UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

NAVIGATING PTSD

TUESDAY E. BURNS, MD

ATTENDING PSYCHIATRIST

CLINICAL ASSOCIATE PROFESSOR, UWMC

SPEAKER DISCLOSURES

No conflicts or disclosures to report

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

Mark Duncan MD
Rick Ries MD
Kari Stephens PhD
Barb McCann PhD
Anna Ratzliff MD PhD
Betsy Payn MA PMP
Esther Solano
Cara Towle MSN RN

©2023 University of Washington

OBJECTIVES

1. Recognize the complex presentations of PTSD
2. Discuss and understand the biologic and psychosocial underpinnings of PTSD and CPTSD
3. Be able to collaborate with patients using evidence-based treatment options in a trauma-informed and inclusive manner

©2023 University of Washington

PTSD IN CLINICAL SETTINGS

- SUBJECTIVE: Patients commonly present with somatic complaints, sleep disturbance and pain
- SOCIAL HISTORY: Substance use (EtOH, cannabis), disclosure of domestic violence, ACEs, housing/food insecurity, historical trauma (both sentinel events and chronic exposure)
- PHYSICAL EXAM: Tachycardia, hypertension, enhanced startle response, impaired short-term recall on mental status exam
- PSYCHOMETRIC RATING SCALES: Elevated GAD-7, PHQ-9; PCL-5, CAPS-5

UW PACC

©2023 University of Washington

PATIENT PRESENTATION

- Somatic complaints (headache, MSK pain, insomnia)
- Higher utilization
- Impaired functional status (work, domestic life)
- Impacted executive function (ADLs, missing appointments)
- Symptoms often compounded by substance use (EtOH worsening sleep architecture etc.)
- Depressed mood and high anxiety with prior medication trials (higher incidence of side effects)

©2023 University of Washington

DIAGNOSTIC CLARIFICATION

- Initial presentation is often consistent with depression, social anxiety, panic attacks, agoraphobia and even ADHD
- Detailed history taking, chart review, ROS and collateral (when available) will help to illuminate trauma as the underlying etiology
- Novel conceptualization of PTSD and CPTSD suggests that many psychiatric conditions evolve in response to trauma (adaptive survival mechanisms)

©2023 University of Washington

CONFOUNDING VARIABLES

- Substance use disorders are frequent
- Impacted sleep may overshadow other concerns
- Preoccupation with management of physical pain
- Autonomic nervous system reactivity (abnormal vitals, changes in weight and hunger cues)
- Previous psychiatric diagnoses may impede work-up (i.e. mood lability due to a bipolar disorder or from untreated PTSD?)
- Healthcare settings are not equally inclusive or trauma-informed

©2023 University of Washington

POST TRAUMATIC STRESS IN 2023

- NIH: Across the pandemic, rates of PTSD have doubled (3.5% of US population in 2019)
- CDC estimates that between 6-9% of adults in the US struggle with PTSD
- WHO: 1 in 3 people who experience trauma will develop PTSD
- Of folx with PTSD, the WHO estimates that nearly ¼ have severe symptoms

©2023 University of Washington

EVOLVING PERSPECTIVES ON PTSD

- Originally recognized in veterans, the constellation of flashbacks, nightmares and hypervigilance were labelled as "shell shock" or combat trauma
- Updating our definition of trauma (sexual assault, violent crimes, traffic accidents, domestic violence, childhood trauma)
- Recognizing the impact of chronic trauma vs. Sentinel events
- The appearance of complex PTSD (CPTSD) in recent years

UW PACC
©2023 University of Washington

DIAGNOSTIC CRITERIA

1. Re-experiencing (nightmares, flashbacks)
2. Autonomic arousal (hypervigilance)
3. Avoidance
4. Changes in cognition or mood

- PTSD typically in response to a sentinel event
- CPTSD in response to sequential, chronic trauma

©2023 University of Washington

PTSD VS. CPTSD

- CPTSD has recently been recognized by the WHO in ICD-11
- DSM 5-TR continues to label Dissociative PTSD as a subset
- Distinctions in how trauma is defined (length of exposure)
- CPTSD also characterized by struggles with:

1. Emotion regulation
2. Sense of self
3. Relationships

- Newer theories place PTSD, CPTSD and BPD on a spectrum

©2023 University of Washington

PATHOPHYSIOLOGY

- Activation of fear circuitry in response to a traumatic event
- Fight, flight or freeze
- This activity should naturally ebb with time, in some it does not
- Amygdala, hippocampus, prefrontal cortex
- Functional imaging shows increased activation of amygdala and reduced activation of DLPFC in patients with PTSD
- This underscores the autonomic arousal, anxiety, shift in HPA-axis (sleep, appetite etc.) and cognitive changes that occur

©2023 University of Washington

DOWNSTREAM CONSIDERATIONS

- Autonomic arousal results in higher levels of circulating corticotropins
- How does this feedback to the HPA-axis?
- Thyroid function, reproductive hormones, adrenals
- Aberrant sleep architecture, fatigue, dysregulated appetite and hunger cues (carbohydrate cravings!), increased reliance on caffeine and substances, OTC sleep aids

UW PACC

©2023 University of Washington

GENETICS, TEMPERAMENT AND ENVIRONMENT

- Not everyone who experiences trauma will develop PTSD
- Higher rates of PTSD in patients with a personal or family history of mental illness or substance use disorders
- ACEs, persistent fear and uncertainty due to extreme weather events, war, abuse, witnessed violence and suffering
- Patients' resources and resilience impact prognosis:

- Ability to access treatment
- Community Support
- Acceptance and self-love

UW PACC

©2023 University of Washington

PSYCHOTHERAPY – ESSENTIAL FOR TREATMENT!

- CBT (Cognitive Behavioral Therapy)
- CPT (Cognitive Processing Therapy)
- PE (Prolonged Exposure Therapy)
- EMDR (Eye Movement Desensitization Reprocessing)
- Mindfulness, autogenics & acupuncture

©2023 University of Washington

BIOLOGIC INTERVENTIONS

- Avoid benzodiazepines!
- SSRIs/SNRIs
- Prazosin, Clonidine
- Symptom Relief (Gabapentin, Propranolol, Buspar, Hydroxyzine, atypical antipsychotics – Quetiapine)
- Magnesium, B12, Iron, NAC

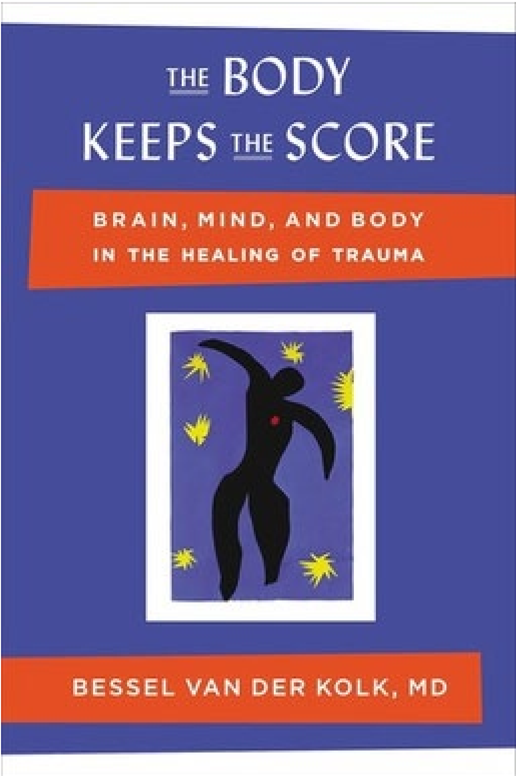
©2023 University of Washington

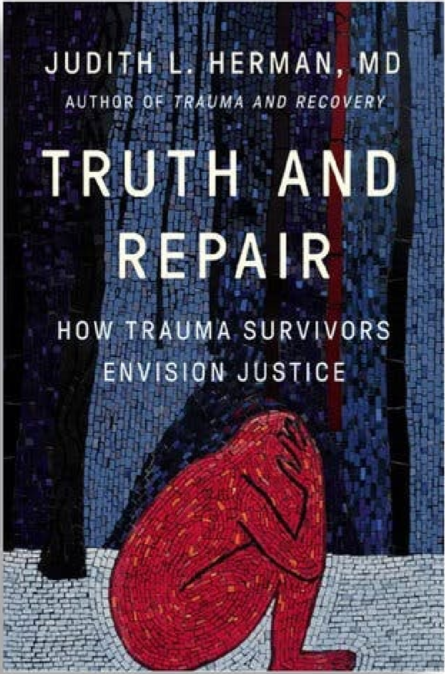
NOVEL APPROACHES TO TREATMENT

- Psilocybin
- via 5HT-2A
- enhanced activation of the prefrontal cortex leads to downregulation of the amygdala
- MDMA
- reduced activation of amygdala and increased connectivity with hippocampus allows for re-processing of trauma
- Ketamine
- modulation of NMDAR and glutamate activity

©2023 University of Washington

EDUCATING AND EMPOWERING OUR PATIENTS





©2023 University of Washington