Challenges to Detection and Management of PTSD in Primary Care

Karen H. Seal, MD, MPH
University of California, San Francisco
San Francisco VA Medical Center
General Internal Medicine Section
PTSD is Prevalent in Primary Care

- Among 368 primary care patients, 11.8% met criteria for partial or full PTSD (PCL-C) (Stein et al., 2000).
- Among 1,259 women seen for care at one VA medical center, 21% screened positive for PTSD (PCL-C) (Dobie et al., 2004).
- Of 746 randomly-selected VA primary care patients, prevalence of PTSD was 11.5% (CAPS) (Magruder et al., 2005).
Under-Detection of PTSD in Primary Care

Of patients diagnosed with PTSD by Clinician Administered PTSD Scale (CAPS), chart review revealed that primary care providers identified only 47% of cases; only 48% had used mental health services. (Magruder et al., 2005)
Challenges to Detection and Management in Primary Care

- PTSD was first codified in the American Psychiatric Association Diagnostic Statistical Manual III in 1980.
  - Why, in 2005, were less than half of patients with a diagnosis of PTSD recognized in primary care?
  - Why did less than half of patients with a PTSD diagnosis use mental health services?
Detection and Early Intervention of PTSD: Important for Mind (and Body?)

- Early intervention for symptoms of PTSD with evidence-based therapies has been shown to prevent chronic mental illness/disability (Friedman et al., 2006; Gray et al., 2004)

- In a prospective study, PTSD was significantly associated with fatal and non-fatal CHD (Kubzansky et al., 2007)
  - Atherogenesis through HPA axis dysregulation?
  - Increased CV risk factors (Falger et al., 1992)
  - Lipid dysregulation (Solter et al., 2002)
Barriers to Detection of PTSD in Primary Care

- Patient-level barriers
  - Not comfortable talking about mental health problems
  - Denial; self-medication with alcohol or substances
  - Stigmatized condition
    - Embarrassment; sign of weakness
    - Concern about current or future employment
    - May not be willing to see mental health specialist
  - Problems articulated as physical complaints
Confounds to Detection of PTSD in Primary Care

- Patients with PTSD report more non-specific physical symptoms than patients without PTSD
  
  (Baker et al., 1997; Frayne et al., 2004; Dobie et al., 2004)

- Report poorer health status overall
  
  (Schnurr et al., 1999)

- Increased utilization of healthcare services
  
  (Hoge, 2007; Seal, 2007)

- Co-morbid with other mental health disorders, e.g., depression and alcohol/substance use disorders
  
  (Shalev et al., 1998; Bremnar et al., 1996; Seal, in press)

- May lead to delays in detection and early intervention
Detection of PTSD in Primary Care

- **Provider-level barriers**
  - Medical training emphasizes medical illness
    - Lack of time (competing priorities)
    - Discomfort in addressing traumatic events
    - Concerned loss of trust in raising stigmatized issues
  - Lack of training:
    - May not recognize PTSD
    - May lack confidence
  - Lack of available specialty mental health services
Assessment of PTSD in Primary Care

**KEY:** Inquire about recent and remote trauma

**Recent trauma: 2 days-4 weeks** *(Acute Stress Disorder)*

- Eliciting detailed recollections of traumatic event *(psychological debriefing)* may be harmful *(Gray et al., 2004)*
- Initially assess for physical and psychological problems stemming from traumatic event
- Initial medical, social and psychological care directed at stabilization, support and safety
PTSD Screening in Primary Care

- Brief “Primary Care PTSD Screen” developed by the National Center for PTSD. (Prins et al., 2004)
  - Four questions cover 4 main symptom clusters of PTSD: re-experiencing trauma, numbing, avoidance, and hyperarousal.
  - Using cut-off score of 3 of 4 items to indicate positive screen, yielded sensitivity of 0.78 and specificity of 0.87

- PTSD Check List (PCL) validated 17-item PTSD inventory. Likely too long/triggering for primary care
1. SCREEN FOR PTSD

   answer all 4 questions

   Have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:
   
   A. Have had any nightmares about it or thought about it when you did not want to?
      * (No) (Yes)
   
   B. Tried hard not to think about it; went out of your way to avoid situations that remind you of it?
      * (No) (Yes)
   
   C. Were constantly on guard, watchful, or easily startled?
      * (No) (Yes)
   
   D. Felt numb or detached from others, activities, or your surroundings?
      * (No) (Yes)

RESULTS OF PTSD SCREENING
(a 'yes' answer to 2 or more of the above questions is a positive screen)

   ( ) PTSD Screen Negative
   ( ) PTSD Screen Positive

Clinical Reminders:
Iraq/Afghan Post-Deployment Screen:

Health Factors: COMPLETE SCREEN (IRAQ/AFGHANISTAN), IRAQ/AFGHAN SERVICE

* Indicates a Required Field
Assessment of PTSD in Primary Care

Remote trauma > 1 month ago

- Assess for PTSD
- Assess for co-morbid mental health disorders, e.g., depression, alcohol and substance use disorders, TBI (combat veterans)
- Assess for somatic symptoms, e.g. insomnia
- Assess for functional and social impairment
PTSD and TBI in Primary Care

- TBI and PTSD co-occur in veterans returning from Iraq and Afghanistan due to high frequency of blast injuries and combat-related trauma.
- Symptoms may overlap, e.g., insomnia, poor concentration, irritability and agitation.
- If TBI suspected, may benefit from additional assessment: neurology, cognitive testing +/- MRI.
- Neuro-rehabilitation may be important adjunct to PTSD treatment.
PTSD Treatment

- Cochran meta-analysis of 29 studies of psychological treatments for PTSD showed that Exposure Therapy and Stress Management were equivalent and superior to waitlist and other therapies (supportive, psychodynamic and hypnotherapy) (Cochran Database Syst Rev, 2005)

- Recent IOM report on PTSD treatment: Only Exposure Therapy has sufficient evidence to support effectiveness; insufficient evidence for all other psychotherapies and pharmacotherapy's.
Primary Care Management of PTSD

- Detect PTSD, related symptoms and problems
- Establish therapeutic alliance and trust
- Assess for safety (SI, HI, DV, weapons)
- Psycho-education normalizes PTSD symptoms
  “You are not alone…”
- Treat PTSD-related symptoms
- Coordinate care: social services
Primary Care Management of PTSD

- Primary care clinicians routinely use SSRIs in treatment of depression

- SSRIs first-line pharmacotherapy for PTSD
  - Associated with relief of core PTSD symptoms (re-experiencing, avoidance, emotional numbing, and hyper-arousal) (Robert et al., 2006)
  - May also be effective for co-morbid depression, anxiety, social phobias, insomnia
Primary Care Management of PTSD

- Benzodiazepines commonly used in primary care to manage PTSD symptoms
  - Not shown to reduce core symptoms of PTSD
  - May lead to dependence syndromes
  - Withdrawal may exacerbate PTSD symptoms

- May be useful as *adjunctive, short-term* therapy for insomnia and anxiety

- Not recommended as mono-therapy for PTSD
Managing PTSD-Related Insomnia

- Sleep hygiene- e.g., decrease caffeine, alcohol
- Trial of antihistamines-diphenhydramine or hydroxyzine
- Anti-depressants: low-dose trazadone or TCAs (daytime somnolence); SSRIs (paroxetine)
- Non-BZD, zolpidem may be useful
- Alpha-blocker, prazosin, titrated up from 1-6 mg may reduce nightmares
Primary Care Management of PTSD

- Refer for mental health specialty treatment when indicated
- Motivational interviewing to decrease barriers to initiating and adhering to mental health treatment
- Case management (if available) when necessary
- Better integration of primary care and mental health services reduces stigma and other barriers
Summary

- PTSD common in primary care, but often not detected
- Ask about recent/remote trauma and use brief primary care screen to assess
- Assure safety
- Symptom-driven treatment
- Active referral for psychotherapy (Exposure Therapy, CBT or Stress Management)
- Ongoing assessment of treatment and functional status