PTSD IN PRIMARY CARE

MICHELE BEDARD-GILLIGAN, PH.D.
ASSISTANT PROFESSOR
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES
UNIVERSITY OF WASHINGTON
GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.
SPEAKER DISCLOSURES

✓ No conflicts of interest
OBJECTIVES

1. Scope and Impact of Trauma Exposure
2. What is Trauma-Informed Care?
3. Current state of the research on PTSD treatment
4. PTSD treatment in primary care settings
5. When and how to refer out to specialty care
DSM-5 STRESSOR CRITERION

- Exposure to actual or threatened death, serious injury, or sexual violence:
  - Directly
  - Witnessed in person
  - Learning the event(s) occurred to close friend or family member. Actual or threatened death - event must have been violent or accidental.
- Repeated or extreme exposure to aversive details of traumatic event
**Post Traumatic Stress Disorder (PTSD)**

- **Intrusions (1)**
  - Flashbacks
  - Distressing involuntary memories
  - Nightmares
  - Physiological reactivity
  - Psychological distress at reminders

- **Avoidance (1)**
  - Thoughts, feelings, & conversations
  - Activities/Places/People

- **Cognitions and mood (2)**
  - Amnesia
  - Distorted blame of self or others
  - Negative trauma-related emotions
  - Loss of interest
  - Emotional detachment
  - Constricted affect

- **Arousal (2)**
  - Sleep difficulties
  - Hypervigilance
  - Irritable/aggressive behavior
  - Self-destructive/reckless
  - Startle
  - Concentration

**DSM V**
EXPOSURE TO TRAUMATIC EVENTS IS RELATIVELY COMMON.

39% - 90% of Americans endorse lifetime traumatic stress exposure

20% endorse current (past year) exposure

50% of people exposed to one event have multiple incident exposures.
Course of PTSD

- 40% of people with PTSD recover within the first year after trauma exposure
- 1/3 to 1/2 of those with PTSD do not recover, even after many years
- Duration of PTSD varies according to severity of traumatic stress exposure
- Duration of symptoms is shorter for survivors who obtain treatment (36 vs. 64 months)
• More likely to seek treatment from a PCP or medical specialist then from a mental health provider

• 6-25% of primary care clinic (PCC) patients suffer from PTSD

• Only 11% of primary care patients with PTSD had the diagnosis listed in their medical charts
TRAUMA INFORMED CARE

“A philosophical/cultural stance that integrates awareness and understanding of trauma”

• May or may not include Trauma-Specific Services
• Refers to awareness and sensitivity of healthcare system and providers to effects of trauma on patients

Hopper et al., 2010
Trauma-Informed Care

- Can be implemented in any setting or organization
- Not specifically designed to treat symptoms related to trauma
- Addresses vicarious traumatization, self-care, and potential trauma history of staff

Harris & Fallot, 2001
PC-PTSD
YES TO 3 ITEMS IS A POSITIVE SCREEN

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you*

1. Have had nightmares about it or thought about it when you did not want to? YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? YES NO
3. Were constantly on guard, watchful, or easily startled? YES NO
4. Felt numb or detached from others, activities, or your surroundings? YES NO
THERE IS A RELATIVE PAUCITY OF RESEARCH ON TREATMENT OF PTSD IN PRIMARY CARE SETTINGS.

What is known more broadly about treatment of PTSD?
Drug treatments for adults
• Should not be used as a routine first-line treatment for adults in preference to a trauma-focused psychological therapy.

Trauma-focused psychological treatment
• Trauma-focused CBT or EMDR should be offered to those with severe post-traumatic symptoms.
• Individual outpatient format
• Duration normally 8–12 sessions.
• Non-trauma-focused interventions (e.g., relaxation, non-directive therapy) not indicated for chronic PTSD
## Psychiatric Medication Management

<table>
<thead>
<tr>
<th>Significant Benefit</th>
<th>Some Benefit</th>
<th>Unknown</th>
<th>No Benefit/harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>• SSRIs – 1st line agents</td>
<td>• Sympatholytics&lt;br&gt;• Prazosin&lt;br&gt;• Propranolol&lt;br&gt;• Novel Antidepressants&lt;br&gt;• Atypical antipsychotics&lt;br&gt;• Bupropion, Venlafaxine, Mirtazapine, Trazadone</td>
<td>• Anticonvulsants&lt;br&gt;• Buspirone&lt;br&gt;• Non-benzo hypnotic</td>
<td>• Benzodiazepines&lt;br&gt;• Typical antipsychotics</td>
</tr>
</tbody>
</table>
EVIDENCE-BASED PSYCHOTHERAPIES FOR PTSD IN ADULTS

Significant Benefit
- Exposure Therapy*
- Cognitive Processing Therapy*
- EMDR
- Cognitive Therapy
- Present Centered Therapy

Some Benefit
- Anxiety/Symptom Management
- Supportive Therapy
- Psychodynamic Therapy
- IPT

Emerging Evidence
- Acceptance and Commitment Therapy
- Behavioral Activation
COMMONALITIES ACROSS EFFECTIVE PTSD PSYCHOTHERAPIES

- Imaginal Exposure
- In Vivo Exposure
- Cognitive Reprocessing around the meaning and implications of the event
PTSD Treatment Outcome

The graph shows the PTSD treatment outcome over time for three different treatments: CPT, PE, and MA. The y-axis represents the PTSD symptom severity scale, while the x-axis indicates time points: Pretx, Posttx, 3 mos, and 9 mos.

- **CPT**: This line starts at a high severity level at Pretx and shows a significant improvement post-treatment (Posttx). The severity remains low at 3 mos and 9 mos.
- **PE**: This line also starts at a high severity level at Pretx. Post-treatment, the severity shows a notable decrease but remains moderate at 3 mos and 9 mos.
- **MA**: This line begins at a moderate severity level at Pretx. Post-treatment, there is a slight decrease, and the severity remains relatively stable at 3 mos and 9 mos.

Overall, CPT appears to be the most effective treatment based on the observed reductions in PTSD symptoms.
CPT & PE ITT ON PTSD DIAGNOSIS AT PRE-TREATMENT AND LONG TERM

- CPT (n=63)
- PE (n=64)
Exposure therapy – administered by rape crisis counselors
Cognitive therapy – administered by lay counselors in Iraq & DRC

In northern Iraq therapists were nested within health clinics and provided non-mental health services as well

In DRC clinical supervisors were all RN’s

Both have been rolled-out successfully at VA’s across the US in specialty care
PTSD responds very well to specific types of psychotherapy
The effects last up to 5-10 years post-treatment
Can be administered successfully by non-specialists

BUT

These treatments typically take 9-15 sessions to complete
Take time to learn to do well
CONSIDERATIONS FOR INTERVENING IN PTSD IN PRIMARY CARE SETTINGS

• Briefer interventions are better accepted by patients and providers

• Co-located collaborative care may be helpful, provides immediate access to behavioral health provider

• Time-limited, problem-focused, & solution focused interventions

• In some settings referral to specialty care may be difficult because of a lack of access to trained specialty care providers
PTSD IN PRIMARY CARE
WHAT DO WE KNOW BASED ON THE RCT’S?

• Five RCTs in primary care
  • Psychoeducation, collaborative care are main components

• Emerging evidence suggests:
  • Findings around collaborative models are more mixed.
  • Most primary care interventions leave out the effective elements from evidence-based psychotherapies for PTSD.
    • Little exposure or trauma-focused cognitive restructuring
    • Focus on psychoeducation, support, and medications
WHAT STRATEGIES ARE AVAILABLE FOR MANAGING PTSD IN PRIMARY CARE?

Collaborative care has some evidence it is effective

- Use of regular monitoring of symptoms and changing interventions based on treatment response
- Providing psychoeducation about PTSD symptoms
- Telepsychology/telepsychiatry

Use of CBT skills in primary care settings

- May want to use auxiliary tools to help with addressing PTSD
  - Websites (http://www.ptsd.va.gov/PTSD/apps/ptsdcoachonline/default.htm)
  - Smartphone apps (PTSDCoach)
- Interventions like behavioral activation have some promise
WHEN TO REFER TO A HIGHER LEVEL OF CARE?

• More severe symptom presentation
• Treatment non-response
• Multiple complex comorbidities
• Safety concerns
• Client is motivated!
REFERRALS

Seattle area (PE and/or CPT)

- HCSATS (206-744-1600)
  - Seattle, Bellevue, Redmond, Shoreline
- UW Outpatient Psychiatry (206-598-7792)
- Evidence-Based Treatment Center (206-374-0109)

Skagit county (CETA)    Yakima county (PE and CPT)

- Mt. Vernon Compass Health    Yakima Comprehensive Health

Snohomish (CETA)

- Seamar
- Compass
OTHER RESOURCES

• International Society for Traumatic Stress Studies
  • www.istss.org
  • Multidisciplinary community of practitioners and researchers
  • CEU’s, webinars, conferences

• National Centers for PTSD
  • www.ptsd.org
  • Videos, assessment materials, tutorials
Thank you!