Deconstructing Delayed Posttraumatic Stress Disorder

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Stichting Arq
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© Cover photograph by Marcel Antonisse, ANP: Enschede, total destruction of homes after the fireworks disaster (13 May 2000)

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Preface

The book before you addresses an important issue in clinical trauma work. More than twenty years ago the question was raised among Dutch practitioners working with victims of the Second World War how to understand the phenomenon known as ‘delayed posttraumatic stress disorder (PTSD)’: the incidence of PTSD symptoms in patients at least six months after the occurrence of a traumatic event. The existence of this phenomenon was evident to clinicians active in the field as they encountered it in some of their patients. Yet the concept of ‘delayed PTSD’ was by no means unambiguous, and even attracted controversy as its very existence was queried or explanations were put forward that pointed to repression of traumatic experiences as its origin.

This controversy now appears to be resolved with the studies brought together in this significant book. Geert Smid, its author and a psychiatrist working at Foundation Centrum ’45, addresses the issue of delayed PTSD in his extensive study and thereby reaches some important and consequential conclusions. Not only does he demonstrate persuasively the prevalence of delayed PTSD symptoms, he also examines the factors explaining their occurrence. Importantly, his research shows that rather than as a result of repression, ‘delayed PTSD’ is better conceptualized as ‘PTSD progression’, stressing the gradual increase of symptoms over time as commonly found in patients. Also, stress sensitization, the heightened reactivity of an individual to stressors following exposure to severe trauma, was found to be a much more relevant factor in the progression, or growth, of PTSD symptoms, than, indeed, repression. Furthermore, and this is of great significance to clinicians and patients alike, Geert Smid maps the implications of delayed PTSD for mental healthcare providers.

Geert Smid has been working as a psychiatrist with Centrum ’45 since 2004. Centrum ’45 – ’45 refers to the liberation of the Netherlands in 1945 – was set up in 1973 as a treatment and research centre for, initially, survivors of the Second World War. After all, the war for many people did not end with the liberation but continued to affect their lives. Over the years, Centrum ’45 has become the main Dutch national centre for psychological trauma treatment and expertise, extending its work to an increasing variety and number of target groups. In 2000 Centrum ’45 initiated the alliance and close cooperation of a number of groups
of trauma specialists, which resulted in the establishment of Arq Psychotrauma Expert Group. Arq currently consists of eight partner organizations offering top-quality specialized health care and expertise. Together, they make up a leading (inter)national group of experts working in the field of psychotraumatology to benefit the individual patient, organization as much as society at large. Constituting a group of experts with the ability to operate in flexible as well as innovation-driven ways, Arq’s mission is to preserve, develop and share this specialist knowledge.

In our work as practitioners in the field of trauma, both hands-on clinical practice and scientific research are of the utmost relevance. Outcomes of academic research such as presented in this book, and especially when based on everyday clinical practice, enable us to simultaneously broaden and refine the scope of our work and help us to deepen our knowledge.

With this study, Geert Smid has not only made a meaningful contribution to our knowledge of what he renames progressive PTSD; he has also brought further recognition to many patients of Centrum ’45.

It is with a sense of great pride that we present this study and share its important findings and our increased understanding of this aspect of posttraumatic stress disorder with a larger public.

drs J.W. (Jan-Wilke) Reerds MBA,
Chair Board of Directors Foundation Centrum ’45
and Arq Psychotrauma Expert Group.
Opgedragen ter nagedachtenis aan mijn moeder
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Chapter 1

Introduction

...AUCH KEINERLEI
Friede.

Graunächte, vorbewußt-kühl.
Reizmengen, otterhaft,
Auf Bewußtseinsschotter
unterwegs zu
Erinnerungsbläschen.

Grau-in-Grau der Substanz.

Ein Halbschmerz, ein zweiter, ohne
Dauerspur, halbwegs
hier. Eine Halblust.
Bewegtes, Besetztes.

Wiederholungszwangs-
Camaïeu.

Paul Celan¹
Paul Celan, one of the major German-language poets of the post-World War II era, born in 1920 into a Jewish family in Romania (now Ukraine), survived forced labor as well as his parents’ deportation and death between 1940 and 1944. After World War II, Celan fled to Paris, where he married and worked as a poet, translator, and teacher at the École Normale Supérieure. He suffered feelings of guilt and fears associated with his war experiences. Tragically, he became victim of false accusations of plagiarism in 1960. About 20 years after the war, Celan developed severe psychopathology, comprising severe depressions and delusions, turning him sometimes violent and suicidal. He underwent multiple hospitalizations and was treated with medication and electroconvulsive therapy, among others. He finally committed suicide in the Seine in 1970.

Celan studied several books on psychiatry and psychology, including works by Freud. Celan’s reading of Freud led him to “rewrite” the concept of repetition compulsion in the final lines of his poem “... auch keinerlei”, cited above. The Freudian concept of repetition compulsion refers to the situation in which a person repeats a traumatic event or its circumstances over and over again. In “...auch keinerlei”, Celan juxtaposes “repetition compulsion” with the artistic and valuable “camaïeu”, thus illustrating the intimate link between his deeply painful memories of the war and his poetry: “Celan’s closing lines, ‘Repetition compulsion/ Camaïeu,’ let the Old French behind ‘Cameo’ suggest that art can cut reliefs out of memory’s damaging recurrence”. Indeed, almost all of Celan’s poetry, such as his famous poem “Todesfuge”, deals in some way with the war and the dead he wanted to revive.

The concept of repetition compulsion is pivotal to the diagnosis of Posttraumatic Stress Disorder (PTSD). Repeated memories of a traumatic event that are perceived as distressing and intrusive and that occur involuntarily comprise core symptoms of PTSD. The diagnosis of PTSD applies when a person has been exposed to a traumatic event to which he or she responded with fear, helplessness, or horror and has three distinct types of symptoms consisting of re-experiencing of the event, avoidance of reminders of the event as well as emotional numbing, and hyperarousal that lead to long-standing suffering.

In a letter to a friend written on 24 January 1964, Celan wrote that he had been diagnosed with “nervous depression”, a diagnosis that he calls simplistic: “Ich war letztes Jahr ziemlich krank: eine nervöse Depression (um den – vereinfachenden – Terminus des Mediziners zu gebrauchen).” Indeed, the many factors that may have contributed to his illness, cannot easily be linked to a single diagnostic category. As his biographer puts it: “Simplistic, Celan says, because
his illness issued from bitterness at Germany’s literary industry, and bitterness grew from anxiety over the plagiary affair, and anxiety stemmed from what happened in a winter season twenty years before, and how could all this be diagnosed clinically?”

Considering the contents of his writing, it appears likely that symptoms of PTSD may have coexisted with his depressive symptoms (Celan’s medical records are not accessible). Perhaps, besides depression, a diagnosis of delayed-onset PTSD, which did not exist during Celan’s lifetime, may complement a clinical summary of the case of Paul Celan. For Celan, exposure to extreme stressors during World War II may have enhanced the impact of the plagiary affair on his distress and thus influenced the development of psychopathology.

The case of Paul Celan poses questions that form the basis of this thesis. How can exposure to extreme remote stressors contribute to and shape psychopathology in an individual who apparently functioned well initially? Can new stressful events trigger the delayed onset of psychopathology? The case of Celan may also serve to illustrate the relevance of the concept of delayed PTSD. Clinically, because the recognition of remote stressor effects is highly relevant for diagnosis as well as treatment. If a diagnosis of delayed PTSD applies, including in cases where past exposure to trauma and its effects was not clear at the first encounter, trauma–focused psychotherapy should be considered as part of the treatment plan. Theoretically, because research on delayed PTSD may contribute to building scientific theory of human responses to extreme stress.

A Brief History of Delayed PTSD

The diagnosis of PTSD was first defined in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)* in 1980. According to DSM-III, delayed PTSD must be diagnosed in individuals fulfilling criteria for PTSD if the “onset of symptoms is at least six months after the trauma.”

Delayed PTSD was included in the initial definition of PTSD to accommodate the syndrome encountered in Vietnam veterans. The onset of symptoms was assumed to be postponed “because a stress reaction in the midst of combat is not adaptive.” Delayed consequences of war had also been described in WWII veterans as well as concentration camp survivors. In addition, delayed grief reactions had been described.

A conceptual precursor of “delayed PTSD” was the so-called “latency period” preceding the onset of the psychosomatic complaints in World War II survi-
Based on a description of 40 cases of ex-members of the resistance, the Dutch psychiatrist Bastiaans outlined in the 1950s a traumatic syndrome consisting of successive stages: first exposure to traumatic war situations, then an initial latency period preceding the insidious onset of an asthenic condition after a mean of 1 year, followed by the onset of psychosomatic symptoms after several years. During the latency period, the survivors concentrated on working hard, avoided talking about the war, and were apparently well adjusted to the post-war situation. A repression barrier warded off the traumatic memories in order to avoid intense feelings of anxiety, guilt, shame, or disgust. Vital exhaustion could lead to a breach of this barrier. Understood within a psychoanalytic framework, the concept of delayed consequences of trauma was broadly accepted. It even led clinicians to predict “delayed stress response syndromes” in Vietnam veterans. Also, it became rooted in the lay literature about trauma and loss.

The introduction of the PTSD diagnosis led to an explosion of research. Up to 1980, much of the scientific knowledge about how adults cope with loss or trauma came from individuals who sought treatment or exhibited great distress. After the introduction of the PTSD diagnosis, epidemiological studies showed that the occurrence of PTSD following a traumatic event was the exception rather than the rule. It became clear that many people are exposed to loss or potentially traumatic events at some point in their lives, and yet they continue to have positive emotional experiences and show only minor and transient disruptions in their ability to function. The occurrence of PTSD in an individual after exposure to a potentially traumatic event appeared to be related to multiple biological, psychological and social risk or resilience factors, framing the disorder within the biopsychosocial model.

The first systematic studies of delayed PTSD examined these factors within Israeli veterans from the Lebanon war, and disaster survivors. The introduction of the delayed PTSD diagnosis also generated controversy. Authors questioned whether this diagnosis was likely to exist at all by outlining a wide array of potential diagnostic validity issues, including the logical fallacy “post hoc ergo propter hoc” (i.e., because one event follows another, it is caused by it), personal preferences of clinicians, and failure to recognize initial symptoms. Restricted diagnostic criteria for delayed onset were therefore proposed. Caution against accepting the delayed PTSD diagnosis as a valid category was expressed by clinicians involved in medico-legal discourses. In a context where compensation claims, disability pensions, or other forms of reward are
at stake, apparent delayed PTSD may merely represent increased symptom reporting over time that may be motivated by secondary gains, instead of true symptom progression.

Controversy surrounding late sequelae of traumatic events can be traced back to the 19th century. Following the rise of accidents and casualties on Britain’s railways between 1840 and 1860, the literature on “railway spine” anticipated the current literature on delayed PTSD. In his influential book *On Railway and Other Injuries of the Nervous System*, the surgeon John E. Erichsen tried to balance conflicting views: “From the absence often of evidence of outward and direct physical injury, the obscurity of their early symptoms, their very insidious character, the slowly progressive development of the secondary organic lesions, and functional disarrangements entailed by them, and the very uncertain nature of the ultimate issue of the case, they constitute a class of injuries that often tax the diagnostic skill of the Surgeon to the utmost”.

**Research Questions**

The present book aims at increasing insight in delayed PTSD. Specifically, five research questions will be addressed that will be introduced below. These are:

1. What is the prevalence of delayed PTSD?
2. What is the nature and role of “prodromal symptoms”, i.e. symptoms that occur during the interval between traumatic event exposure and the onset of delayed PTSD?
3. What are implications of delayed PTSD for mental health service utilization?
4. What factors may explain symptom progression?
5. Does stress sensitization play a role in explaining PTSD progression?

**Prevalence of delayed PTSD.** Widely varying prevalence estimates of delayed PTSD are found in the literature. So far, no meta-analysis has been carried out to establish the prevalence of delayed PTSD. In Chapter 2, we systematically identified prospective studies in populations exposed to circumscribed potentially traumatic events comprising assessments within specified time frames relative to the event in order to establish the prevalence of delayed PTSD from the pooled data.

“**Prodromal symptoms**”. "Prodromal symptoms" are symptoms of PTSD that occur during the interval between traumatic event exposure and the onset of full clinical delayed PTSD. These symptoms represented a definitional