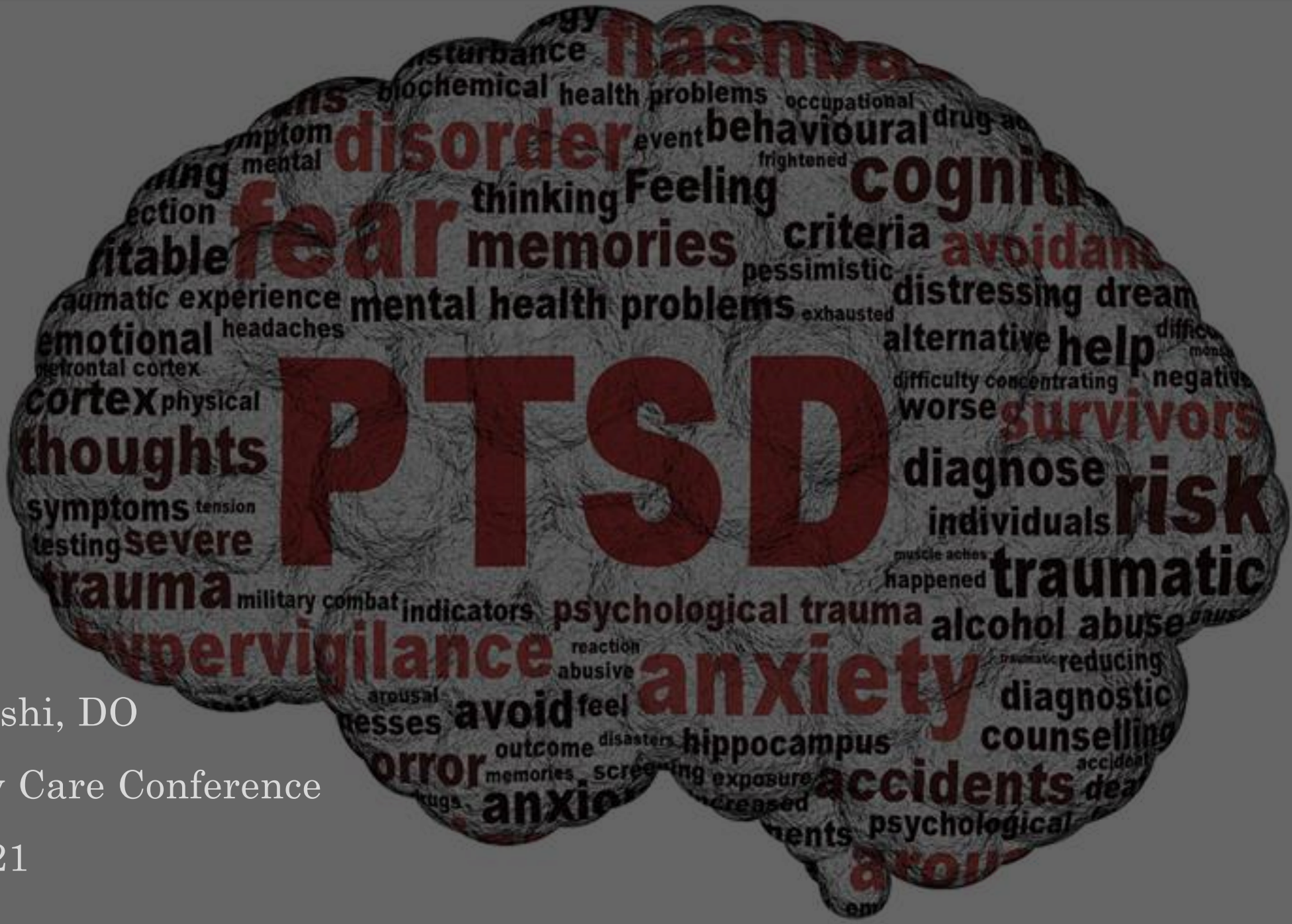


Neel Doshi, DO

Primary Care Conference

8.12.2021

Objectives

1. Understand basics of diagnosing PTSD
2. Learn how to approach PTSD during the FP visit
3. Be able to initiate basic treatment strategies

History / Origin

- Recognized by Shakespeare in *Henry IV:* ***Hotspur's wife, Kate, was complaining about her husband's regular involvement in mortal combats and his consequent odd behavior***
- Civil War descriptions
- WWI- *shell shock* and *soldier's heart*
- WWII- *operational fatigue* and *combat neurosis*
- First appeared in DSM-III (1980)

Definition

- Posttraumatic stress disorder (PTSD) develops after experiencing or witnessing an extreme, overwhelming traumatic event during which a person feels intense fear, helplessness, or horror.
- PTSD is as an anxiety disorder. Anxiety disorders may come on suddenly or gradually over a period of several years.

PTSD ≠ TRAUMA

and

TRAUMA ≠ ANYTHING BAD

- Traumas do not always lead to PTSD
- Traumas may lead to PTSD, but then the person can recover
  - Post Traumatic Growth
- And, many bad things happen to people, affecting them deeply, that are not “trauma”

Figure II-14: Overlapping of Multiple Health Issues [121]

Overlapping of Symptoms

Risk factors for PTSD

Being female

Being poor

Less education

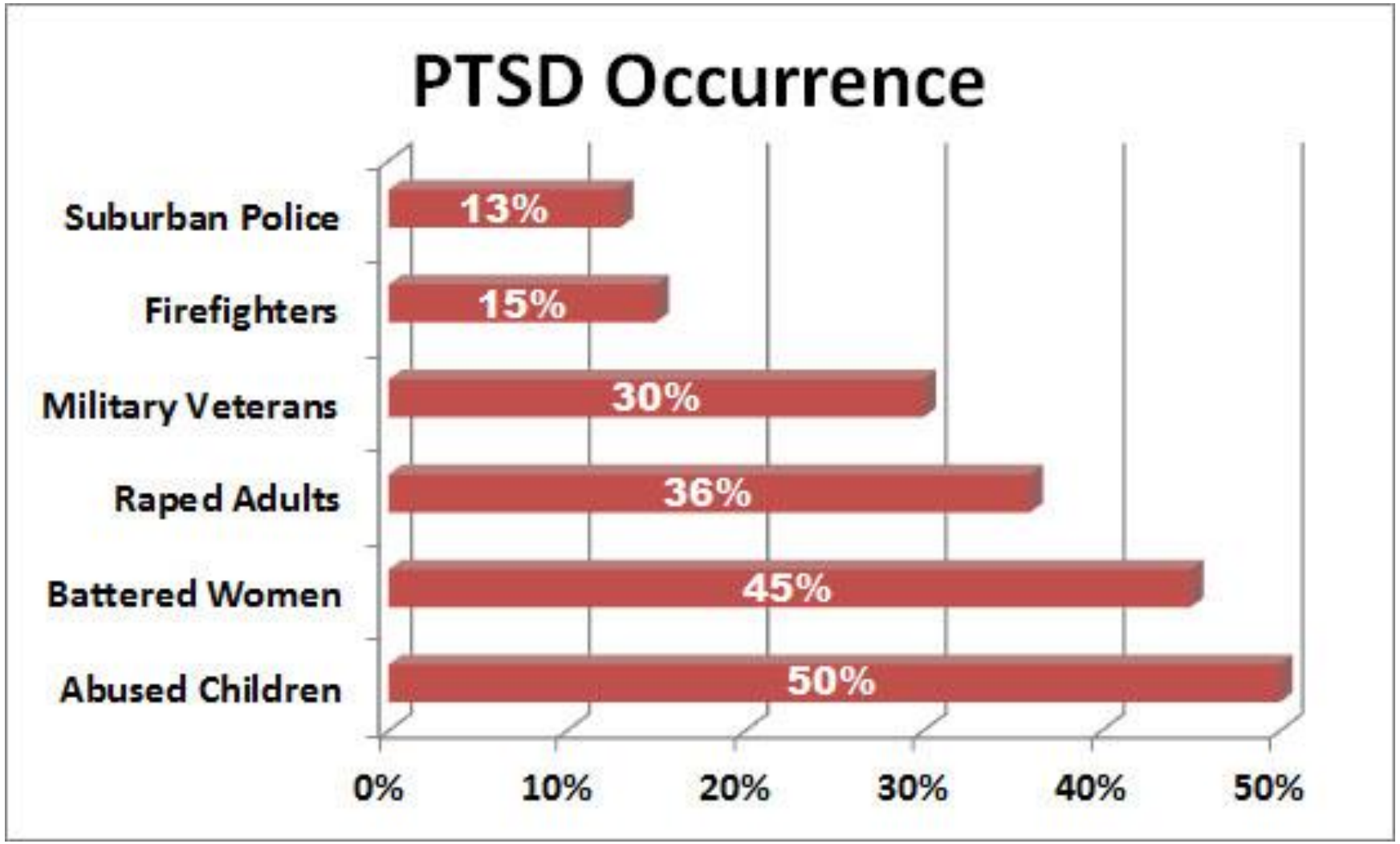
Bad childhood

Previous psychological problems

***Strength or severity of the stressor**

Characteristics of the trauma:

- Greater perceived life threat
- Feeling helpless
- Unpredictable, uncontrollable


PTSD Occurrence
Suburban Police
13%
Firefighters
15%
Military Veterans
30%
Raped Adults
36%
Battered Women
45%
Abused Children
50%
0%
10%
20%
30%
40%
50%

70s/80s/90s vs Today

When / Who played / Where / Training / Rewards

Youth sports have changed from leisure activities to a more strict athletics definition

Unintended consequences of ESS

Gyms promote teams, competition, social media posting

Trauma in Athletics

- Suck it Up
- Tough it Out
- No pain, no gain
- There is no “I” in Team
- Your Team is your Family
- He/She’s a Warrior / Battle-Tested
- Leave it all out on the Field/Court

Locker Room Talk

Consequences

- Psychiatric injuries underreported in sports
  - Scholarships / Camaraderie
- Meds heavily stigmatized
  - “The body is a Temple”
- Injury to an athlete can mean loss of identity. Large difference from control group.
  - ESS; Strict training regimens mean missing normal social/restorative events. When injury occurs, sacrifices seem in vain.

PTSD after TBI

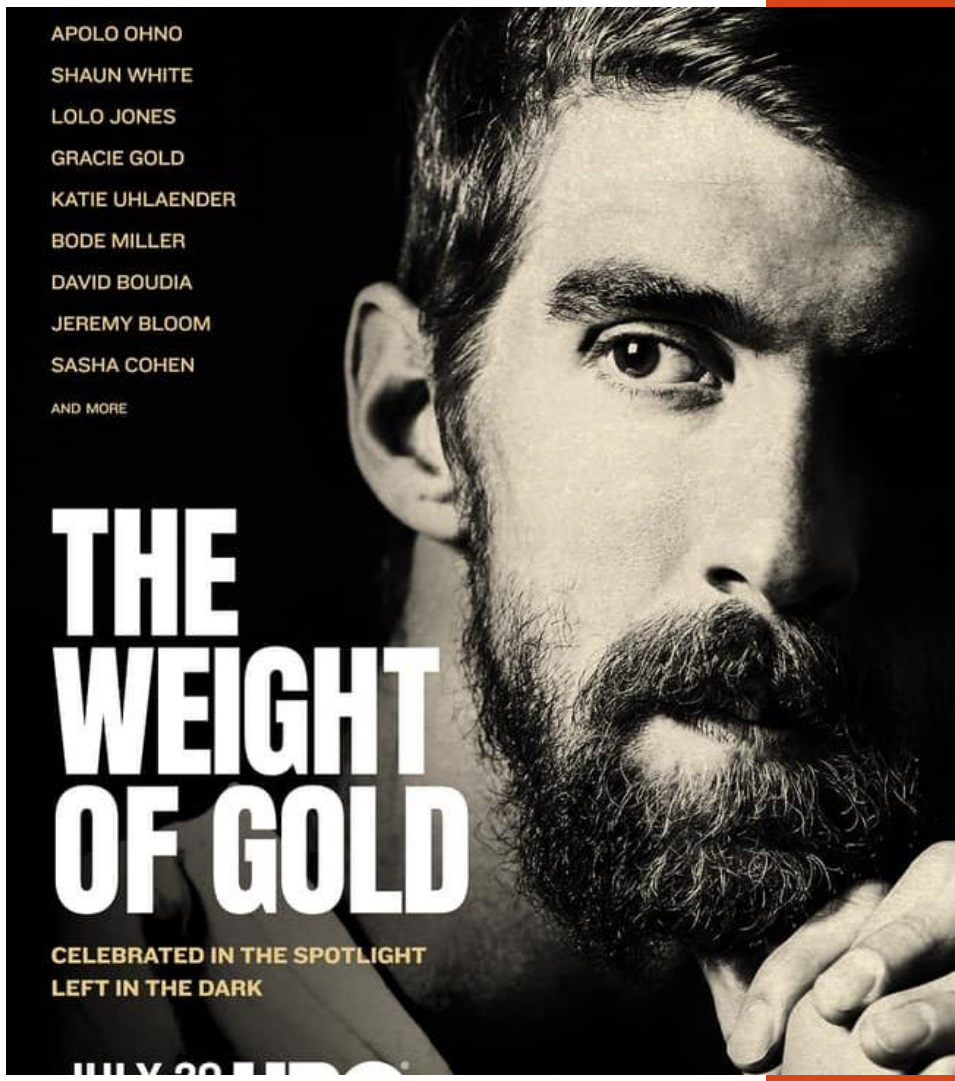
- Concussions are common and threaten physical/neurocognitive/psychological integrity
- Injured athletes have higher rates of intrusive thoughts and avoidance than non-injured athletes
- Athletes were as stressed by their concussions as drivers in Motor Vehicle Accidents
- Athletes with TBIs reported less anxiety/fear, but more insomnia, avoidance, and perseveration than non-athletes with TBIs

Long-Term

- 10% of athletes have severe, long-term psychological consequences
- High prevalence of anger/depression in injured athletes
- Injured athletes experience depression 6 times as often as non-injured athletes
- The sport itself may be the athlete's outlet / coping skill. Injury precludes this mechanism.
  - Self-Esteem lower immediately after injury and again at 2 month follow up.
- Substance Abuse is higher than Non-Athletes.
  - May try to recreate the high associated with athletics

Suicide in Athletes

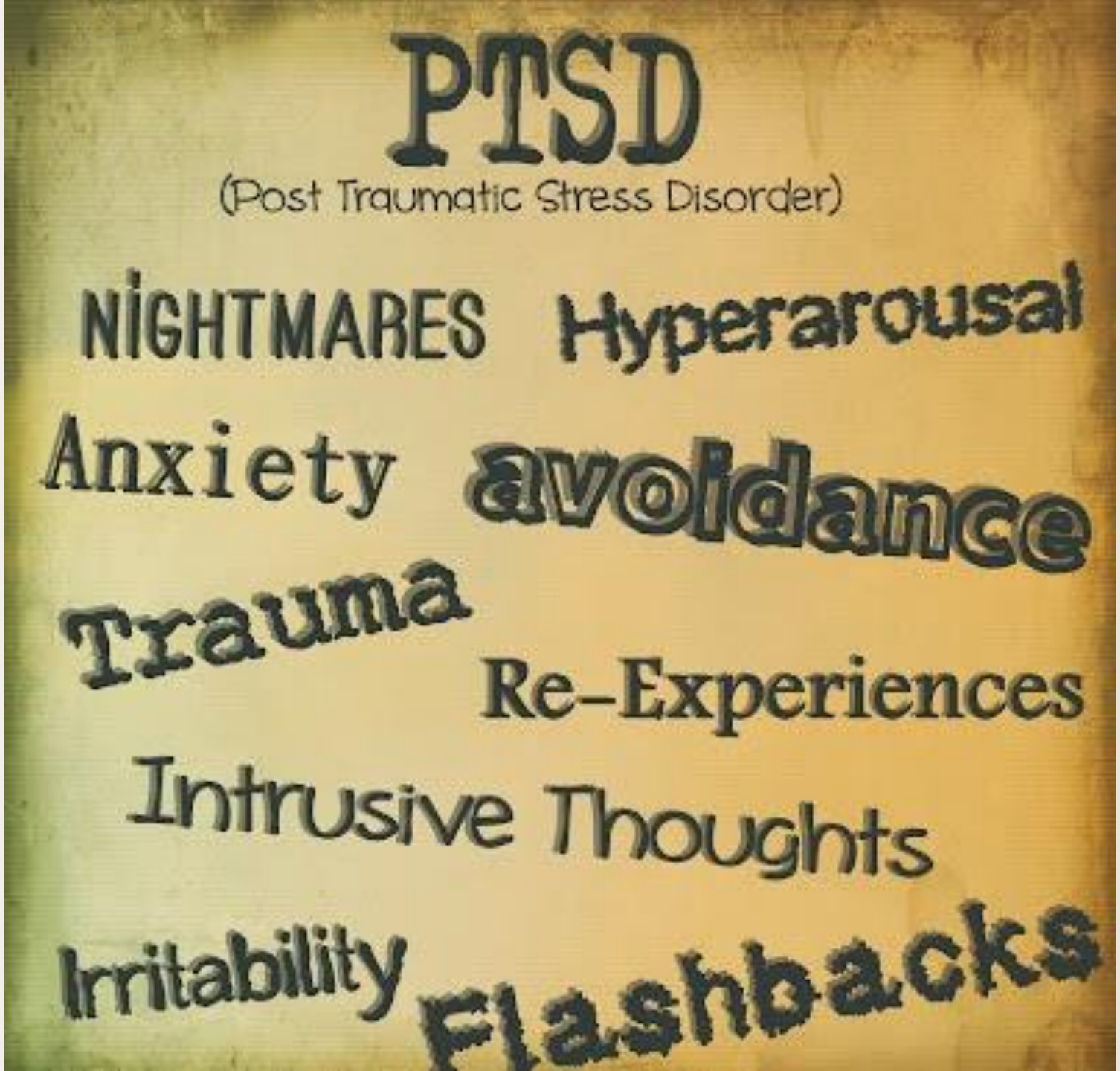
- For some athletes, career-ending injuries lead to suicidal behaviors. A study of 5 athletes who attempted suicide after sustaining an injury found 5 common characteristics:
  - • all were successful in their sport before getting injured
  - • all sustained an injury severe enough to warrant surgery
  - • all endured a lengthy rehabilitation
  - • all were not as successful at their sport when they returned to play
  - • all were replaced by a teammate



Smith AM, Milliner EK. Injured athletes and the risk of suicide. J Athl Train. 1994;29(4):337-341.

Eyes Ahead

- Identity not based on sports trajectory
  - Writing about the game/experiences, coaching, commenting, mentoring
  - Single Factor Identity is a risk



Diagnostic Criteria

Diagnostic Criteria

- Acute PTSD - symptoms < three months
- Chronic PTSD - symptoms > three months
- Although symptoms usually begin within 3 months of exposure, a delayed onset is possible months or even years after the event has occurred.

PTSD Mnemonic

- ***D***etached - general numbing of emotional responsiveness.
- ***R***eexperiences the event in the form of nightmares, recollections or flashbacks.
- ***E***vent involved substantial emotional distress, with threatened death
- ***A***voids places, activities or people that remind the patient of the event.
- ***M***onthlong symptoms
- ***S***ympathetic hyperactivity or hypervigilance, which may include insomnia, irritability and difficulty concentrating.

Course and Prognosis

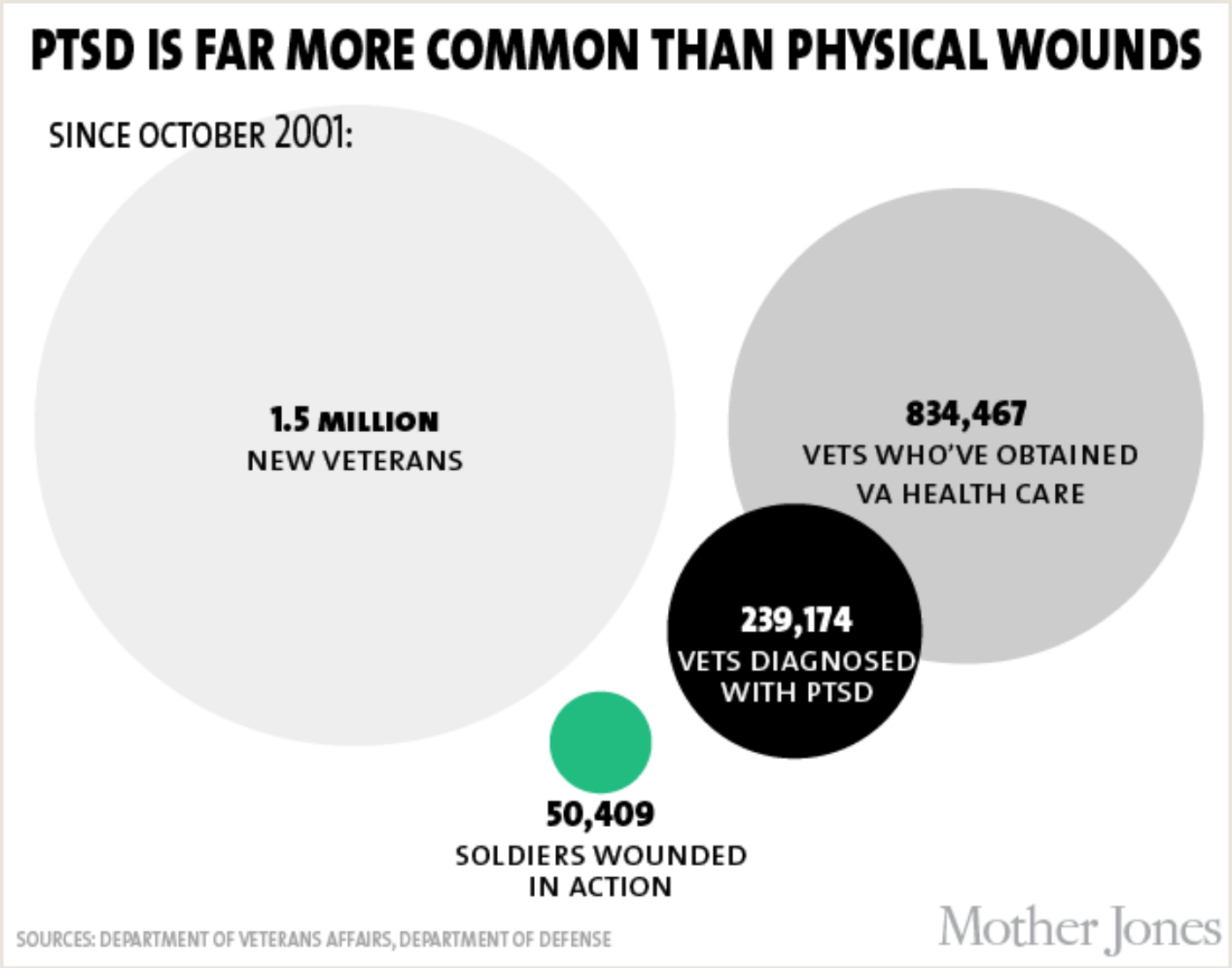
- 30% recover completely
- 40% continue with mild symptoms
- 20% moderate symptoms
- 10% unchanged or worsen
- Startle, nightmares, irritability and depression often worsen with age
- Comorbidity is high (MDD, OCD, Panic, substance abuse)

Children vs. Adults

- **Do children react differently than adults?**
- Bedwetting, when they'd learned how to use the toilet before
- Forgetting how or being unable to talk (selective mutism)
- Acting out the scary event during playtime
- Being unusually clingy with a parent or other adult.
- Older children and teens usually show symptoms more like those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Older children and teens may feel guilty for not preventing injury or deaths. They may also have thoughts of revenge.

Children with PTSD

- Characteristic differences of PTSD symptoms in patients who experienced most of their trauma in childhood (eg, physical and sexual abuse)
- Compared with controls, these individuals often show greater difficulty with affect regulation (eg, unmodulated anger), and often demonstrate more dissociation, somatization, self-destructive behavior, and suicidal behavior.
- Trauma-Focused therapy is key



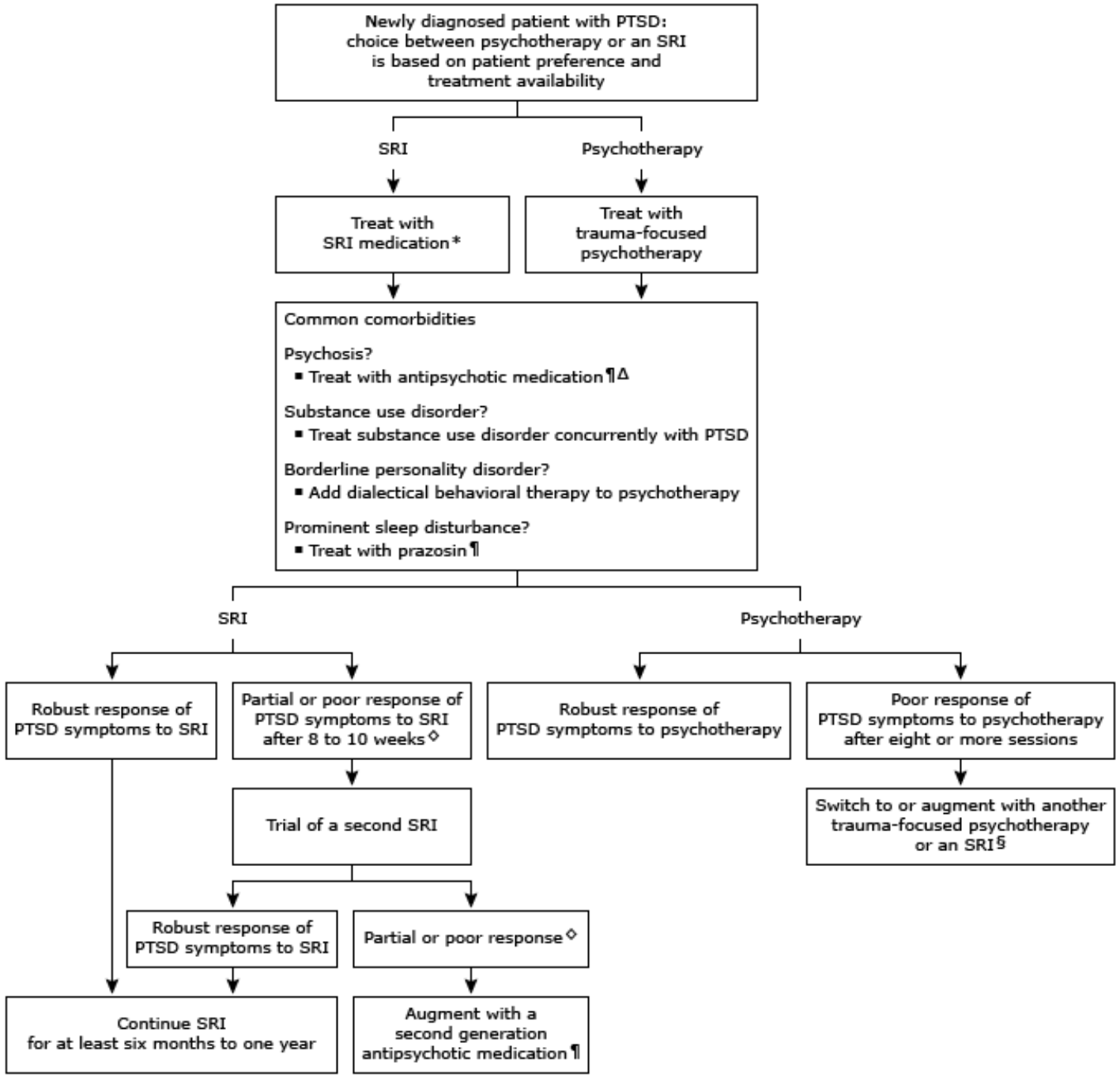
Common Enemy

Clinical Presentation

- Relationship or Work issues, but no clear stressor or context for this…suspect PTSD
- Sleep issues that do not respond to conventional sleep hygiene or medication interventions
- Sudden shifts in careers / lines of work (but also be weary of mania)
- Long history of failed relationships or resistance to being in new relationships/friendships (watch for personality disorders)
- *Heavy Drinking in College Students must be investigated.
  - Athletes use of Recreational drugs far surpass their use of PEDs.

Medication Management

- All bets are OFF. (Daniel Auerbach, MD)
- SSRIs first-line (Paxil / Zoloft FDA-approved)
- Keep in mind that the current general aim of psychopharmacology in PTSD is to minimize its symptoms, rather than to “cure” it.
- Getting some comfort from meds can often enable a patient to more easily face the tough work of exposure or other psychotherapies. Symptoms that are most easily addressed by medications include those of hyperarousal, along with nightmares.


Newly diagnosed patient with PTSD: choice between psychotherapy or an SRI is based on patient preference and treatment availability
SRI
Psychotherapy
Treat with SRI medication*
Treat with trauma-focused psychotherapy
Common comorbidities
Psychosis?
Treat with antipsychotic medication¶Δ
Substance use disorder?
Treat substance use disorder concurrently with PTSD
Borderline personality disorder?
Add dialectical behavioral therapy to psychotherapy
Prominent sleep disturbance?
Treat with prazosin¶
SRI
Psychotherapy
Robust response of PTSD symptoms to SRI
Partial or poor response of PTSD symptoms to SRI after 8 to 10 weeks◇
Robust response of PTSD symptoms to psychotherapy
Poor response of PTSD symptoms to psychotherapy after eight or more sessions
Trial of a second SRI
Switch to or augment with another trauma-focused psychotherapy or an SRI§
Robust response of PTSD symptoms to SRI
Partial or poor response◇
Continue SRI for at least six months to one year
Augment with a second generation antipsychotic medication¶

Prazosin for nightmares

- Dosed initially at 1mg qhs, increased by 1mg weekly while watching for orthostasis
- Decreases CNS adrenergic activity, as this is heightened in PTSD
- Simple, effective, inexpensive
- Less stigma
- VA study
- Can also use Clonidine, 0.1mg to 0.3mg.

Troubleshooting

- Trazodone, while a helpful sleep aid in depression/anxiety, can make nightmares WORSE.
- SSRIs can be taken morning or night, so make sure patients are taking it at the right time for them. May cause VIVID dreams.

Medication Management

- Hyperarousal can be most disabling feature, so a benzo would seem to make sense—
- Research shows that not only are they not all that helpful, they can be potentially harmful: 1)Significant comorbidity of substance abuse in PTSD 2)might contribute to emotional numbing of PTSD and prevent integration of the traumatic event
- Therapists often cannot do their work effectively when a benzo is on board or the dosage is too high