# PTSD in Primary Care

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# Faculty/Presenter Disclosure

**Faculty:** Dr. Jon Davine
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# Disclosure of Financial Support

- **This program has not received financial support**
- **This program has not received in-kind support**

- **<u>Potential for conflict(s) of interest</u>:**
  - Jon Davine has not received any funding for this program

# Mitigating Potential Bias

- Dr. Jon Davine

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- I have received no funding from anyone for this presentation.
- Any meds I discuss are based on reviews of the literature
- My honoraria have been received from academic institutions, medical societies, and family medicine groups

# Objectives

Learn effective questioning to make the diagnosis of PTSD

Identify a number of potential situations that may lead to PTSD

Use effective psychotherapeutic techniques that can be used in the primary care setting

Prescribe evidence-based, effective psychopharmacological therapies that can be used in primary care

# Posttraumatic Stress Disorder

- Lifetime prevalence in Canada 9.2%
- Onset mid to late 20’s
- Women > men

# PTSD

- Associated with high rates of chronic pain, sleep problems, sexual dysfunction
- Suicide attempts increase two- to three-fold
- Increased use of mental health care

# DSM-V Diagnosis of PTSD

- Applies to >6 years of age
- A. Exposure to actual or threatened death, serious injury or sexual violence by:
  - Directly experiencing the event
  - Witnessing the event in person, as it occurs to others
  - Learning that the traumatic event occurred to a close family member or a close friend. The event(s) must have been violent or accidental.
  - Experiencing repeated exposure to aversive details of traumatic events (police, 1st responders). Not to exposure through electronic media

# DSM-V Diagnosis of PTSD
# Re-experiencing

- B. One or more.
- The traumatic event is re-experienced, with intrusive symptoms:

  - Recurrent, involuntary, distressing memories
  - Recurrent distressing dreams, related to the traumatic event
  - Dissociative reactions (flashbacks) in which the individual feels as if the event is recuring

# DSM-V Diagnosis of PTSD Triggers

- Intense or prolonged psychological distress a exposure to internal or external cues that resemble an aspect of the traumatic event
- Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event
- May include panic attacks

# DSM-V Diagnosis of PTSD
# C. Avoidance (one or both)

- Persistent avoidance of memories or thoughts about the event
- Avoiding external reminders (people, places, activities, objects, situations), that arouse distressing memories associated with the trauma.

# DSM-V Diagnosis of PTSD

- E. Persistent symptoms of increased arousal and reactivity including 2 (or more) of the following:
  - Irritable behaviour and angry outbursts
  - Reckless or self-destructive behaviour
  - Hypervigilance
  - Exaggerated startle
  - Decreased concentration
  - Decreased sleep

# DSM-V Diagnosis of PTSD

- duration of the disturbance is more than one month
- the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**T**RAUMATIC EVENT

**R**E-EXPERIENCE

**A**VOIDANCE/NUMBING

**U**NABLE TO FUNCTION

**M**ONTH

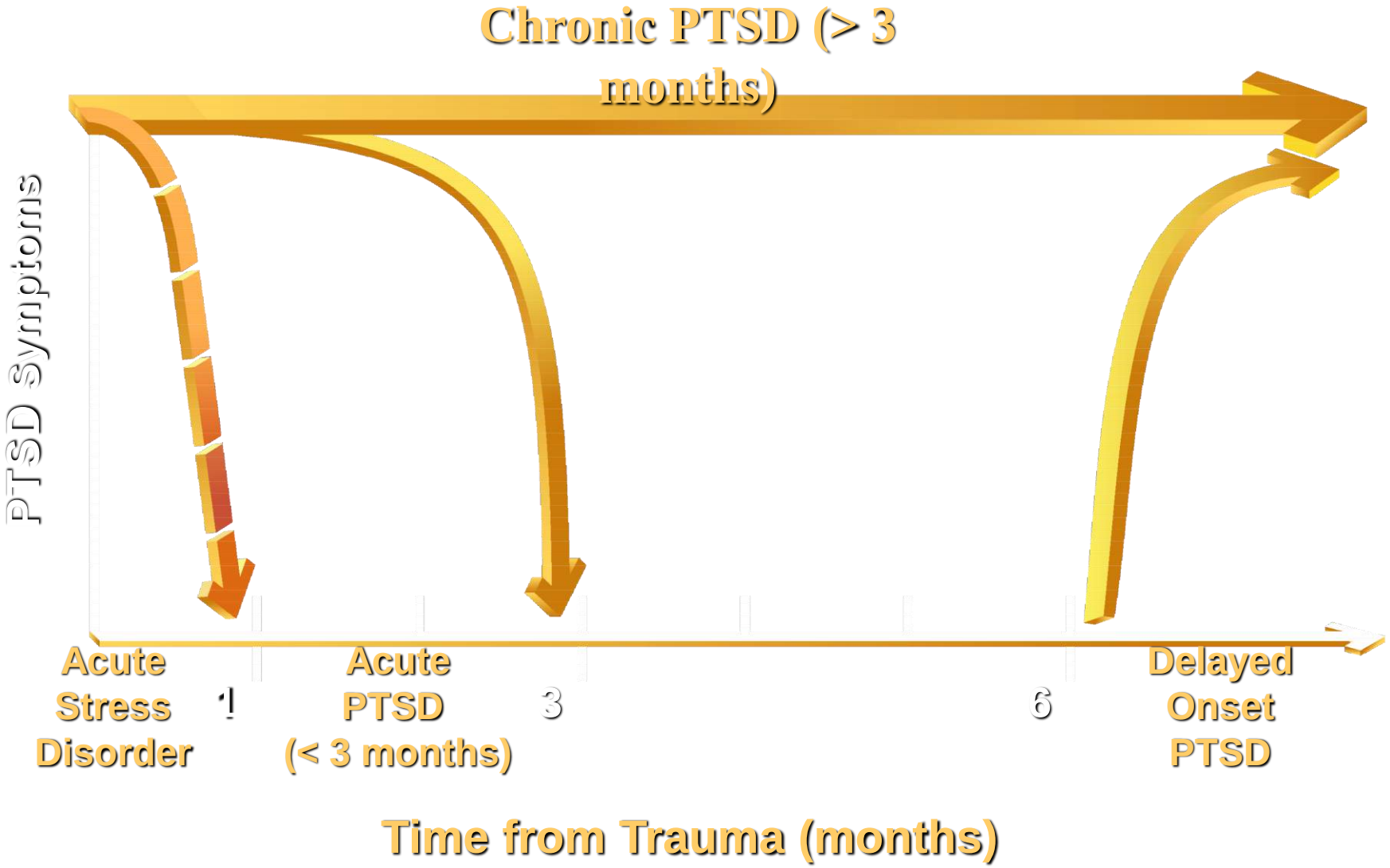
**A**ROUSAL (HYPERAROUSAL)

# POST TRAUMATIC STRESS DISORDER

- Specify if:
  - Acute:  if duration of symptoms is less than three months
  - Chronic:  if duration of symptoms is three months or more

- Specify if:
  - with delayed onset:  if onset of symptoms is at least six months after the stressor.

# PTSD: Subtype Specifiers



# ACUTE STRESS DISORDER

- The disturbance lasts for a minimum of three days and a maximum of  one month
- Essentially same symptoms as PTSD

# Screening Questions

1. Do you find it hard to stop thinking about the event that has happened to you?
2. Do you find that you have nightmares related to the event that happened to you?
3. Do you find that you have flashbacks and by that I mean very vivid daydreams or what we may call a “day mare” about the event that has happened to you?
4. When something happened that reminds you of the difficult event that happened to you, do you find that triggers a very large response to you?

# Screening Questions

4. Do you find that you avoid things that remind you of the very difficult event you experienced?
5. Do you feel generally anxious since the event and have trouble sleeping or startle easily?
6. Do you feel that this event and the way it has left you feeling still gets in the way of your life?

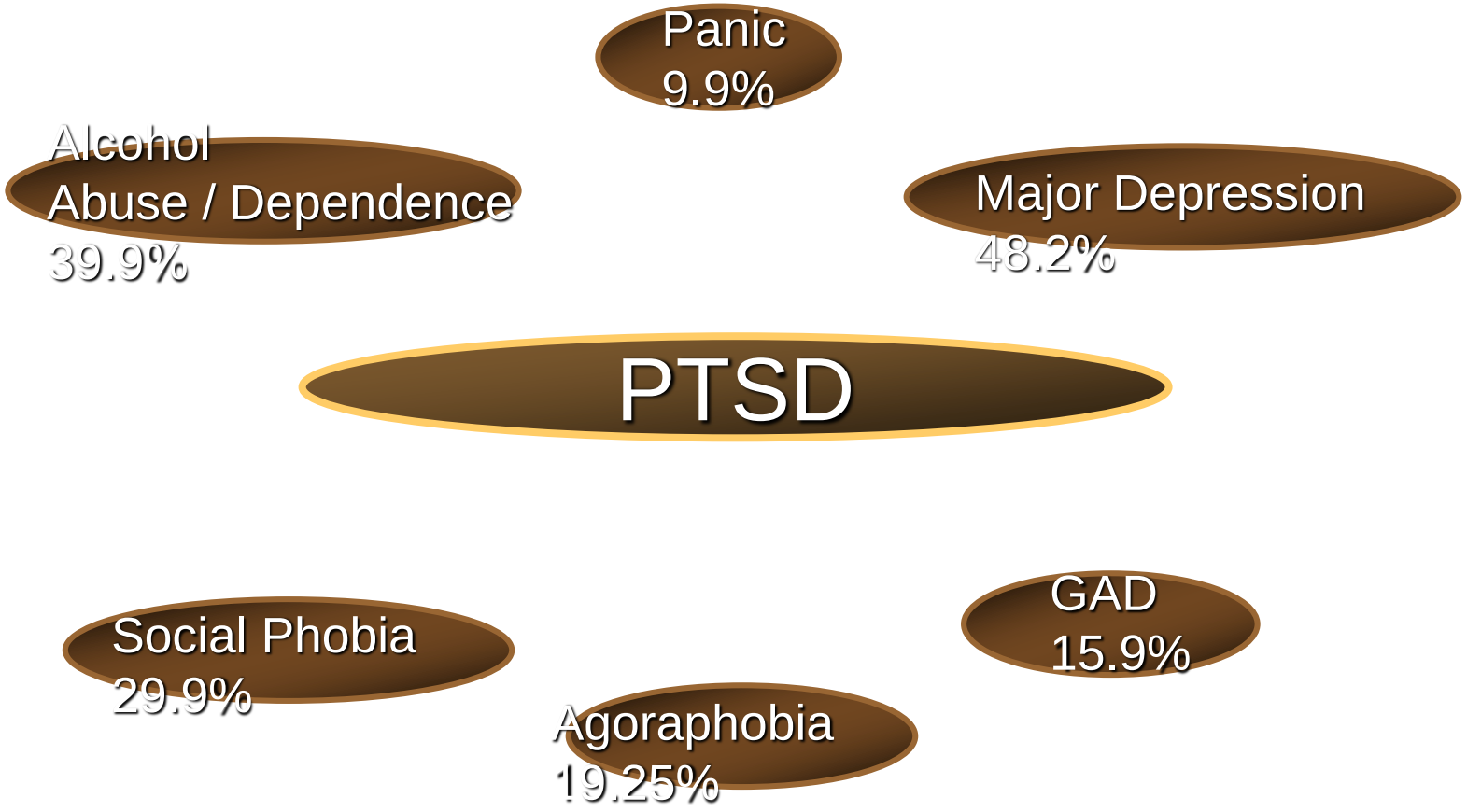
# When is a hallucination NOT a hallucination

- 1.
- 2.
- 3.

# PTSD Comorbidity

- 75% have another psychiatric disorder:
- Anxiety Disorders
- Depression
- Substance use disorders, Alcohol Dependence
- Borderline personality disorder
- May frequently present with somatic sx’s or pain

# Psychiatric Comorbidity (lifetime)



# Lifetime Prevalence Of PTSD ~10%

- Breslan et al ‘91
  - 9.2%
- National Comorbidity Survey ‘91 (NCS)
  - 8.7%
  - 5-6% males
  - 10-14% females
- Detroit Area Survey of Trauma ‘96
  - 14%
  - 10% males
  - 18% females

# Exposure To Traumatic Events

- Lifetime exposure to traumatic events
  - 40-69%
  - 10% get PTSD
- Higher in males/females
  - 1.2 M : 1 F

# Exposure To Trauma

| **Trauma type** | **NCS** | |
|---|---|---|
| | Male | Female |
| Rape | 0.7 | 9.2 |
| Sexual Assault | 2.8 | 12.3 |
| Combat | 6.4 | 0.0 |
| Witnessing Violence | 35.6 | 14.5 |
| Accidents | 25.0 | 13.8 |
| Car Accidents | 32.8 | 23.5 |
| Threatened with a weapon | 19.0 | 6.8 |
| Physical attack | 11.1 | 6.9 |
| Natural Disaster | 18.9 | 15.2 |
| Learning about trauma to others | 63.1 | 61.8 |
| Sudden unexpected death | 61.1 | 59.0 |

# Conditional Risk Of PTSD

- 9.2% (DSM-V)
- Females > males  2:1 (adjusted for trauma type)

# Conditional Risk For PTSD

| Trauma Type | %PTSD |
|---|---|
| Assaultive violence | 20.9 |
| Raped | 49.0 |
| Shot or stabbed | 15.4 |
| Badly beaten up | 31.9 |
| Serious car accident | 6.1 |
| Learning about trauma to others | 0.2 |
| Sudden unexpected death of a close friend or relative | 14.3 |
| Any trauma | 9.2 |

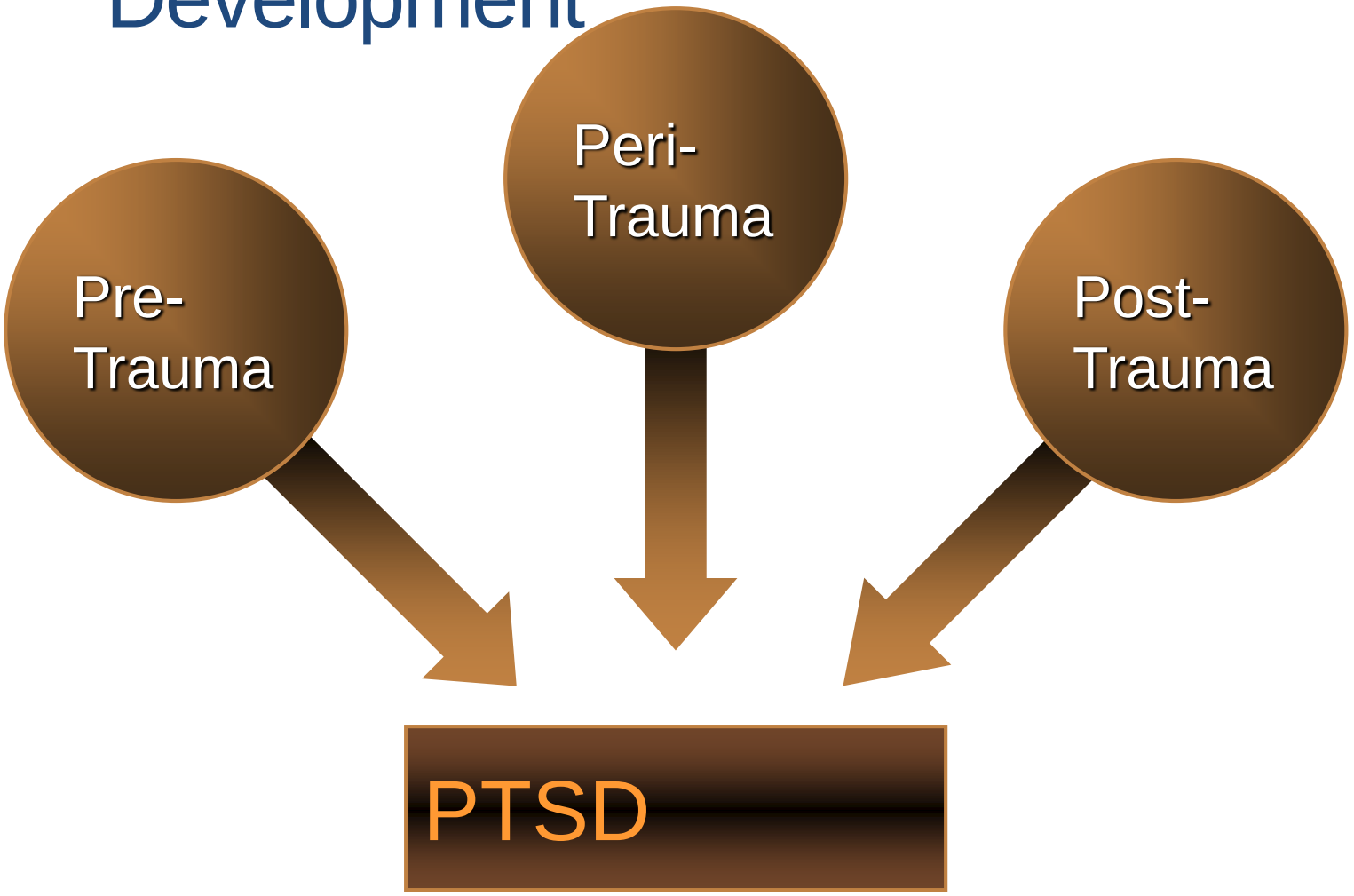
# Rape Conditional Risk

- 65% of men
- 46% of women

# Most Common Precipitating Events

- Sudden unexpected death of loved one
- 39% of PTSD in men; 27% in women. Most common cause of PTSD
- Sexual assault
- Serious illness or injury to someone close
- Having a child with serious illness
- Being beaten by a partner or caregiver
- MVA's

# Risk Factors for PTSD Development



# Pre-Trauma Risk Factors

- Female gender
- Previous trauma / younger age at time of trauma
- Childhood abuse
- Borderline Personality Issues

# Peri-Traumatic Risk Factors Influencing PTSD

- Nature of trauma (personal assault)
- Severity of trauma / chronicity of trauma

# Post-Trauma Risk Factors

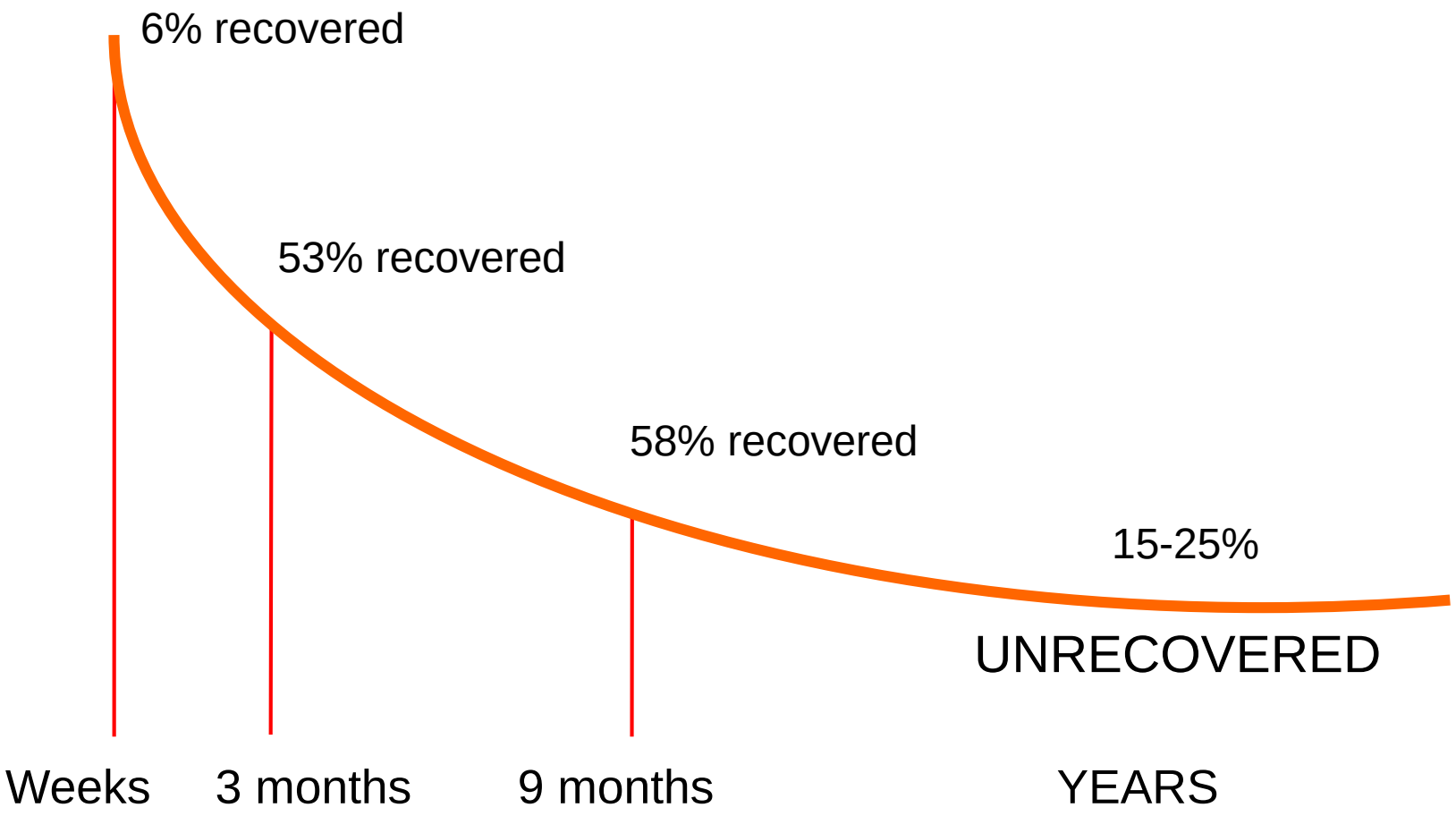
- Lack of social support
- Lack of appropriate early treatment or access to services

# Longitudinal Course

- 53% recovered at three months
- 58% recovered at nine months
- 15-25% unrecovered after years

- (natural history)

# Longitudinal Course of PTSD Symptoms




Shalev & Yehuda, Psychological Trauma 1998

# Treatment Options

Canadian Clinical Practice Guidelines for the management of Anxiety, PTSD, and OCD

Martin Katzman, et al 2014.

# Prevention and Early Intervention

- Meta analyses do not support debriefing in individuals who have been exposed to a traumatic event, but are not suffering from psychological difficulties

- In fact, these interventions may have an adverse effect on some individuals

# PTSD-Psychological Treatment

- A number of treatments have been shown to be effective. These effects have also been sustained over years:
- CBT
- EMDR
- Stress Management
- Cognitive Processing Therapy (CPT)
- Prolonged Exposure (PE), both imaginal and in vivo
- ICBT and VRE

# Combination Meds and Psychotherapy

- Research limited
- Varying results
- More studies needed

- We probably recommend doing both, though not yet evidence based

# Controversy

- Must you re-explore the trauma
  - No!
- When is the most appropriate timing
  - When the patient is ready

# CBT - Psychoeducation/Supportive Counselling

- Normal to be upset and have symptoms
- PTSD symptoms does not mean “going crazy”
- This is a common condition (10%), that is often quite treatable

# CBT-Imaginal Exposure, a Behavioural Treatment (PE)

- This is healing. It gets rid of the power of the event
- Literally, talking about the very thing you'd rather not talk about
- This is the hallmark of therapy
- Family docs can do this

# CBT- In-Vivo Exposure Therapy (PE)

- Behavioural homeworks involve exposure to avoided activities
- Usually done as hierarchy
- Can pair it with muscle relaxation
- Must stay in the activity until calm. Don’t stop activity while still anxious
- E.g. driving a car after an accident

# CAUTION!!

- I tell people talking about the difficult event is healing…..as long as they feel ready to do it

- If they feel it’s too much, I say “wait until you feel ready, and then we’ll do it”

# COGNITIVE THERAPY (CBT)

- Challenge automatic thoughts with evidence for and against
- Re-formulate to more realistic ones
- e.g. all men will assault me
- e.g. I will always have an accident

# Stress Management Training

- Give your patient the skills to handle anxiety
  - E.g. relaxation training, deep muscle
  - Self instruction
  - Breathing retraining
  - Distraction technique/thought stopping

# EMDR

- EMDR - Eye movement desensitization and reprocessing
- Pairs imaginal exposure with the induction of saccadic eye movements

# Recommendation for Pharmacotherapy for PTSD

**First-line**

Fluoxetine, paroxetine, sertraline, venlafaxine XR

**Second-line**

Fluvoxamine, mirtazapine, phenelzine

**Third-line**

Amitriptyline, aripiprazole, bupropion SR, buspirone, carbamazepine, desipramine, duloxetine, escitalopram, imipramine, lamotrigine, memantine, moclobemide, quetiapine, reboxetine, risperidone, tianeptine, topiramate, trazodone

# Recommendation for Pharmacotherapy for PTSD

***Adjunctive Therapy:***

Second-line: eszopliclone, olanzapine, risperidone

Third-line: aripiprazole, clonidine, gabapentin, levetiracetam, pregabalin, quetiapine, reboxetine, tiagabine

Not recommended: bupropion SR, guanfacine, topiramate, zolpidem

**Not recommended**

Alprazolam, citalopram, clonazepam, desipramine, divalproex, olanzapine, tiagabine

# Treatment

- Prazosin has been shown to be significantly effective for reducing trauma nightmares and improving sleep quality in patients with PTSD (Level 1 evidence)

- Start at 1 mg. HS, can increase to 2 mg. , 5 mg., 7 mg. Watch for signs of hypotension.

# Pharmacotherapy

- For insomnia, consider treatment with Trazodone 25-50mg PO QHS
- For significant anxiety, short term treatment with a Benzodiazepine can be used, though we try to avoid
- Atypical antipsychotics have been used as adjuncts in difficult cases (Psychiatry)

# Example: Sexual Abuse

- Ask regarding nightmares, flashbacks, avoidance, triggers, mood
- “Not your fault”, “metaphorically bound and gagged”
- “If there’s anything I ask you that you would rather not answer, you don’t ...”
- Support
  - Validate feelings – anger, hatred
- Normalize issue of self esteem, trust, intimacy, sexuality
- Pressure cooker analogy

# WE'RE DONE!!

Questions?

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# Please fill out your session evaluation n

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Session #:S56

Session Name:Approach to PTSD in Primary Care

YOUR FEEDBACK IS IMPORTANT TO US!