Approach to PTSD in Primary Care

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Faculty/Presenter Disclosure

- **Faculty: Dr.** Jon Davine

- **Relationships with financial sponsors:**
  - **Any direct financial relationships including receipt of honoraria: Pri-Med Canada/Humber River Health, William Osler Health, Peterborough FHT, McMaster CME, KW Family Medicine, Ont. College of Family Physicians, Touchstone Institute, Trillium Health, CME Away by Sea Courses, Trillium Health Partners.**
  - **Memberships on advisory boards or speakers' bureau: No**
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  - **Other: financial relationships/investments: CAMH, Toronto, Co-Editor of Book, "Psychiatry in Primary Care"**

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Objectives

Learn effective questioning to make the diagnosis of PTSD

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

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

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.

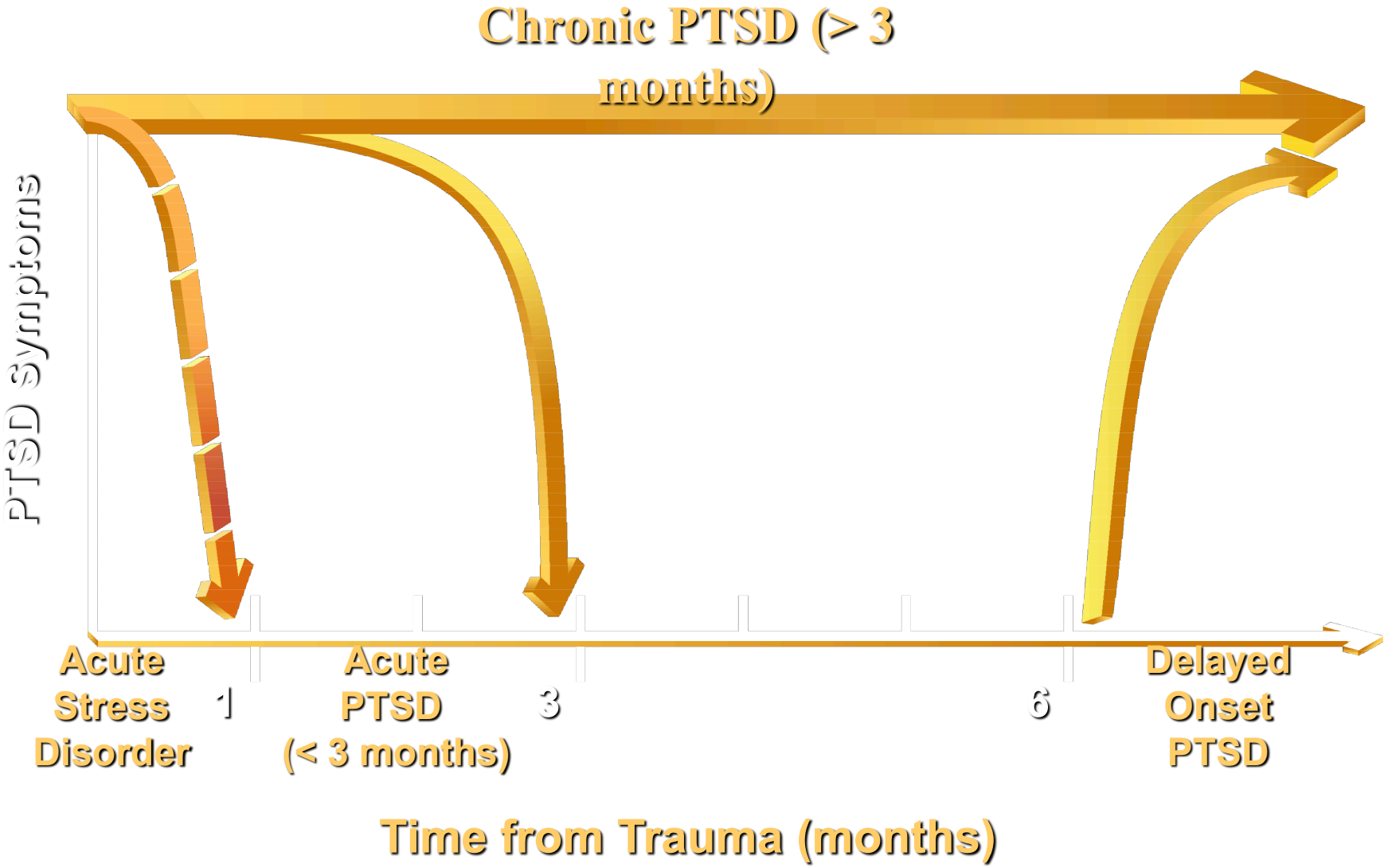
DSM-V Diagnosis of PTSD

- 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.

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?

PTSD Screens

1. “Primary Care PTSD DSM-5” (PC-PTSD-5)

   This is a 5 item self report. If you google this they will tell you how to score, and you can download the questionnaire

2. 2. PTSD Checklist for the DSM-5 (PCL-5)

   This is a 20 item self report. This can be used for both screening and following treatment results. Again, if you google this, it tells you how to score and and you can download the questionnaire.

Primary Care PTSD DSM-5 (PC-PTSD-5)

- 1. Exposure to abusive, assaultive event
- If yes,
- 5 yes or no questions, e.g nightmares, avoiding, on guard, numb, guilty.
- 3 or more considered positive screen

PTSD Checklist (PCL-5)

- In the past month have you been bothered by…
- 20 questions, from 0 (not at all) to 4 (extremely)
- Unwanted memories, disturbing dreams, flashbacks, triggers, avoiding, etc.
- Scored out of 80.
- 31-33, or more is considered positive for PTSD dx.
- This can be used for both Dx and following Tx results

When is a hallucination NOT a hallucination

- 1. Hypnagogic and hypnopompic (always ask when!)
- 2. Grief Reactions (always ask who!)
- 3. PTSD flashbacks (always ask re meaning, can be any of the 5 senses)

PTSD Comorbidity

- 75% have another psychiatric disorder:
- Anxiety Disorders
- Depression (48%)
- Substance use disorders, Alcohol Dependence (40%)
- Borderline personality disorder
- May frequently present with somatic sx’s or pain

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)

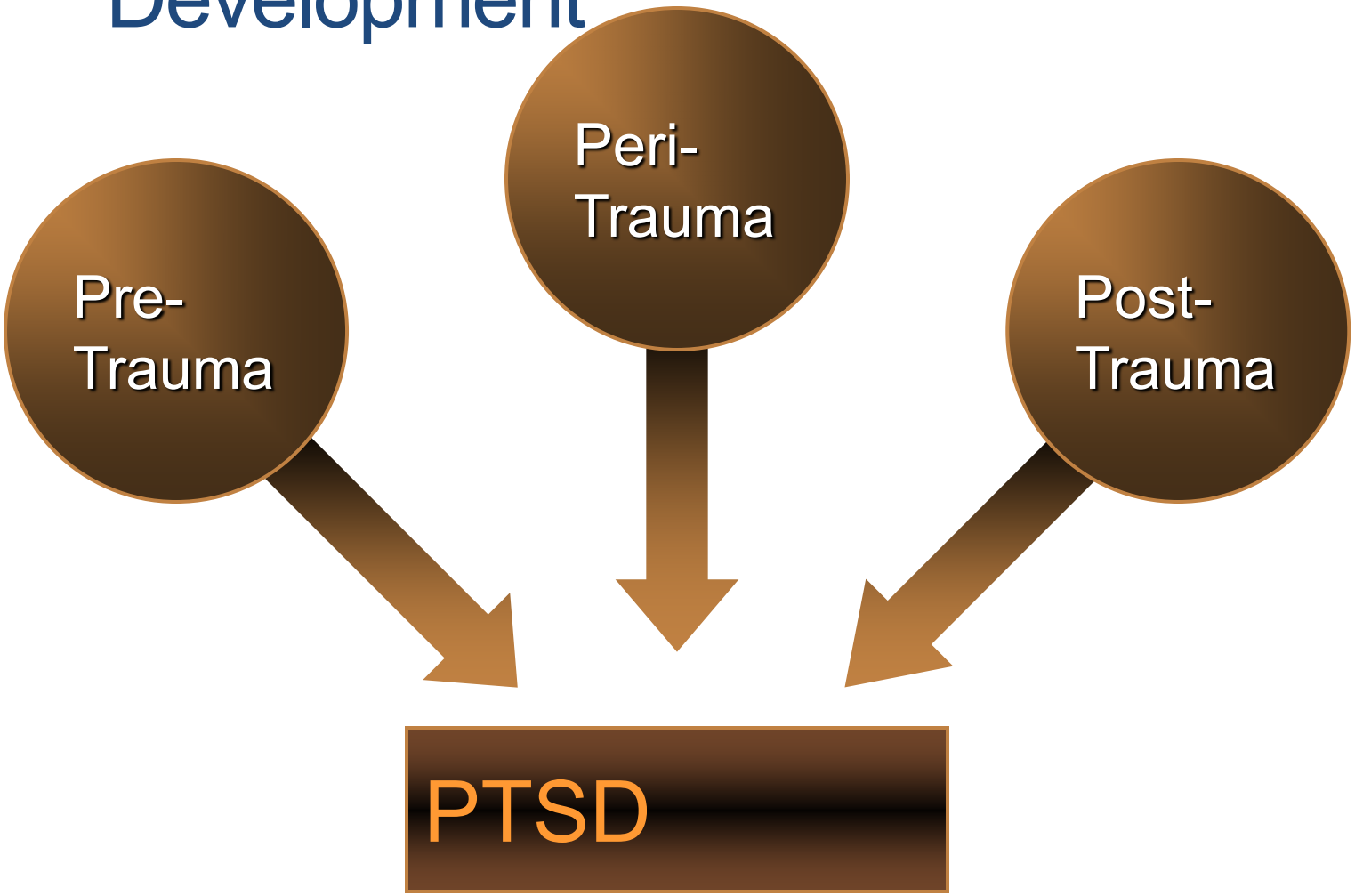
Conditional Risk For PTSD

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

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

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

Martin Katzman, et al 2014.

NICE Guidelines (2018)

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

- This is supported by the NICE guidelines (Dec. 2018)

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
- Prolonged Exposure (PE), both imaginal and in vivo

- NICE guidelines (Dec. 2018) support CBT, EMDR, stress management, PE, CBT-insomnia, and internet CBT(if not severe)

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

Complex PTSD

- ICD-11 has subset called Complex PTSD
- Usually horrific, threatening, prolonged, repetitive, personally assaultive
- Often associated with severe problems in affect regulation
- DSM-5 has “dissociative subtype”
- Personal difficulties in relationships, deep feelings of shame, guilt

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
- Primary Care Practitioners 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
  - Breathing retraining

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

Katzman M et al, 2014.

NICE Guidelines (Dec. 2018)

- Recommend SSRI's, using Sertraline as their example
- Also recommend Venlafaxine
- Recommend Risperidone if severe, psychotic, or not improving with other drugs
- No drugs in the under 18 population

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

WE'RE DONE!!

Questions?