Bedside Recognition of Acute Stress Disorder or Post-traumatic Stress Disorder in Your Trauma Survivors

October 2018

AMERICAN TRAUMA SOCIETY WEBINAR

PRESENTED BY:

- **Doug Zatzick, MD**, Professor, Department of Psychiatry and Behavioral Sciences at University of Washington School of Medicine and Core Research Faculty, Harborview Medical Center Injury Prevention and Research Center.
- **Ann Marie Warren, PhD**, Director, Baylor Scott & White Institute for Rehabilitation and Co-Director, Baylor University Medical Center Trauma Research Center.
- **Peter Thomas, JD**, Principal, Powers Law Firm; Board of Directors, American Trauma Society; Chairman, Trauma Survivors Network Committee; and Trauma Survivor.
- **Eileen Flores, LCSW,** National Trauma Survivors Network Coordinator, American Trauma Society.

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AGENDA

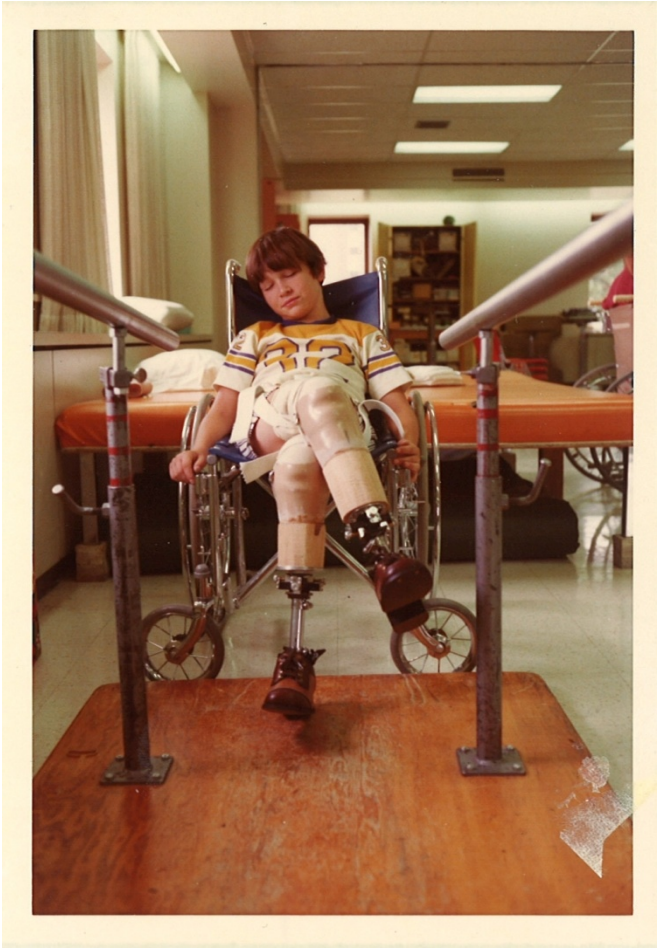
- Survivor Perspective and Importance of Topic
- Stress Disorders After Exposure to Traumatic Life Events: An Introduction & Discussion
- Screening for ASD and PTSD at Trauma Centers and Trauma Outpatient Clinics
- Early Intervention and Supportive Techniques with Patient-Centered Care
- TSN Services Supporting Survivors with ASD and PTSD
- Question & Answer

Survivor Perspective and Importance of Topic

PRESENTED BY: PETER THOMAS, JD

SURVIVOR STORY

- Car accident in 1974
- Double amputee at young age
- Impact of Peer Visit in the ICU from another survivor
- Rehabilitation for 2 1/2 months
  - 13 sets of prosthetics over 44 years.



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RESILIENCY IN RECOVERY

- Physical, Occupational, Recreational Therapy
- Adaptive Sports
- Social and Emotional Support
- Advancing Educational and Career Goals in Law

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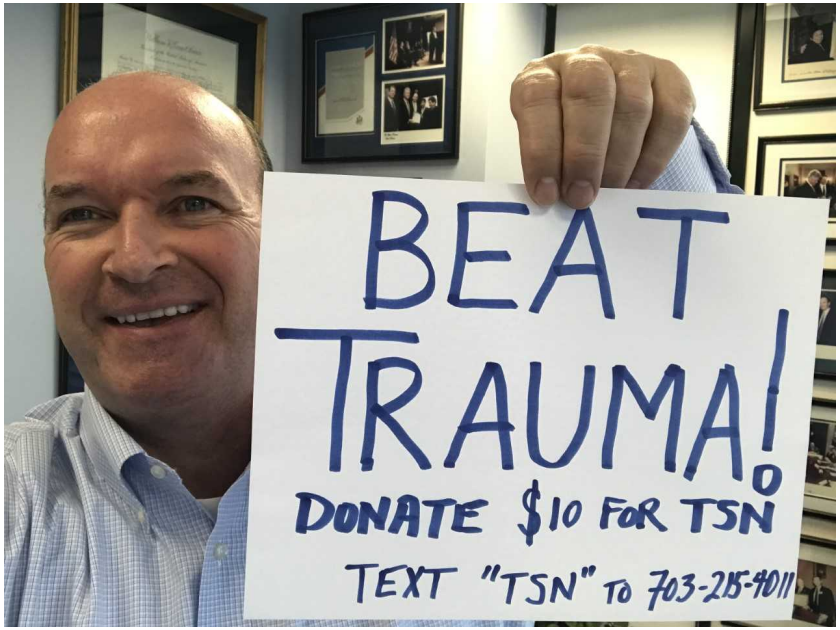
EMPOWERMENT & ADVOCACY FOR SURVIVORS

- Ongoing research
- Leadership and service on multiple Board of Directors including ATS
- National advocacy for survivors



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Stress Disorders After Exposure to Traumatic Life Events: An Introduction & Discussion

PRESENTED BY: DOUG ZATZICK, MD

LEARNING OBJECTIVES

- Define Posttraumatic Stress Disorder (PTSD)
- Acute Stress Disorder (ASD) vs. PTSD
- DSM-IV vs. DSM-5 Stress Disorders
- Stress disorders association with impaired function
- Risk factors for stress disorders
- Screening for stress disorders
- Behavioral treatments for stress disorders
- Other treatments (e.g., medications)

POSTTRAUMATIC STRESS DISORDER (PTSD): DSM-IV

- A. Traumatic Event
- B. Intrusive Symptoms
- C. Avoidant Symptoms
- D. Arousal Symptoms
- E. 1 Month
- F. Functional Impairment

PTSD DSM-IV TRAUMATIC EVENT

- Experienced, witnessed, or has been confronted with an event that involved actual or threatened death or serious injury or threat to physical integrity to self or others

PTSD INTRUSIVE SYMPTOMS

- Memories
- Nightmares
- Flashbacks
- Distress at reminders

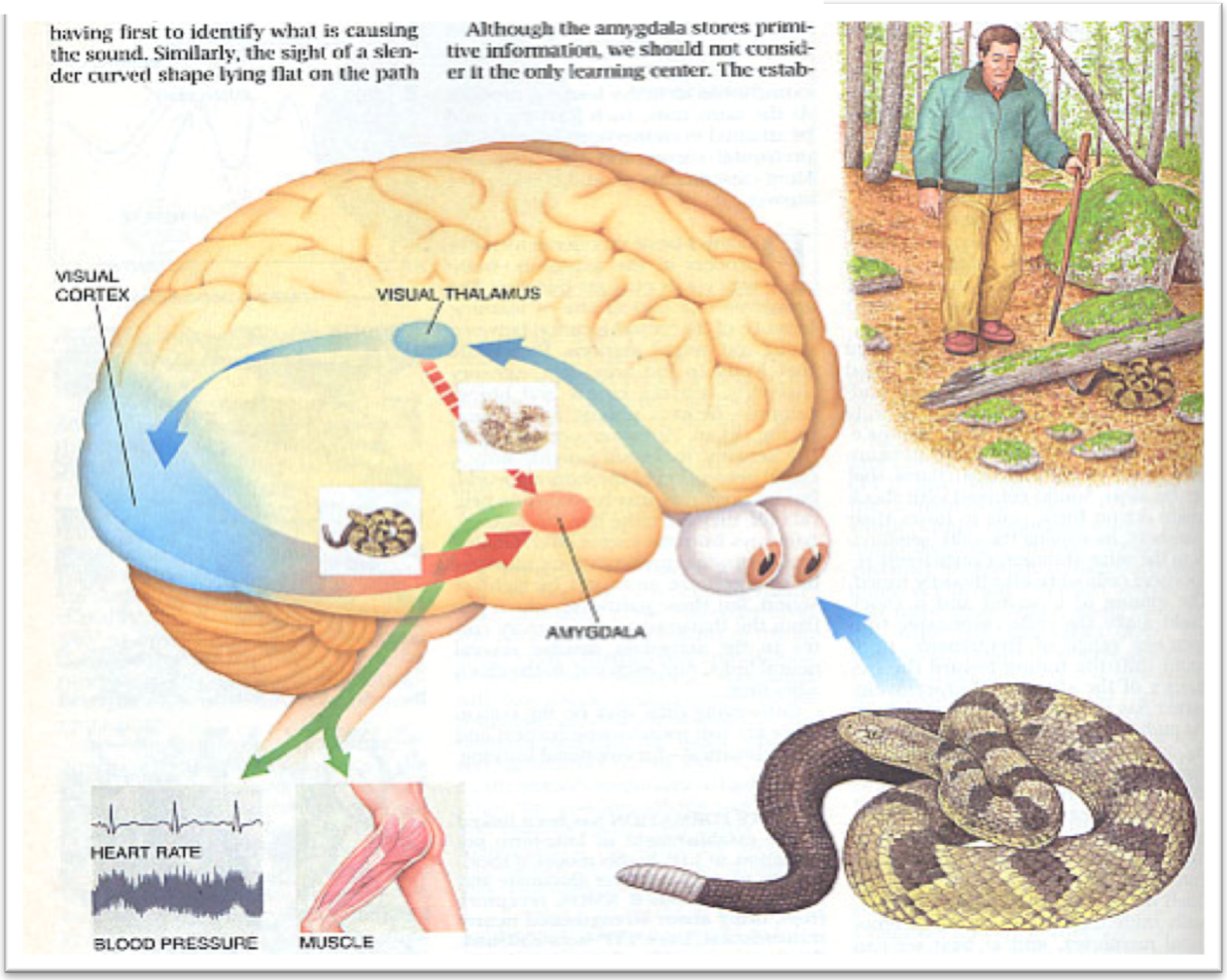
PTSD AVOIDANT SYMPTOMS

- Avoiding thoughts
- Avoiding reminders
- Emotional numbing
- Social isolation

PTSD AROUSAL SYMPTOMS

- Insomnia
- Irritability
- Hypervigilance
- Startle
- Poor concentration

THE BIOLOGY OF PTSD



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THE BIOLOGY OF PTSD: TAKE HOME

- Stress response biology and symptoms are part of being human

ACUTE STRESS DISORDER VERSUS PTSD

- Within 3 days to 1 month after the injury
- Similar Intrusive, Avoidant & Arousal symptoms
- Adds “Dissociative” symptoms

DSM-IV VERSUS DSM-5: MAJOR DIFFERENCES

- Addition of negative mood symptoms such as shame, guilt and risk behaviors

CROSS-CUTTING DIAGNOSTIC ISSUE: PTSD & RELATED COMORBIDITIES ARE ASSOCIATED WITH FUNCTIONAL IMPAIRMENT

- DSM Criteria F: Symptoms are associated with:
  - Impairment in social function
  - Impairment in role function
  - Impairment in physical function

ANNALS OF SURGERY 2008
(AMERICAN SURGICAL ASSOCIATION, 2007)

ORIGINAL ARTICLES

A National US Study of Posttraumatic Stress Disorder, Depression, and Work and Functional Outcomes After Hospitalization for Traumatic Injury

Douglas Zatzick, MD, Gregory J. Jurkovich, MD,† Frederick P. Rivara, MD, MPH,‡ Jin Wang, PhD, MS,‡ Ming-Yu Fan, PhD,* Jutta Joesch, PhD,* and Ellen Mackenzie, PhD§*

Objective: To examine factors other than injury severity that are likely to influence functional outcomes after hospitalization for injury.

Summary Background Data: This study used data from the National Study on the Costs and Outcomes of Trauma investigation to examine the association between posttraumatic stress disorder (PTSD), depression, and return to work and the development of

Conclusions: PTSD and depression occur frequently and are independently associated with enduring impairments after injury hospitalization. Early acute care interventions targeting these disorders have the potential to improve functional recovery after injury.

(*Ann Surg* 2008;248: 429–437)

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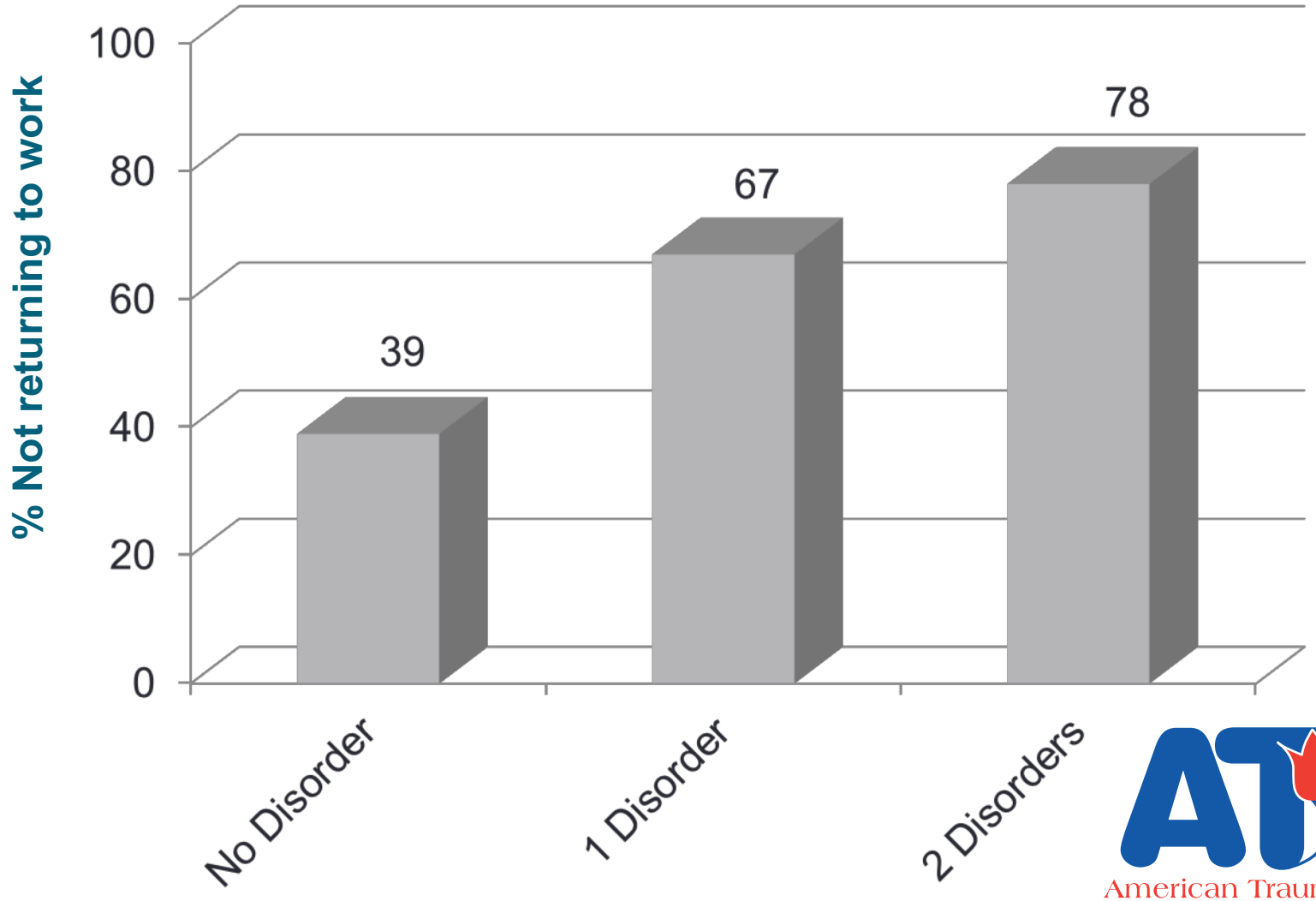
"DOSE RESPONSE" PTSD & DEPRESSION NOT RETURNING TO WORK



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PSYCHOPHARMACOLOGY: CONSIDERATIONS

- Patients are so overwhelmed that no new verbal learning can occur
- High levels of insomnia/ arousal
- Previously on psychotropic meds
- Very high levels of PTSD/ depression unlikely to respond to therapy or care management alone

EVIDENCE-BASED PTSD MEDICATION: PTSD & DEPRESSION

- Selective Serotonin Reuptake Inhibitors (SSRI)
  - Sertraline (FDA Approved PTSD)
  - Paroxetine
  - Fluoxetine
  - Citalopram
- Serotonin Norepinephrine Reuptake Inhibitors (SNRI)
  - Venlafaxine
  - Duloxetine
- Require 4-6 weeks for full effect

PTSD MEDICATION: HIGH AROUSAL, INSOMNIA, NIGHTMARES

- Prazosin
- Trazadone
- Atypical Antipsychotics? (e.g., Quetiapine)
- May have immediate impact on symptoms

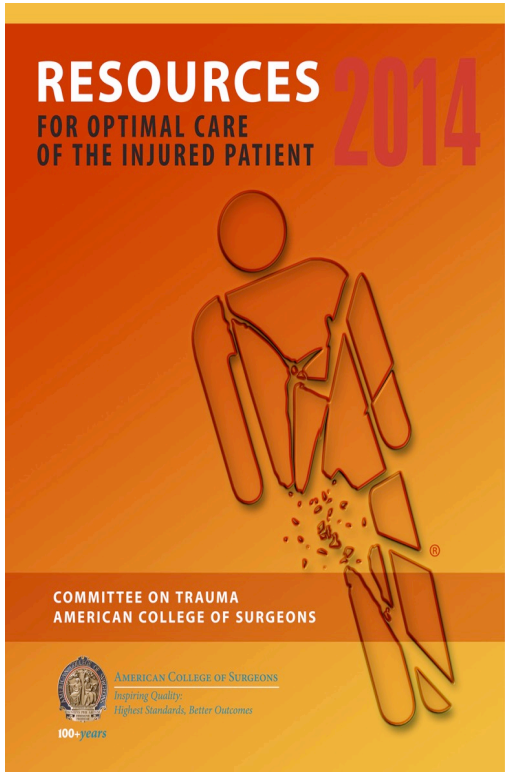
EVIDENCE-BASED PTSD MEDICATION: WHAT NOT TO PRESCRIBE

- Benzodiazepines
  - Habit forming
  - Not efficacious for PTSD

Screening for ASD and PTSD at Trauma Centers and Trauma Outpatient Clinics

PRESENTED BY: ANN MARIE WARREN, PhD

WHY SHOULD WE SCREEN FOR PTSD AND COMORBID DEPRESSION?



" The disciplines of psychology and psychiatry are important to the trauma center's acute care and rehabilitation teams….Early screening and referral for psychotherapy and pharmacologic treatment of PTSD and related co-morbid depression following injury have the potential to improve symptomatic and functional outcomes."

Rates of PTSD in this population range from 10-40 % compared to US average of 7.8%

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RISK FACTORS FOR PTSD

- Prior trauma history
- Premorbid psychiatric history
- Peritraumatic response
- Dissociation
- Poor social support
- Substance use
- Female gender
- Low SES
- Substance use
- Co-morbid TBI
- Genetic factors
- Type of injury (i.e. interpersonal, penetrating vs blunt)

PTSD AND DEPRESSION SCREENS USED IN TRAUMA CENTERS

- PTSD Checklist for DSM5 (PCL-5)
  - 20 item self report using DSM5 symptoms of PTSD
    - Screening, symptom monitoring and provisional PTSD diagnosis

- Primary Care PTSD Screen for DSM5 (PC-PTSD-5)
  - Have had nightmares about it or thought about it when you didn't want to?
  - Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
  - Were constantly on guard, watchful or easily startled?
  - Felt number or detached from others, activities or your surroundings?

- Patient Health Questionnaire-9 (PHQ-9)
  - 9 item measure
  - 8 item measure (removes suicide item)
  - 2 item measure (frequency of depressed mood and anhedonia)

INJURED TRAUMA SURVIVORS SCREEN (ITSS)

- Terri deRoon-Cassini, PhD at Medical College of Wisconsin

- Injured Trauma Survivors Screen (ITSS): 9 item tool for PTSD and depression in individuals with a traumatic injury
    - Takes 5 minutes to administer
    - Sensitivity, 75% for PTSD and depression; specificity, 93.9% for PTSD, 95.5% for depression
    - Stable at six month follow up

- Screens administered by social workers

- Positive screens noted in EMR and initiate a consult by a trauma psychologist who determines intervention plan

TRAUMA SURVIVORS OUTCOMES AND SUPPORT (TSOS)

- Doug Zatzick, MD University of Washington Harborview Injury Prevention Center
- Population-based automated screening tool using exclusively EMR data elements
- 10 item domain EMR PTSD Risk Screen of information captured as part of routine trauma care (i.e. gender, ethnicity, ICU admission)
  - Reduces burden of additional questions/measures
- Identifies those with needs for further PTSD assessment and intervention

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PERCEIVED CHALLENGES/BARRIERS TO SCREENING IN TRAUMA CENTERS

- Less than 10% of trauma centers screen
- Resources
- Medical acuity of the patient (pain, fatigue, sedation, cognitive deficits)
- Approaching individuals in physical and psychological distress/pain
- Fear that asking these questions will illicit a negative response
- Perceived lack of interest/lack of participation

SUCCESSFUL SCREENING STRATEGIES

- Identifying physician and administrative leadership support
  - **Identify a champion** for your screening program
- Providing in-service training for staff on need for screening
- Teaching screeners to develop rapport with injured patients
- Critical to treat each individual patient with ***respect***
- ***Essential*** for screeners to have a comfort level in an acute medical setting
- Understand and value multicultural differences
- Balance empathy with objectivity and adherence to screening protocols

BEHAVIORAL INTERVENTIONS

- Psychoeducation
  - National Center for PTSD (www.ptsd.va.gov)
- Behavioral activation
  - setting goals to increase rewarding activities
- Exposure Based Cognitive behavioral therapy
  - Prolonged Exposure Therapy (PE)
  - Cognitive Processing Therapy (CPT)
- Stepped Care (Zatzick and colleagues)
  - Care management (treatment retention)
  - Motivational interviewing (engagement)
  - Pharmacological interventions (symptom reduction)
  - Exposure Based CBT (symptom reduction

IN SUMMARY

- Brief psychological screening following physical injury for psychological conditions, particularly PTSD and depression, is recommended by the ACS-COT
- Individuals admitted to trauma centers after physical injury may have risk factors for PTSD in addition to the traumatic injury
- PTSD and depression screeners can be easily implemented into a trauma center practice using EMR, traditional measures or a combination of both
- Behavioral intervention strategies can be used at both the trauma center and in follow up to reduce symptoms

Early Intervention and Supportive Techniques with Patient-Centered Care

PRESENTED BY: DOUG ZATZICK, MD