Hyperarousal: the Critical Determinant of Post-Trauma Sequelae

Thesis submitted for the degree of Doctor of Philosophy

By

Jason Blunt

March 2016

The University of Adelaide, Australia

Centre for Traumatic Stress Studies

School of Medicine

Jason Blunt 2016

i. Table of Contents

i. Table of Contents	2
ii. List of Tables	5
iii. List of Figures	
iv. Abstract	8
v. Declaration	11
vi. Acknowledgements	12
_	
1. Background and Introduction	
1.2. Background	
1.3. PTSD Diagnosis and Diagnostic Criteria	
1.4. Defining hyperarousal (criterion D)	
1.5. Understanding the phenomenon: the neurobiology of PTSD and hyperarousal	
1.5.1. Animal models, sensitisation and kindling	
1.6. Delayed onset and sub-syndromal PTSD	27
1.7. Why is hyperarousal a central construct in PTSD	
1.8. Predictors of hyperarousal symptom severity	
1.8.1. Cumulative trauma	
1.8.2. Trauma type	
1.9. The relationship between hyperarousal and other psychological disorders su	
depression/anxiety	
1.10. Impact of hyperarousal on functional impairment and quality of life	
1.11.1. Why the symptoms? Breaking down the indicators of hyperarousal	
1.11.2. Irritability or outbursts of anger	
1.11.3. Difficulty concentrating	
1.11.4. Hypervigilance	
1.11.5. Exaggerated startle response	
1.11.6. Summary	
1.12. Conclusion	
2. Samples and Methodology	EO
2.1. Introduction	
2.2. Middle East Area of Operations (MEAO) Health Study	
2.2.1. Measures	
2.2.2. Participants	
2.2.3. Non-responders	
2.3. The South East Life Study (SELIFE)	
2.3.1. Measures	
2.3.2. Procedure	68
2.3.3. Participants	68
2.3.4. Non-Responders	
2.4. The Injury Vulnerability (IVS) Study	
2.4.1. Measures	
2.4.2. Procedure	
2.4.3. Participants	
2.4.4. Non-responders	81

2.5. St	ımmary	83
B. Hype:	rarousal following deployment: The impact of deployment and comb	bat-
	auma on the presentation of hyperarousal symptoms in Australian l	
	OF) members	
•	ommentary	
	troduction	
_	ethod	
3.3.1.	Measures	88
3.3.2.	Procedure	93
3.3.3.	Participants	93
3.3.4.	Data analysis	93
3.4. Re	esults	
3.4.1.	Hyperarousal pre and post deployment - presentation of symptoms	
3.4.2.	Hyperarousal criteria over time: proportion meeting hyperarousal criteria at	pre and
post d	eployment	
3.4.3.		
3.4.4.	Predictors of post-deployment hyperarousal	
3.5. Di	scussion	111
. Predi	cting future disorder: The role of hyperarousal in predicting onset o	of future
	ommentary	
	troduction	
	ethod	
4.3.1.	Participants	
4.3.2.	Measures	
4.3.3.	Procedure	
4.3.4.	Data analysis	
4.4. Re	esults	
4.4.1.	Demographic characteristics of the final sample compared to those excluded	129
4.4.2.	Rates of psychiatric disorder in those with and without hyperarousal	131
4.4.3.	Hyperarousal as a predictor of new onset disorder	134
4.5. Di	scussion	137
. Quali	ty of Life and Impairment 12 months post-injury: The contributions	of DTCD
_	, C and D	
	ommentary	
	troduction	
	ethod	
5.3.1.	Participants	
5.3.2.	Measures	
5.3.2.		
5.3.4.	Data Analysis	
	esults	
5.4.1.	Summary of findings	
	scussion	
	ving a traumatic injury: exploring the longitudinal interaction of	
	usal symptoms	
	ommentary	
	troduction	
	ethod	
6.3.1.	Participants	171

	6.3.2	2. Measures	172
	6.3.3	3. Procedure	173
	6.3.4	4. Data Analysis	173
(5.4 .	Results	175
	6.4.	1. Demographics	175
	6.4.2	2. Acute hyperarousal symptoms predicting hyperarousal symptoms at three mo	nths.178
	6.4.3	 Acute hyperarousal symptoms predicting hyperarousal symptoms at twelve m 184 	onths
	6.4.4	4. Three-month symptoms of hyperarousal predicting hyperarousal symptoms a	t twelve-
	mor	nths 190	
	6.4.	5. Proportion of symptoms met in those with and without PTSD over twelve mon	ths197
(5.5 .	Discussion	203
7.	Con	clusion	209
		Summary of findings	
	7.1.		
	7.1.		
	7.1.		
	7.1.4		
•		Implications	
		Limitations of this research	
	7.3.		
	7.3.	1	
•	7.4.	Recommendations for future research	
•		Final thoughts	
3.	Ref	erence List	241
9.	App	oendices	264
		MEAO Prospective Health Study Questionnaire, Physical and Neurocognitive	
		nt Form	U
		MEAO Prospective study pre-deployment questionnaire	
		MEAO Prospective study post-deployment questionnaire	
		South East Life Study Consent Form	
		South East Life Study follow-up questionnaire	
		IVS participant follow-up letter	
•		IVS Clinician Administered PTSD Scale (CAPS)	

ii. List of Tables

Table 1.1 Aims and hypotheses examined within this theses by chapter	54
Table 2.1. Demographic and service characteristics of the MEAO prospective study populati	
Table 2.2. Proportion of MEAO prospective study participants who completed pre and post	
deployment surveydeployment survey	63
Table 2.3. Length of most recent deployment for pre and post responders in the MEAO	
prospective study	64
Table 2.4. Role on most recent deployment for MEAO prospective study survey responders.	
Table 2.5. Responders and non-responders differences in the MEAO prospective study	65
Table 2.6. Marital status of SELIFE participants at the 28 yr follow-up (n=133 were missing	data)
	69
Table 2.7. Occupational Status of SELIFE participants at the 28 yr follow-up	69
Table 2.8. A comparison of responders and non-responders in the SELIFE study	70
Table 2.9. IVS study participants N(%) from each hospital site	72
Table 2.10. Previous literature published utilising data from the Injury Vulnerability Study	74
Table 2.11. Gender of participants across each follow-up of the IVS study	79
Table 2.12. Marital status of participants at each follow-up assessment in the IVS Study	
Table 2.13. Employment status of participants N(%) at each follow-up assessment in the IVS	S
studystudy	
Table 2.14. Prevalence of mechanisms of injury in the IVS sample	
Table 2.15. Differences between responders and non-responders at acute stage of follow-up	
the IVS sample	
Table 3.1. Categories of traumatic deployment exposures in the MEAO sample	92
Table 3.2. Proportion N (%) of personnel who met B, C, D criteria for PTSD at pre and post	
deployment in the MEAO prospective study	
Table 3.3 Prevalence of symptoms at pre and post deployment in the total MEAO prospective	
study sample	
Table 3.4 Univariate and multivariate predictors of pre-deployment hyperarousal in the ME	
sample	
Table 3.5 Univariate and multivariate predictors of post-deployment hyperarousal in the M sample: demographics and service characteristics	
Table 3.6 Univariate and multivariate models of role on deployment and total time away as	100
predictors of post-deployment hyperarousal in the MEAO sample	102
Table 3.7 Number of exposures predicting hyperarousal symptoms post-deployment, control	
for pre-deployment symptoms in the MEAO samplefor	
Table 3.8 Deployment traumas predicting post-deployment hyperarousal whilst controlling	
pre-deployment hyperarousal symptoms in the MEAO sample	
Table 3.9 Number of prior lifetime traumas predicting hyperarousal symptoms post-	101
deployment, controlling for pre-deployment symptoms in the MEAO sample	106
Table 3.10 Type of prior trauma exposure predicting post-deployment hyperarousal whilst	
controlling for pre-deployment hyperarousal symptoms in the MEAO sample	
Table 3.11. Multivariate logistic regression of previously significant predictors of post-	
deployment hyperarousal in the MEAO sample	110
Table 4.1 Characteristics of the final SELIFE sample and those excluded from the analysis (t	
with previous lifetime disorder)	
Table 4.2 Rates of disorder between time 4 and time 5 in those who did and did not meet	
hyperarousal criteria at time 4 in the SELIFE study	133
Table 4.3 Univariate logistic regressions examining hyperarousal at time 4 as a predictor of	
novel episodes of disorder between time 4 and time 5 in the SELIFE sample	
Table 4.4 Results of multivariate logistic regressions with hyperarousal, gender and numbe	r of
traumas entered as covariate predictors of novel episodes of disorder between time 4 and t	ime
5 in the SELIFE sample	136

Γable 5.1. Mechanism of injury in the 12 month IVS follow-up sample148
Table 5.2 Mean (SD) of functional outcomes for the whole IVS sample, and for participants with
No PTSD and PTSD at 12-months post-injury152
Table 5.3 Multivariate regression analyses of re-experiencing, avoidance and numbing,
hyperarousal and PTSD diagnosis as predictors of quality of life outcomes in IVS sample at 12-
months post-injury154
Гable 5.4 Multivariate regression models of PTSD symptom criterions, PTSD diagnosis, and
other known demographic chararacteristics as predictors of quality of life and disability at 12-
months post-injury in the IVS sample156
Γable 6.1 Proportion of the IVS sample endorsing each hyperarousal symptom at the acute, 3
and 12-month follow-up assessments (N=1,156)175
Γable 6.2. Proportion of IVS participants meeting criteria for each of the hyperarousal symptoms
by 3 month group: no PTSD in the 3 month follow-up period, new onset PTSD at 3 months;
stable PTSD diagnosis from acute months to three months
Γable 6.3. Proportion of IVS participants meeting criteria for each of the hyperarousal symptoms
by 12 month group: no PTSD in the 12 month follow-up period, new onset PTSD at twelve
months; stable PTSD diagnosis from three months to twelve months201

iii. List of Figures

Figure 6.1 Change in the proportion of the IVS sample that met each of the hyperarousal
symptoms over time
Figure 6.2 Model 1: Acute hyperarousal symptoms predicting sleep difficulties at 3-months 178
Figure 6.3 Model 2: Acute hyperarousal symtpoms predicting irritability at 3-months179
Figure 6.4 Model 3: Acute hyperarousal symptoms predicting concentration problems at 3-
months
Figure 6.5 Model 4: Acute hyperarousal symptoms predicting hypervigilance at 3-months 181
Figure 6.6 Model 5: Acute hyperarousal symptoms predicting startle response at 3-months 182
Figure 6.7 Model 6: Acute hyperarousal symptoms predicting sleep difficulties at 12-months 184
Figure 6.8 Model 7: Acute hyperarousal symptoms predicting irritability at 12-months185
Figure 6.9 Model 8: Acute hyperarousal symptoms predicting concentration problems at 12-
months
Figure 6.10 Model 9: Acute hyperarousal predicting hypervigilance at 12-months187
Figure 6.11 Model 10: Acute hyperarousal symptoms predicting startle response at 12-months
Figure 6.12 Model 11: 3-month hyperarousal symptoms predicting sleep difficulties at 12-
months
Figure 6.13 Model 12: 3-month hyperarousal symptoms predicting irritability at 12-months. 192
Figure 6.14 Model 13: 3-month hyperarousal symptoms predicting concentration problems at
12-months
Figure 6.15 Model 14: 3-month hyperarousal symptoms predicting hypervigilance at 12-months
194
Figure 6.16 Model 15: 3-month hyperarousal symptoms predicting startle response at 12-
months
Figure 6.17 Full model of most significant paths between symptoms of hyperarousal from acute
to 3-months, and 3-months to 12-months in the IVS sample (B≥.2)
Figure 7.1 Full model summary of hyperarousal symptom interaction over 12-months in the IVS
sample (B>.2)

iv. Abstract

Background

Recent literature has revealed the prognostic role of the hyperarousal criteria as a predictor of further PTSD symptom onset, maintenance, and severity. Despite this, there is a distinct gap in the literature as to the aetiology of hyperarousal, and the impact of these symptoms on an individual's post-trauma sequelae outside of the PTSD paradigm.

Aims

This thesis examined hyperarousal in the context of post-trauma sequelae. Specifically, the chapters of this thesis focus on which trauma-related factors predicted this criterion following a traumatic experience; the role of hyperarousal in the development of psychological disorders other than PTSD; how hyperarousal affects an individual's quality of life and disability level following a trauma; and finally, delineating the relationships between the individual symptoms of hyperarousal as they manifest longitudinally following a traumatic event.

Method

Such a breadth of analysis required the use of data from three very distinct epidemiological data sets. The Military Health Outcomes Program (MILHOP) of research, designed to establish the prevalence of mental disorder and psychological distress in currently serving Australian Defence Force (ADF) personnel, was utilised to assess how different aspects of trauma (i.e. the nature and number of traumas) predict the onset of hyperarousal. The South East Lifetime Impact of Fire Exposure Study (SE LIFE) a longitudinal study of individuals exposed to the Ash Wednesday Bushfires of February 16th, 1983, was utilised to assess whether hyperarousal significantly predicted novel episodes of disorder other than PTSD. Finally, the Injury Vulnerability Study (IVS), a

Jason Blunt 2016

large-scale national multisite study of psychopathology following traumatic injury, was utilised to assess both the impact of hyperarousal on quality of life and disability following trauma and how the symptoms of hyperarousal manifest longitudinally following a traumatic event.

Results

Highlighting the significant association between cumulative trauma and the development of hyperarousal, the results presented in this thesis also emphasise the role of hyperarousal criterion in the prediction of both future episodes of PTSD and other anxiety and affective disorders. An examination of the contributions of the different symptom criteria of PTSD in predicting quality of life and disability following trauma highlighted the role of hyperarousal in particular predicting poorer physical and environmental self-reported quality of life and increased disability. A closer examination of the relationships between the symptoms of hyperarousal following a traumatic experience illustrated the significant role that hypervigilance plays in promoting further symptom recruitment within this criteria and perhaps the disorder.

Conclusion

The results presented in this thesis highlight the significant role of the hyperarousal criteria post-trauma. Significantly influenced by both the nature and number of traumas experienced, hyperarousal has a prominent role in post-trauma sequelae, predicting future novel episodes of disorder, poorer quality life and an increased level of disability. Suggestions for trauma interventions include early-targeted treatment of hyperarousal symptoms, particularly hypervigilance, which was shown to predict the onset of further hyperarousal symptoms. Future research should focus on expanding the paradigm of hyperarousal and providing a better understanding of the neurological and biological

underpinnings of these symptoms, which play a critical role in critical determining post-trauma sequelae.

v. Declaration

I certify that this work contains no material which has been accepted for the award of

any other degree or diploma in my name, in any university or other tertiary institution

and, to the best of my knowledge and belief, contains no material previously published

or written by another person, except where due reference has been made in the text. In

addition, I certify that no part of this work will, in the future, be used in a submission in

my name, for any other degree or diploma in any university or other tertiary institution

without the prior approval of the University of Adelaide and where applicable, any

partner institution responsible for the joint-award of this degree.

I give consent to this copy of my thesis, when deposited in the University Library,

being made available for loan and photocopying, subject to the provisions of the

Copyright Act 1968.

I also give permission for the digital version of my thesis to be made available on

the web, via the University's digital research repository, the Library Search and also

through web search engines, unless permission has been granted by the University to

restrict access for a period of time.

Jason Blunt

I believe that this thesis is properly presented and conforms to the specifications for the

degree of sufficient standard to be, prima facie, worthy of examination

Professor Alexander Cowell McFarlane

Principal Supervisor

vi. Acknowledgements

Firstly, I would like to thank my principal supervisor Professor Sandy MacFarlane. His guidance and insight over the course of the last 4 years has helped me develop my knowledge to a higher level than I thought possible. I am grateful to have had the opportunity to study under someone with such expertise and extensive knowledge in the field of trauma and PTSD.

Thank-you to Dr Miranda Van Hooff, who although listed as co-supervisor spent the most time with me in the trenches of this PhD and whose continued support, guidance and feedback was critical to my completion. Your support, guidance and feedback kept me on track and meeting deadlines during the final stages of my timelines, and I appreciate the support you provided during this demanding period.

Thank-you to Dr Ellie Lawrence-Wood, who came in late to my project as a cosupervisor but proved invaluable in helping me complete this thesis. Your continued enthusiasm towards, and willingness to review the many drafts that came across your desk is a testimony to both your passion for research and your commitment to the students under your supervision. I cannot thank you enough for all the times you sat with me whilst I was on the verge of a breakdown and helped me problem-solve.

A big thank-you to all the staff of CTSS, both past and present, for their continued support and friendship throughout the journey. A huge thank-you in particular to Maria, Andy, Derek, Laura, Jenelle, Liz and Matt. The many lunches, drinks and other extracurricular activities throughout my time at CTSS truly kept me sane. Having such great, supportive friends in the workplace was priceless, and I'm so grateful to know each and every-one of you.

To Mum, Dad, Jake and Shelley, words can't express how appreciative I am to all of you. Your love, support and tolerance throughout this process, in both the high points but especially in the low points, kept me going. You continued to have faith in me, even when I had lost faith in myself, and I cant thank you enough. I never would have achieved this without you.

To my close friends, thankyou for the constant encouragement and support. Writing this thesis has, at times, been an exercise in sustained suffering, for both myself and the people around me. I can always rely on your support and encouragement, which helped me to finally succeed. I owe you.