# Posttraumatic Stress Disorder With Vignettes

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12/11/18

# DSM-5 Criteria

- Exposure
  - Actual/threatened death, serious injury, sexual violence.
- Intrusion/Re-experiencing
  - One or more: Intrusive memories, nightmares, flashbacks, distress or physical reaction to symbols of trauma.
- Avoidance
  - Of memories and/or physical reminders.

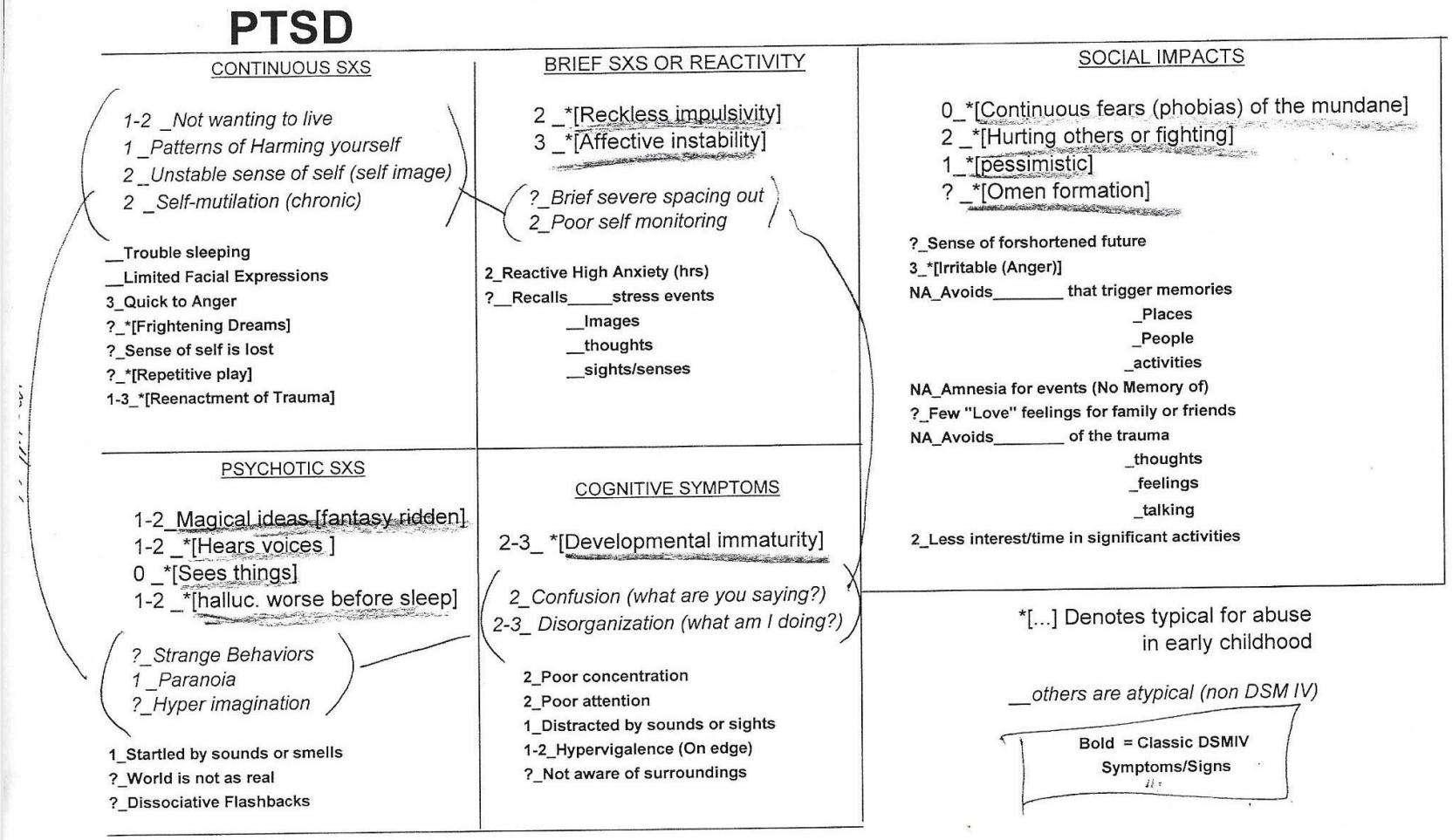
# DSM-5 Criteria

- Alterations in cognition or emotion:
  - 2 or more: Can't remember event, persistent negative beliefs ("can't trust anyone"), distorted self blame, ongoing negative emotional state, anhedonia, emotionally numb, can't experience good emotions.
- Arousal/reactivity:
  - 2 or more:  Irritability toward objects/people, self-destruction/riskiness, hypervigilance, jumpiness, diminished concentration, sleep disturbance.

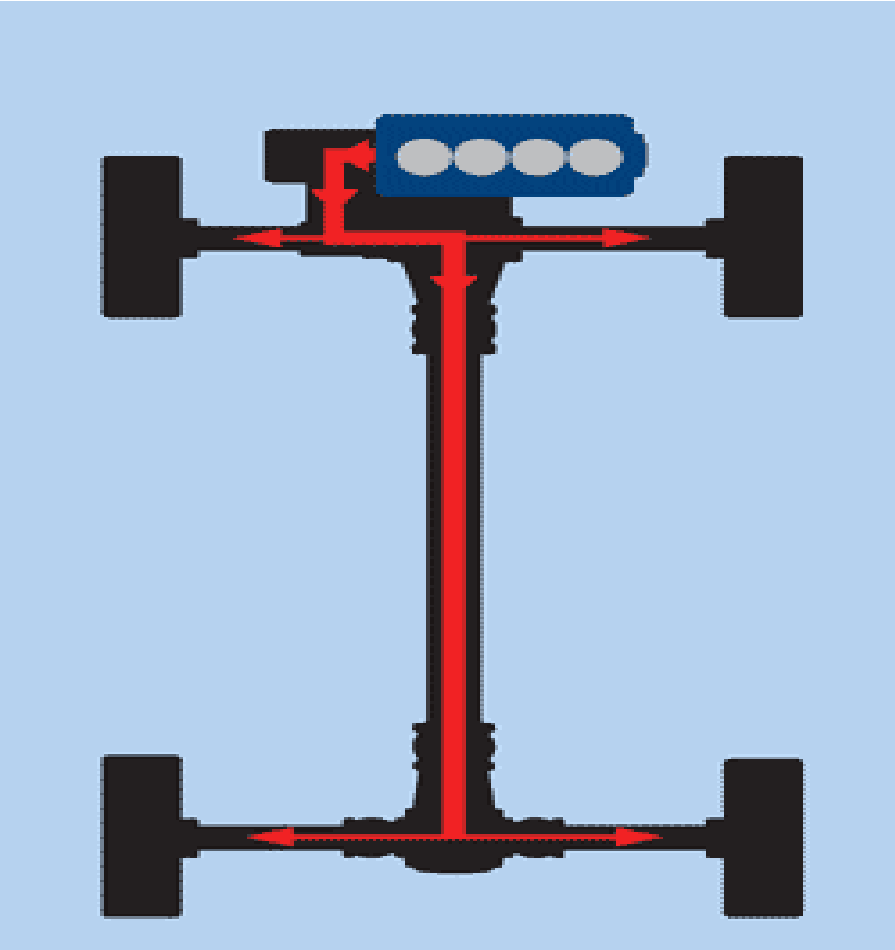
# DSM-5 criteria

- Duration is longer than 1 month.
- Causes clinically significant distress/impairment.
- Is not due to the effects of a substance.

# PTSD Symptoms



# PTSD Symptoms



# Prevention

- Widespread debriefing ("First Aid")
  - Not effective in reducing rates or intensity of PTSD
  - May actually be harmful to some trauma survivors
    - Interferes with natural supports(?)
- Multi-session, trauma-focused CBT
  - Effectively reduces rates of PTSD
- So… Screening and treating appropriate survivors (not everyone) is recommended

# Prevention

- Medications
  - Not much data.
  - Benzodiazepines directly following trauma: does not work and may increase risk of developing PTSD.
  - Gabapentin and pregabalin: not effective.
  - Propranolol: Promising, but not a lot of data yet. Did reduce intensity of PTSD, and likelihood of developing it, in one study.
  - SSRIs: reduced symptoms by parent report, but not child report, in a study on children and PTSD.

Shalev, 2009

# Treating PTSD Symptoms

- Therapy
  - Trauma Focused CBT (Has most supportive evidence)
    - Cognitive Therapy (CT) or Cognitive Processing Therapy (CPT): Addresses cognitive distortions common to trauma survivors.
    - Prolonged Exposure (PE): Just like it sounds…
  - EMDR (also has good evidence of efficacy)
    - Basically exposure therapy + lateral eye movements.

# Medications

- SSRIs
  - Considered 1st line (sertraline, paroxetine FDA-approved).
  - Generally accepted as most efficacious, yet response rates rarely reach 60% and only 20-30% achieve remission.
- SNRIs, mirtazapine, bupropion, serotonin agonists
  - Often conflicting results.
  - But… do treat common sequelae (remember the car diagram).
  - Watch for vivid dreams (worse nightmares) with trazodone
  - Use caution with bupropion – can increase arousal, anxiety, insomnia

# Medications

- Prazosin
  - Multiple trials show positive effect for nightmares and insomnia in PTSD
  - Also used in daytime doses for physical anxiety (exaggerated startle response, panic, hypervigilance)
- Antipsychotics
  - Trial with olanzapine showed potential.
  - Often used as adjuncts for mood stabilization
  - Quetiapine (Seroquel) occasionally used for *refractory* insomnia
  - *Think about side effects!*

# Medications

- Clonidine and propranolol
  - For physical anxiety
  - Mixed results for core PTSD symptoms
  - Caution r.e. using clonidine with minimally compliant patients.
- Mood stabilizers
  - Promising study with valproate
  - Mixed results from lamotrigine, topiramate, carbamazepine (but these can be effective at treating mood instability)

Shalev, 2009; Katzman, et. al, 2014

# Medications

- Benzodiazepines
  - Ineffective for treatment and prevention.
  - But they reduce anxiety (one of the car wheels)... so why not use them?
  - Specific to patients with PTSD, associated with:
    - More severe PTSD symptoms
    - Increased likelihood of developing PTSD after trauma
    - Worse psychotherapy outcomes
    - Increased aggression, depression, substance use
  - Relatively Contraindicated.

Guina, et. al, 2015

# Medications

- Pearls:
  - Treat the symptom, not the diagnosis.  But, the diagnosis is important!
  - Treat the most distressing symptom(s) first, and consider medications with quick efficacy.
  - Remember that full remission is rarely achieved with medications alone, so recommend therapy
  - Avoid the temptation of benzodiazepines, and to a lesser degree, atypical antipsychotics

# Complex PTSD

- Definition:  a proposed diagnostic term for a set of symptoms resulting from prolonged stress of a social and/or interpersonal nature
- Potential Causes:
  - Concentration/POW camps
  - Forced prostitution
  - Long term domestic violence
  - Long term childhood physical abuse
  - Long term childhood sexual abuse
  - Child exploitation rings
  - Individual traumas in an unsupportive home(?)

# Complex PTSD

- Chronic Difficulties With:
  - Emotional Regulation (anger, suicidality, sadness).
  - Consciousness (dissociation, not remembering).
  - Self Perception (shame, guilt, helplessness, not like others).
  - Distortions r.e. the Perpetrator (total power, preoccupation, revenge).
  - Interpersonal Relations (isolation, distrust, rescuer).
  - “Meaningfullness” (loss of faith, despair, hopelessness).

# Complex PTSD

- Can be looked at as PTSD + a Personality Disorder.
  - If you have heard me talk about personality disorders, this should sound familiar…
    - Personality is an organized pattern of behaviors developed through the ongoing interaction between temperment, character and environment.
    - An ongoing dysfunctional environment  creates dysfunctional personalities.

# Treating Complex PTSD

- 92% of people considered to have Complex PTSD also met criteria for (traditional) PTSD. So, standard treatments are indicated.
- For additional symptoms, treatment should focus on:
  - Interpersonal Difficulties
  - Restoring Control and Power
  - Creating Safe Relationships
  - Promoting Reconnection with Everyday Life
  - DBT
  - Results from medication trials to treat personality disorders are mixed at best

# Vignette 1

Jane is a 52 y.o. woman referred after a Health Aide visit where she complained about anxiety and depression. She shows significant psychomotor slowing, and endorses low energy, problems falling asleep, anhedonia, sadness, passive suicidality, and persistent guilt. She also complains about episodes of anxiety where she gets nervous and can't sit still. Her daughter was recently sexually assaulted, and her husband just went to jail after sexually assaulting a young girl. Jane reveals she was sexually abused throughout her teens, and has started having flashbacks about these traumas since the recent events in her family. She is also jumpy. She avoids being out in public whenever possible because she sees things/people that remind her of her own sexual trauma and it puts her on edge.

# Vignette 1

- Diagnosis?
- She mentions she is most bothered by feeling anxious and fidgety, but admits she is also quite depressed.
  - Treatment?
    - Psychotherapy
    - SSRI
    - Beta blocker/anti adrenergic
    - Bupropion
    - Sleep aid
    - All of the above

# Vignette 1

She started sertraline initially, then PRN trazodone two weeks later. Sertraline was titrated to 150 mg over the next 2-3 months. Sleep is a little better. Mood remains quite depressed; she still looks slowed down. She is less anxious in general, not fidgety, with anxiety episodes occurring only when she is triggered and this is happening less often. Has attended a few therapy sessions, which have been marginally helpful.

# Vignette 1

- What now?
  - Motivational interviewing r.e. going to therapy
  - Add an anti adrenergic
  - Add bupropion
  - Change SSRI

# Vignette 1

I added bupropion, with copious warnings to watch for worsening anxiety. Significant improvement in mood, especially in low energy depression over the next few weeks. Anxiety is unchanged. Using trazodone less often now. Also, after a number of conversations about therapy and relying on psychosocial supports, she is talking regularly with a village elder, which she feels is more helpful than counseling.

# Vignette 2

John is a 31 y.o. man doing residential treatment for alcohol use at AHC. He was in jail before treatment and has been sober for ~ 3 months. He disclosed years of sexual molestation by an uncle between the ages of 4 and 8 to his clinician and was referred for an evaluation. At AHC, he is described as manipulative, angry and aggressive one minute, then happy and placating the next; he has made several people cry during group sessions, he is sexually provocative, and he is always caught up in any drama that occurs in treatment. Several times he has made superficial cuts on his arms, which he discretely makes sure people see, then covers them up.

# Vignette 2

During our interview, he is initially sullen and withdrawn. But eventually starts endorsing nearly every symptom asked about, including depression, mania (always short-lived, for an hour or two), and terrible panic. He believes he has bipolar disorder – he will be feeling exuberant/hyper, then will immediately feel depressed as soon as he is confronted with mildly disappointing news. He used to have nightmares “all the time” when he was a kid, says he has flashbacks (but actually describes vague intrusive memories about abuse “when someone like you brings it up”), he gets really angry if someone surprises or startles him, and he has periods of time where he avoids “everything”. Feels anxious all day after being startled. Despite asking for some specifics about these latter symptoms, he remains vague.

# Vignette 2

- Diagnosis:
  - PTSD?
  - Substance use?
  - Bipolar Disorder?
  - Personality Disorder?
  - Anxiety and Depression?

# Vignette 2

John is treated with sertraline for 10 weeks, up to 150 mg. No discernible effect, although he has complained of several, improbable, adverse effects. He has stayed sober. Remains irritable, continues to cause problems interpersonally, and continues to complain of constant “mood swings” (daily, abrupt changes from happy to upset or sad). He finished residential treatment and, although he has gone to some AA meetings, he quit going to counseling/therapy because he couldn’t get along with the clinician. He also mentions that, the longer he has been sober, the more he has been dreaming. Occasionally his dreams are of him being assaulted. They wake him up and he can’t get back to sleep.

# Vignette 2

- What now?
  - Does the diagnosis change?  What else would we want to know?
  - Should his medications change, and how?
  - What is his prognosis in terms of recovery?

# Questions?

# References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