CHAPTER 9
TRAUMA AND POST-TRAUMATIC STRESS DISORDER IN PATIENTS WITH HIV/AIDS

Exposure to a traumatic event is normally accompanied by distress. For most individuals such distress resolves spontaneously without the onset of any psychiatric illness. Among a subset of people, the type, severity, and duration of symptoms that develop following trauma will meet criteria for either acute stress disorder (ASD) or post-traumatic stress disorder (PTSD).

ASD is not as well studied as PTSD. Some trauma researchers feel ASD is on a continuum with PTSD and that the cut-off times for the two disorders are arbitrary. Therefore, a more detailed description of trauma and its treatment is provided in Section I: *Post-Traumatic Stress Disorder*.

Trauma can affect both psychological and physical functioning. Some research has suggested that the physical effects of trauma have been related to significant health problems, such as diminished functioning of the immune system and increased susceptibility to infections. The psychological effects of PTSD may manifest in increased risk-taking behavior, such as substance use, poor eating habits, or unsafe sexual activity. In addition, patients with PTSD may suffer from depression, social isolation, impairments in trust and attachments, and feelings of anger. Patients with HIV/AIDS may be affected by past trauma to the point that it manifests in problems with disease management, such as disrupted or negative interactions with medical personnel and/or medication non-adherence.

> **Key Point:**
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> Exposure to traumatic events can lead to increased risk-taking behavior, including substance use, unsafe sexual practices, and difficulty forming therapeutic relationships with medical personnel.

I. POST-TRAUMATIC STRESS DISORDER (PTSD)

PTSD can result from a single traumatic event, such as a car accident, rape, or experience of a natural disaster, or from an ongoing pattern of traumatic experiences, such as childhood abuse (physical and/or sexual), domestic violence, homelessness, or severe chronic illness. Because the psychological symptoms that commonly occur following a traumatic event will remit spontaneously over time for most people, some researchers conceptualize PTSD as a disorder of recovery.

Key Point:

The likelihood of a patient developing PTSD varies according to the vulnerability of the affected person and the severity of the stressor.

A history of previous traumatic experiences increases a person's vulnerability to developing PTSD upon exposure to a new trauma because previous traumatic experiences may impair his/her ability to handle future stressors. The more severe the trauma is, the greater the likelihood will be that the patient will develop PTSD.

The rate of PTSD following exposure to a particular trauma ranges from 12% to 70%, with the higher rates occurring in populations exposed to traumas that involve interpersonal violence (e.g., rape, sexual abuse, torture). Women have higher rates of PTSD than men. Among women, sexual assault is the most common precipitating trauma, whereas among men, the most common trauma is combat exposure.

Although PTSD has a lifetime prevalence rate of approximately 1.3% to 7.8% in the general population, the rates of PTSD in the HIV-infected population are higher. Among a national probability sample of 1489 patients with known HIV infection who received medical care in 1996, 10.4% were diagnosed with PTSD.[1] Although onset of a severe, life-threatening illness (such as HIV/AIDS) can sometimes in itself be a traumatic experience leading to PTSD, more often a history of physical or psychological trauma (and diagnosis of PTSD) co-occurs with an individual's HIV status. Among people with the most severe mental illnesses, specifically schizophrenia, schizoaffective disorder, and bipolar disorder, comorbid PTSD is an important predictor of HIV infection.[2]

A. Presentation

Patients with PTSD may show a variety of symptoms, which must persist for more than 1 month to meet the criteria for PTSD. The symptoms may be straightforward or may vacillate between overwhelming emotions caused by memories of the event and emotional numbness and dissociation. Dissociation is a disruption in the ordinary integration of consciousness, memory, or identity. It can present as flashbacks, depersonalization, derealization, and/or episodes of lost time.

B. Diagnosis

RECOMMENDATIONS:

The primary care clinician should screen for PTSD annually or more often as clinically indicated.

Clinicians should use the criteria listed in the DSM-IV for a diagnosis of PTSD in patients with HIV/AIDS (see Table 9-1)**.**

Clinicians should screen patients with PTSD or significant trauma histories for clinical depression, anxiety disorders, or alcohol or other substance use disorders.

Key Point:

Patients with PTSD may have dissociative symptoms, which may be mistaken for HIV-related dementia or other HIV-related neuropsychiatric disorders.

In patients with a history of traumatic experience, it is important to assess for the presence of PTSD by asking about the experience of the trauma and reviewing the symptoms. PTSD is diagnosed when symptoms have been present for more than 1 month and an individual meets the other criteria listed in Table 9-1.

C. Management of Survivors of Trauma

RECOMMENDATIONS:

Clinicians should refer patients with symptoms of PTSD to a mental health professional as soon as possible for evaluation for psychotherapy or other forms of psychiatric treatment. The goal of treatment should be to reduce symptoms and fully reintegrate a safe sense of self.

If specialized services are unavailable, the primary care clinician should prescribe medications (see Appendix I) **and monitor the degree of improvement achieved with this strategy alone.**

During the acute phase of treatment, clinicians should assess the patient's risk for harm to him/herself or others.

Some patients respond to medication and brief supportive interventions; most require psychotherapy and specialized mental health intervention. However, if such services are not available, the primary care clinician should prescribe medication and monitor the degree of improvement achieved with this strategy alone.

There is no single medication that treats all of the symptoms of PTSD. Currently, sertraline and paroxetine are the only FDA-approved medications for PTSD. Paroxetine should be avoided in patients less than 18 years old because of its possible association with increased suicide risk. All SSRIs (in the same doses used for depression) are helpful in treating symptoms of depression and anxiety. Moreover, controlled and open studies of various SSRIs as well as other classes of antidepressants have shown benefit in treating PTSD symptoms. Open trial studies of mood stabilizers have also shown some benefits. Long-term benzodiazepine use is not a preferred treatment. If benzodiazepines are prescribed, careful monitoring is required due to the potential for abuse and concerns about disinhibition in those with significant dissociative symptoms.

TABLE 9-1
DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death, serious injury, or a threat to the physical integrity of self or others
2. The person's response involved intense fear, helplessness, or horror

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions
2. Recurrent distressing dreams of the event
3. Acting or feeling as if the traumatic event were recurring (e.g., a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated)
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
5. Physiological reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hypervigilance
5. Exaggerated startle response

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

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

Key Point:

Although patients with PTSD may seek help for associated somatic symptoms, they may perceive medical intervention as intrusive and thus re-traumatizing.

Empirically validated psychotherapy treatments include exposure therapy, anxiety management programs, and cognitive therapy. These treatments modify fear and false cognitions created in response to single or multiple traumas and improve coping skills in the face of new stressors. Treatment is offered through individual and group modalities. Several studies show that psychodynamic treatments can also be helpful. Early evidence supports concurrent treatment of PTSD and addiction.

II. Acute Stress Disorder (ASD)

Recommendation:

For patients who meet the criteria for ASD, clinicians should follow the same guidelines as those recommended for management of PTSD (see Section I. C: *Management of Survivors of Trauma*)**.**

Many of the symptoms of ASD (Table 9-2) overlap with those of PTSD. ASD defines a severe stress response that follows shortly after a traumatic event, whereas PTSD cannot be diagnosed until symptoms have persisted for 30 days or longer. The presence of full or partial ASD is associated with an increased risk of developing PTSD. In various studies, the presence of numbing, depersonalization, a sense of reliving the trauma, motor restlessness, and peri-traumatic dissociation were found to predict progression to PTSD.[3] These associations raise the possibility that effective early treatment of trauma symptoms can be a useful strategy in the prevention of PTSD. However, it should be noted that many trauma survivors who develop PTSD do not have initial ASD symptoms, and many individuals with ASD will not develop PTSD.

TABLE 9-2
DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER

A. The person has been exposed to a traumatic event in which both of the following were present:

1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death, serious injury, or a threat to the physical integrity of self or others
2. The person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

1. A subjective sense of numbing, detachment, or absence of emotional responsiveness
2. A reduction in awareness of his/her surroundings (e.g., "being in a daze")
3. Derealization
4. Depersonalization
5. Dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently re-experienced in at least one of the following ways:

Recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people)

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness)

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by brief psychotic disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder

REFERENCES

1. Vitiello B, Burnam MA, Bing EG, et al. Use of psychotropic medications among HIV-infected patients in The United States. *Am J Psychiatry* 2003;160:547-554.
2. Essock SM, Dowden S, Constatine NT, et al. Risk factors for HIV, hepatitis B, hepatitis C among persons with severe mental illness. *Psychiatric Services* 2003;54:836-841.
3. Harvey AG, Bryant RA. The relationship between acute stress disorder and post-traumatic stress disorder: A prospective evaluation of motor vehicle accident survivors. *J Consult Clin Psychol* 1998;66:507-512.

FURTHER READING

Yeduda R (ed). *Treating Trauma Survivors With PTSD*. American Psychiatric Publishing Inc, Washington DC, 2002.