Episode 048: The Unspeakable Mind: Stories of Trauma and Healing from the Frontline of PTSD Science

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There are no conflicts of interest for this episode.

On today's episode of the podcast, I am interviewing Dr. Shaili Jain. We cover Dr. Jain's personal interest in PTSD work, moral injury, causes of PTSD, presentation of PTSD and treatment modalities for PTSD.

An overview of PTSD

PTSD, or Post Traumatic Stress Disorder, occurs when someone experiences, or subjectively experiences, a near death or psychologically overwhelming event, and then goes on to develop specific symptoms because of it. Different types of trauma/stressors that can lead to PTSD include sexual violence, combat experience, medical conditions (e.g. myocardial infarction), and natural disasters (e.g. hurricane) (Chivers-Wilson, 2006; Edmondson et. al, 2012; Grieger et al., 2006; Hussain, Weisaeth & Heir, 2011).

It is characterized by:

- Direct exposure or witnessing of trauma/stressor
- Presence of intrusive symptoms post-traumatic experience
- Avoidance of traumatic stimuli
- Negative changes in mood and cognition
- Hyper-reactivity
- Hyper-arousal (APA, 2013).

Here are a few stats about PTSD:

- In 2017, over 47,000 Americans died by suicide (CDC, 2019). This number has been climbing about 1,000 new cases per year from 31,000 American deaths by suicide in 2000 (CDC, 2019). One contributor to this statistic are people with

Post-traumatic stress disorder (PTSD), who are at increased risk of suicide (Wilcox, Storr & Breslau, 2009).

- The lifetime prevalence of PTSD in the general population of the US was found to be 6.1% in one national epidemiological study of certain populations at higher risk for PTSD (e.g. female sex, low socioeconomic status, previously married status, experienced trauma at a young age, African Americans, Native Americans, refugees or immigrants from countries with conflicts) (Alegría et al., 2013; Brewin, Andrews & Valentine, 2000; Goldstein et al., 2017; Kisely et al., 2017; Marshall, Schell, Elliott, Berthold & Chun, 2005).

Symptoms and Diagnosis of PTSD

Certain symptoms of PTSD, like negative changes in mood and cognition, can be associated with other conditions, like anxiety, depression, and borderline personality disorder. Using screening tools like PCL-5 can help delineate PTSD from other conditions, although they can come with false positives (more people who are labeled as having PTSD than actually have it). Experienced clinicians can correctly diagnose through detailed history taking. Diagnosing PTSD begins with listening for a history of major trauma, which can take many forms. The patient will usually describe that they felt their sense of normalcy was shattered, and that they felt totally helpless in the face of that traumatic event.

During the first 4 weeks after the trauma, the impact of the trauma should be noted, and the duration of the symptoms should also be observed. The diagnosis of PTSD involves a disturbance of > 1 month with characteristic symptoms such as intrusive nightmares, flashbacks, memories, hypervigilance (APA, 2013). Subtle signs to look for are the patient's mood states such as shame, guilt, anger, fear, horror, which are particular for PTSD (Hendin & Haas, 1991).

These patients also show a restricted range of emotion (they never show pure happiness, anger or sorrow). Avoidance is another key characteristic of patients with PTSD as they avoid places, people and memories associated with the traumatic event.

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This avoidance behavior is particularly tricky to deal with as some patients never make it to see a mental health professional.

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Complex PTSD

Complex PTSD is a subtype of PTSD with complex symptomatology in response to chronic trauma (Herman, 1992). Usually, the patient has an extensive history of childhood abuse where the patient can't remember a time when they weren't being abused. Another example of chronic trauma includes victims of long-term intimate partner violence. In comparison with textbook patients with PTSD, who have a distinct life before and after their traumatic experience, patients with complex PTSD are only familiar with the traumatic experience.

Patients with complex PTSD have issues with emotional regulation, and can range from rageful to regretful in a single session, much like patients with borderline personality disorder. Patients with complex PTSD often get caught up in cycles of re-enactment where they act out in their personal relationships, and even in their therapeutic relationships, in ways that mimic the trauma that they've felt. In Dr. Jain's experience, although patients with complex PTSD exhibit emotional lability, just like borderline personality disorder, she would think a diagnosis would lean more towards borderline personality disorder if the classic symptoms (such as identity issues, self-injury, chronic suicidality and attachment issues) were present (APA 2013).

Dissociative PTSD

Dissociative PTSD is a subtype of PTSD that occurs in 15-30% of PTSD patients, in which the patient not only meets the criteria for PTSD, but also exhibit persistent dissociative symptoms (e.g. depersonalization, derealization) (APA, 2013; Armour, Karstoft & Richardson, 2014).

Derealization is the feeling of detachment from one's environment, while depersonalization is the feeling of detachment from one's body, thoughts, perceptions

and actions (APA, 2013). Patients often describe the feelings of depersonalization and derealization as “they don’t feel real,” or that “the world around them doesn’t feel real.”

Because patients with the dissociative subtype of PTSD experience these symptoms persistently, their day is often derailed as they don’t live in the present, but in their dissociative world. Patients who have had severe childhood abuse tend to have the dissociative subtype, which is associated with a poorer prognosis. Patients can dissociate in many environments, including the therapy environment, thus grounding techniques such as breathing techniques and anxiety-reducing exercises may be useful to bring patients from their dissociative state.

PTSD Treatments

Therapy and PTSD

The gold-standard treatment for PTSD is psychotherapy, with an emphasis on a strong therapeutic alliance. In her book, Jain Shaili talks about the importance of the story being given a voice. Many times when someone experiences trauma, it has violated the heart of what they find to be sacred and true, and the effects can be that they have experienced things they find completely unspeakable.

When memories remain unspeakable, even unthinkable, they become sticking points that prevent the brain, and person, from being able to move on. Because of this, many people with PTSD are difficult to reach, emotionally. It’s built into the nature of the disorder that they can be avoidant, don’t want to address the trauma, and are often mistrustful.

As a result of this psychosocial stress, patients with PTSD experience many negative emotions such as guilt, shame and remorse as well as increased suicidality (Hendin & Haas, 1991). PTSD thrives when patients hold it in, rather than talking about it, so an important part of treatment is to establish a therapeutic alliance so that the patient feels comfortable sharing their traumatic experience. Another important factor that contributes

to healing is connecting the patient's spiritual beliefs to their moral injury (Currier, Holland & Drescher, 2015).

The Search for Meaning

In the face of trauma, there are some that show resilience by making meaning out of the trauma and catapulting their lives into a direction where trauma is integrated into their lives rather than directing it.

Although not everyone is fortunate enough to arrive at that place by themselves, trauma-focused psychotherapy can add new learning, adjust maladaptive beliefs and help patients re-evaluate their trauma and its impact on their lives so that they can move forward meaningfully.

Medications for PTSD:

- SSRIs/SNRIs
    - The most well-studied medication class used to treat PTSD and are 1st line due to favourable adverse effect profiles (Asnis, Kohn, Henderson & Brown, 2004).
    - Sertraline and paroxetine are also both FDA-approved for the treatment of PTSD (Asnis, Kohn, Henderson & Brown, 2004). However, in practice, SSRIs and SNRIs are pretty much equivalent, so tailor fit the medication according to the patients needs. For example, many patients with PTSD have chronic pain, so Venlafaxine (Effexor®) would be a good choice.
    - Fluoxetine, paroxetine, and sertraline have been found to reduce hypervigilance, emotional numbing, and intrusion levels in clinical trials of over 3,000 participants with PTSD with over 60% of participants seeing a reduction in their symptoms (Kapfhammer, 2014). Many patients with PTSD are mistrustful of medication, so developing a good relationship with the patient through the therapeutic alliance can help convince patients that medications and medication adherence are in their best interest. With a

strong therapeutic alliance and good medication management, that 60% can be even higher.

- Mirtazapine
    - Can be used to treat insomnia at lower doses (7.5 mg - 15 mg). Has antidepressant effects at higher doses.
    - We try to avoid polypharmacy. If treating PTSD with medications, only starts with 1 medication at a low dose and see how that works. Patients that suffer from insomnia can improve dramatically after a few weeks of good sleep from such a medication as mirtazapine.
    - For insomnia, Dr. Jain prefers to use non-pharmacological therapy like Cognitive Behavioral Therapy for Insomnia (CBTI) and only uses medication for the short term to get them to the point where therapy like CBTI can treat the root cause of their insomnia.
- Mood stabilizers
    - Once again, the general approach is to put the patient on SSRIs/SNRIs at a lower dose and move up the dose as needed.
    - In patients that have issues with hostility, aggression, harm to self and don't improve on SSRIs/SNRIs, we would consider mood stabilizers as a possible treatment.
- Second generation antipsychotics
    - Used to be popular in the past to give a low dose for patients with PTSD that exhibited hostility and aggression. Unfortunately, risperidone was shown to not be an effective treatment for PTSD and came with many worrying side effects (e.g. metabolic syndrome, fatigue, sleepiness) (Krystal et al., 2011) .
- Benzodiazepines
    - In the past, patients with PTSD used to be put on benzodiazepines, but it is now known that benzodiazepines are just a band aid rather than a true treatment for PTSD with especially concerning side-effects in the elderly population (i.e. increased risk fall and impaired cognition) (Cumming & Le Conteur, 2003).
    - In 2012, a study involving over 10,000 patients who were prescribed benzodiazepines were found to have 50% increased mortality with long-term use (Kripke, Langer & Kline, 2012).

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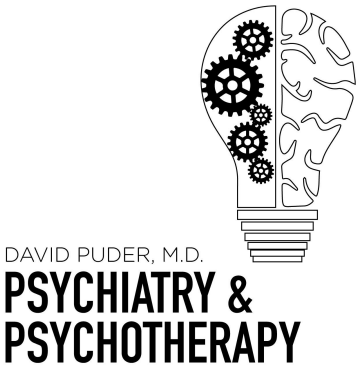

    - Dr. Jain would only prescribe very-short term prescriptions (5 day supply) for emergencies like horrific flashbacks and dissociative events.
    - PTSD and addiction go hand in hand due to the addictive nature of benzodiazepines, so education is important in teaching patients that there are serious side-effects associated with benzodiazepines (e.g. impairment in cognition and increased fall risk in the elderly) and that other treatment modalities can be helpful in managing their PTSD.
- Marijuana
    - Although there are many strong personal testimonies and anecdotes concerning the efficacy of marijuana in alleviating the various symptoms of PTSD, there were no high quality randomized clinical trials as of 2016 that have looked at the efficacy of marijuana for PTSD (Wilkinson, Radhakrishnan & D'Souza, 2016).
    - There are clinical trials underway (one in a VA in Arizona) testing CBD for PTSD.
    - 3 things worry about marijuana usage in patients with PTSD

1. Adverse interactions between psych meds and marijuana are currently unknown and can be dangerous as patients are often taking both their medications and marijuana.
2. Marijuana impairs driving, attention, memory, IQ, and increases rate of psychosis. View my prior blog, Youtube and podcast on Marijuana: here

- Ketamine and MDMA
    - There are currently ongoing studies in the VA, but it's still too early to tell without seeing the data.

I would highly recommend checking out Dr. Jain's book:

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Here are several of my prior episodes on PTSD:

How to Help Patients With Sexual Abuse

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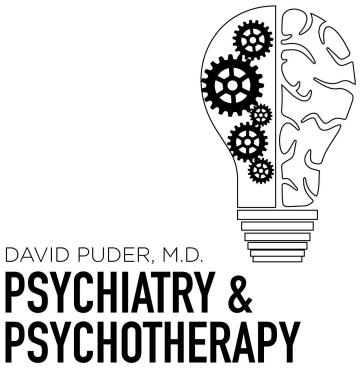

How to Treat Emotional Trauma

Emotional Shutdown—Understanding Polyvagal Theory