NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Posttraumatic Stress Disorder and Trauma
Trauma Management
Trainee Guide

Contributors
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Pre-Assessment Learning

- Watts, B. V., Schnurr, P. P., Mayo, L., et al. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *Journal of Clinical Psychiatry, 74*, e541-550. doi:10.4088/JCP.12r08225

Go to: https://www.ptsd.va.gov/appvid/video/index.asp
Under the "For Patients" tab, view the following videos (few minutes each):
1. Prolonged exposure
2. Cognitive Processing Therapy
3. EMDR for PTSD

Learning Objectives
By the end of this session, the learner will be able to
1. Identify various types of trauma
2. Understand the basic principles of Trauma Informed Care
3. Discuss evidence based treatments for PTSD
4. Compare and contrast various therapy modalities recommended for trauma management
5. Review medication management options for PTSD
6. Identify available resources for further learning

Part 1 of the Case

Chief Complaint: referral from PCP for low mood in postpartum period

History of Present Illness:
Catori is a 37 year old married, employed Native American female being seen for an intake. She has been referred to psychiatry for assessment in context of her low mood after giving birth two months ago.

Pregnancy: While it was unplanned, both she and her husband desired the pregnancy. She describes having a rough pregnancy with a lot of initial nausea and vomiting followed by a 70 lb weight gain. The pregnancy strained her marriage, and some body image issues had resurfaced for Catori.

Delivery: Though initially reluctant to discuss her experience of labor and delivery, she eventually described a significant complication that was traumatic for her. Labor stopped progressing, and she had to undergo a C-Section for which she was unprepared. When the he possibility had been raised earlier she had refused as she was worried about needing pain medication after. Per Catori, the scar split open after her C-Section and the wound got infected. She was afraid to go on pain medication due to her history of opioid use disorder with multiple years of sobriety and opted to stay on NSAIDS. This resulted in a prolonged recovery as well as pain with moving. Meanwhile the baby was in the ICU for "some breathing issue." She discusses being "terrified" and feeling like a failure. Says "if I weren't so fat, none of this would have happened and my baby would have been fine."

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Postpartum: The baby is currently 2 months old and may have residual deficits and possible Cerebral Palsy. Catori is trying to go back to work for financial reasons, but she is having difficulty concentrating. She is unable to stay at work the whole day, worrying something might have happened to her baby. Her manager has been flexible finding her things she can do from home, but Catori worries this support will not last long. She finds it difficult to be at her desk as she feels "jumpy", noting that when co-workers put a hand on her chair she starts "freaking out", becoming overwhelmed with a sense of dread and panic. She reports intrusive thoughts about the day of the birth, noting "most moms love to tell their birth story, but I cry when someone asks about it." She reports she doesn't feel like herself anymore. She finds it hard to do dressing changes on her wound, which is still healing. She reports feeling her emotions are more numbed. She also reports feeling restless and tense.

She has had her mother-in-law move in to the house to help with the kids and housework. She alludes to increased tension between herself and her husband but is quite reluctant to discuss details when probed.

Mental Status Exam:
Adult Native American women, obese, with good hygiene and casual attire. Makes fair eye contact, is tearful at times, with mild psychomotor slowing. No tics, tremors, or other abnormal movements noted. Mood is "not good". Affect is congruent, dysthymic, reactive with a restricted range. Speech is somewhat monotonous with normal rate/volume/prosody. Thought process is logical, linear, and goal-directed. There is no evident suicidal or homicidal ideation, intent, or plan. No evidence of delusions, obsessions, or compulsions. Does not appear to be responding to internal stimuli. Is alert and fully oriented, with normal recent and remote memory, attention, and concentration as per responses to interview. Insight and judgment are fair. Gait is normal.

Discussion Questions

1. What is your differential diagnosis?

2. What additional information would you like?

Past Psych History
Suicide attempt: Age 24 via overdose describes it as "I wanted to escape I'm not sure I wanted to die"

Hospitalizations: 2 admissions to inpatient rehab
Medications: Has been on Methadone in the past. She was also tried on Wellbutrin- "I think it worked", unsure why this was discontinued

Therapy: Substance use groups in the past, none for several years

Family Hx:
Diagnosis: positive for depression, anxiety on both sides of the family. Reports her mom has finally started seeking help from the services available on the reservation and has been diagnosed with MDD. Mother is currently on Prozac.

Suicide: Maternal Uncle died by suicide. Two cousins died by overdose- she thinks these were intentional.

Substance Use: Describes significant alcohol and marijuana use on both sides of the family in immediate and extended family members. Her father had a severe alcohol use disorder and died from liver cirrhosis.

Substance Use Hx:
Started at age of 14 with THC and alcohol. Denies any history of heavy marijuana or alcohol use.

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Identifies heroin as her substance of choice- Started using heroin at age 16, last use age 25. Initially with intranasal use, then used IV heroin (up to 8 bags/day). Reports medication, individual and group therapy combo was vital in staying sober. Continues to attend NA groups when she can.
No tobacco or any other substance use.
Caffeine: 3 cups of coffee and 2 cans of soda daily.

Medical History:
BMI 32
PCOS
Hx of concussion and broken ribs at the age of 20 (assaulted by boyfriend)
Denies hx of seizures.
Currently breastfeeding

Labs:
CBC, CMP are WNL
TSH status unknown
Vitamin D level 25.3

OBGYN:
Two normal vaginal deliveries, 1 C-section
Contraception : Her initial plan had been an IUD for birth control however, the idea of having another procedure albeit a minor one has been terrifying to her. No current contraception.

Allergies: Sulfa Medications

Social Hx: She works a desk job and her husband is a bouncer at a strip club. They have two daughters, ages 9 and 6. There are no guns at home. She graduated HS.

Legal Hx: Has filed a restraining order against an ex-boyfriend who assaulted her at age 20. Patient has no past/current legal charges and no history of incarceration/involvement with legal system otherwise.

Discussion Questions

1. What are Catori's identifiable risk factors for her primary diagnosis?

2. What would you propose as a treatment plan? (Consider all aspects of the biopsychosocial model.)

Part 2 of Case: Second Appointment- 3 months later

Catori returns to you now 5 months postpartum. In the last 3 months she has been started on an SSRI and you have helped with getting FMLA as well as using local resources (MomBabyCare, a free service where an RN visits the home to help with teaching basic baby care) As per your initial plan, the goal was to stabilize her using medications to get her to the point of being able engage in some form of therapy.

Catori shares more about her personal life this visit. She grew up on the Navajo reservation in abject poverty and describes a childhood exposed to addiction, suicide, mental illness, and sexual violence. She has three brothers and four sisters; most of them continue to live on the reservation. She has left the reservation and lives in a city one hour away from it. She felt she needed to leave as she couldn't succeed with gaining sobriety while at the reservation but notes that this was a difficult decision. She has a good relationship with her mom and feels her mom "did the best she could" with being protective of her. Her father died from cirrhosis. She remembers him as "an angry drunk".

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She describes a long history of being sexually abused by her uncle. In her childhood, he would come into her room at night when he was intoxicated and rape her, telling her he would kill her if she ever told anyone. She also had a series of physically and sexually abusive relationships as a teen and young adult.

Her husband is Caucasian. They met 10 years ago and got married within a year of meeting. She is currently dependent on him financially. She states that "he has a temper". She describes one incident where he got very upset and she felt reminded of her previous boyfriends. This occurred a few weeks before her second visit, and since then she has noticed she has episodes of hyperventilation, sweating, heart racing and chest pressure. She thinks something maybe wrong with her heart. She often wakes up in the middle of the night after a horrific dream and experiences the symptoms described above.

Discussion Questions

1. How would you go about discussing intimate partner violence (IPV) with the patient?

2. How do you incorporate your suspicion of IPV into your treatment plan?

3. What are different therapy modalities you would consider for this patient?

4. What medication options are there for her current panic attacks and nightmares?

Part 3 of Case- 6 Months Later

Catori has noted a reduction in PTSD symptoms and panic attacks since engaging in EMDR and taking Lexapro (escitalopram). Over the last 1-2 months she has no longer required PRN propranolol. She is no longer experiencing nightmares.

She has also been working on assertiveness in therapy and is better able to communicate with her husband. She has returned to work fulltime, relieving much of the financial strain on her family. Her daughter is coming up on her first birthday. While she doesn't have cerebral palsy, she is still under routine monitoring for seizures.
Catori is planning to go to the reservation for a month as her mother has fallen quite ill. She is concerned about reemergence of symptoms when surrounded by the setting of her earlier trauma. She tried to find a therapist there but can't get in on short notice. She is worried her symptoms may return if she is not engaged in therapy.

Discussion Questions

1. How would you counsel the patient on symptom management?

2. What resources would you recommend while she is away?

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Resources

- International Society for Traumatic Stress Studies (ISTSS)
- International Society for the Study of Trauma and Dissociation (ISSTD)
- National Center for PTSD (https://www.ptsd.va.gov/)

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