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POST-TRAUMATIC STRESS DISORDER LIBRARY

# POST-TRAUMATIC STRESS DISORDER Factsheet

**August 2021**

## What are trauma characteristics?

Trauma characteristics, along with personal characteristics, are factors that influence the risk of a person developing PTSD.

## What is the evidence for risk of PTSD in people exposed to physical illness and injury?

Moderate quality evidence found the prevalence of PTSD following a coronavirus infection was around 29-32%. Rates of PTSD were higher in female coronavirus patients, in infected healthcare workers, in patients with a previous physical illness, in patients with avascular necrosis, functional impairment, pain, and a sense of lack of control. Rates were highest when measured during coronavirus outbreaks, in patients with MERS rather than SARS, and in studies using the Impact of Event scale to measure PTSD.

A medium-sized increase in PTSD was found in people with a traumatic brain injury (TBI) compared to people without a TBI. Rates of PTSD were higher in military than civilian TBI samples, in TBI samples with more males than females, in TBI samples exposed to a blast rather than a motor vehicle accident, in TBI samples from the USA, and in samples with a TBI rather than another physical injury. Shorter post-trauma amnesia and more memory of the traumatic event were also associated with increased risk of PTSD following a traumatic brain injury.

The prevalence of PTSD after a fall in the elderly was 27.5%, which represents a small increased risk in PTSD compared to older people with no fall history. The prevalence of PTSD after any acute orthopaedic trauma was around 26.6%, with rates higher in females, and higher in patients with lower versus higher extremity fractures.

The prevalence of PTSD symptoms in critical illness survivors was between 25% and 44% up to 6 months post-ICU, and between 17% and 34% by 12 months. ICU risk factors for PTSD symptoms included benzodiazepine administration and post-ICU memories of frightening ICU experiences.

The prevalence of PTSD in people with chronic pain was around 9.7%. PTSD prevalence was higher in people with chronic widespread pain and headache, and lower in people with back pain. Prevalence was higher in studies using self-reported PTSD symptoms than in studies using clinical interviews to assess PTSD.

The prevalence of PTSD in people with cancer was around 11%. This represents a small increase in the risk of PTSD in people with cancer compared to people without cancer. Rates of PTSD were higher in studies using self-report instruments than clinical assessments, in samples with brain cancer, in samples undergoing chemotherapy, in Middle Eastern samples, in samples with prior trauma, in younger samples, and in samples with a longer time since cancer diagnosis.

The prevalence of PTSD in children after an injury was around 20.5%. Rates were highest in girls, in older children and in children injured in hurricanes. A large effect of more PTSD symptoms was found in parents of chronically ill children than in parents of healthy children. Rates were highest in parents of children with epilepsy or diabetes, in mothers, in parents of children with more illness severity, longer treatment duration and intensity, and in parents of children with PTSD symptoms. Rates were lowest in parents of children with longer illness duration, longer time since active treatment, and in parents with more social support.

Risk factors associated with PTSD following a burn injury include (in descending order of effect); more life threat perception, intrusion symptoms, pain, low socioeconomic status, alcohol use disorders, increased age, avoidance symptoms, dissociation, negative emotions or distress, acute stress symptoms, having previous psychiatric disorders, substance use disorders, need for psychological treatment, being injured by an explosion, more body surface area affected, more anxiety and depression, longer hospitalisation stay, having low openness, being female, having more surgeries, low narcissism, and feeling responsible for the burn injury. Risk factors associated with PTSD symptoms after a spinal cord injury include (in descending order of effect); depressed mood, poor cognition, distress, anxiety, pain, history of previous trauma, being female, having less time since the trauma, and having a higher education.

**For more information see the technical table**

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*NeuRA (Neuroscience Research Australia) is one of the largest independent medical and clinical research institutes in Australia and an international leader in neurological research.*

*Diseases of the brain and nervous system pose the greatest health, economic and social burden of any disease group because they are chronic, debilitating and have no known cures.*

*Medical research is the cornerstone of efforts to advance the health and wellbeing of families and the community. Our dedicated scientists are focussed on transforming their research into significant and practical benefits for all patients.*

*While we hope you find this information useful, it is always important to discuss any questions about PTSD and its treatment with your doctor or other health care provider.*

## HOW YOUR SUPPORT HELPS

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NeuRA (Neuroscience Research Australia) Foundation
**T** 1300 888 019 **F** +61 2 9399 1082
ABN 57 008 429 961

**Margarete Ainsworth Building**
Barker Street, Randwick NSW 2031
PO Box 1165 Randwick Sydney NSW 2031 Australia

neura.edu.au