TRAUMA AND STRESSOR RELATED DISORDERS

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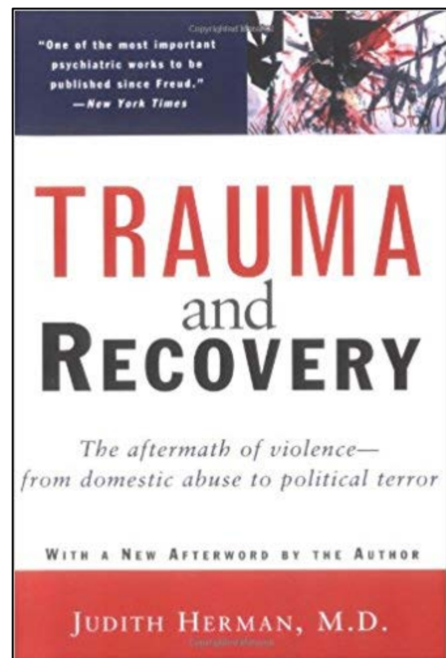

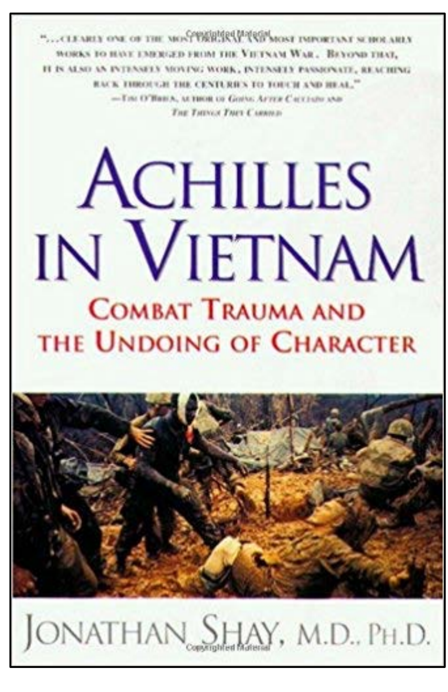

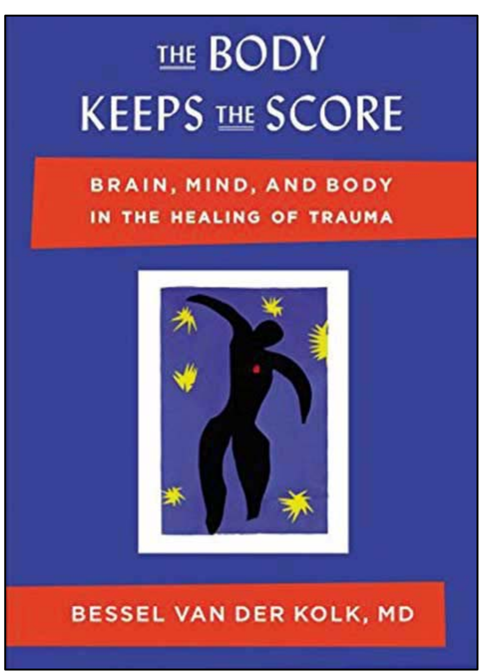

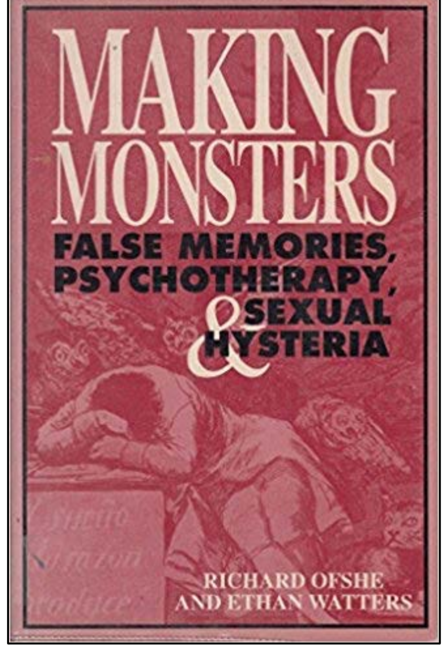

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THE RELATIONSHIP BETWEEN TRAUMA AND PSYCHOPATHOLOGY

- This has been debated at least since the time of Freud with wide pendulum swings where trauma is ignored and then over-endorsed as the source of psychopathology.
- Some people believe that every psychopathology is related to some kind of trauma, and some people believe that even personality disorders are mostly genetically determined.

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PERSONAL OPINIONS BASED ON MY EXPERIENCE…

- It is certainly the case that trauma can cause or significantly contribute to almost any kind of psychopathology (anxiety, depression, psychosis, dissociation, etc.)

- It is NOT the case, however, that everyone who has a psychopathology was traumatized in the past. Expecting to find childhood sexual abuse, for example, where there isn't any can be very damaging to patients and society.

- Kids bring their own temperaments and personalities into relations with parents. Some children's personalities are poor fits for their parents. Traumas and injustices can be perceived by one child and not another because of these vulnerabilities.

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THOUGHTS CONT'D…

- Having a time-limited traumatic experience as a teenager or adult is very different from growing up in an environment that is fundamentally unsafe or abusive (never knowing safety).

- Some psychiatrists (Herman, Van Der Kolk) have suggested the designation of COMPLEX PTSD to describe people with repeated early childhood experiences of trauma.

  - These individuals respond more slowly and poorly to almost all standard treatments for PTSD.

  - Much (but NOT all) of what is currently called 'Borderline Personality Disorder' might fall under the designation of **COMPLEX-PTSD**.

  - I personally feel more compassion when I mentally use the designation of Complex PTSD rather than labels that have become pejorative such as 'Borderline.'

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SOMATIZATION

- This varies from culture to culture, but many people who repeatedly seek care for physical complaints that never seem to get better – or only get better to morph into another complaint – have been traumatized.

- In Freud's day, the somatization of choice was **hysteria**.
    - What we might today call Conversion Disorders

- In our day, **chronic pain**, **abdominal complaints**, **fatigue**, and **headaches** can all be surrogates for trauma.
    - Thus the title of the recent book "The Body Keeps the Score."

THE BODY KEEPS THE SCORE
BRAIN, MIND, AND BODY IN THE HEALING OF TRAUMA
BESSEL VAN DER KOLK, MD

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How do you start a conversation with someone who you suspect is having bodily complaints that are related to psychic pain?

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Now Back to Trauma and Stressor-Related Disorders, Proper…

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WHAT THESE DISORDERS ALL HAVE IN COMMON

- Something bad needs to have happened to the patient.
- First two are pediatric diagnoses:
  - Reactive attachment disorder: child is inhibited and socially withdrawn with limited ability to have positive affect, and irritability/sadness even with non-threatening interactions with caregivers. Child had extremely insufficient care.
  - Disinhibited Social Engagement Disorder: child experienced a pattern of insufficient care and subsequently has no reticence in approaching and interacting with unfamiliar adults, overly familiar verbal or physical behavior, doesn't mind running away from adult caregiver, even in unfamiliar settings.

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ACUTE STRESS DISORDER

- Exposure to actual or threatened death, serious injury, or sexual violation by directly experience, witnessing, learning of the event happening to a FAMILY member or CLOSE friend, or repeated exposure to details of trauma (as in a prosecutor who works for sexually abused children).

- Having symptoms of intrusion, negative mood, dissociation, avoidance, and arousal (at least 9/14) as detailed on the next slide…

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ACUTE STRESS DISORDER CONT'D

Intrusions

- Recurrent, involuntary, and intrusive distressing memories.
- Recurrent distressing dreams
- Flashbacks
- Intense or prolonged distress in response to reminders/ cues (internal or external)

Negative mood

- Persistent inability to experience positive emotions

Dissociative Symptoms

- Altered sense of reality of one's surroundings or one's self (slowing of time)
- Inability to remember important aspects of traumatic event

Avoidant symptoms

- Efforts to avoid distressing memories, thoughts, or feelings associated with event
- Efforts to avoid external reminders of the event

Arousal

- Poor sleep
- Irritable behavior and angry outbursts; Hyper-vigilance
- Problems with concentration
- Exaggerated Startle response

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For Acute Stress Disorder, symptoms must last at least 3 days, but can last up to a month (at which time it becomes Post Traumatic Stress Disorder). If symptoms resolve within 3 days, it is "normal."

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PREVALENCE OF ACUTE DISTRESS DISORDER

- Overall about 20% of individual are identified with Acute Stress Disorder who have not had interpersonal trauma
  - For assault, rape, or witnessed mass shootings rates are higher – up to 50%
- 13 – 21% of MVA survivors
- 14% of mild traumatic brain injury
- 10% of severe burns

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HOW CAN YOU HELP AFTER YOUR PATIENT EXPERIENCES A TRAUMA?

- In very distressed patients:
  - Judicious use of sleep aids or benzos is not unreasonable with the BIG CAUTION that benzos will likely interfere with a person's ability to face the anxieties which is essential for full recovery.

- There are some experimental treatments for people exposed to trauma:
  - They include propranolol administration to reduce adrenergic response, Morphine administration right after trauma, high dose glucocorticoid immediately following trauma exposure. Intranasal Neuro-peptide Y has some promise (but where would you get that?)

- Most authors suggest supportive treatments as per the next slide

Source: S.R Horn et al. Experimental Neurology 284 (2016) 119-132

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Other interesting things…

About half of people with PTSD had ASD – so half didn't have this response until much later.

Women are more likely to have ASD. This may be related to neurobiological differences, but women are also more likely to experience the kind of stressors which increase the risk (rape/ assault).

ASD causes problems leaving the house (to work/appointments).

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PRINCIPLE	RATIONALE	INTERVENTION
Promoting a sense of safety	Patients who maintain or reestablish a sense of safety have a decreased risk of posttraumatic stress disorder; physicians are encouraged to take measures in which patients are brought to a safe place and assured safety.	After mass trauma, patients should be encouraged to limit conversations about rumors and horror stories (often termed the "pressure cooker" effect), which may enhance psychological distress. Because of patient concerns about family members, it is important to provide information about their well-being. Limiting exposure to news media stories about traumatic events is also recommended.
Promoting a sense of calm	Some anxiety is normal, but it becomes problematic when it interferes with sleep, eating, hydration, decision making, and conducting normal tasks.	Physicians may encourage therapeutic grounding (i.e., patients are no longer in a threatening situation), deep breathing, muscle relaxation, yoga, mindfulness, cognitive behavior strategies, and normalization of the stress reaction.
Promoting a sense of self-efficacy and collective efficacy	Patients feel better when they can overcome threats and solve their own problems.	Physicians may remind patients of their pre-trauma sense of self-efficacy (i.e., their ability to overcome adversity), support community efforts to mourn, attend religious activities, and collaborate on projects for the betterment of the community.
Promoting connectedness	Connection allows patients to obtain essential information and to gain social support and a sense of community.	Patients should be counseled about services and support-seeking connections with others—especially loved ones—as quickly as possible. Physicians should provide formal support if informal support is unavailable.
Instilling hope	Maintaining a reasonable degree of hope helps to combat the shattered worldview, foreshortened future, and catastrophizing that may occur after trauma.	Cognitive behavior therapy addresses patients' exaggerated sense of personal responsibility for events, corrects catastrophizing, normalizes patient reactions, stresses that most persons recover spontaneously, and prevents extreme avoidance.

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PSYCHOLOGICAL FIRST AID

CORE ACTION	TASKS
Contact and engagement	Respond to contact initiated by patient by introducing self, inquiring about immediate needs, and assuring confidentiality
Safety and comfort	Enhance immediate and ongoing safety while providing physical and emotional comfort
Stabilization	Calm, stabilize, and orient emotionally overwhelmed patients, and discuss the role of medication
Information gathering: current needs and concerns	Obtain information on nature and severity of experiences, concerns about post-trauma circumstances, separation from loved ones, physical or mental health problems, losses, extreme feelings of guilt or shame, thoughts about harming self or others, social support, prior alcohol or drug use, and prior exposure to trauma
Practical assistance	Offer practical assistance, identify immediate needs, clarify needs, discuss an action plan, and address needs
Connection with social support	Enhance access to and use of primary support persons and local community resources
Information on coping	Provide basic information about stress reactions; review common psychological reactions to traumatic experiences and losses; discuss physical and emotional reactions; provide basic information on coping strategies, simple relaxation techniques, and management of anger and other emotions; assist with sleep problems; and address alcohol and substance use
Connection with collaborative services	Provide direct links to additional services, refer as appropriate, and promote continuity

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MAIN TAKEAWAYS…

After a trauma, recovery depends mostly on:

- The availability and quality of social support
- The intensity of the psychological pressure a person faces during the recovery period

Psychological First Aid is helpful. However, routine group post-trauma briefings (called CISD: Critical Incident Stress Debriefing) have been shown to be HARMFUL and should not be routinely used.

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Some People will progress to PTSD.

There are risk factors to help us figure out who will.

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RISK FACTORS FOR POST-TRAUMATIC STRESS DISORDER

- Avoidance behavior
- Below average IQ or cognitive ability
- Excessive safety behavior (e.g., taking excessive precautions, excessively avoiding trauma reminders)
- Family history of anxiety or mood disorders
- Female sex
- Greater distress at time of event
- Greater perceived threat to life
- Greater symptom severity at one to two weeks after trauma
- High level of hostility
- History of sexual or physical abuse in childhood

- Less social support after trauma
- Low level of self-efficacy
- Mental defeat (i.e., processing the trauma as a complete loss of personal autonomy)
- Negative self-appraisals
- Nowness of trauma memories (i.e., when remembering the trauma, feeling as though it is happening now)
- Peri-traumatic dissociative symptoms during assault
- Peri-traumatic emotional responses
- Prior psychological problems (e.g., anxiety or mood disorder)
- Rumination about trauma
- Severity of trauma

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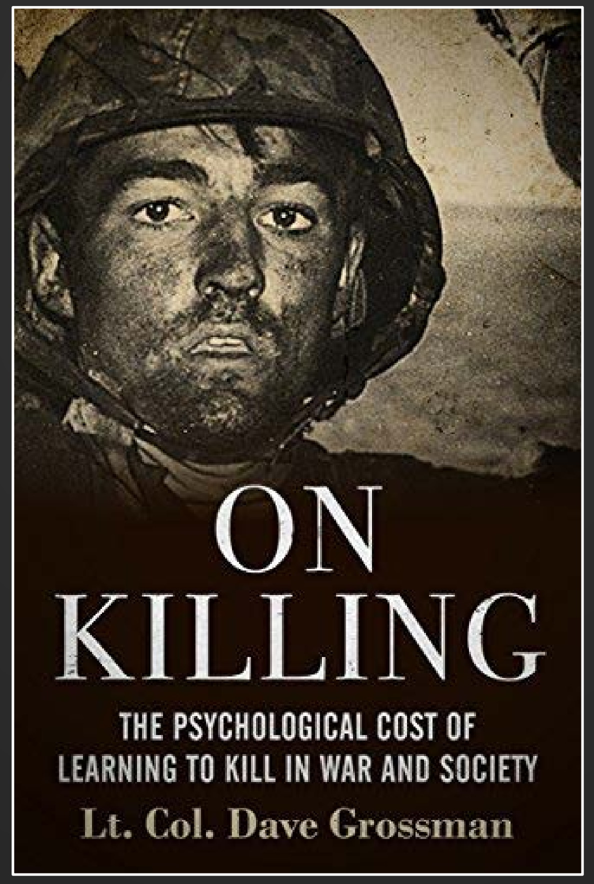
And again, interpersonal trauma is scarier to anticipate and is harder to recover from…



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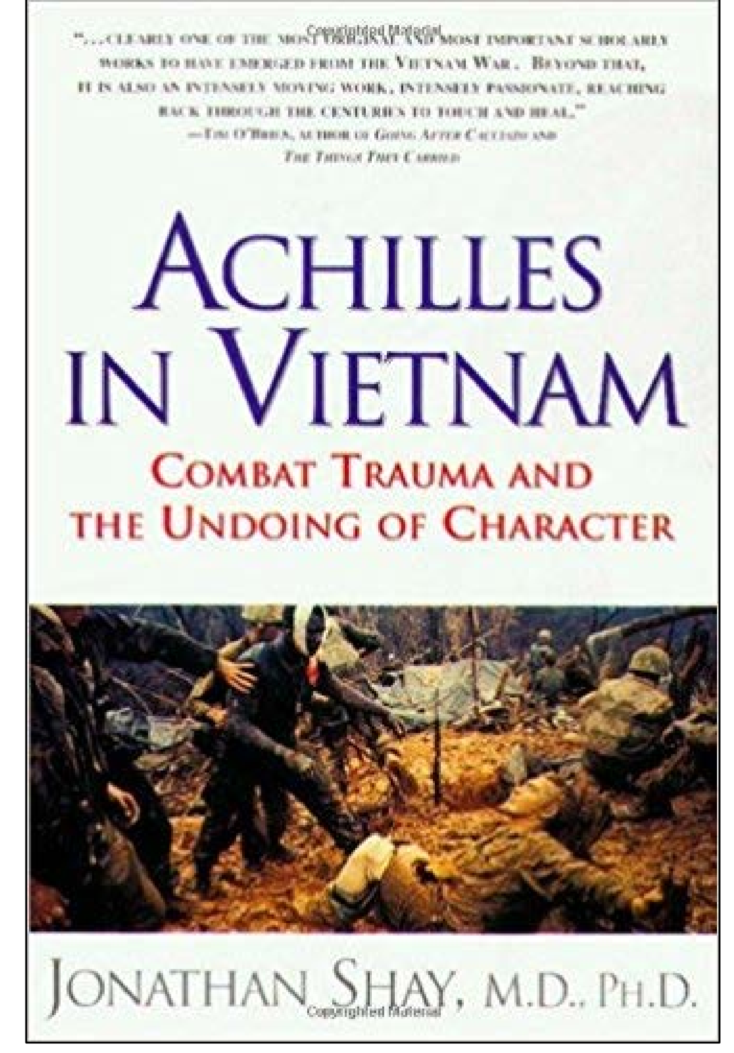
MORAL INJURY IS A HUGE PROBLEM, PARTICULARLY AMONGST MILITARY SERVICE MEMBERS WITH PTSD.



'Moral Injury': When Soldiers Betray Their Sense Of Right And Wrong | WBUR
http://legacy.wbur.org/2013/06/21/moral-injury-illustration

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POST-TRAUMATIC STRESS DISORDER

A: **Something bad happened** – experienced directly, witnessed, learned about something that happened to family member/close friend, or repeated/extreme exposure to aversive details of traumatic events.

- At least one **Intrusive Symptom** (memories, dreams, flashbacks, distress at cues, physiological reaction to cues)
- At least one **Avoidance Symptom** (efforts to avoid memories, thoughts, feelings OR efforts to avoid external reminders)

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POST-TRAUMATIC STRESS DISORDER CONT'D

At least two **Cognition/Mood Symptoms**:

- Inability to remember parts of trauma
- Persistent exaggerated beliefs about oneself/others
- Persistent unrealistic thoughts about the trauma that lead individual to blame self
- Persistent negative emotional state (fear, horror, anger, guilt)
- Limited participation in activities
- Persistent inability to experience positive emotions

At least two **Arousal and Reactivity Symptoms:**

- Irritable behavior, angry outbursts, or verbal/physical aggression
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Problems with sleep

Condition lasts more than one month, and causes dysfunction.

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PTSD MODIFIERS

With Dissociative symptoms:

- **De-personalization**: persistent or recurrent experiences of feeling detached from ones body and thoughts.
- **De-realization**: persistent or recurrent experiences of unreality of surroundings

With Delayed Expression:

- Full criteria are not met for at least 6 months after the trauma

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PTSD TIDBITS

- Lifetime risk by age 75 is 8.7%.
- 12 month prevalence is 3.5% in USA, lower in virtually every other part of the world.
- In the US, Latin Americans, African Americans, and Native Americans have higher rates that non-Latino white. Asian Americans have lowest rates – even when adjusted for rates of traumatic exposure.
- Highest rates are amongst veterans and survivors of rape, combat, captivity, genocide (1/3-1/2).
- Half will recover in 3 months, but some remain symptomatic indefinitely. Symptoms tend to worsen at times of stress.
- F> M, likely because females are more likely to experience the kinds of trauma most likely to produce PTSD symptoms.

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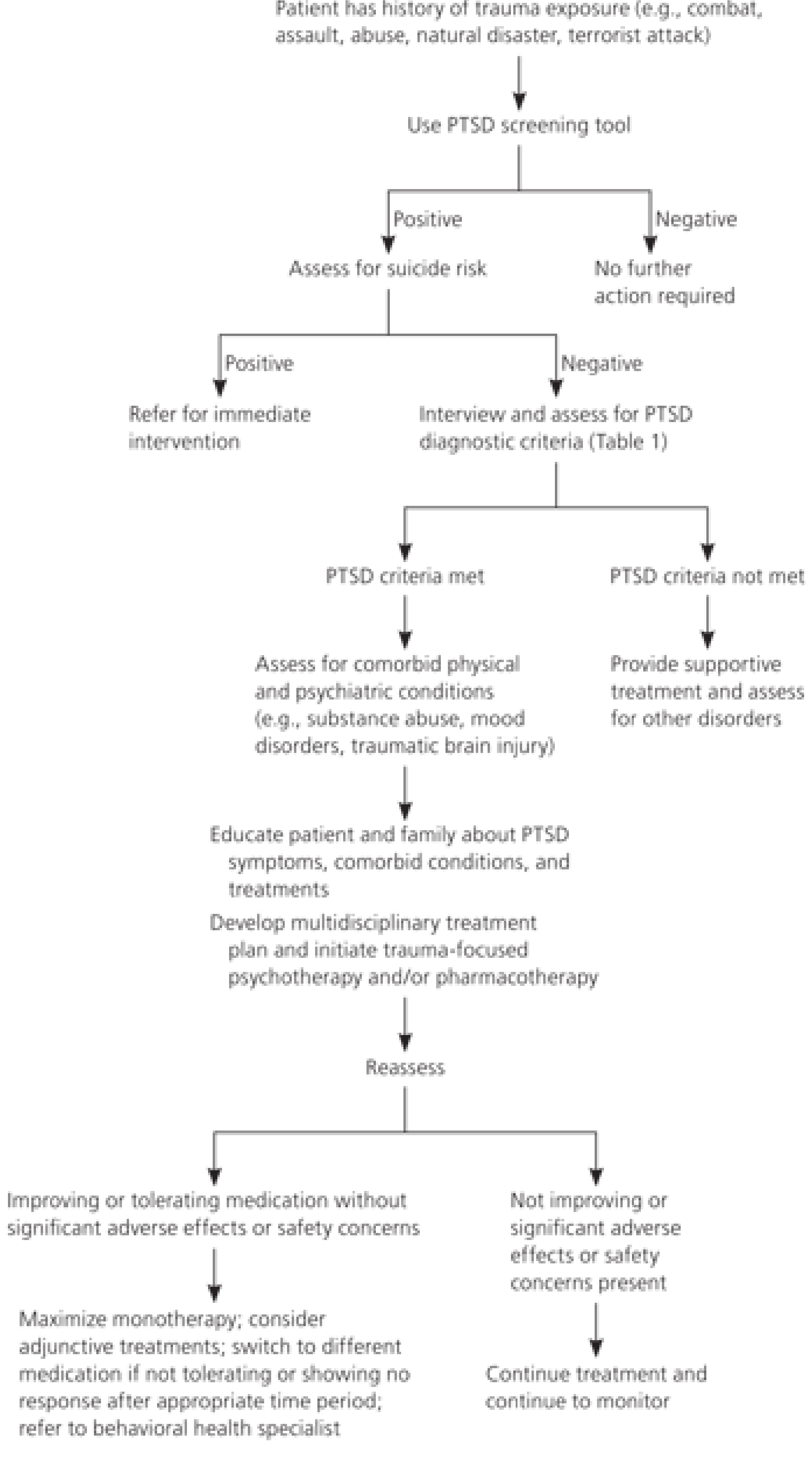

Suggested interview questions for assessing PTSD criteria

Reexperiencing:

- Do you have times during the day when you relive the event, even though it is not happening?
- Do you have nightmares or think about the event when you do not want to?
- When you are reminded of the event, do you get fearful or anxious?

Avoidance:

- Since the event, do you avoid certain places, people, or situations?
- Do you stay away from certain conversation topics or feelings because they remind you of the event?
- Do you find it difficult to remember the specifics of what happened?
- Since the event, are there things you used to enjoy doing that you no longer do? Why?
- Do you feel less connected to your family and friends? Have others noticed this?
- Have others noticed that you seem unhappy?
- Have your life goals or plans changed since the event? How so?

Increased arousal:

- Since the event, do you have trouble sleeping?
- Since the event, are you angrier, more prone to arguments, or even violent?
- Are you able to remain focused and complete tasks?
- Do you feel like you are always on guard? Where do you feel safe?
- Do certain things startle you that didn't before the event?

First-line treatments for PTSD:

Trauma-focused psychotherapy (e.g., cognitive processing therapy, eye movement desensitization and reprocessing, prolonged exposure)

Pharmacotherapy (Table 3)

- Selective serotonin reuptake inhibitors
- Serotonin–norepinephrine reuptake inhibitors

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PSYCHOTHERAPY FOR PTSD

There are several modalities of therapy with evidence, including:

- PE (prolonged exposure)
- Cognitive Processing Therapy
- Interpersonal therapy
- Relaxation Therapy
- EMDR (Eye movement desensitization and reprocessing therapy)

For some very disturbed patients or patients with long-standing childhood trauma starting with **DBT (Dialectical Behavior Therapy)** or **STAIR (Skills Training in Affect and Interpersonal Regulation)** may be a helpful approach to get people to tolerate the painful feelings associated with no longer avoiding the traumatic memories. However, evidence seems to indicate that decompensation and suicide with any of the therapy modalities is rare and approximately equal.

Source: Westfall et al, State of the Art Prevention and Treatment in PTSD, Psychiatric Ann. 2016; 46(9) 533-549

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EMDR

- This is a therapy developed for people who have been traumatized (PTSD, childhood abuse/neglect).

- The basic premise is that by providing **bilateral** (both left and right brain) **stimulation** to the nervous system while processing the trauma (by discussing it), helps to reprogram the way that the BODY remembers and reacts to the trauma.

- *For example:* a patient has PTSD from military service in Iraq. He does an exercise with a therapist where he looks back and forth between stimuli while recounting a traumatic event. The muscle/nerve memory of that event are altered.

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TRAUMA FOCUSED CBT

COGNITIVE REPROCESSING THERAPY + PROLONGED EXPOSURE

- Utilizes cognitive and behavioral techniques, including exposure and response prevention and cognitive reframing to help patients "habituate the trauma responses"
  - Reprocess the trauma in a healthy way

- *For example:* a woman who was raped and is plagued by PTSD symptoms and the feeling that she did not do enough to prevent the rape is encouraged to record herself telling the story of her rape and listen to it over and over again. Her therapist helps her understand that she was a victim, there was nothing she could have done differently, and that not every situation will lead to rape.

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PHARMACOTHERAPY

Secondary Prevention (preventing PTSD after the exposure)???

- Some evidence of prevention of PTSD with early administration of Hydrocortisone, Morphine, or Beta Blockers right at the time of the trauma. This is experimental, but worth a shot if you are a prescriber on the front lines, for example.

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PHARMACOTHERAPY

Start with an SSRI or SNRI:

- Paroxetine, Fluoxetine, Sertraline, and Venlafaxine have evidence. Of these, Paroxetine has the best evidence and the largest effect size (0.4 compared to ~0.2 for the others).
    - Caveat: there is some concern that military PTSD amongst mostly men does not respond as well to SSRIs/SNRIs than predominately female survivors of sexual abuse.
- Amitriptyline (TCA), Mirtazapine, and Phenelzine (MAOI) are also reasonable options. Antipsychotics (quetiapine, risperidone, and olanzapine) are reasonable for severe cases and have some evidence.
- Clonidine (alpha-2 antagonist) has evidence. Guanfacine has less.
- Most guidelines recommend against the use of Benzodiazepines.

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WHAT ABOUT PRAZOSIN?

- Alpha 1 receptor antagonist
- Used previously as a BP medication and for BPH
- Has very GOOD evidence for reducing nightmares and improving sleep in people with PTSD
- Can be a miracle drug for some people
- Some SE: drowsiness, dizziness, orthostasis; **don't use within 5 hours of phosphodiesterase inhibitor (VIAGRA)**

For women: start at 1 mg and titrate up to 4mg until symptoms resolve.

For men: evidence that titrations up to 20mg may be required for symptoms to resolve. 1mg → 2mg → 4mg → 5mg → 10mg →15mg → 20mg

<u>Watch BP during titration!</u> Most people adjust.

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BORDERLINE PERSONALITY DISORDER

- Very likely to be associated with trauma or perceived trauma.
- People with Borderline Personality Disorder often seek out care, so they are seen in doctor offices a lot.
- Almost all of them have been told that they have Bipolar Disorder and many of them are very wed to this idea.

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MY APPROACH TO SOMEONE WHO I SUSPECT HAS BORDERLINE PERSONALITY DISORDER…

1. I bring up the term 'Borderline Personality Disorder' and ask them if they have ever heard of it, and if they have, what they have heard?

2. I read over the criteria and have them count with their fingers how many of the criteria apply to them.

3. We talk about which criteria seemed to fit and which didn't.

4. I ask them if they would agree that they met criteria for the illness.

5. If they do, I tell them that this is good news because we have a therapy which works well for this condition and that they can get better if they do this therapy. The therapy is **Dialectal Behavioral Therapy.**

6. We discuss medications which may help with distress and main symptoms of concern. These could be antidepressants, mood stabilizers, or even antipsychotics.

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BORDERLINE PERSONALITY DISORDER

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(**1**) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.;

(**2**) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation;

(**3**) identity disturbance: markedly and persistently unstable self image or sense of self;

(**4**) impulsivity in at least two areas that are potentially self-damaging (e.g., pending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.;

(**5**) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior;

(**6**) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days);

(**7**) chronic feelings of emptiness;

(**8**) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights); and

(**9**) transient, stress-related paranoid ideation or severe dissociative symptoms.

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DBT: DIALECTICAL BEHAVIORAL THERAPY

- A **behavioral therapy** aimed at helping distressed patients replace harmful/poor coping and interpersonal communication with effective skills to manage distress.

- Clinician helps patient examine the steps leading up to and those that followed a incident of self harm/interpersonal conflict with an eye towards utilizing skills that in the future may be able to prevent similar events.

- *For example:* a patient with PTSD from childhood trauma has repeated problems maintaining romantic relationships and will frequently sabotage budding romances. Therapist helps patient to think through where these romances go wrong/get scary and help patient use more adaptive skills to manage conflict.

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SPECIAL THANKS!

CME Article

State-of-the-Art Prevention and Treatment of PTSD: Pharmacotherapy, Psychotherapy, and Nonpharmacological Somatic Therapies

Nils C. Westfall, MD; and Charles B. Nemeroff, MD, PhD

ABSTRACT

Posttraumatic stress disorder (PTSD) is a distressing and disabling disease of great public health significance that is often associated with substantial psychiatric and medical comorbidity. It commonly goes unreported and untreated and many cases become chronic in course. Unfortunately, only a minority of patients with chronic PTSD achieves remission. Indeed, it is unusual for patients with PTSD to achieve complete symptom remission after receiving monotherapy with medications or psychotherapy. However, great advances in the prevention and treatment of PTSD have been made in the last quarter century since it was first recognized as a distinct diagnostic entity in the *Diagnostic and Statistical Manual of Mental Disorders*, third edition. This article discusses the current state-of-the-art prevention and treatment interventions for PTSD, including pharmacotherapies, psychotherapies, and nonpharmacological somatic treatments in active duty military personnel and veterans, adult civilians, and children and adolescents. [***Psychiatr Ann.* 2016;46(9):533-549.**]

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Identifying and Managing Posttraumatic Stress Disorder 827

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