Lifetime prevalence of trauma exposure and PTSD is high among adults living with HIV/AIDS.

- 62% of HIV positive adults endorse traumatic experiences
- 30% of women LWHA meet criteria for PTSD
- PTSD occurs in 8.7% of the general population

What is the cost of trauma?

- Inferior health functioning
- Inferior quality of life
- Increased bed disability and hospital stay
- Higher number of ER visits

Learning Objectives

1. Recognize the symptoms of Posttraumatic Stress Disorder (PTSD).

2. Identify changes to PTSD criteria in DSM-5.

3. Identify HIV-related factors associated with PTSD.

4. Review how to manage HIV for reducing the impact of PTSD on HIV course.
Stress Pathways

Source of stress
(memory or environment)

Cerebral cortex

Hypothalamus

Pituitary gland
(secretes ACTH)

Adrenal cortex
(secretes corticosteroids)

Sympathetic
nervous system

Adrenal medulla
(secretes epinephrine and norepinephrine)
Factors Involved in Stress Response

- Coping strategies
- Physical factors
- Environmental and cultural factors
- Cognitive factors
- Personality factors
How does PTSD develop?
The smell of something your mother cooked: Conditioned Stimulus

Feeling of Comfort: Conditioned Response
Feeling of loss:
Conditioned Response

Hearing a song that a deceased love one used to play: Conditioned Stimulus
911 victims see airplane flying over Manhattan: Conditioned Stimulus

Anxiety: Conditioned Response
Traditional Definition of Psychological Trauma

- The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death, serious injury or a threat to physical integrity.
- The person's response involved intense fear, helplessness, or horror.
  - Uncontrollable
  - Unpredictable
  - Change/Challenge capabilities or self-concepts
Events that Induce PTSD in General Population

**Disasters**
- Tornadoes, floods, earthquakes, fires

**Common Traumatic Events**
- Car accidents, sudden deaths of loved ones

**Combat and War-Related Traumas**
- Combat fatigue syndrome, “Shell Shock”

**Abuse**
- Physical, emotional, sexual
How does trauma feel?
DSM-IV-TR Diagnostic Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event.
B. The traumatic event is persistently experienced.
C. Persistent avoidance of stimuli associated with trauma or numbing.
D. Persistent symptoms of increased arousal.
Reexperiencing Symptoms

1 or more

- Recurrent and distressing recollections (images or thoughts)
- Recurrent and distressing dreams about the event
- Acting or feeling as if the event were recurring (i.e. illusions, dissociative episodes, flashbacks, hallucinations)
- Intense psychological distress upon exposure to internal or external cues
- Physiological reactivity or arousal upon exposure
Arousal Symptoms

2 or more

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response
Avoidance Symptoms

3 or more

- Efforts to avoid thoughts, feelings or conversations associated with the trauma
- Efforts to avoid activities, places or people that arouse recollections of the trauma
- Inability to recall and important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect
- Sense of foreshortened future
Benefits of Revisions

- A descriptive approach allows mental health professionals from different orientations to utilize the same diagnostic system
- Improved diagnostic reliability among mental health providers
- Standardized definitions that can be used across research settings
- Facilitated drug development for new indications
- Improves patient education by demystifying the diagnostic process
DSM-5 Revision Process

- Workgroups identified problems with DSM-IV definitions
- Literature reviews and data reanalysis
- Proposed changes were posted on DSM-5 website for professional feedback
- Public comments were reviewed from website
- Field trials reviewed for reliability and validity of diagnoses (11 academic centers)

http://www.dsm5.org/MeetUs/Pages/WorkGroupMembers.aspx
PTSD: Changes to Stressor Criteria

- Trauma: exposure to actual or threatened death, serious injury or sexual violence

- No longer a criterion for fear, helplessness or horror.
Changes to Trauma Criteria

- Modes of Exposure:
  - Direct experience
  - Witnessing in person or others
  - Learning threat event happened to family member or close friend
  - Repeated or extreme exposure to aversive details (e.g., first responders)
Reorganization of PTSD Symptom Clusters

**DSM -5**

A. Trauma
B. Intrusion symptoms
C. Avoidance symptoms
D. Negative alteration in cognition in mood
E. Alteration in arousal and reactivity

- Added: reckless or self-destructive behavior

**DSM -IV**

A. Trauma
B. Re-experiencing symptoms
C. Avoidance of stimuli and numbing of general responsiveness
D. Increased arousal
Negative alterations in cognitions and mood associated with the traumatic event(s) beginning or worsening after the traumatic event occurred, as evidenced by two or more of the following:

1. Inability to remember an important aspect of the traumatic events typically due to dissociative amnesia and not to other factors, such as head injury, alcohol or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others and the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt or shame).
5. Feelings of detachment or estrangement from others.
6. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfactory or loving feelings).
Specify whether:

- **With dissociative symptoms:** The individual’s symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

  1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from and as if one were an outside observer of, one’s mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality or self or body or of time moving slowly).

  2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted).
PTSD in Children 6 Years and Younger

A. In children 6 years and younger, exposure to actual or threatened death, serious injury or sexual violence in one (or more of the following ways)

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event as it occurred to others, especially primary caregivers.
3. Learning that the traumatic event(s) occurred to the parent or caregiving figure.

Note: Witnessing does not include events that are witness only in electronic media, television, movies or picture.
PTSD in Children 6 Years and Younger: Criterion B

Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic events occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event. **Note:** Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s). **Note:** It may not be possible to ascertain that the frightening content is related to the traumatic event.

3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic events were recurring; such as trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Marked physiological reactions to reminders of the event(s).
PTSD in Children 6 Years and Younger: Criterion D

Alterations in arousal and reactivity associated with the traumatic event, beginning or worsening after the traumatic event occurred:

1. Irritable behavior and angry outburst (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
2. Hypervigilance.
3. Exaggerated startle response.
4. Problems with concentration.
5. Sleep disturbance.
PTSD Criteria, Cont.

- Duration of the symptoms is more than 1 month
- Disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning
Acute Stress Disorder

- Similar to PTSD, but occurs within one month of stressor, and lasts four weeks or less
- Dissociative symptoms are prominent

Adjustment Disorder

- A category that can be used for less severe stressors
- People who are experiencing emotional and behavioral symptoms after a stressor, but do not meet criteria for PTSD, ASD or mood disorders.
Associated Features

- Developmental regression
- Auditory pseudo-hallucinations (i.e. having sensory experience of hearing one’s thoughts spoken in different voices)
- Paranoid ideation
- Difficulty regulating emotions
- Difficulty maintaining stable relationships
MRI and PET Findings

- Non-specific white matter lesions (cognitive function)
- Decreased hippocampal volume (learning, memory)
- Increased activation of amygdala (emotions - fear, “smoke alarm”)
- Greater deactivation Broca’s area, the prefrontal cortex (speech)

A Case of PTSD
28-year-old woman with AIDS

- Trauma: Political Rape
- Reexperiencing: nightmares, intrusive thoughts
- Avoidance: “I will never go home again”.
- Emotional numbing
  - “I don’t exist anymore”
  - “If I could get rid of my child, I would”.

Hear story:
A Case of PTSD
22-year-old woman with AIDS

- Hypervigilance and chronic arousal
  - Sleep Disturbance
  - Distrust & Always Afraid
- Triggers
  - Men  - HIV status  - Scars
  - Loud Noise  - Changed Appearance
- Limited support
  - Homeless
  - Recent relocation to U.S
Explanations of PTSD Vulnerability

**Environmental factors**
1. Severity, duration, proximity of trauma
2. Social support
3. Lower SES
4. Perceived life threat

**Psychological factors**
1. Personal assumptions and negative appraisal
2. Distress
3. Emotion-focused coping
4. Prior psychiatric hx

**Biological factors**
1. Physiological hyperactivity
2. Genetics
Explanations of PTSD Vulnerability for K.S

Sociocultural factors
1. Severity: humiliation
2. Duration: one time event
3. Proximity: less proximal
4. Social Support: limited

Psychological factors
1. Assumption: I am unclean.
2. Distress: high levels
3. Emotion-focused coping

Biological factors
1. Scars/ Changes in physical appearance
2. Genetics: no family history of mental illness
How is PTSD different among adults living with HIV/AIDS?
Possible Pathways to Poorer Health Outcome

- PTSD is associated with more health compromising and risky behaviors
- More reports of unexplainable pain and somatic complaints
- PTSD might directly impact immune functioning
- Treatment fatigue may be more pervasive among patients with PTSD

Diagnosis, treatment and physical symptoms associated with a life-threatening illness can sometimes be a traumatic event in itself.

Other HIV Specific PTSD issues

- Disease progression- onset of AIDS
- Multiple AIDS related losses/bereavement
- Disclosure of HIV status
- Abuse & Neglect
- Domestic Violence (55% of WLWHA)
- Sexual Trauma and Exposure to Violence
- Survivor Guilt
Dissociative symptoms can be easily mistaken for HIV-related dementia or other forms of cognitive impairment.
Although patients with PTSD may seek help for associated somatic symptoms, they may perceive medical visits as intrusive and re-traumatizing.
Experiencing and avoidance symptoms may lead to failure to:

- Return to the site of diagnosis
- Failure to attend medical appointments
- Unwillingness to adhere to medical regimen
- Refusal to disclose one's status to significant others
For African American men, perceived discrimination may mediate the relationship between PTSD and poor treatment adherence.

- PTSD may influence drinking motivations though multiple pathways.
  - There is a relationship between self-reported PTSD symptoms and self-reported drinking to cope.
  - There may be biological underpinnings for motivation to drink among PLWHA and PTSD.

Nugent, Nicole R; Lally, Michelle A; Brown, Larry; Knopik, Valerie S; McGeary, John E. AIDS and Behavior. Vol.16(8), Nov 2012, pp. 2171-2180.
More childhood trauma, more stressful life events, less social support and more psychological distress put HIV-infected persons at risk for greater fatigue.

Low levels of mental health literacy and stigma may contribute to delayed treatment seeking and poorer outcomes.

Recommendations
Screening & referrals for recent & past trauma & PTSD should be considered a core component of HIV treatment in this population.

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you thought your life was threatened?

In the past month, you...

1. Have had nightmares about it or thought about it when you did not want to?

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

3. Were constantly on guard, watchful, or easily startled?

4. Felt numb or detached from others, activities, or your surroundings?
Screen for Comorbid Conditions

- Depression
- Substance Abuse
- Other Anxiety Disorders
- Bipolar disorder
- Personality disorders
Management of Patients with PTSD

- Medical providers should refer patients with symptoms of PTSD to a mental health professional for evaluation and treatments.
- Medical providers should continue to assess for patient risk of harm.
- Care coordination of multiple services is key to the patients success in treatment.
Treatments for PTSD

- **Cognitive behavioral therapy**
  - Systematic desensitization is used to extinguish fear reactions to memories; cognitive techniques are used to challenge irrational thoughts.

- **Stress management**
  - Therapist helps client solve concrete problems to reduce stress; may use thought stopping strategies to quell intrusive thoughts.

- **Biological therapies**
  - Antianxiety and antidepressant drugs are used to quell symptoms

- **Sociocultural approaches**
  - PTSD symptoms are understood and treated within the norms of people’s culture.
Goals of Clinical Treatment for PTSD

- Reduction of symptoms that interfere with HIV treatment adherence.
- Exposing the client to what they fear and cannot avoid during daily routine.
- Challenging distorted cognitions about the trauma and health.
- Helping reduce stress in daily lives.
- Improving coping capacity.
Pharmacotherapy

SSRI’s recommended as first-line medication

- Sertraline and Paroxetine are FDA approved for treatment of PTSD
- Other SSRIs
  - Associated with relief of core PTSD symptoms – experiencing, avoidance/numbing, hyper arousal
  - Treat for co-morbid psychiatric disorders
  - Reduce symptoms that complicate PTSD management (e.g., suicidal, aggressive behavior)
- Relatively few side effects
Caution Advised for Benzodiazepines

Use short term – helpful with anxiety and sleep but treatment efficacy with core symptoms not established

- Close monitoring
- Dependency potential
- Possibility of worsening of PTSD symptoms after withdrawal of benzodiazepines
Does it help to tell the story?

- A brief (4-session) guided written emotional disclosure intervention resulted in significant and meaningful reductions in PTSD, depression, and physical symptoms for women with HIV, but not for men.

Case Management with PTSD

Increase social support and familial connections

Increase general sense of control, safety and predictability
Advocacy for Patients with PTSD

- Be nonjudgmental and objective
- Avoid overidentification or hero syndrome
- Be aware of desensitization and estrangement
- You do not need similar experiences to help
- Be aware of potential for uncontrolled anger or violent reactions
Resilience

- Good problem-solving skills
- Seeking help
- Believing there is a way to manage feelings and cope
- Social support
- Self-disclosure of the trauma to loved ones
- Spirituality
- Sense of mastery
- Finding positive meaning in the trauma
- Higher intelligence

Mathew Tull, PhD (2007): “Posttraumatic Stress (PTSD): Overcoming Trauma” (3) (http://ptsd.about.com/od/causesanddevelopment/a/resiliency)
Part of vicarious trauma is also the helplessness, frustration, and stress experienced by support persons when trying to help the traumatized individual.
www.hivguidelines.org

Treatment of PTSD

http://www.ptsdsupport.net/treatments.html
The Columbia University HIV Mental Health Training Project, with funding from the New York State Department of Health AIDS Institute, now offers the Warmline. Mental health care providers with HIV clients can access assistance from a psychiatrist who specializes in the relationship between HIV and mental health. All calls will be returned within 48 business hours.
To schedule a Psychiatric Consultation please contact James Satriano, PhD, at

SATRIAN@PI.CPMC.COLUMBIA.EDU

OR 212/543-5591

To schedule a Training Activity, please contact Veronica Pinho at

VAP2112@COLUMBIA.EDU

OR 212/543-6028

OR visit us on the web at:
http://www.columbia.edu/cu/hivmentalhealthtraining
1. IMPACT OF MENTAL HEALTH DISORDERS ON HIV ILLNESS
2. IDENTIFICATION AND MANAGEMENT OF PERSONALITY DISORDERS AND HOW THEY CAN AFFECT HIV/AIDS CARE
3. NEUROPSYCHIATRIC ASPECTS OF HIV INFECTION
4. HIV/AIDS AND POST-TRAUMATIC STRESS DISORDER
5. WORKING WITH PEOPLE WITH SEVERE MENTAL ILLNESS AND HIV/AIDS
6. WORKING WITH CHILDREN/ADOLESCENTS WITH OR AFFECTED BY HIV/AIDS
7. SUICIDE PREVENTION STRATEGIES FOR HIV CLIENTS
8. APPROACHES TO ENGAGING CLIENTS IN HEALTH-RELATED BEHAVIOR CHANGE
9. LEGAL/ETHICAL ASPECTS OF CARING FOR PEOPLE WITH HIV/AIDS
10. CROSS-CULTURAL ISSUES AND CULTURAL PROFICIENCY IN DIAGNOSIS AND TREATMENT
11. ASK THE PSYCHIATRIST


Leserman et al. (2005). How Trauma, Recent Stressful Events, and PTSD Affect Functional Health Status and Health Utilization in HIV-Infected Patients in the South. *Psychosomatic Medicine, 67, 500-7.*

