PTSD in Primary Care

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What to expect today?

- Defining and assessing PTSD
- Approach for doing differential diagnosis of PTSD
- Best practices for pharmacological management
- A few brief words on treatment
DIAGNOSIS AND ASSESSMENT OF PTSD

MHIP
17% of 12,399 patients charted with PTSD

Post-Traumatic Stress Disorder

Diagnosing PTSD

Exposure to trauma

Reexperiencing (1)

Hyperarousal (2)

Avoidance (3)

>1 month
• Significant distress or impairment

Criterion B
• Flashbacks
• Distressing recollections
• Dreams
• Physiological reactivity
• Psychological distress at reminders

Criterion C
• Thoughts, feelings, & conversations
• Activities/Places/People
• Amnesia
• Detachment
• Loss of interest
• Restricted affect
• Foreshortened future

Criterion D
• Sleep difficulties
• Hypervigilance
• Irritability & anger
• Startle
• Concentration
Most people *do not* get PTSD as a result of trauma (i.e., post Katrina, 9/11 studies, combat)

70-90% of people report having had at least one traumatic experience

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>• 6.8% of all adults;</td>
<td>• Vietnam War: 30.9% men, 26.9% women</td>
<td></td>
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<tr>
<td>• 3.6% men, 9.7% women</td>
<td>• Gulf War: 10.1%</td>
<td></td>
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<tr>
<td></td>
<td>• OEF/OIF (2008): current prevalence 13.8%</td>
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</table>

Influences On Behavior ...

- Experience
- Biology/Physiology
- Cognitive Schemes
- Emotional Responses
Stress response biology and symptoms are part of being human. They are a natural, functional responses to trauma. PTSD is something that is experienced “in your body.”

When fear responses go awry ...

“safety behaviors” actions taken to increase safety = partial avoidance

ANXIETY is... maintained and increased
What characteristics make a trauma more of a stressor?

- Threat to life and bodily injury
- Involvement with brutality or the grotesque
- Significant object loss (death of loved one)
- Assaultive violence vs. "Acts of God"
- Real/perceived responsibility for tragic outcomes
- Betrayal post-trauma
- Uncontrollability
- Unpredictability
- Severity (intensity and duration)

What makes a person more likely to get PTSD?

- Individual and family cumulative trauma burden
- Physical injury
- Female gender
- Low SES
- High early posttraumatic distress
- Ethno-racial minority status
What is a traumatic event?

Experienced, witnessed, or confronted an event involving actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.

Response involving intense fear, helplessness, or terror.

Traumatic Event (Criterion A)

Tips for asking about trauma:

#1
To prevent dissociation and triggering of PTSD symptoms...

Encourage short, concise descriptions of the trauma
- ask for 2-3 sentences or 25 words or less to get a general sense of the trauma without
- be directive and feel free to stop the telling if you see the patient getting upset
- Normalize the extreme difficulty patients often have in re-telling their stories

#2
Because patients...
- Often have unique post-injury concerns
- Interpret trauma uniquely
- Post-injury distress may be described differently

Don’t go down a checklist
- Encourage them to tell their story in their own words
- Use open-ended questions

Remember, you don’t need the details to make the diagnosis

#3
If patient dissociates...

Help the patient ground themselves by directing them to engage their immediate environment

Once grounded, educate on dissociation
CREATING AND WORKING THROUGH A DIFFERENTIAL DIAGNOSIS FOR PTSD

PTSD Differential Diagnosis

- Panic Disorder
- Generalized Anxiety Disorder
- Substance Use Disorder
- Bipolar Disorders
- Malingering
- Psychosis
**Chronicity/Timing:** make sure symptoms of avoidance, numbing, and increased arousal begin after the stressor (r/o Brief Psychotic Dis, Conversion Dis, MDD)

Avoidance is due to traumatic event, not consequences of traumatic event

Flashbacks vs. illusions/hallucinations/other perceptual disturbances (substance use, psychosis, etc.)

Malingering (financial, benefit elig, forensic)

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**PTSD often presents with other co-morbidities and is associated with increased risk of other diagnoses.**

(Kaysen, 2009)

Women

Men

Kessler et al., 1995

Kessler, 2000
PTSD
Common Co-morbidities

- Major Depressive Disorder
- Substance Use Disorder
- Generalized Anxiety Disorder
- Bipolar Disorders
- Dysthymia
- Borderline PD

Primary Care PTSD Screen (PC-PTSD)
Considered "positive" if a patient answers "yes" to any three items.

<table>
<thead>
<tr>
<th>In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you...</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had nightmares about it or thought about it when you did not want to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were constantly on guard, watchful, or easily startled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt numb or detached from others, activities, or your surroundings?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Post-Traumatic Stress Disorder

PCL-C

Scale ranges:

- 30-44 moderate PTSD
- ≥45 severe PTSD

GAD-7
PTSD & Depression

30%-50% of PTSD patients have significant depressive symptoms

Patients with PTSD & MDD in primary care:
Campbell et al. (2007)
- More severe depression
- Lower social support
- More likely to report suicidal ideation
- More frequent health care visits

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead, or of hurting yourself in some way

Over the last 2 weeks, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not at all
- Somewhat difficult
- Very difficult
- Extremely difficult

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PTSD and Substance Use Disorders (SUD) Schäfer & Najavits (2008)

- 21-43% with lifetime history of PTSD suffer with SUD
- 75% of combat veterans with PTSD struggle with alcohol abuse or dependence
- 15-41% of people with lifetime history of SUD have current PTSD

Prevalence of PTSD Among Substance Users in a General Population *

- 33% Opioid Use Disorder
- 24% Amphetamine Use Disorder
- 5.4% Alcohol Use Disorder
- 5.2% Cannabis Use Disorder

*Mills et al. (2006): Australian National Survey of Mental Health and Wellbeing
Symptoms overlap

• Anger & Irritability
• Cognitive Impairment
• Dissociation
• Sweats & Tremors
• Hyperarousal
• Paranoia & Hallucinations

Therefore...

• Ask about periods of sobriety
• Look more closely at re-experiencing symptoms
• Look at the function of substance use - does it help reduce PTSD symptoms?

GAIN-SS

Substance Use Scale (GAIN-SS SDS Score):

- a. Did you use alcohol or drugs weekly?
- b. Did you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?
- c. Did your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?
- d. Did your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?
- e. Did you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still, or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?

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Tips for screening and diagnosing PTSD:

#1  
Expect co-morbidity  
- Screen comprehensively based in symptoms and patient history  
  - Always screen for depression  
  - Always screen for substance use  
  - PHQ-9, GAIN-SS, PCL-C, PC-PTSD  
  - If PTSD is diagnosed, prioritize use of PCL-C to track symptoms

#2  
Have high suspicion for substance use  
- Establish pattern history and pattern of substance use  
- Think ahead about referring for chemical dependency evaluation and/or treatment

PHARMACOLOGICAL MANAGEMENT OF PTSD
“Patients’ trust and adherence are maximized when physicians ask patients about their experience with the medication’s effectiveness and side effects during follow-up visits, and when patients feel that physicians believe and work with their perceptions of their medicine.”

Nakell (2007): Adult Post-Traumatic Stress Disorder: Screening and Treating in Primary Care

Same Goal: Different Perspectives

**Patient’s Perspective**
- Immediate distress
- Immediate relief: “I need something NOW!”
- Medication relieve “Boiling”
- Medications “As Needed”

**Provider’s Perspective**
- Symptom and Syndrome focused
- Address immediate AND long-term recovery
- Goal: relieve symptoms AND improve overall function
- Medications “Daily Dosing”
PTSD Pharmacotherapy

Medication Plan

Co-Morbid Illnesses
Severity of Symptoms
Side effects/Interactions

Thorough and Careful
• History
• Physical Examination

SSRI’s

First line medications for treating PTSD Core Symptoms
Sertraline (Zoloft)
Paroxetine (Paxil)
Citalopram (Celexa)
Fluoxetine (Prozac)
Escitalopram (Lexapro)

What do SSRI’s do?
• Treat core PTSD symptoms
• Treat co-existing depression symptoms
• Manage acute and long term symptoms

How to use?
• Start low dose and gradually increase
• Look for initial response in 4-6 weeks
• If symptoms remit, continue for additional 9-12 months

How to support patients?
• Educate about when to expect response
• Educate & ask about side effects OFTEN
• Use PCL-C to track symptoms
• Communicate information to PCP
PTSD Pharmacotherapy: SNRI’s

**Venlafaxine XR (Effexor XR)**

*What do SNRI’s do?*
- Effective for core symptoms of PTSD
- Particularly helpful for re-experiencing and avoidance

*How to use:*
- Start low dose
- Initial dose goal 150 mg once daily

*Be aware of:*
- Risk for high blood pressure at doses 300mg or greater
- Discontinuation symptoms (headaches, irritability, electric shocks)

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PTSD Pharmacotherapy

**Mirtazapine (Remeron)**
- Antidepressant with alternative mechanism
- Shown to be effective for core PTSD symptoms
- Sedating at lower doses
- Significant weight gain

**Benzodiazepines**
- Alprazolam, Lorazepam, Clonazepam, Valium
- ARE NOT FIRST LINE
- HIGHLY ADDICTIVE!!
- Used to address residual symptoms
- Prescribe scheduled NOT "prn";
  CAREFUL MONITORING

**Atypical Antipsychotics**
- Risperidone & Olanzapine as adjuncts
- Address co-morbid psychotic or mood disorder (bipolar disorder)
- Risk of movement side effects and the metabolic syndrome

**Sleep**
- Prazosin: trauma related dreams and insomnia; lightheadedness
- Trazadone: can help; risk of priapism
- Benadryl: anti-histamine sedation; cholinergic side effects; Vistaril

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OTHERS
PTSD Pharmacotherapy

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

Tips for Medication Support:

#1
- Start with thorough history and medical examination
- Clarify history over time
- Remember, medications treat SYMPTOMS
- Start medications as soon as possible, & advance doses as tolerated
- Regularly track symptoms

#2
- Benzodiazepines
  - For those with remote or no substance use history
  - Use SCHEDULED dosing
- Prazosin
  - Effective in TRAUMA RELATED sleep disturbance
Cautions for Behavioral Treatment of PTSD

Iatrogenic Dangers:
- Exposure with no coping or habituation
- Repressed memories
- Exploring the past in psychotherapy

Required for engaging Trauma Focused CBT (gold standard tx):
- able to come to sessions
- support
- TF resource available
- adequate mental status
- coping skills

STEPPED APPROACH

Engagement
Assessment
Medications
Brief Behavioral Interventions
Referrals for Psychotherapy

Symptom Measurement (PHQ-9, GAD-7, PCL-C)
PTSD Resources

National Center for PTSD
- http://www.ptsd.va.gov/
- PTSD in Primary Care: http://www.ptsd.va.gov/professional/pages/screening-ptsd-primary-care.asp

Behavioral Activation for PTSD

Contact us:
- Kari Stephens: kstephen@uw.edu
- Wayne Bentham wbentham@uw.edu

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PTSD Pharmacotherapy

**Table 4. Medications Targeting Insomnia**

<table>
<thead>
<tr>
<th>Medication (Dose)</th>
<th>Evidence Base for Medication</th>
<th>Side Effect Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphenhydramine (25-50mg)</td>
<td>Clinical trial evidence suggesting some efficacy in primary insomnia¹⁰</td>
<td>Anticholinergic symptoms*</td>
</tr>
<tr>
<td>Trazadone (50-200mg)</td>
<td>Expert clinical consensus recommending this medication for presentation of insomnia with PTSD¹²</td>
<td>Prapism</td>
</tr>
<tr>
<td>Prazosin (5-10mg)</td>
<td>Open trials²⁶, ²⁷</td>
<td>Orthostasis</td>
</tr>
<tr>
<td>Low-dose sedating Tricyclic Anti-Depressants-</td>
<td>Clinical trials targeting primary sleep disturbances and PTSD suggest efficacy²⁰</td>
<td>Anticholinergic symptoms*; Consider interaction with SSRIs</td>
</tr>
<tr>
<td>Amitriptyline, Doxepin (10-50mg)</td>
<td>Single randomized trial suggests study these agents may be effective as adjunctive agents targeting sleep²⁸</td>
<td>Major tranquillization of patient</td>
</tr>
<tr>
<td>Low-dose Atypical Antipsychotic (e.g.,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risperidone 0.5-2mg, Olanzapine 5-10mg)</td>
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</tbody>
</table>

*Anticholinergic symptoms include dry mouth, constipation, urinary hesitancy or retention, and blurred vision
## PTSD Pharmacotherapy

### Table 3. Serotonin Specific Reuptake Inhibitors (SSRIs) Dosing in the Treatment of PTSD

<table>
<thead>
<tr>
<th>Medication</th>
<th>Begin</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
<th>Highest Doses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>10mg Qday</td>
<td>10mg Qday</td>
<td>20mg Qday</td>
<td>30mg Qday</td>
<td>40mg Qday</td>
<td>50-60mg Qday</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>25mg BID</td>
<td>50mg BID</td>
<td>50mg BID</td>
<td>75mg BID</td>
<td>75mg BID</td>
<td>150mg BID</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>10mg Qday</td>
<td>20mg Qday</td>
<td>50mg Qday</td>
<td>40mg Qday</td>
<td>40mg Qday</td>
<td>40-60mg Qday</td>
</tr>
<tr>
<td>Sertraline</td>
<td>25mg Qday</td>
<td>50mg Qday</td>
<td>50mg Qday</td>
<td>100mg Qday</td>
<td>150mg Qday</td>
<td>200mg Qday</td>
</tr>
<tr>
<td>Citalopram</td>
<td>10mg Qday</td>
<td>20mg Qday</td>
<td>30mg Qday</td>
<td>40mg Qday</td>
<td>40mg Qday</td>
<td>50mg Qday</td>
</tr>
</tbody>
</table>

Abbreviations: Qday, every day; BID, twice daily.