UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

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

KARI A. STEPHENS, PHD

PSYCHIATRY & BEHAVIORAL SCIENCES

UNIVERSITY OF WASHINGTON

UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

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

None

UW PACC

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

UW PACC

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

UW PACC

COMMON CASE PRESENTATIONS

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

UW PACC

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)

NCS-R (2001-03) US lifetime prevalence:

- 6.8% of all adults;
- 3.6% men, 9.7% women
- No diff in rural/urban
- Higher among indigenous people

National Epidemiologic Survey on Alcohol and Related Conditions – III (2012-13):

- 4.7 and 6.1 %,
- higher for female, White, Native American, younger, those with <high school education and lower incomes, and rural residents
- 59.4 % sought treatment

Among Vets lifetime prevalence:

- Vietnam War: 30.9% men, 26.9% women
- Gulf War: 10.1%
- OEF/OIF (2008, 2009): prevalence 13.8 – 68.2%

UW PACC

SCREEN FOR IT:
PRIMARY CARE PTSD SCREEN (PC-PTSD)

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

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, *in the past month*, you…	Yes	No
Had nightmares about it or thought about it when you did not want to?		
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?		
Were constantly on guard, watchful, or easily startled?		
Felt numb or detached from others, activities, or your surroundings?		

http://www.ptsd.va.gov/professional/pages/assessments/pc-ptsd.asp

UW PACC

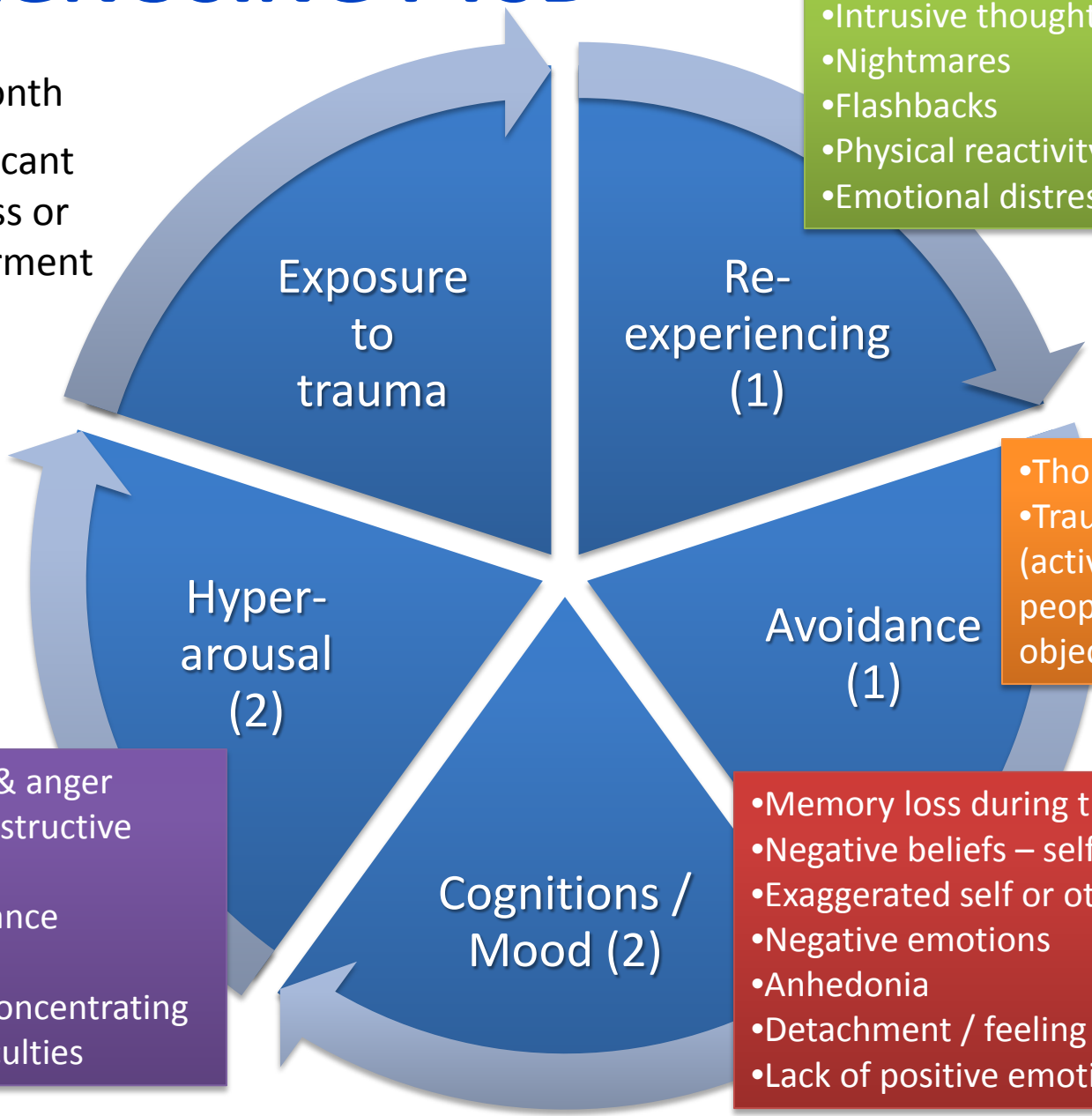
WHAT IS A TRAUMATIC EVENT?

The person was exposed to: death, threatened death, 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

- >1 month
- Significant distress or impairment



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

- 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?…

7-8% (NCS-R)
(Beck & Clapp, 2011)

Rates likely higher among ethnic minorities
(Buchwald et al., 2005)

PTSD cohort with pain →
20-80%
Pain cohort with PTSD →
10-50%
(Fishbain, 2016)

More likely in chronic pain patients with:

- Headache / facial pain
- Pelvic pain
- Miscellaneous pain
- Pain after MVA
- Veterans
  (Fishbain, 2016)

Higher pain:

- more affective distress
- more disability

(Asmundson et al., 2002; Geisser et al., 1996; Turk & Okifuji, 1996)

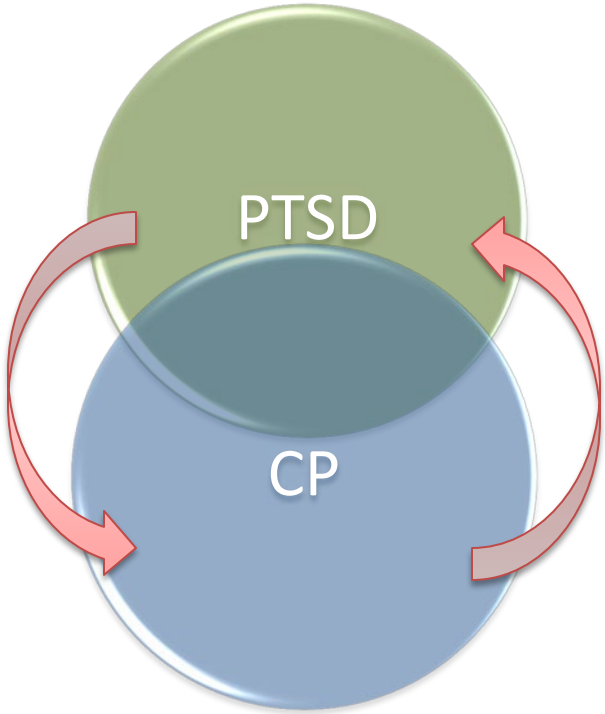
Neuro-biological overlaps to improve tx
(Scioli-Salter et al., 2014, 2015)

- pharmacologic-al 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



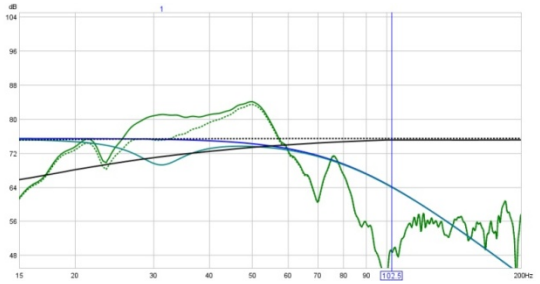
tend to either get worse or better in unison

UW PACC

TREATING PTSD:
WHAT CAN A PCP DO?

UW PACC

MEASURE IT:
IS TREATMENT WORKING…



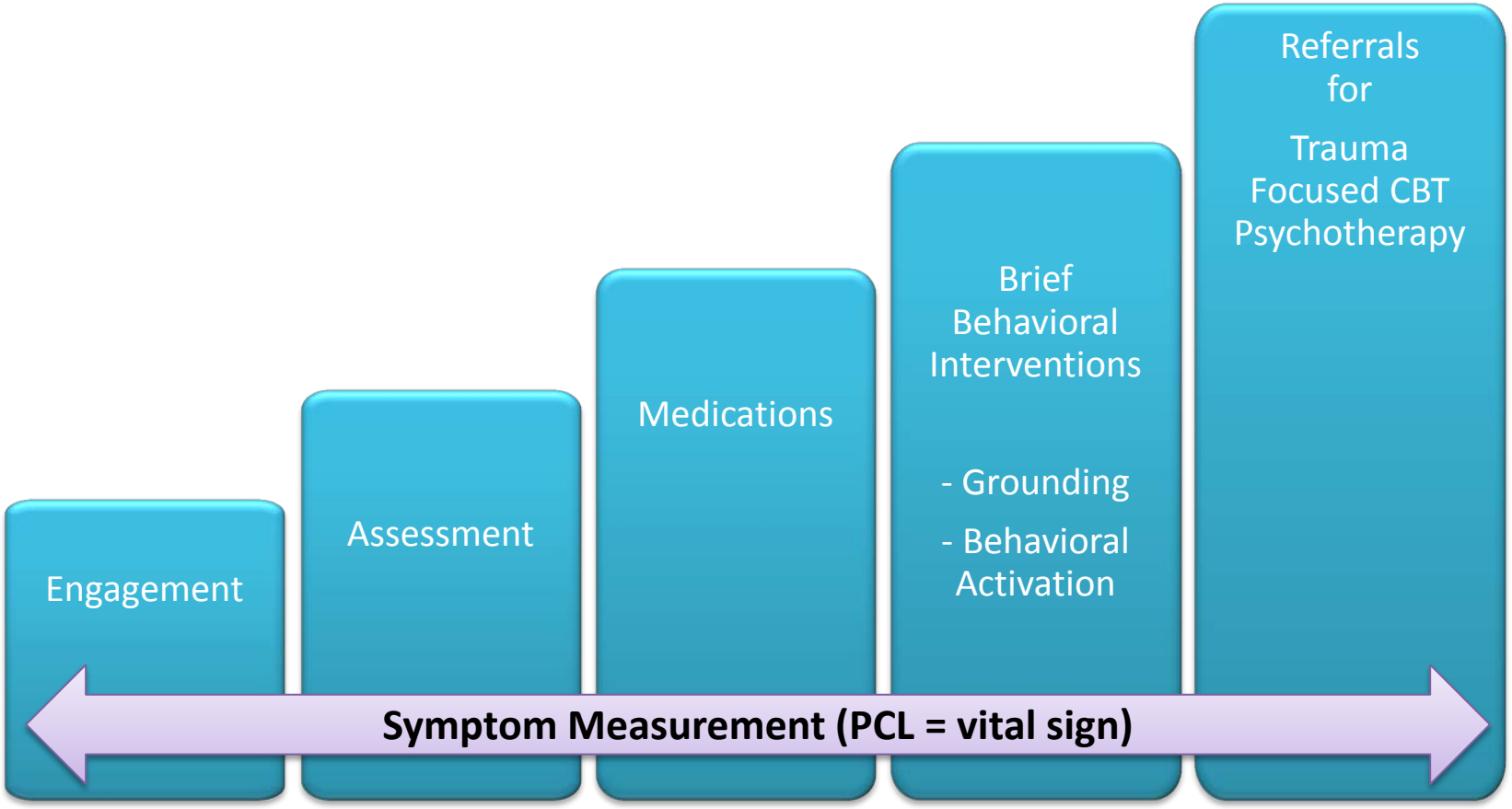
- PTSD
  - Use the PCL-C or PCL-5

http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

- 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

UW PACC

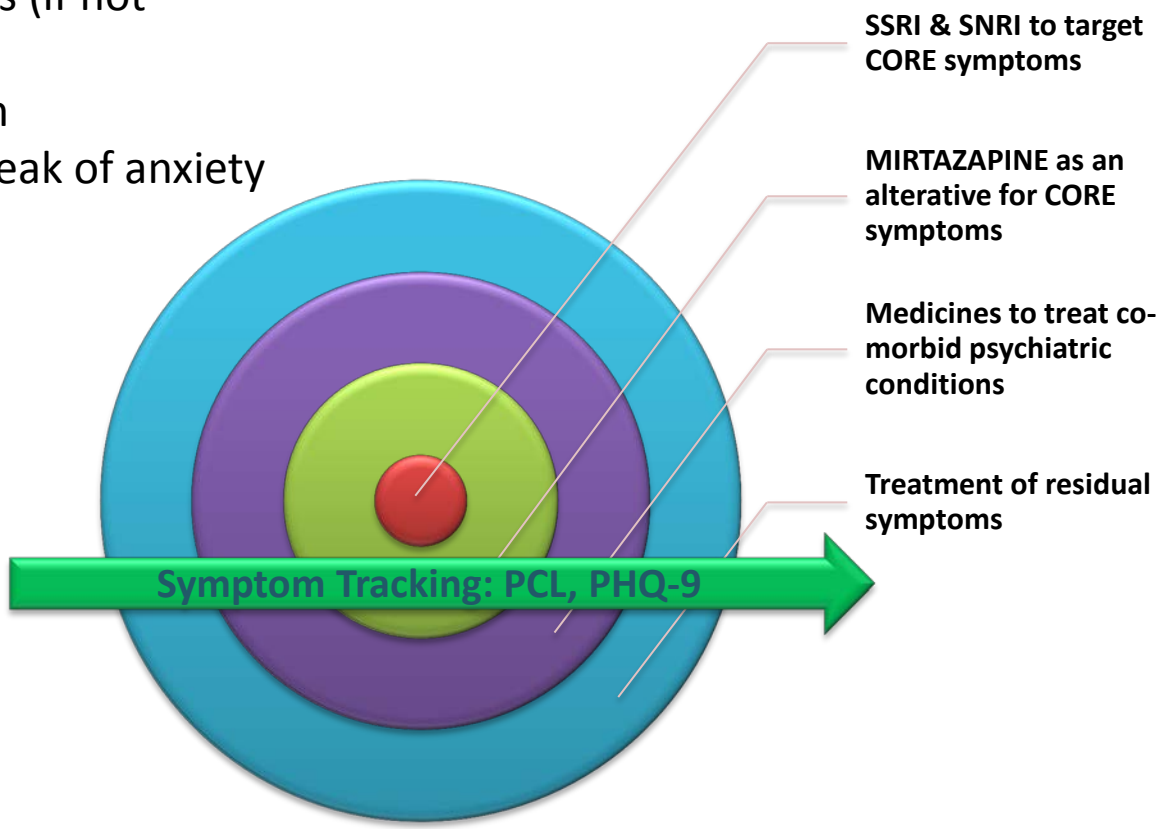
STEPPED APPROACH



UW PACC

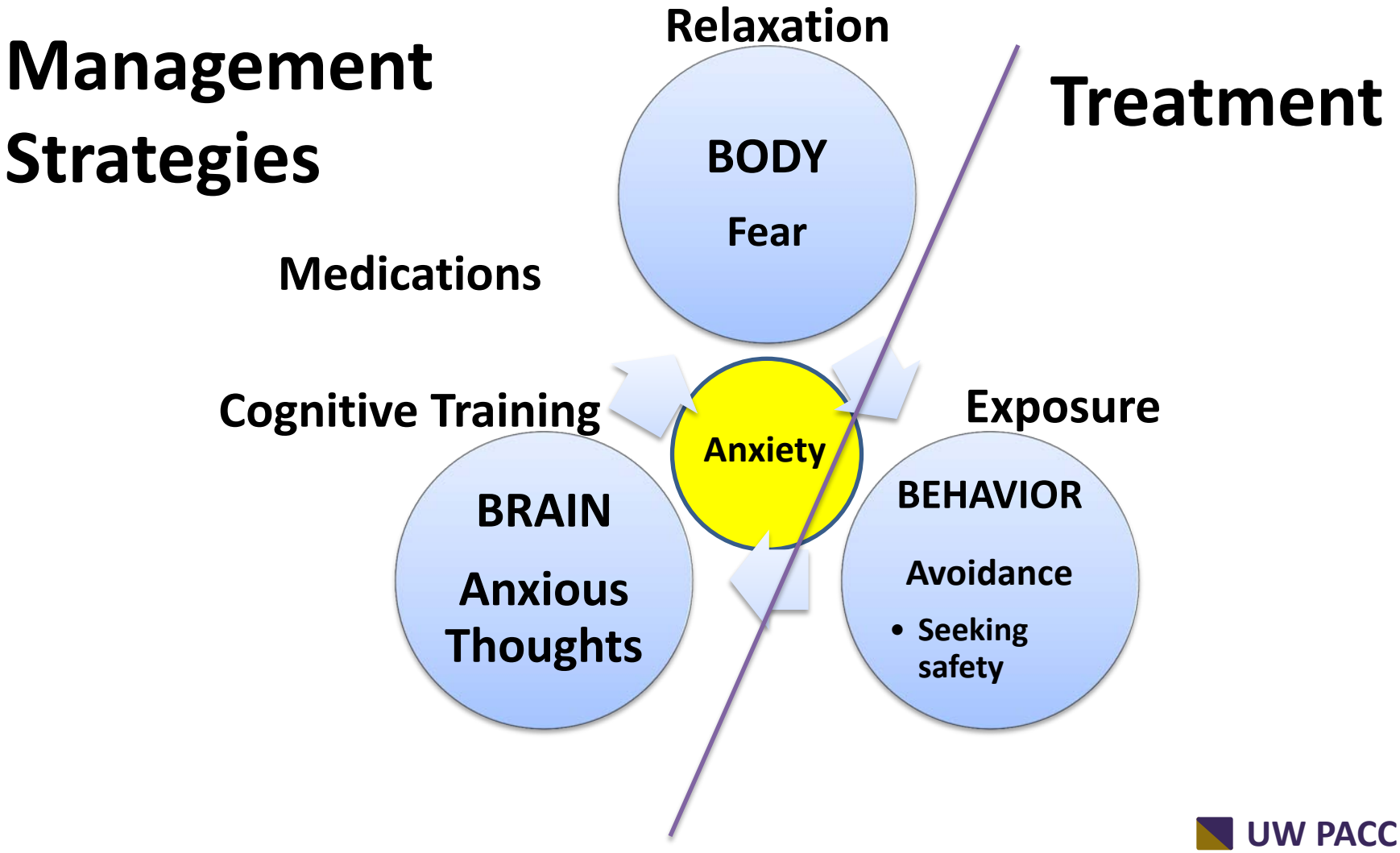
PTSD PHARMACOTHERAPY: TREAT THE CORE SYMPTOMS – DEPRESSION, ANXIETY, NIGHTMARES

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



UW PACC

EXPLAINING ANXIETY TO PATIENTS…



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

UW PACC

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

UW PACC

BEST EVIDENCE-BASED TX'S FOR PTSD

CBT Therapies	EMDR	Active Component

• PE: Prolonged Exposure (Foa)
• CPT: Cognitive Processing Therapy (Resick)
	• Most available in communities
	• Some evidence it may work best with hyperarousal symptoms
	• Often involves a shorter number of sessions than CBT
		• Exposure
		  • Facing the trauma
		  • Facing the thoughts
		  • Facing avoidant behaviors
		
		Brief versions are being tried

UW PACC

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

UW PACC

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

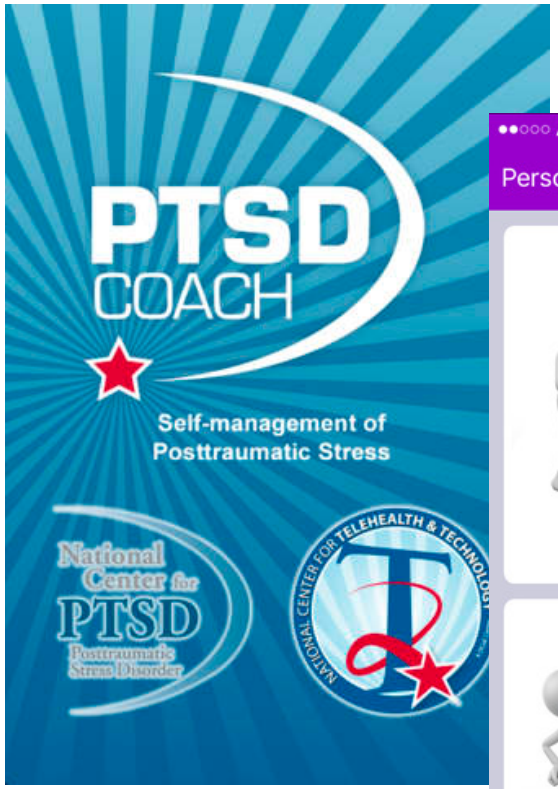
TIP

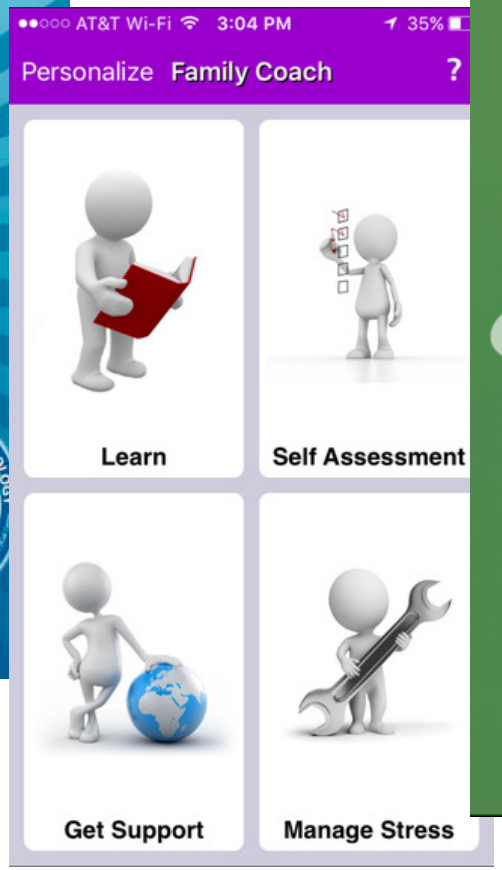
Look for the hidden issue

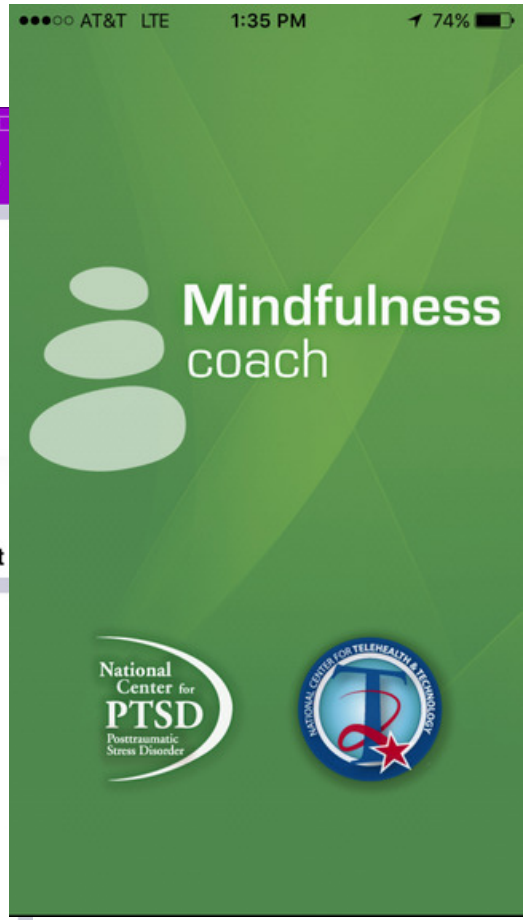
- Screen for PTSD
- Think about avoidance motivations
- Look for flat or unusually **subdued reactions to bad events** and **negative beliefs about the self**

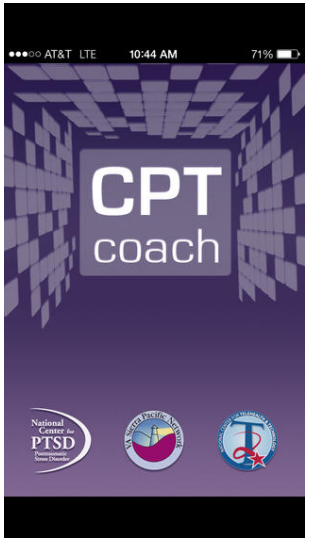
VA'S COACH APPS

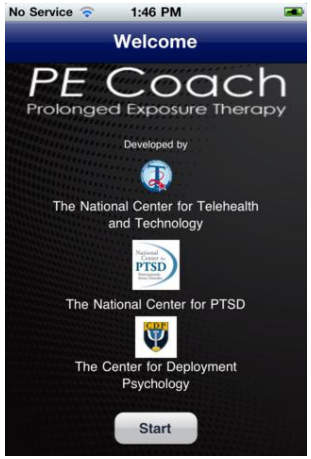
- iPhone
- (Android)











UW PACC

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

My Contact: Kari Stephens, PhD kstephen@uw.edu