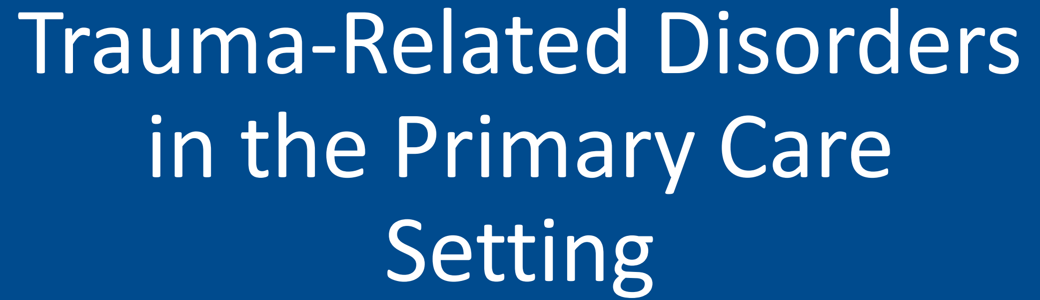

Trauma-Related Disorders in the Primary Care Setting

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Disclosures

- I have no conflicts of interest to disclose

Objectives

- Identify potential risk factors that may predispose an individual for an underlying trauma related disorder
- Understand how to accurately diagnose trauma related disorders
- Understand how to treat/manage trauma related disorders
- Identify when to refer to psychiatrist for additional management

Trauma- and Stressor-Related Disorders

- DSM IV vs DSM V – Anxiety Disorder umbrella
- DSM V-TR
  - Trauma-Related
    - Posttraumatic Stress Disorder (PTSD)
    - Acute Stress Disorder (ASD)
  - Stressor-Related
    - Adjustment Disorders
    - Prolonged Grief Disorder
  - Childhood
    - Reactive Attachment Disorder
    - Disinhibited Social Engagement Disorder

PTSD Risk Factors

- Pretraumatic
  - Temperamental
    - Childhood emotional problems
    - Prior mood or anxiety disorder
    - Personality – neuroticism
    - Impulsivity – substances or aggressive behavior
  - Environmental
    - Lower socioeconomic status
    - Childhood trauma
    - Divorce, family separation or family dysfunction
    - Social support protective
  - Genetic
    - Modestly heritable
    - Some genetic areas identified (8 regions from Americans of European descent tied to reexperiencing sx)
    - Epigenetic factors also a concern

PTSD Risk Factors

- Peritraumatic
  - Environmental
    - Severity (perceived)
- Posttraumatic
  - Temperamental
    - Negative appraisals
      - Guilt
  - Environmental
    - Repeating upsetting reminders
    - Adverse costs
    - Social support protective

Gender Differences

- Men vs Women
  - Lifetime prevalence
    - 4.1%-5.4% (men)
    - 8.0%-11.0% (women)
  - Women more likely to be sexually assaulted (both as child and adult)
    - Also interpersonal violence
  - Men more likely to experience combat trauma
    - 11%-20% of OIF/OEF veterans have PTSD
  - Gender differences in trauma processing
  - Symptoms similar despite differences

Suicide

- Risk increased with trauma related disorder
  - Numbers vary based on study
  - 1.8 to 6 times rate (military)
    - With vs without diagnosis
  - Veterans
    - Approximately 1 suicide every hour
  - Current Military
    - Approximately 1 suicide every day

DSM V TR Criteria (Exposure)

A . Exposure to actual or threatened death, serious injury, or sexual violence in one or more:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

DSM V TR Criteria (Reexperience)

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific reenactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

DSM V TR Criteria (Avoidance)

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

DSM V TR Criteria (Negativity)

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia, and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

DSM V TR Criteria (Hyperarousal)

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

PTSD vs ASD

- Time
  - PTSD > 1 month
  - ASD < 1 month (at least 3 days after trauma)
- Non-specific
  - ASD requires 9 or more symptoms
    - Intrusion
    - Negative mood
    - Dissociative
    - Avoidance
    - Arousal

Treatment

- Trauma-focused therapy
  - Cognitive Processing Therapy (CPT)
  - Eye Movement Desensitization and Reprocessing (EMDR)
  - Prolonged Exposure (PE)
- Medications
  - Targeting symptoms
    - Hyperarousal – SSRI, BZD PRN, hypnotics
    - Negative mood - SSRI
    - Reexperiencing – Alpha 1 antagonist
    - Intrusion – SSRI, hypnotics
    - Avoidance (mostly targeted in therapy)

Treatment

- Medications
  - Foundational Medication
    - SSRIs
      - Sertraline (Zoloft) – FDA approved
      - Paroxetine (Paxil) – FDA approved
        - Caution in pregnancy
      - Fluoxetine (Prozac)
        - Good starter medication
        - Better in younger patients
    - SNRIs
      - Venlafaxine (Effexor)

Treatment

- Sleep
  - Trazodone
    - 50 – 100mg QHS
  - Quetiapine (Seroquel)
    - Low dose 25 – 100mg QHS
- Nightmares
  - Prazosin
    - Typical dose 1 - 5mg QHS (occasionally more required)

Treatment

- Clinical Pearls
  - Make sure to titrate SSRI high enough
    - Zoloft usually needs to reach 200mg QDAY
  - Avoid Bupropion (Wellbutrin)
    - Can worsen anxiety symptoms
  - Sleep treatment is critical
    - Often improvement will lag if not adequately addressed
  - Use Benzodiazepines with caution

Referral

- Any patient endorsing safety concerns should be considered for psychiatric referral
- Severe symptoms that have not responded to first line medication intervention
- Patient's requiring more than two psychotropic medications
- Any patient who has lost their job or is in threat of losing their job due to severity of symptoms
- Any patient with concurrent substance use issues

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