Diagnosing and Treating PTSD

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September 12th, 2024

ACCESS Mental Health for Moms

Disclosures

I have no financial conflicts of interest to disclose in relation to this presentation.

How often are you treating trauma survivors?

What are you hoping to get out of today's session?

Agenda

1 / About Trauma & PTSD

2 / Guidance on Management

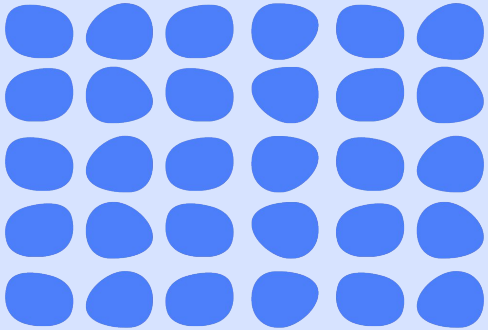
3 / Questions

All About PTSD

PTSD is a growing, concerning issue in the US

83%

of Americans have
suffered a clinical trauma



30 million

Americans with
diagnosed PTSD

80%

of survivors receive
no treatment at all

Most who experience trauma will experience immediate PTSD symptoms but the majority will recover

Risk Factors

- Age, gender, trauma type
- Repeated exposure
- Low social support
- Lack of job training
- Low work experience

Psychological Changes

- Fear conditioning and avoidance
- Persistence of maladaptive thinking

Neurobiological Changes

- Strengthened “fear circuitry”
- Reduced hippocampal volume
- Reduced activity and size of prefrontal cortex
- Increased amygdala reactivity
- HPA axis dysfunction

PTSD is a problem for perinatal populations

Existing PTSD can worsen

Due to stress and hormone changes of pregnancy, existing PTSD often worsens during the perinatal period.

Traumatic birth experiences cause PTSD

In high risk perinatal patients, risk of PTSD from perinatal trauma is as high as 19%

Underdiagnosed and undertreated

Women's health providers are primary clinicians for this population, but only 11% of OB/GYN residencies teach about PTSD. Interpersonal traumas are most likely to cause PTSD and women are 2x more likely to develop PTSD than men.

Sources: National Institute of Mental Health, World Health Organization (2021), Psychiatr Clin North Am (2010), American Journal of Emergency Medicine (2020).Obuobi-Donkor G, Oluwasina F, Nkire N, Agyapong VIO. A Scoping Review on the Prevalence and Determinants of Post-Traumatic Stress Disorder among Military Personnel and Firefighters: Implications for Public Policy and Practice. Int J Environ Res Public Health. 2022 Jan 29;19(3):1565. doi: 10.3390/ijerph19031565. PMID: 35162587; PMCID: PMC8834704.

How to screen for and diagnose PTSD

PTSD and DSM-5 Diagnostic Criteria

Post Traumatic Stress Disorder (PTSD) is triggered by exposure to trauma, such as death, injury, abuse, or assault. Symptoms include intrusive thoughts such as nightmares or flashbacks, hypervigilance, self-blame and avoidance.

With usual care, many patients do not recover from PTSD and develop further co-morbidities, such as suicidality, substance use, chronic medical illnesses, & more.

1. Criterion A traumatic event
2. Intrusion symptoms (*1 required*)
3. Avoidance symptoms (*1 required*)
4. Arousal symptoms (*2 required*)
5. Negative alterations in cognition and mood (*2 required*)

Criterion A traumatic event: the person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): Direct exposure, Witnessing the trauma, Learning that the trauma happened to a close relative or close friend, Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics).

In your clinic

- Use a screener (PC-PTSD 5)
- If >=3, likely PTSD and requires further assessment
- Refer to Access hotline!

	Please continue to section **C**		
C	Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: • A serious accident or fire • A physical or sexual assault or abuse • An earthquake or flood • A war • Seeing someone be killed or seriously injured • Having a loved one die through homicide or suicide		
Have you ever experienced this kind of event? Please circle the response that indicates your answer:		**NO**	**YES**
If NO, you are finished. Thank you for completing this survey! If YES, please continue:			
In the past month, have you…			
have had nightmares about the event(s) or thought about the event(s) when you did not want to?		**NO**	**YES**
tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?		**NO**	**YES**
been constantly on guard, watchful, or easily startled?		**NO**	**YES**
felt numb or detached from people, activities, or your surroundings?		**NO**	**YES**
felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have		**NO**	**YES**
Done! Thank you for completing this questionnaire!			

DSM-5 Criteria for PTSD (1 of 3)

Criterion A
(1 required)

The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that the trauma happened to a close relative or close friend
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B
(1 required)

The traumatic event is persistently re-experienced, in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C
(1 required)

Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

DSM-5 Criteria for PTSD (2 of 3)

Criterion D
(2 required)

Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E
(2 required)

Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F
(1 required)

Symptoms last for more than 1 month.

Criterion H
(1 required)

Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion G
(1 required)

Symptoms are not due to medication, substance use or other illness.

DSM-5 Criteria for PTSD (3 of 3)

Specification 1

Dissociative Specification

In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

Depersonalization:
Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).

Derealization:
Experience of unreality, distance, or distortion (e.g., "things are not real").

Specification 2

Delayed Specification

Full diagnostic criteria are not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

Millions are affected by PTSD and unable to access evidence-based, effective treatment

25M have PTSD +
40M incoming cases

Only 20%
get treatment

Treatments today...

- Lack evidence-based care
- Do not permanently improved symptoms
- Are siloed

...which all translate into poor outcomes and ongoing medical and behavioral costs

The first-line, evidence-based treatments are focused on exposure and/or cognitive restructuring

Cognitive Processing Therapy (CPT):

- 10-12 50-minute sessions
- Practice Assignments
- Exposure not required

Prolonged Exposure (PE):

- 8-16 90-minute sessions
- Practice Assignment
- Exposure required

Eye Movement Desensitization & Reprocessing (EMDR)*:

- 8-12 60-minute sessions
- No practice assignments
- Exposure required

**EMDR not recommended as first line across all guidelines*

Alternatives for when individual trauma-focused psychotherapy is not readily available or not preferred

Pharmacotherapy

Antidepressants with proven efficacy in PTSD such as Sertraline, Paroxetine, and Venlafaxine

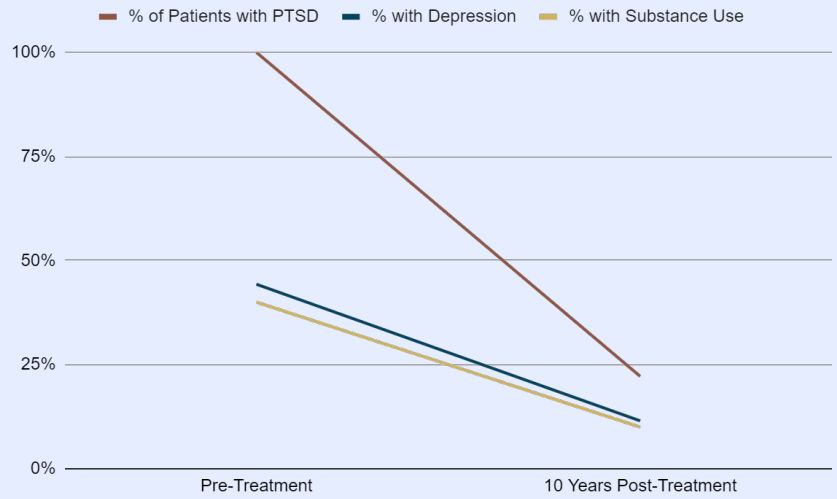
Note: Internal Family Systems, Brainspotting, EFT (tapping) are not considered EBTs nor are they recommended alternatives to EBTs

Non-Trauma Focused Manualized Therapies

Including:
Present-Centered Therapy (PCT)
Stress Inoculation Training (SIT)
Interpersonal Psychotherapy (IPT)

CPT, a time-limited treatment that works through cognitive restructuring, is considered the gold standard for PTSD

Diagnoses Over Time Pre and Post CPT Treatment



Lasting outcomes

CPT leads to a significant reduction in PTSD symptoms in 90% of all patients & treats related co-morbidities. Patients sustain improvements even after 10 years.

Works for many people

CPT has been shown to improve outcomes for people regardless of age, gender, race/ethnicity, number or type of trauma, even if administered decades after a trauma.

Cost effective

CPT is significantly more cost-effective to deliver than other PTSD therapies, and demonstrates equivalent outcomes when delivered via telehealth vs. in person.

Sources: Resick PA, Williams LF, Suvak MK, Monson CM, Gradus JL. (2012) Long-term outcomes of cognitive-behavioral treatments for posttraumatic stress disorder among female rape survivors. J Consult Clin Psychol.

Pharmacologic Management

Not as effective as therapy and **always** considered second-line.
Below based on 2023 DOD guidelines

Strong For →	Sertraline, paroxetine and venlafaxine
Weak For →	MBSR, prazosin (for nightmares only)
Insufficient evidence →	Stellate ganglion block, psychedelics, MDMA, bupropion, lamictal, all other SSRIs/SNRIs
Weak Against →	Atypical antipsychotics and prazosin (for PTSD symptoms), ECT, prazosin
Strong Against →	BZAs and cannabis

Guidance on Management

Best practices for early support

- → Goal is to **reduce likelihood of developing PTSD and timely treatment referral**
- → Provide psychoeducation, support and early connection to treatment as needed
  - Almost everyone has post-traumatic stress symptoms after trauma
  - PTSD is a recoverable illness
  - **Full recovery is possible & expected**
  - IF symptoms are severe or last >30 days, refer to care
- → Mandatory trauma "first aid" can actually **increase** symptoms
- → Minimize fragilizing patients while supporting choices
- → Respect recovery preferences while building clear structure for safe return to work
- → Address modifiable risk factors
- → Can suggest Tetris!

Risk Factors

- Age, gender, trauma type
- Repeated exposure
- Low social support
- High risk pregnancy

Best practices for PTSD treatment

- Goal is **effective, timely treatment to maximize recovery**
- **Get patients with PTSD into an evidence-based PTSD treatment ASAP**
  - CPT
  - Prolonged Exposure (PE)
  - EMDR
  - Each has its own directory of certified therapists
  - **If inaccessible, consider meds**
- For best results, find therapists who do massed (or intensive) treatment
- Co-morbidities are the norm - they are NOT an excuse to not start treatment
- For treatment-resistant cases:
  - Complete 2nd EBT
  - Can offer short course of medications with expectation of taper

Best practices for sustaining recovery

- Goal is to reduce redevelopment of PTSD and promote resilience
- PTSD EBT usually leads to sustained recovery
- Some patients may require “booster” sessions of PTSD EBT
  - Usually still time-limited
- If on medication, can taper within 3-6 months of symptom stability
- If re-develops symptoms, return to treatment

Questions?

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