PTSD (and Pain) for the PCP: How to Diagnose and Behavioral How To’s

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

None
OBJECTIVES

1. Be able to quickly screen for PTSD
2. Understand the relationship between chronic pain and PTSD
3. Describe some brief behavioral strategies to help patients with PTSD
COMMON CASE PRESENTATIONS

Angry patient

- 75 y/o mixed race female, hx of DV and sexual abuse
- Hx of severe scoliosis
- Meds: morphine, gabapentin...
- Extremely tearful, terse, frequent visits

Differential diagnoses

- Chronic pain and dissatisfaction from care
- Medication seeking
- Generalized anxiety
- Somatization
I’m “Fine,” but nothing is getting better

- 43 y/o African American female, childhood abuse, DV, MVA
- Bilateral hip pain, generalized and cervical pain
- Meds: gabapentin, sertraline, cyclobenzaprine
- Pleasant, but doesn’t improve much, even after multiple pain self management therapy visits

Differential diagnoses

- Unmotivated / disengaged patient
- Depression
- Hit the ceiling on improvement
## DOES TRAUMA ALWAYS CAUSE PTSD?

Most people *do not* get PTSD as a result of trauma. 70-90% of people report having had at least one traumatic experience.

(Breslau, 2002; Kessler et al., 1995; McCall-Hosenfeld, Mukhergee, & Lehman, 2014; Goldstein et al., 2016; Kisely et al., 2017)

<table>
<thead>
<tr>
<th><strong>NCS-R (2001-03) US lifetime prevalence:</strong></th>
<th><strong>National Epidemiologic Survey on Alcohol and Related Conditions – III (2012-13):</strong></th>
<th><strong>Among Vets lifetime prevalence:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• 6.8% of all adults;</td>
<td>• 4.7 and 6.1 %, higher for female, White, Native American, younger, those with &lt; high school education and lower incomes, and rural residents</td>
<td>• Vietnam War: 30.9% men, 26.9% women</td>
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<tr>
<td>• 3.6% men, 9.7% women</td>
<td>• 59.4 % sought treatment</td>
<td>• Gulf War: 10.1%</td>
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<tr>
<td>• No diff in rural/urban</td>
<td></td>
<td>• OEF/OIF (2008, 2009): prevalence 13.8 – 68.2%</td>
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<td>• Higher among indigenous people</td>
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SCREEN FOR IT:
PRIMARY CARE PTSD SCREEN (PC-PTSD)

Considered "positive" if a patient answers "yes" to any three items

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, <em>in the past month</em>, you...</td>
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<tr>
<td>Had nightmares about it or thought about it when you did not want to?</td>
<td></td>
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<tr>
<td>Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?</td>
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<tr>
<td>Were constantly on guard, watchful, or easily startled?</td>
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<tr>
<td>Felt numb or detached from others, activities, or your surroundings?</td>
<td></td>
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http://www.ptsd.va.gov/professional/pages/assessments(pc-ptsd.asp
WHAT IS A TRAUMATIC EVENT?

The person was exposed to:
dead, threatened
dead, actual or
threatened
serious injury, or
actual or
threatened sexual
violence, in the
following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that a relative or close
friend was exposed to a trauma
- Indirect exposure to aversive
details of the trauma, usually in
the course of professional
duties (e.g., first responders,
medics)
DIAGNOSING PTSD

- Exposure to trauma
- Re-experiencing
- Hyper-arousal
- Cognitions / Mood
- Avoidance

- Intrusive thoughts
- Nightmares
- Flashbacks
- Physical reactivity to reminders
- Emotional distress at reminders

>1 month
Significant distress or impairment

• Thoughts or feelings
  • Trauma reminders (activities, places, people, conversations, objects, situations)

• Memory loss during trauma
• Negative beliefs – self / world
• Exaggerated self or other blame
• Negative emotions
• Anhedonia
• Detachment / feeling isolated
• Lack of positive emotions

• Irritability & anger
• Risky or destructive behavior
• Hypervigilance
• Startle
• Difficulty concentrating
• Sleep difficulties
How do chronic pain and PTSD overlap?...

<table>
<thead>
<tr>
<th>7-8% (NCS-R) (Beck &amp; Clapp, 2011)</th>
<th>More likely in chronic pain patients with:</th>
</tr>
</thead>
</table>
| Rates likely higher among ethnic minorities (Buchwald et al., 2005) |  • Headache / facial pain  
  • Pelvic pain  
  • Miscellaneous pain  
  • Pain after MVA  
  • Veterans (Fishbain, 2016) |
| PTSD cohort with pain → 20-80% Pain cohort with PTSD → 10-50% (Fishbain, 2016) | Higher pain: |
|                                            |  • more affective distress  
  • more disability |
|                                            | Neuro-biological overlaps to improve tx (Scioli-Salter et al., 2014, 2015) |
|                                            |  • pharmacological approaches that target relevant NPY or GABA  
  • deacetylase inhibitors or exercise  
  • Neuroactive steroid therapeutics |
|                                            | Neg beliefs about self mediated pain interference (Porter et al., 2013) |
PTSD AND CP: STUCK TOGETHER?

- Bosco, Gallinati, & Clark (2013)
  - Integrated treatment model within a Vet population
  - Address avoidance for both pain and PTSD
- Stratton and colleagues (2014)
  - PTSD influences pain symptoms in Vet population
- Andersen, Andersen, & Andersen (2014)
  - Multidisciplinary pain tx no less effective for those with PTSD

PTSD and CP tend to either get worse or better in unison.
TREATING PTSD:
WHAT CAN A PCP DO?
MEASURE IT:
IS TREATMENT WORKING...

• PTSD
  – Use the PCL-C or PCL-5

• Chronic Pain
  – The Cleeland’s Brief Pain Inventory (BPI)
  – Distinguish pain intensity versus interference
    • How much is pain interfering in your life?
    • Pain may not improve → target pain interference
STEPPED APPROACH

- Engagement
- Assessment
- Medications
- Brief Behavioral Interventions
  - Grounding
  - Behavioral Activation
- Referrals for Trauma Focused CBT Psychotherapy

Symptom Measurement (PCL = vital sign)
PTSD PHARMACOTHERAPY: TREAT THE CORE SYMPTOMS – DEPRESSION, ANXIETY, NIGHTMARES

Benzodiazepines (if not avoidable):
• schedule them
• never at the peak of anxiety

SSRI & SNRI to target CORE symptoms
MIRTAZAPINE as an alternative for CORE symptoms
Medicines to treat co-morbid psychiatric conditions
Treatment of residual symptoms

Symptom Tracking: PCL, PHQ-9
EXPLAINING ANXIETY TO PATIENTS...

Management Strategies

- Medications
- Cognitive Training

BRAIN
- Anxious Thoughts

BODY
- Fear

BEHAVIOR
- Avoidance
  - Seeking safety

Relaxation

Exposure

Treatment
TREATING DISSOCIATION THROUGH GROUNDING

Dissociation can become a conditioned response

- Dangerous and dysfunctional for the patient
- Shut down immune functioning

What PCP’s can do:

- Educate
- Use/teach grounding skills – orienting to the present through cuing to date, time, location, safety, physical, etc.
  - Name 5 things you hear, see, feel, smell
USING BEHAVIORAL ACTIVATION TO TREAT AVOIDANCE AND DEPRESSION

Avoidance maintains PTSD symptoms

- Limits functionality
- Reinforces anxiety
- Increases pain interference

What PCP’s can do:

- Encourage behavioral activities to approach rather than avoid to “unlearn” fear and target functionality
- Start with VERY small targets (can be physical or mental), follow-up with patients
# Best Evidence-Based TX's for PTSD

## CBT Therapies
- **PE:** Prolonged Exposure  
  (Foa)
- **CPT:** Cognitive Processing Therapy  
  (Resick)

## EMDR
- Most available in communities
- Some evidence it may work best with hyperarousal symptoms
- Often involves a shorter number of sessions than CBT

## Active Component
- Exposure
- Facing the trauma
- Facing the thoughts
- Facing avoidant behaviors

Brief versions are being tried
CAUTIONS FOR PSYCHOTHERAPY FOR PTSD

Iatrogenic Dangers:
- Exposure with no coping or avoidance prevention
- Repressed memories
- “Exploring” the past in psychotherapy

Requirements:
- Able to attend sessions
- Adequate support
- Trained provider available
- Adequate mental status
THE ANGRY PATIENT...

- 75 y/o mixed race female, hx of DV and sexual abuse
- Hx of severe scoliosis
- Meds: morphine, gabapentin...
- Extremely tearful, terse, frequent visits
- PTSD *and* Borderline Personality Disorder
- Post PTSD tx – PCL 52 to 35

TIP

Engagement first!

• Spend a couple extra minutes listening, reflecting, asking if they’re heard
• Screen for PTSD
• Medications for core symptoms
I’M “FINE,” BUT NOTHING IS GETTING BETTER...

- 43 y/o African American female, childhood abuse, DV, MVA PCL 52
- Bilateral hip pain, generalized and cervical pain
- Meds: gabapentin, sertraline, cyclobenzaprine
- Pleasant, but doesn’t improve much, even after multiple pain self management therapy visits
- PTSD *and* OCD
- Post PTSD tx – PCL 52 to 42

TIP

Look for the hidden issue

- Screen for PTSD
- Think about avoidance motivations
- Look for flat or unusually subdued reactions to bad events and negative beliefs about the self
VA’S COACH APPS

• iPhone
• (Android)
PTSD RESOURCES

VA website on PTSD & CP:
http://www.ptsd.va.gov/professional/ptsd101/course-modules/PTSD_and_Pain.asp

National Center for PTSD (includes patient handouts and resources)
http://www.ptsd.va.gov/

PTSD Screening in Primary Care (PC-PTSD):
http://www.ptsd.va.gov/professional/pages/screening-ptsd-primary-care.asp

Behavioral Activation for PTSD
http://www.docstoc.com/docs/2971515/Behavioral-Activation-Strategies-for-the-Treatment-of-PTSD

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