Post-Traumatic Stress Disorder in Primary Care Practice

by

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Abstract

Post-traumatic stress disorder (PTSD) is one of many psychiatric problems that may be evaluated, diagnosed, and managed by the primary care practitioner. Patients with PTSD are being diagnosed and treatment is being sought in a variety of settings. There are numerous patient populations that have been identified as having the potential for developing this disorder. PTSD is a disorder where psychological and physiological reactions are closely related. The practitioner must be aware of diagnostic criteria and options for treatment for this disorder.
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Introduction

Post-traumatic stress disorder (PTSD) is one of many psychiatric problems that may be evaluated, diagnosed, and managed by the primary care practitioner. The world continues to be a stressful and often violent place to live. New patients with PTSD are being diagnosed daily. Treatment is being sought in a variety of clinical settings, including inpatient, outpatient, general and psychiatric practices. PTSD is a disorder where psychological and physiological reactions are intertwined. The practitioner must be aware of diagnostic criteria and options for treatment for this disorder.

Diagnosis

PTSD is the best-known psychiatric sequela of trauma. It was first established as a diagnosis in 1980 and consists of three clusters of symptoms: reexperiencing, avoidance, and hyperarousal (American Psychiatric Association, 1994). DSM-IV of the American Psychiatric Association (pp. 427-429) states:

The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

Peebles-Kleiger and Zerbe (1998) state that whether or not psychiatric symptoms develop depends on the characteristics of the traumatic event, a person’s psychological health before the trauma and age at the time of the trauma, the unique meaning of the
event to the person, and the support systems during recovery. Table 1 lists all DSM-IV diagnostic criteria for this disorder (American Psychiatric Association, 1994).

In addition to these criteria, it must be specified that this episode of PTSD is acute, chronic or delayed onset. PTSD is acute if the duration of symptoms is less than three months. PTSD is chronic if duration of symptoms is three months or more. Delayed onset is diagnosed when onset of symptoms is as least 6 months after the traumatic stressor.

Williams (1987) describes a theoretical model for understanding acute and chronic PTSD. The acute trauma model (Figure 1) delineates three distinct phases of acute post-trauma reactions: the shock phase, the impact phase, and the recovery phase. The practitioner may encounter a patient at any place along this continuum.

Zimmerman and Mattia (1999) found that PTSD is frequently overlooked in routine clinical practice when symptoms of PTSD are not the presenting complaint. In this prospective study, the investigators sampled 1000 patients for PTSD in a psychiatric outpatient practice. The first 500 were administered a diagnostic screening questionnaire that included a PTSD subscale. In this first group, 7.2% were diagnosed with PTSD and an additional 18.6% of the same sample screened positive for PTSD on the questionnaire, but were not diagnosed with PTSD. The next 500 patients were interviewed with the Structured Clinical Interview for DSM-IV (First, Spitzer, Williams & Gibbons, 1997). The diagnosis of PTSD was two times higher (14.4% vs. 7.2%) in this second group. The strength of this study is the large sample size and that it included psychiatric professionals who are trained in use of the instruments.
The investigators concluded that practitioners might limit their attention to a patient’s presenting complaint of depression or panic attacks and fail to inquire about a trauma history and symptoms of PTSD. From the pharmacological perspective, improving the recognition of PTSD might not have that great an impact, as medications that are effective for depression and anxiety are the same ones that have also been shown to reduce symptoms of PTSD. The difference in treatment may be in the realm of cognitive-behavioral therapy. If PTSD is not appropriately recognized, patients may not receive this potentially effective form of treatment. Even in a specialty such as psychiatry PTSD is often underdiagnosed (Zimmerman & Mattia, 1999).

Samson, Bensen, Beck, Price and Nimmer (1999) studied patients in an outpatient primary care facility in a large health maintenance organization (HMO). The sample was drawn from 7444 patients who visited the facility during the study period. A computerized psychiatric screening questionnaire was administered to patients with symptoms of depression or anxiety. As a result of the screening questionnaire, 296 patients were referred for consultation with a structured interview. Of the 296 patients interviewed 114 (38.6%) met criteria for PTSD. The investigators concluded that PTSD is often unrecognized among patients in a primary care setting.

Diagnosis of PTSD can be complicated by several factors. Symptoms can occur months or years after the traumatic event and can persist for years. Symptoms can go away, only to recur years or decades later, often triggered by events psychologically or temporally related to the original incident (Peebles-Kleiger & Zerbe, 1998). PTSD can be cyclic and progressive (Samson, Bensen, Beck, Price & Nimmer, 1999).
The majority of patients with PTSD seek treatment in primary care settings, not mental health settings. In the medical setting, a patient may present with an array of apparently unrelated problems.

Andreski, Chilcoat, and Breslau (1998) found that there is a strong association between PTSD and somatization symptoms. In this prospective study a random sample of 1200 patients was drawn from the list of all twenty-one to thirty year-old members of a large HMO. A total of 1007 respondents (84% of the sample) were interviewed in their homes. Approximately three years after the initial interview, a follow-up interview was conducted that involved 979 of the original respondents. Five-year follow-up interviews were also conducted with 979 of the 1007 respondents. The investigators concluded that persons with PTSD were at least twice as likely as those with other disorders to have a history of multiple somatization symptom groups.

Dickinson, deGruy, Dickinson, and Candib (1998) found neither the patient nor practitioner may be aware that the current distress may be linked to events that occurred during developmental years. Since most practitioners do not ask their patients about past abuse, the underlying trauma may likely go unrecognized and treatment of the presenting problem may prove inadequate and achieve only transient improvement in the patient’s condition. Some patients may be inappropriately diagnosed with personality disorders.

Medical service utilization increases after a traumatic event. PTSD patients have more somatic complaints than other patients do. These complaints include musculoskeletal, gastrointestinal, cardiovascular, neurological, and gynecological symptoms. Patients usually seek treatment for specific physical complaints and often do not recognize the connection between the past trauma and present symptoms.
Additionally, there is much symptom overlap between PTSD and other psychiatric disorders such as depression, anxiety, substance abuse, and personality disorders. Practitioners may identify symptoms of anxiety or depression and treat them with medication without diagnosing and specifically treating PTSD. Samson, Bensen, Beck, Price and Nimmer (1999) suggest using screening questions for post-traumatic stress disorder to increase the likelihood of recognition by a primary care practitioner (Table 2).

Through education the medical community has an increased awareness and greater understanding of PTSD. It is being diagnosed more frequently and more attention has been given to research into contributing factors and treatment. In a letter to the editor Synott (1997) states that he is finding the definition of “traumatic event” in DSM-IV difficult to interpret. He questions, if the determination of what constitutes a traumatic event should be an objective assessment, or should it be the patient’s subjective interpretation? Natural disasters and “man-made” events (e.g., car crashes, physical assaults or rape) are traumatic by any objective assessment. When the traumatic event appears less extreme (e.g., workplace conflict or near-crashes/incidents), the practitioner’s ability to judge it as traumatic becomes clouded.

Synott further suggests that it may be the intensity of the traumatic event that is the important factor in making the diagnosis. If this were true it would take away from the patient’s ability to see an event as traumatic. It would then become the responsibility of the practitioner to decide whether an event is traumatic or not, which leaves it open for the practitioner’s subjective interpretations. If the individual’s right to decide what is traumatic for them is preserved, then almost any event (either environmental or
intrapsychic) could be perceived as traumatic, depending on an individual’s circumstances and psychological profile.

Epidemiology

The most recognizable PTSD population is the combat veteran. It was not until World War I that specific clinical syndromes came to be associated with those who experienced combat duty. In earlier wars, it was assumed that such syndromes were merely manifestations of poor discipline and cowardice. During World War I, it was theorized that the high air pressure of the exploding shells caused actual physiological damage, thus labeled “shell shock”. During subsequent wars the percentage of psychological casualties increased. After much research the diagnosis of post-traumatic stress disorder was added to DSM-III in 1980 (Williams, 1987).

Conlon, Fahy and Conroy (1999) reported a prevalence of posttraumatic stress symptoms in non-hospitalized, ambulant motor vehicle crash victims, as early as one week post-crash. This prospective study assigned forty consecutive trauma clinic patients involved in separate motor vehicle crashes who sustained minor injuries not requiring hospital admission. After assessment subjects were randomly assigned to an intervention or monitoring group. The intervention was in the form of a single counseling session. Seventy-five percent of study participants reported significant levels of distress at one week post-trauma. By three months this had decreased to 35%, and 22% were still significantly impaired.

Ursano et al., (1999) found that rates of PTSD are high in victims of serious motor vehicle crashes and remains high nine months later. This study involved following 122 victims of serious motor vehicle crashes over twelve months with a comparison
group of 42 victims who had been involved in minor, non-motor-vehicle accidents. The authors found that female patients have an increased risk of acute, but not chronic PTSD. Individuals who have a history of PTSD are at risk of acute and chronic PTSD. A personality disorder diagnosis is predictive for developing chronic PTSD.

Over three million persons are injured in motor vehicle crashes each year (Butler, Moffic and Turkal, 1999). Many of these patients develop PTSD symptoms that can become chronic. Early identification of these patients is critical to allow for timely intervention and prevent greater impairment and restriction. Risk factors for PTSD following a motor vehicle crash include: (a) severe accident, (b) fatalities or severe injury among those involved, (c) perceived life-threatening event, (d) intrusive memories immediately following the event, (e) subsequent difficulty driving or traveling in vehicles, (f) history of prior traumatic experiences, (g) history of underlying psychiatric disorder, and (h) ongoing litigation.

Natural and man-made disasters are a common cause of psychological trauma and distress. The primary care practitioner can help identify patients who may not readily identify the need for psychological help. Stein and Myers (1999) authored a primary care physician’s guide to the emotional sequelae of disasters. Key points include that the first goal in treating disaster victims is assessment and ensuring that the patient is medically stable. Once the immediate health concerns of the patient are addressed, the psychological problems may become evident and should receive attention. The authors suggest a brief disaster-related mental health screen should be done at the six-month or one-year anniversary of the disaster.
Gavagan and Martinez (1997) describe a case series of three patients who are torture survivors from Guatemala. Torture can be described as the methodical destruction of personality, family, formal and informal institutions, and community in order to control persons and communities that a government considers dangerous to its interests. The authors estimate that for every person who was physically tortured, five have been psychologically tortured.

Weinstein, Dansky and Iacopino (1996) found that treatment of patients who have been exposed to torture and war violence present a special problem for practitioners. Symptoms of illness in this population may be vague and persistent; signs of torture can be subtle and may be overlooked, if patients cannot talk about the trauma. Torture is one of the new epidemics that is sweeping the world. With mass migration, the practitioner must be prepared to diagnose and compassionately treat the many survivors for whom the sanctuary of the United States can provide only partial safety. In gaining awareness of this PTSD population, the practitioner may help refugee survivors of torture find some measure of security and well being.

Briggs and Joyce (1997) studied women survivors of childhood sexual abuse to ascertain which childhood abuse experiences are associated with PTSD symptomatology. Seventy-three predominantly Caucasian women attending a Family Health Counseling Service’s Sexual Abuse Program participated in a study looking at the effectiveness of sexual abuse counseling. Participants completed a series of self-report questionnaires, including a measure of PTSD symptoms, and were interviewed about childhood abuse experiences. They found that PTSD symptoms were associated with higher levels of all psychopathology. Severity of PTSD symptoms was also associated with the extent of
childhood sexual abuse that involved actual sexual intercourse. One of the long-term effects of childhood sexual abuse is PTSD. Women who reported multiple abusive episodes that involved sexual intercourse had increased symptoms of PTSD. The investigators found this result to be statistically significant.

PTSD and substance abuse are underdiagnosed in hospitalized female veterans. Discharge diagnoses of 31 female and 31 male veterans hospitalized at a large urban VA medical center were reviewed to examine possible biases in clinicians' diagnostic practices (Grossman, Willer, Stovall, McRae, Maxwell & Nelson, 1997). In this study women were diagnosed significantly less often, as having PTSD, than were men. Only one woman in the sample received a diagnosis of PTSD while seven men received this diagnosis. Twice as many women as men were diagnosed as having an affective disorder. This difference was not statistically significant, which may be a result of the small sample size. No gender differences were found in the diagnosis of psychotic disorders or personality disorders. PTSD among this female veteran population may be significantly under diagnosed and should be further investigated.

Ouimette, Brown and Najavits (1998) found patients with PTSD might have comorbid substance use disorders (SUD). There are only a few completed treatment studies of SUD and PTSD comorbidity and many of the findings are still preliminary. Currently practitioners have little empirical evidence as to how to best treat and manage patients with this dual diagnosis. The investigators offer recommendations regarding this patient population in Table 3.

"Secondary traumatic stress" describes a helper's encounter with another's traumatic incident (Stamm, 1997). Sims and Sims (1998) conducted a review of 70
victims of psychological trauma, in which they were helpers in a major disaster, but not physically injured. They found that depression and depersonalization were major factors in accounting for psychiatric disability. Depressive disorder was the single most significant diagnosis in terms of prognosis for this specific cohort study.

Pathophysiology

Overwhelming traumatic experiences affect both the body and the mind. PTSD, perhaps more than any other psychiatric disorder, demonstrates the degree to which psychological and physiological reactions are closely related. A person’s response to trauma is relatively constant across traumatic stimuli. The central nervous system seems to react to any overwhelming threatening and uncontrollable experience in a consistent pattern. Regardless of the traumatic event, people continue to have a poor tolerance for arousal and respond to stress, in an all-or-nothing way. Responses are either unmodulated anxiety (which can be accompanied by acts of aggression against self or others) or social and emotional withdrawal (van der Kolk, 1987).

Acute stress is associated with a variety of physiologic responses. Responses include the activation of the hypothalamic-pituitary-adrenal (HPA) axis with a concomitant peripheral release of adrenocorticotropic hormone (ACTH), epinephrine, norepinephrine, glucagon and cortisol; a significant increase in centrally controlled peripheral sympathetic nervous system tone; and the activation of a variety of neurochemical systems in the central nervous system (Giller, 1990). Catecholamine induced symptoms include anxiety, tachycardia, shortness of breath and sweating. Given the wide variety of escapable and inescapable stressors to which patients with PTSD have been exposed to for variable time periods, it is difficult to predict with any certainty the
direction of expected changes in catecholaminergic function at baseline in a given patient (Giller, 1990).

The role of catecholamines are thought to be significant in the pathophysiology of PTSD, but research findings have been controversial. Yehuda et al., (1998) studied combat veterans who were diagnosed with PTSD. The study sample included equally distributed subjects with a major depressive disorder and PTSD (n=15), PTSD alone (n=12), and nonpsychiatric comparison subjects (n=13). Results indicate that increased norepinephrine levels in PTSD may be confined to the subgroup of subjects, who do not have comorbid depression, and as such, may serve to resolve some of the discrepancies in the literature regarding basal catecholamine activity in PTSD patients.

Baker et al., (1999) sought to test the hypothesis that elevations in cerebral spinal fluid (CSF) corticotropin-releasing hormone (CRH) concentrations exist in patients with PTSD. The authors also investigated the relationship among PTSD symptoms, adrenocortical activity, and CSF CRH levels. By studying combat veterans (n=11) and normal volunteers (n=12), they found high basal CSF CRH concentrations and normal 24-hour urinary-free cortisol excretion in the combat veteran sample. These findings are unique among psychiatric conditions studied. However, these results should be interpreted cautiously due to the small sample size.

Pharmacotherapy

Van der Kolk (1987) states that for cognitive-behavioral treatment to be effective, medications that decrease the anxiety accompanying the recurrent intrusive reexperiencing of the traumatic event should be given. As the autonomic nervous system is involved in many symptoms of PTSD, utilizing medications that decrease autonomic
arousal is the goal of pharmacotherapy. There are a variety of medications that can reduce autonomic arousal at different levels in the nervous system. Clonidine (Catapres) and beta adrenergic blockers (e.g., Inderal) inhibit noradrenergic activity. Benzodiazepines (e.g., Valium) increase the inhibitory effect of the GABAnergic system with gabanergic agonists and thereby have anxiolytic action. Lithium (Lithobid) and carbamazepine (Tegretol) assist in stabilizing the central nervous system.

Antidepressants are widely used for treatment of chronic PTSD, as depression is a major component. Tricyclic antidepressants, MAO inhibitors and SSRIs have all been helpful in treatment. Table 4 summarizes medications that are commonly used in treatment of PTSD (Butler, Moffic, & Turkal, 1999).

Although no formal study has been completed, two case reports by Krashin and Oates (1999) found that risperidone (Risperdal) has been helpful in treatment of hypervigilence and flashbacks experienced by some PTSD patients. In addition, risperidone has potential for having helpful anxiolytic or antidepressant effects. Risperidone may be helpful, as it has a much lower incidence of extrapyramidal side effects such as akathesia, rigidity, bradykinesia, and dystonias. Depending on severity, these side effects can interfere with treatment and compliance.

Non-Pharmacologic Treatments

Peebles-Kleiger and Zerbe (1998) found that practitioners need to provide appropriate drug therapy, clinical office management, and referral to outside consultants when indicated. Clinical office management includes even minimal interventions, such as support and encouragement, which can have a profound impact. The role of the practitioner is crucial in establishing a healing environment. Effective treatment of PTSD
is a three-stage process consisting of stabilization of symptoms, processing of traumatic perceptions, and integration of trauma into the patient’s world-view and self-view. The practitioner can play an important role in the first stage of symptom stabilization. Weinstein, Dansky and Iacopino (1996) suggest guidelines for interviewing torture survivors (Table 5). These guidelines may be helpful in interviewing other trauma survivors, as well.

When obtaining a history of the trauma, the patient may experience flashbacks of the traumatic event. Uncontrolled flashbacks are not therapeutic and can be harmful, if they are persistent and recurring. These should be stopped by reorienting the patient to the here and now. Some patients will self-blame or have guilt reactions to the trauma. By blaming themselves or feeling guilt, they create the illusion that they could have controlled what happened. Help the patient sort out what actually could have been controlled or at least influenced and learn what might be done differently in the future. Assist the patient in finding small activities to restore active control, which will decrease the paralytic passivity caused by acute trauma. Explore current support in the patient’s life such as family, church, friends, clubs, coworkers, and community self-help group mechanisms (Peebles-Kleiger & Zerbe, 1998).

To complete the second and third stage of treatment for PTSD, patients may require medication and psychotherapy specifically focused on the past trauma (Samson, Bensen, Beck, Price & Nimmer, 1999). A mental health referral may be helpful, if the practitioner identifies any of the following: (a) symptoms are worse or new symptoms have occurred six months after the initial trauma; (b) the patient has undergone personality changes since the trauma; (c) the patient suddenly shows symptoms that fit
the criteria of PTSD, but seem unrelated to anything in the immediate past; (d) the patient begins engaging in life-threatening behaviors, such as excessive alcohol or drug use, inappropriate eating behavior, or suicidal ideation; and (e) several family members have trauma-type symptoms and signs of decreasing coping mechanisms (Peebles-Kleiger & Zerbe, 1998).

An adjunct to traditional psychotherapy is Eye Movement Desensitization and Reprocessing (EMDR). EMDR is a relatively new clinical treatment that has been shown to be effective for victims of trauma (Shapiro, 1995). It consists of an eight-phase treatment approach that includes using eye movements or other left-right stimulation. The eye movements seem to stimulate the patient’s innate information-processing system to alter dysfunctional, self-denigrating thoughts into less threatening, more palatable information. EMDR helps victims of trauma reprocess disturbing thoughts and memories. As this is a relatively new therapy, not all mental health practitioners have been trained in this method.

Prognosis

The prognosis for PTSD depends on several factors (Peebles-Kleiger & Zerbe, 1998). One of the most important factors is whether the disorder is considered simple or complicated. Simple trauma is more likely when a single traumatic event of brief duration occurs during adulthood and does not involve human violence (fire, natural disasters without severe loss or community disruption, and some motor vehicle crashes). Simple reactions can resolve relatively quickly, especially with adequate family support or brief crisis intervention.
Complicating trauma involves an unrelenting series of events lasting over a long time span. It often begins in childhood and is associated with violence, as well as unpredictability (childhood physical or sexual abuse, prolonged war, and torture). The symptoms of complicated stress disorder do not abate spontaneously, and pharmacotherapy coupled with psychotherapy is often needed. Table 6 summarizes the features of simple versus complicated trauma.

Freedman, Brandes, Peri and Shalev (1999) conducted a prospective study to evaluate predictors of PTSD at four months and one year. The strengths of this study are the prospective design and sample size (n=236). Most patients who, shortly after trauma, express symptoms of PTSD recover within one year of their traumatic experience. Patients who remain ill for one year rarely recover completely. The authors found that depressive symptoms were the best predictors of PTSD at both four months and one year. Intrusive symptoms and peri-traumatic dissociation were better at predicting four-month PTSD, than one-year PTSD. They also concluded that the occurrence of depression during the months that follow a traumatic event is an important mediator of chronicity in PTSD. The authors suggest that depression in the recently traumatized should be targeted for early treatment and should become a focus of further research and clinical attention.

Summary

It is important that practitioners accurately diagnose and prescribe appropriate treatment for patients with PTSD. Increasing awareness of affected populations will assist the practitioner in identifying patients who are at risk for PTSD. Using appropriate treatment modalities, the practitioner can assist the patient to gain control of the psychological and physiological reactions to the traumatic event. Knowledge of
appropriate pharmacotherapy and referral to mental health professionals will aid patients in their recovery.
References


hydroxyphenyglycol concentrations and severity of depression in combat posttraumatic stress disorder and major depressive disorder. Biological Psychiatry, 44 (1), 56-63.

Table 1

Diagnostic Criteria for 309.81 Posttraumatic Stress Disorder

1. The person has been exposed to a traumatic event in which both of the following were present:
   
   (a) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
   
   (b) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

2. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   
   (a) recurrent and intrusive distressing recollections of the event, including images thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   
   (b) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
   
   (c) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
   
   (d) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
(e) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

3. Persistent avoidance of stimuli associated with the trauma and numbering of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (a) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (b) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (c) inability to recall an important aspect of the trauma
   (d) markedly diminished interest or participation in significant activities
   (e) feeling of detachment or estrangement from others
   (f) restricted range of affect (e.g., unable to have loving feelings)
   (g) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

4. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (a) difficulty falling or staying asleep
   (b) irritability or outbursts of anger
   (c) difficulty concentrating
   (d) hypervigilence
   (e) exaggerated startle response

5. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

6. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Table 2

**Suggested Screening Questions for Posttraumatic Stress Disorder**

1. Have you ever encountered an event that was life-threatening to you or someone else?
2. Have you ever encountered an event where you feared for your safety or the safety of someone else?
3. Have you ever experienced an event that deeply frightened you and left you feeling shocked or helpless?
4. Have you ever been physically, sexually, or emotionally abused?
5. Have you ever been in a physically abusive relationship as an adult?

If the response to any of the above questions is positive, also ask:

1. Do you have thoughts or images about the trauma that continue to bother you?
2. Do you feel you do not care about things as much or feel numb as a result of the experience?
3. Do you avoid certain people, places, or situations since the trauma?
4. Do you feel stressed, hyper, on guard, anxious, or depressed as a result of the experience?
5. Are you having more difficulty doing your job or getting along with coworkers?
6. Have you had any trouble with the law?
7. Do you feel more uncomfortable interacting with family or friends, or are you having more difficulty getting along with them?

Table 3

Substance Use Disorder-Post-Traumatic Stress Disorder Patient Management

1. SUD patients should be screened for traumatic stress experiences and PTSD.

2. SUD-PTSD patients should be provided with direct referral for concurrent trauma/PTSD treatment, or psychological treatment with the recommendation that trauma/PTSD issues be addressed.

3. SUD-PTSD patients should be offered more intensive substance abuse counseling, e.g. more sessions.

4. SUD-PTSD patients should be referred for concurrent participation in self-help groups and for family treatment.

<table>
<thead>
<tr>
<th>Target symptoms</th>
<th>Medication class</th>
<th>Medications</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociative flashbacks or intrusive memories</td>
<td>Beta blockers</td>
<td>Propanolol (Inderal), 10 mg one to two tablets four times a day, as needed</td>
<td>Can be used as needed or on a regular basis</td>
</tr>
<tr>
<td>Nightmares of trauma</td>
<td>Benzodiazepines</td>
<td>Various</td>
<td>Try to avoid chronic, daily use; cyproheptadine (Periactin), 4 mg at bedtime, is an alternative treatment</td>
</tr>
<tr>
<td>Psychotic-like illusions or hallucinations of the trauma</td>
<td>Atypical neuroleptics</td>
<td>Olanzapine (Zyprexa), 2.5 to 5 mg once a day, as needed</td>
<td>Other atypical or traditional neuroleptic medications can also be used</td>
</tr>
<tr>
<td>Avoidance, numbing and diminished interests</td>
<td>Antidepressants</td>
<td>Various (SSRIs recommended as initial therapy)</td>
<td>Other SSRIs, as well as tricyclic antidepressants, can be tried</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Hyperarousal or irritability</td>
<td>Beta blockers</td>
<td>Propranolol, as above</td>
<td>Alternatives include usual doses of antianxiety medication such as buspirone (Buspar) and benzodiazepines</td>
</tr>
<tr>
<td>Mixed symptoms</td>
<td>Anticonvulsant mood mood stabilizers</td>
<td>Divalproex (Depakote), 250 to 500 mg three times a day, or all at bedtime</td>
<td>Carbamazepine (Tegretol), 400 to 800 mg per day, is an alternative treatment</td>
</tr>
</tbody>
</table>

**Note.** Many of these medications have limited scientific support for us in treating these symptoms. SSRIs = selective serotonin reuptake inhibitors. From “Post-traumatic stress reactions following motor vehicle accidents,” by D. J. Butler, H. S. Moffic, and N. W. Turkal, 1999, *American Family Physician, 60* (2), 524-531. Copyright 1999 by the American Academy of Family Physicians.
Table 5

Interviewing Torture Survivors

1. The setting

(a) as un-cell-like as possible

(b) comfortable climatic conditions

(c) all objects in view (no screens)

(d) awareness that anxiety can be triggered by seemingly innocent objects

2. The process

(a) waiting for appointments may trigger patient anxiety because of the remembered waiting for torture

(b) decrease anxiety by explaining who you are, what your role is, and how the interview and examination will work; it is critical to diminish the element of surprise, especially with certain examinations or treatments such as venipuncture or pelvic examination

(c) give patient some sense of control—for example, to take a break or use washroom

(d) questioning should be done gently

(e) questions should be tactful but direct—for example, “People with memory problems or bad dreams have often been tortured or traumatized. Is this something that has happened to you?”

(f) acknowledge that disclosure is difficult

(g) educate patient about symptoms—that it is common to feel that the symptoms are indications of mental illness; offer reassurance that these are normal reactions to abnormal events
(h) correct misperceptions—for example, sexual torture usually does not result in impotence or sterility

3. Interpreters

(a) use interpreters, but be aware that problems exist with using family members, fellow nationals, or North Americans who may miss cultural nuances; sensitivity is critical

4. Education

(a) teach about the North American health care system

(b) refer for psychological counseling and know referral centers

(c) refer for social services

**Table 6**

<table>
<thead>
<tr>
<th>Simple versus Complicated Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple trauma</td>
</tr>
<tr>
<td>Involves single event</td>
</tr>
<tr>
<td>Is of brief duration</td>
</tr>
<tr>
<td>Occurs late in life (after ego</td>
</tr>
<tr>
<td>development solidified</td>
</tr>
<tr>
<td>Contains no violence created by</td>
</tr>
<tr>
<td>human beings</td>
</tr>
<tr>
<td>Allows patient active role</td>
</tr>
<tr>
<td>Carries advance warning</td>
</tr>
<tr>
<td>Has time-limited symptoms</td>
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<tr>
<td>Symptoms resolve spontaneously</td>
</tr>
<tr>
<td>or with support in the recovery</td>
</tr>
<tr>
<td>environment</td>
</tr>
<tr>
<td>If professional intervention is</td>
</tr>
<tr>
<td>necessary, it typically is brief</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

Figure 1. Acute Trauma Response