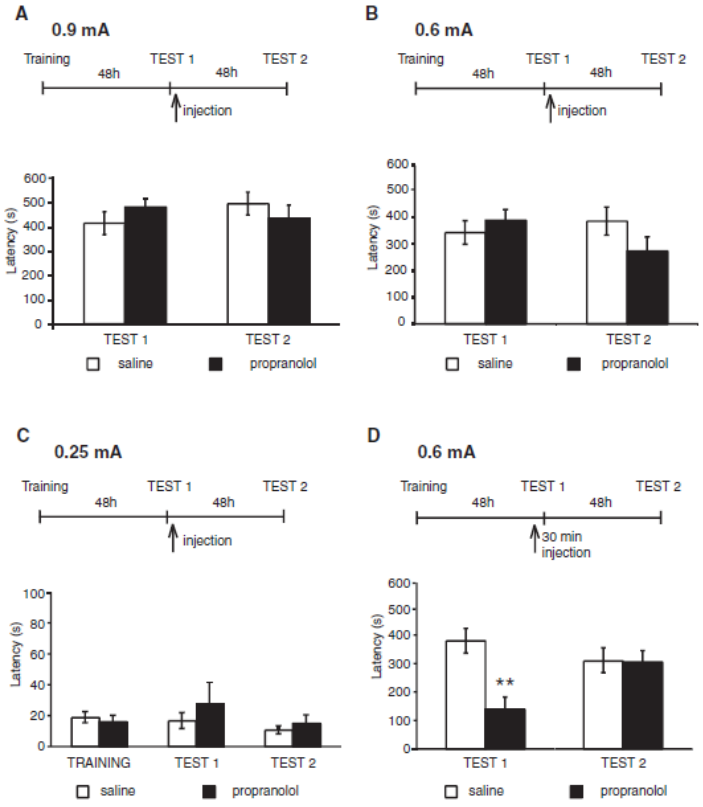


Figure 1. Propranolol administered systemically impairs IA retrieval but has no effect on reconsolidation. Experimental timelines are shown *above* each experiment. Values of latencies are expressed in seconds (s) and shown as means ± SEM. (*A*) Animals were trained in IA with 0.9 mA footshock intensity, 48 h later they were tested (Test 1), and immediately after, they were injected i.p. with propranolol or saline. Rats were tested again 48 h later (Test 2). No significant effect of treatment was found among groups. (*B*) Animals underwent the same experimental protocol as in *A*, except that 0.6 mA footshock intensity was used during training. No significant effect of treatment was found among groups. (*C*) Animals underwent the same experimental protocol as in *A*, except that 0.25 mA footshock intensity was used during training. No significant effect of treatment was found among groups. (*D*) Animals underwent the same experimental protocol as in *B*, except that they received an i.p. injection of propranolol 30 min before reactivation (Test 1). Compared with saline, propranolol significantly disrupted IA retention at Test 1 (**, $P < 0.01$), but not at Test 2.

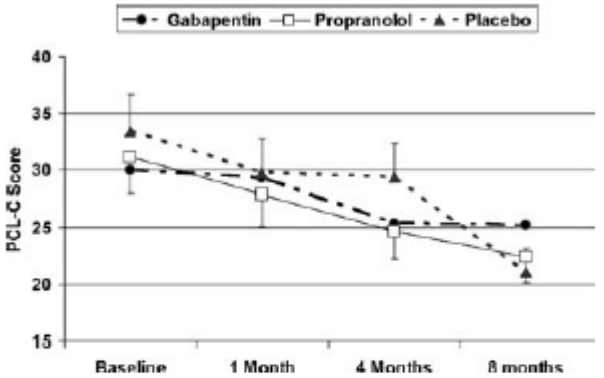


Figure 2. Mean observed Posttraumatic Stress Disorder Checklist (PCL) scores over time. Error bars represent standard errors of means and are shown for placebo (bars going up) and propranolol (bars going down); gabapentin standard errors of the means are of similar magnitude.

(Muravieva 2010, Stein 2007)

Table A-4 Early Interventions after Exposure to Trauma (4 to 30 days after exposure)

	Balance of Benefit and Harm			
SR	**Significant Benefit**	**Some Benefit**	**Unknown Benefit**	**No Benefit**
A	- Brief Cognitive Behavioral Therapy (4-5 sessions)			
B				
C		- Social support		
D				- Individual psychological debriefing ⊘ - Formal psychotherapy for asymptomatic survivors ⊘ - Benzodiazepines ⊘ - Typical Antipsychotics ⊘
I		- Psychoeducation and normalization	- Imipramine - Propranolol - Prazosin - Other Antidepressants - Anticonvulsants - Atypical Antipsychotics - Spiritual support - Psychological First Aid	- Group psychological debriefing

⊘= *Potential harm; SR = Strength of recommendation (see Appendix A)*

Tratamento do TEPT

Table 8.4 Strength of evidence of pharmacotherapy for PTSD

Agent	Level of evidence
Antidepressants	
SSRIs	
Fluoxetine (591–593)	1
Paroxetine (594–596)	1
Sertraline (597–600)	1
Citalopram (600–602)	+3 to –3[a]
Fluvoxamine(603–607)	3
Escitalopram	4
MAOIs and RIMAs	
Phenelzine (610,611)	1
Moclobemide (618)	3
TCAs	
Amitriptyline (608,609)	1
Imipramine (610,611)	1
Desipramine (612)	–2
Other antidepressants	
Venlafaxine XR (613)	2
Mirtazapine (614–616)	2
Bupropion (617)	3
Other therapies	
Anxiolytics	
Benzodiazepines	
Alprazolam (619)	–2
Clonazepam (571,620,621)	–3
Azapirones	
Buspirone (622,623)	3
Atypical antipsychotics	
Adjunctive risperidone (637–640)	1
Adjunctive olanzapine (641)	2
Adjunctive quetiapine (642,643)	3
Olanzapine monotherapy (644–646)	–2
Anticonvulsants	
Lamotrigine (624)	2
Carbamazepine (625,626)	3
Valproate (627,628)	3
Adjunctive topiramate (629–631)	3
Adjunctive tiagabine (632–634)	4
Adjunctive gabapentin (635,636)	4
Other agents	
Adjunctive clonidine (647)	3
Fluphenazine (645)	3
Trazodone (648)	3
Naltrexone (649–652)	+3 to –3[a]
Prazosin (653–656)	3
Cyproheptadine (657)	–2

[a]Conflicting data

NICE guidelines, 2006

[Intervention Review]

Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD)

Sarah E Hetrick[1], Rosemary Purcell[2], Belinda Garner[2], Ruth Parslow[3]

Analysis 1.1. Comparison 1 Combined SSRI plus CBT versus SSRI alone (adults), Outcome 1 PTSD symptom severity (clinician rated) post intervention (final scores SIP).

Review: Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD)

Comparison: 1 Combined SSRI plus CBT versus SSRI alone (adults)

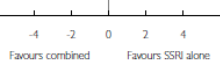
Outcome: 1 PTSD symptom severity (clinician rated) post intervention (final scores SIP)

Study or subgroup	Combined N	Mean(SD)	SSRI only N	Mean(SD)	Mean Difference IV,Fixed,95% CI	Weight	Mean Difference IV,Fixed,95% CI
Rothbaum 2006	34	10.2 (8.83)	31	14.9 (15.27)		100.0 %	-4.70 [-10.84, 1.44]
Total (95% CI)	**34**		**31**			**100.0 %**	**-4.70 [-10.84, 1.44]**

Heterogeneity: not applicable

Test for overall effect: Z = 1.50 (P = 0.13)

Test for subgroup differences: Not applicable



Analysis 1.3. Comparison 1 Combined SSRI plus CBT versus SSRI alone (adults), Outcome 3 Depression severity (self rated) post intervention (change scores).

Review: Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD)

Comparison: 1 Combined SSRI plus CBT versus SSRI alone (adults)

Outcome: 3 Depression severity (self rated) post intervention (change scores)

Study or subgroup	Combined N	Mean(SD)	SSRI alone N	Mean(SD)	Std. Mean Difference IV,Fixed,95% CI	Weight	Std. Mean Difference IV,Fixed,95% CI
Otto 2003	5	-8.6 (7.2)	5	-8.6 (6)		13.9 %	0.0 [-1.24, 1.24]
Rothbaum 2006	34	-3.2 (7.52)	30	0.3 (7.52)		86.1 %	-0.46 [-0.96, 0.04]
Total (95% CI)	**39**		**35**			**100.0 %**	**-0.40 [-0.86, 0.07]**

Heterogeneity: $Chi^2 = 0.46$, df = 1 (P = 0.50); $I^2 = 0.0\%$

Test for overall effect: Z = 1.68 (P = 0.093)

Test for subgroup differences: Not applicable

Citation: Hetrick SE, Purcell R, Garner B, Parslow R. Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews* 2010, Issue 7. Art. No.: CD007316. DOI: 10.1002/14651858.CD007316.pub2.

Considerações finais

- Catástrofes: maioria das pessoas não apresentarão doença psiquiátrica
- Atenção especial para traumas individuais
- Identificar pessoas em risco e com sintomatologia
- *Primum non nocere*

Don't **Pathologize**: ie, "normal response to an abnormal situation"
Don't **Psychologize**: ie, don't facilitate emotional reaction via group therapy, debriefing etc
Don't **Pharmacologize**: ie, don't use benzodiazepines or sleeping pills in the first few hours