SANDHILLS CENTER
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INTEGRATED CARE NEWS

Periodic Updates and Information for the Sandhills Center Provider Network

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ADDRESSING POST-TRAUMATIC STRESS DISORDER

The problem of Post-Traumatic Stress Disorder (PTSD) in the United States is enormous, with about 8 percent (or 24.4 million) of Americans affected. In fact, it is estimated that 70 percent of adults have experienced some type of traumatic event at least once in their lives.

However, experiencing a traumatic event does not always result in a diagnosis of PTSD. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for PTSD, diagnoses include a history of exposure to a traumatic event that meets specific stipulations and symptoms from four symptom groups: intrusion; avoidance; negative alterations in cognition and mood; and alterations in arousal and reactivity.

THE DSM-5 CRITERIA FOR DIAGNOSING PTSD

Criterion A (one required) -- The person was exposed to death, threatened death, acutal or threatened serious injury, or actual or threatened violence in the following ways:

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

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

- Intrusive thoughts
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminder
- Physical reactivity after exposure to traumatic reminders

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

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

Criterion D (two required) -- Negative thoughts or feelings that began or worsened after the trauma in the following way(s):

- Inability to receall 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

Criterion E (two 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

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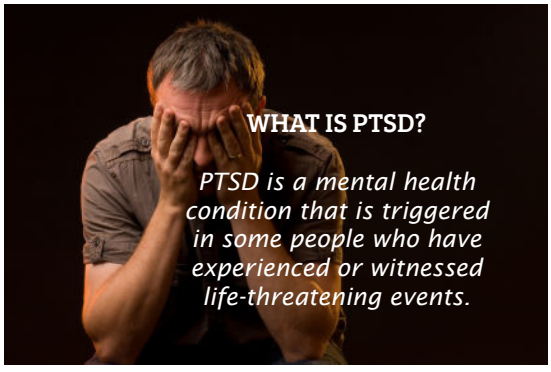


Criterion F (required) -- Symptoms last for more than one month.

Criterion G (required) -- Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H (required) -- Symptoms are not due to medication, substance use or other illness.

Two specifications:

- **Dissociative Specification** -- In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following 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")
- **Delayed Specification** -- Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

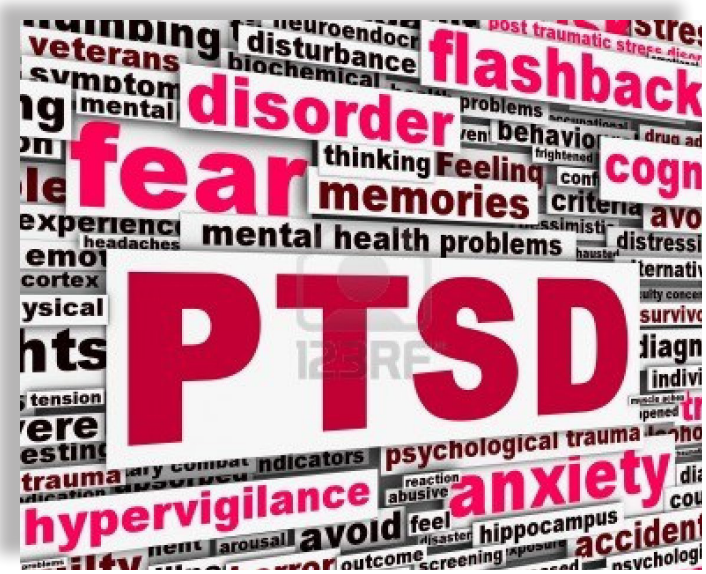
Note: The DSM-5 introduced a preschool subtype of PTSD for children ages six years and younger.

Best evidence-based practice guidelines indicate an appropriate diagnostic evaluation be performed that includes determination of DSM criteria, acute risk of harm to self or others, functional status, medical history, and relevant family history (CCA, DA).

For people who are suspected to be experiencing PTSD, a structured diagnostic interview may be considered. Additionally, periodic screening using PC-PTSD in primary care settings, or PCL-5 (self-report) in initial treatment planning and treatment progress is recommended. These assessments can be found on the U.S. Department of Veterans Affairs (VA) website, located at *www.ptsd.va.gov/professional/index.asp.*

New treatment guidelines were released by the VA in June 2017. The guidelines recommend individual, manualized trauma-focused therapy over pharmacologic, or non-pharmacologic, non-trauma-focused interventions, unless there is no trauma-focused therapy available.

Trauma-focused therapy should have a primary component of exposure and/or cognitive restructuring



including Prolonged Exposure, Cognitive Processing Processing Therapy EMDR, specific cognitive behavioral therapies, Brief Eclectic Psychotherapy, Narrative Exposure Therapy and written narrative exposure. Video teleconferencing should only be implemented with proven PTSD modalities.

The VA also suggests that non-trauma-focused therapy should be utilized if trauma-focused therapy is not available. This includes Stress Inoculation Training, Present-Centered Therapy, and Interpersonal Psychotherapy. The VA further recommends manualized group therapy, as well as internet-based CBT over no therapy at all.

It is interesting to note that DBT, Skills Training in Affect and Interpersonal Regulation, Acceptance and Commitment Therapy, Seeking Safety, and supportive counseling were not included as best treatment interventions for PTSD, nor did they recommend PTSD be addressed in couples therapy.

Co-occurring conditions should not prevent patients from receiving PTSD treatment. Best practices require clinicians to complete a thorough trauma history during initial assessment to reduce the frequency of undiagnosed PTSD. In addition, independent assessment of co-occurring sleep disturbances, particularly when issues predate PTSD onset, or remain following successful completion of treatment, is recommended.

Sources: U.S. Department of Veterans Affairs, Vocational Rehabilitation and Employment Services (2017); New VA/DOD Clinical Practice Guidelines for Treatment of PTSD.