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# THE ROLE OF GENERAL PRACTITIONER IN POST-TRAUMATIC DISORDER CASES

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**ABSTRACT**

**Introduction** – Post-traumatic stress disorder (PTSD) is a mental illness whose criteria are listed in DSM-5 and ICD 11 marked by an inability to recover after experiencing or watching a horrific event that lasts more than 1 month. PTSD should be considered in any patient who has experienced a significant tumultuous occasion.
**Methods** – The author makes this article based on several kinds of literature that discuss PTSD, the role of GP in PTSD patients, psychological first aid, and psychological, and pharmacological treatment for PTSD patients. The literature used is limited from 2009 to 2021.
**Results** – Approximately 3% of the adult population suffers from PTSD. Often the first point of contact, General Practitioners are positioned to assist patients who have contemporarily experienced a traumatic life event and who are at risk for developing PTSD.
**Discuss** –Post-traumatic stress disorder (PTSD) is a mental illness whose criteria are listed in DSM V and ICD 11 marked by an inability to recover after experiencing or watching a horrific event that lasts more than 1 month that can be treatable. As primary healthcare providers, general practitioners are the first healthcare practitioners accessible to individuals who have experienced a horrifying episode.
**Conclusion** – General practitioners take an important part in recognizing people with PTSD and giving psychological first aid, managing their care with psychological or pharmacological treatment, and referring them for specialized care when needed.

**Keywords:** post-traumatic stress disorder, general practitioner, psychological.

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## INTRODUCTION

A disaster is an occurrence or series of occurrences that endangers and disrupts people's lives and livelihoods, resulting in human casualties, environmental damage, property losses, and psychological effects due to natural and/or non-natural factors as well as human ones.[1] The geographical and geological location makes Indonesia an area that is prone to the threat of various natural disasters such as tornados, floods, earthquakes, tsunamis, landslides, volcanic eruptions, and so forth.[2-4] The impact of natural disasters is loss of human life and deteriorating health status both in terms of physical and non-physical.[5] Non-physical forms of loss such as trauma to events that have been experienced are one of the psychological impacts that are often encountered in people who are victims of disasters, namely Post Traumatic Stress Disorder (PTSD). Post-traumatic stress disorder (PTSD) is a mental illness whose criteria are listed in DSM-5 and ICD 11 marked by an inability to recover after experiencing or watching a horrific event that lasts more than 1 month.[6-12] Any patient who has been through a serious traumatic event should be evaluated for PTSD. At any given time, approximately 3% of the adult population suffers from PTSD.[3,13-15] Research on victims of natural disasters in West Sumatra and West Java involving 859 children and young adults found that 19.9% of participants met the criteria of PTSD.[4] According to the World Mental Health Surveys, high-income countries (Northern Ireland: 3.8 percent; United States 2.5 percent; New Zealand: 2.1 percent) had higher 12-month prevalence rates than a country with a low-to-middle income (Colombia: 0.3 percent; Mexico: 0.3 percent).[16] Psychological first aid, as well as monitoring and assessing the development of PTSD symptoms, are required for patients who have recently undergone trauma. A general practitioner is a health practitioner who provides primary care to patients, which is usually the first time they see a doctor. As a result, patients who have recently undergone a stressful life event and are at risk of developing PTSD can benefit from the services of general practitioners.[5] In this article, we will review the role of a general practitioner of a patient with post-traumatic stress disorder.

# METHOD

The author used the literature review method by using several kinds of literature that discuss PTSD, the role of GP in PTSD patients, psychological first aid, psychological, and pharmacological treatment for PTSD patients. The literature used is limited from 2009 to 2021.

# RESULT

**Post-Traumatic Stress Disorder**

PTSD can be enforced by a diagnostic approach based on the DSM-V with the following characteristics[6]:

A. Actual or impending death, serious injury, or sexual violence as a result of one (or more) of the following:
   1. Having a horrific experience incident firsthand
   2. Observing the event(s) as they occurred to other in person
   3. Discovering that the terrible event(s) happened to a close relative or acquaintance
   4. Exposure to adverse details of the traumatic incident on a regular or frequent basis

B. Following the tragic experience (s), one (or more) of the following intrusive symptoms related with the traumatic event(s):
   1. Distressing memories of the traumatic experience(s) that are recurrent, automatic, and invasive
   2. Recurrently painful dreams in which the dream's content and/or affect are linked to the traumatic experience(s)
   3. Dissociative reactions (e.g., flashback) occur when a person behaves or feels as though the traumatic experience(s) are re-enacting themselves
   4. Internal or external stimuli that symbolize or mimic an aspect of traumatic experience(s) cause intense or enduring psychological suffering.
   5. Physiological response to internal or external signals that represent or resemble a traumatic experience(s)

C. One (or more) of symptoms listed below must appear after the event(s) or deteriorate following the event(s), demonstrating prolonged avoidance of stimuli associated with the traumatic event(s), or unfavorable mood modification associated with the traumatic event(s):
   Persistent avoidance of stimuli:
   1. Avoiding or attempting to stay away from activities, locations, or physical reminders of the painful experience(s)
   2. Avoiding or attempting to avoid individuals, dialogues, or interpersonal circumstances that trigger unpleasant memories

   Negative alterations in cognitions
   3. A rise in the frequency of unfavorable emotional feelings (e.g., worry, wrong-doing, sorrow, discomfort, indecision)
   4. Significantly reduced interest in or engagement in important tasks
   5. Socially withdrawn manners
   6. A steady decrease in the manifestation of happy feelings

D. Arousal and reactivity changes related to the traumatic event(s), which started or exacerbated after the traumatic event(s) as demonstrated by combining two (or more) of the following:
   1. Irritable conduct and furious outbursts (with /without provocation) usually manifest as verbal or physical aggressiveness directed at persons or things
   2. Hypervigilance
   3. A heightened startle response
   4. Problems with concentrations
   5. Sleep deprivation

E. The commotion has been going on for over a month

F. The disruption produces clinically substantial distress or impairment in connection with father/mother, brothers/sisters, fellow, or another caretaker, as well as in school performance.

G. The disturbance is neither caused by a substance's physiological effects nor is it caused by another medical condition.

The chapter on 'Anxiety Disorders' in DSM V has been taken out of the chapter on 'Trauma-and Stressor Related Disorders). There are two types of PTSD: acute and chronic. Symptoms of acute PTSD remained at least one month but no more than three months following the traumatic event in those who had it. Symptoms that appear more than three months following trauma exposure are considered chronic PTSD.[7] Another subdivision of PTSD namely delayed-onset PTSD, basically elucidated for many years, has been represented more than six months after exposure to stress, with cases of PTSD purportedly beginning many decades after the tragedy happened. According to systematic reviews, approximately 25% of individuals who get PTSD may be delayed-onset instances.[16]

# DISCUSS

**The role of GP in PTSD patient**

General practitioners are the first line to be able to recognize the symptoms of PTSD and provide initial treatment.
What are the roles of general practitioners in managing PTSD patients, are described below[5]:

- Providing primary support and monitoring (eg PFA which means psychological first aid)
- Early detection, first assessment, and management that is supportive
- The use of pharmacotherapy as a first line of defense
- Proper and well-timed referral for further treatment (e.g specialist care(psychiatric))
- Support and concern from relatives
- Crisis support
- Comorbid medical conditions management
- Treatment for a chronic ailment that needs to be maintained

**Recognizing PTSD**

PTSD can manifest itself in a variety of ways. Reliving the traumatic event through upsetting memories, flashbacks, or nightmares, avoiding trauma-related reminders, and heightened vigilance are the most prevalent PTSD symptoms in adults. General practitioners should be in charge of assessing and coordinating care for persons who come into primary care with clinically significant PTSD symptoms. However, national survey data shows that individuals with PTSD face major challenges in receiving a diagnosis; for example, just one in every eight people who tested positive for PTSD had been diagnosed by a health professional. Patient circumstances, time constraints, and comorbidity with other psychiatric or physical problems that complicate differential diagnosis are all possible causes for the poor detection rate. Essentially, the guidelines state that general practitioners should evaluate a PTSD diagnosis early on and inquire about the patient's traumatic experiences. General practitioners should be aware that many people do not get PTSD as a result of a stressful event if they are not treated. Sleep deprivation, anxiety, and rumination are common early signs of suffering in the hours, days, or weeks after a terrible occurrence. It should be regarded as a "normal reaction to an aberrant experience" if it is just transient and does not significantly interfere with daily functioning. However, chronic distress symptoms accompanied by functional impairment should raise the chances of a PTSD diagnosis if they remain one month after the incident.[8]

***Psychological first aid***

While psychological distress is normal in the aftermath of a traumatic event, most people will recover with the help of their existing coping methods and social support. As a result, general practitioners should evaluate the patient's mental state during the first few weeks (during the first two weeks) after trauma, urge patients to maintain their customary routines to the degree that functioning allows and employ existing social support and coping mechanisms. The goal of this method, dubbed "psychological first aid", is to help people who are suffering from mental illness.[9] WHO encouraged that psychological first-aid should be allocated to those who were harmed as a result of a calamity (an early psychosocial intervention approach), also in the following days and weeks after the accident, with a particular emphasis on those that require further attention, such as individuals who are socially isolated, severely afflicted, and suffering from bad health. The PFA's main principles of action from WHO are straightforward : (1) Take a look – make sure everyone is secure and keep track of anyone who is having a hard time, (2) listen – approach those people, inquire about their wants and worries, and assist them in feeling at ease (unlike psychological debriefing, this does not necessarily include discussion of the crisis event), (3) link(connection) – addresses basic needs, facilitates access to resources, and provides social support, and (4) understand PFA's limitations and when professional help is required. Five scientifically derived concepts can guide general practitioners in their early response: providing a sense of safety, relaxation, self-efficacy, connectedness, and hope.[11] Last but not least, PFA is not a replacement for expert treatment.[12] Psychological first aid's major goals are to put up psychoeducation about the symptoms of acute stress, to promote normalization and stability of the process, to facilitate a return to normal life before the incident, and to protect the individual from the long-term effects of the traumatic experience.[13]

***Psychological Therapy***

There are a variety of psychological therapies for PTSD, including both trauma-focused and non-trauma-focused approaches. Non-trauma-focused treatment tries to alleviate PTSD symptoms without addressing the ideas, emotions, emotions, or feelings associated with the traumatic experience. Interpersonal therapy, relaxation, and stress inoculation training (SIT) are examples of non-trauma-focused treatments.[17,18] Trauma-focused psychological therapy, or TFPT, may be prescribed when a patient is first diagnosed with PTSD. Trauma-focused treatments target memories of the traumatic incident, as well as thoughts and feelings that come with it[18]. This commonly requires referral to an appropriate mental health practitioner, except that the general practitioner is skilled in administering this type of therapy. The intervention with the most vigorous evidence base for efficacious management of PTSD is a trauma-focused psychological therapy (TFPT) that consists fundamentally of three components, specifically[9]:

a. Prolonged Exposure (PE)
   For PTSD patient's treatment, PE is strongly advised by both the APA and the VA/DoD recommendations. Prolonged exposure involves psychoeducation regarding PTSD and ordinary trauma reactions, breathing retraining, and two types of exposure: imaginal and in vivo exposure. According to the experts, this therapy is usually finished in 8-15 sessions. Breathing retraining is a technique that is given to patients to help them cope with stressful situations, however, it is not to be utilized during exposure. Imaginal exposure comprises patients who are encouraged to confront memories, ideas, and emotions related to the traumatic incident they have been avoiding. In vivo, exposure helps individuals to approach events, certain areas, and people they have been avoiding owing to a fear response triggered by the traumatic incident repeatedly until their misery subsides. Patient's fear structures are activated and new information is incorporated through these two sorts of experiences (imaginal and in vivo exposures). According to much evidence-based research, when compared to supportive counseling, calming training, and treatment as usual, including medicine, those randomly assigned to PE have much higher pre-posttreatment involvement in PTSD symptoms.[18]
b. Cognitive therapy
   Cognitive therapy consists of two, there are cognitive processing therapy (CPT) and cognitive behavioral therapy (CBT). These are the other strongest recommended therapies by the VA/DoD (Veterans Health Administration and Department of Defense) and APA (American Psychological Association. In CPT, it is therapy that uses social cognition theory and informed emotional processing theory to help people cope with their emotions. After a traumatic incident, survivors strive to make meaning of what happened, according to CPT, which can lead to erroneous impressions of themselves, the world, and

others. Memory activation is possible with CPT, and it also detects maladaptive cognitions (i.e assimilation occurs when new knowledge is manipulated to confirm existing ideas, which can lead to self-blame for traumatic occurrence, and over-accommodation is the process of modifying one's view to avert future trauma, which can lead to views about the dangers of the world or untrustworthy individuals) resulting from the traumatic incident. CPT's main purpose is to change beliefs toward accommodation, which is defined as a shift in beliefs sufficient to accommodate new information. This is divided into 12 weekly sessions. According to meta-analysing, CPT is beneficial in considerably lowering PTSD symptoms. In CBT, the goals of this treatment are modifying negative evaluations, restoring autobiographical memories, and deleting problematic behavioral and cognitive processes. CBT usually incorporates both behavioral (exposure) and cognitive (cognitive restricting) approaches. Exposure therapy is divided into traumatic memory and trauma-related stimuli. In traumatic memory, imaginal exposure, writing the painful narrative, or reading the traumatic memory out loud. In vivo, exposure or educating patients to recognize re-experiencing triggers and practicing "then vs now" discrimination are commonly used in trauma-related stimuli. In cognitive restructuring, patients are trained to detect dysfunctional concepts and thinking errors, elicit logical alternative thoughts, and reappraise views about the trauma, themselves, and their surroundings.[18]

c. EMDR (Eye Movement Desensitisation and Reprocessing)
Unprocessed traumatic or other painful experiences that are still driving an individual's psychological instability are identified during treatment. The client is asked to recollect the most distressing component of the memory, as well as any current negative cognitions and body sensations that go with it. They were also advised to shift their eyes from side to side or apply some other sort of bilateral stimulation at the same time. The effect is to desensitize the patient to intrusive memory while also reprocessing the memory to make the related cognition more adaptive.[14]

Although these remedies are displayed as unique, they all include the emotional processing of traumatic memories and the integration of new corrected knowledge.[16]

***Initial Pharmacotherapy***

The goal of PTSD drug therapy is to minimize symptoms and stabilize the patient. When initiating pharmacological therapy, remind the patient that it is critical to take the drug every day, even if their symptoms improve, because stopping might cause insomnia, irritability, depression, and anxiety. To provide for enough response time, clinical standards prescribe an 8-week trial period for any new medicine. If symptoms do not improve after eight weeks, the dose may be increased to the highest acceptable level or the medicine can be switched. To avoid the recurrence of symptoms, the drug should be continued for six months to a year if it is beneficial. Clinicians should check drug adherence, monitor adverse events, and evaluate symptomatic improvement at each subsequent appointment.[15] Evidence is accumulating that PTSD is marked by specific psychobiologic dysfunction, according to VA/DoD recommendations, which has sparked a surge in interest in the use of drugs to treat trauma-related biological effects.[7] General practitioners should consider using pharmacological therapy in the following conditions[5]:

- Where it assists the patient to reach the level of stabilization required to be appropriate for TFPT
- Are reluctant or unable to obtain preferred first-line psychiatric care
- Have concomitant depression or other symptoms that necessitate medication
- Have comorbid that are not sufficiently stable
- Does not have benefit from trauma-focused psychological treatment.

Given treatment guideline recommendations and outcomes from numerous clinical trials, for PTSD patients, SSRIs are the first-line treatment. SNRIs (Serotonin and Norepinephrine inhibitors) should be explored as a second-line treatment if SSRIs are not tolerated or are unsuccessful. Venlafaxine, an SNRI, has been proven to be effective in the treatment of PTSD[7]. One of the most popular reasons these medicines are recommended is because they help people with major depressive disorder, which is frequently associated with PTSD.[16] Monoamine oxidase inhibitors (MAOIs), are a class of antidepressant drugs that are usually used as third-line therapy and should be prescribed by the psychiatrist. Although atypical antipsychotics are not licensed by the FDA (which stands for Food and Drug Administration) for PTSD patient treatment, they can be helpful in severe cases or when psychotic symptoms occur and also should be prescribed by a psychiatrist.[8,9]

Another drug that can be given is a beta-adrenergic antagonist, namely Propanolol because the idea that PTSD is mostly caused by an increase in noradrenergic release during the immediate post-traumatic event has led to efforts to lower noradrenergic activity. Because preclinical research suggests that these medications impair the consolidation of fear memories, this endeavor has concentrated on delivering these drugs within hours or days of trauma exposure[16]. This administration of drugs decreases the risk of PTSD.[17]

Several studies have found another pharmacological agent that can be used for specific PTSD symptoms, namely Prazosin (an Alpha 1-adrenergic antagonist) which is effective in lowering nightmares and hyperarousal.[16]

## CONCLUSION

Post-traumatic stress disorder (PTSD) is a mental illness whose criteria are listed in DSM V and ICD 11 marked by an inability to recover after experiencing or watching a horrific event that lasts more than 1 month that can be treatable. As primary healthcare providers, general practitioners are the first healthcare practitioners accessible to individuals who have experienced a horrifying episode. Therefore, they take an important part in recognizing people with PTSD and giving psychological first aid, managing their care with psychological

or pharmacological treatment, and referring them for specialized care when needed.

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