

PTSD: Assessment, diagnosis, treatment and management in primary care

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Disclosure

No financial relationships to disclose

Unfixable Suffering

Trauma: sense of helplessness in the face of unfixable suffering

Judith Herman

Outline

- Assessment and Diagnosis
- Treatment
 - Psychopharmacological
 - Psychological
- In-office skills

Assessment and Diagnosis

PTSD DSM-IVTR Diagnostic Criteria

- A. Exposed to a traumatic event
- B. Traumatic event is persistently re-experienced
- C. Persistent avoidance of stimuli associated with traumatic event and numbing
- D. Persistent symptoms of hyperarousal not present before event
- E. Symptoms' duration is more than 1 month
- F. Symptoms cause clinically significant distress or impairment at home or work

PTSD DSM-V Diagnostic Criteria

- A. Exposure or witness
- B. Re-experiencing
- C. Avoidance
- D. Negative cognitions and mood
 - From a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event
- E. Arousal
 - Aggressive or reckless or self-destructive behaviour, sleep disturbance, hypervigilance or related problems

B Intrusion (1/5 symptoms needed)

1. Recurrent, involuntary and intrusive recollections
2. Traumatic nightmares
3. Dissociative reactions (e.g. flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness
4. Intense or prolonged distress after exposure to traumatic reminders
5. Marked physiological reactivity after exposure to trauma-related stimuli

C Avoidance of Trauma-related Stimuli (1/2):

1. Trauma-related thoughts or feelings
2. Trauma-related external reminders (e.g. people, places, conversations, activities, objects or situations)

D. Negative alterations in cognitions /mood began or worsened after event (2/7)

1. Inability to recall key features of event
2. Persistent negative beliefs and expectations about oneself or world (e.g. “I am bad,” “the world is completely dangerous”)
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences
4. Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame)

D. Negative alterations in cognitions /mood began or worsened after event (2/7)

5. Markedly diminished interest in (pre-traumatic) significant activities
6. Feeling alienated from others (e.g. detachment or estrangement)
7. Constricted affect: persistent inability to experience positive emotions

E. Trauma-related alterations in arousal and reactivity after event

(2/6)

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

PTSD Symptoms: Clinical Course

- PTSD symptoms usually present within first 3 months following the traumatic event
 - Less frequently, symptom onset may be delayed for months or years
 - Symptoms of PTSD may persist for months or years
- Approximately 50% of all cases are chronic
 - Acute: Duration of symptoms of less than 3 months
 - Chronic: Duration of symptoms is 3 months or more

Common Misdiagnosis

PTSD SX

1. Flashback
2. Avoidance
3. Numbing
4. Hyperarousal
5. Hypervigilance

Mis-Dx

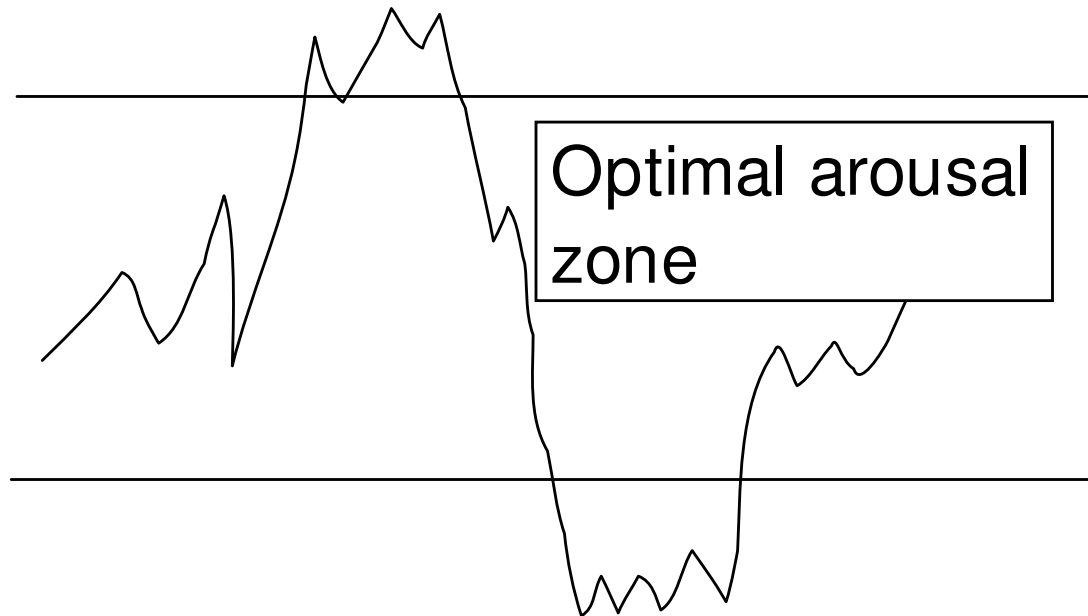
1. Hallucinations
2. Schizoid/avoidant PD
3. Depression
4. Anxiety, Bipolar
5. Paranoia

Cyr & Farrar, Ann Pharmacother 2000

Window of Tolerance

Hyperarousal

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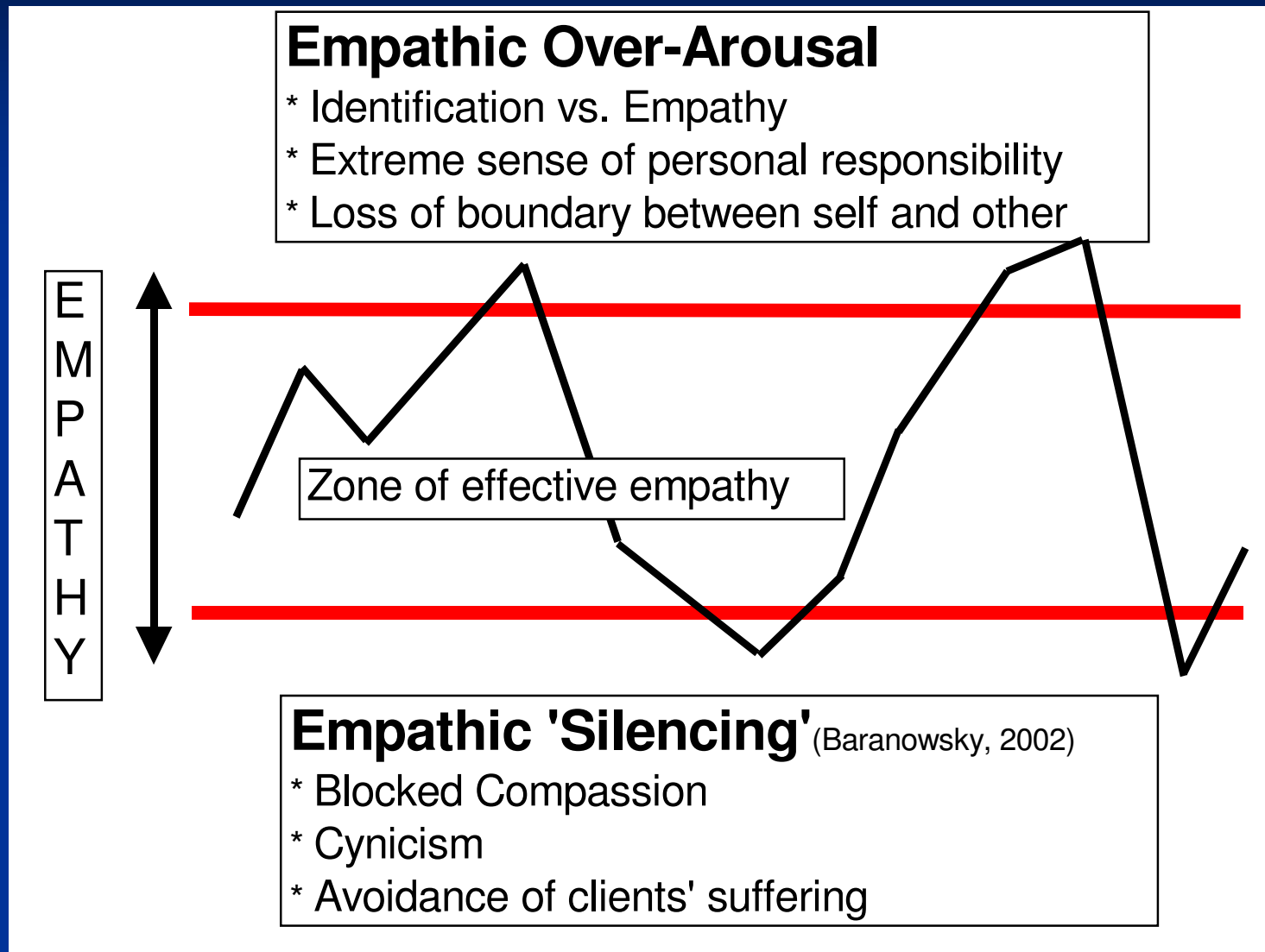


Hypoarousal

Vicarious Traumatization

- Vicarious Traumatization (McCann & Pearlman, 1990)
 - incomplete empathic engagement and sense responsibility to help
- Secondary Traumatic Stress (Stamm, 1995)
 - knowledge of trauma experienced by another
- Compassion Fatigue (Figley, 1995)
 - preoccupation with individual or trauma

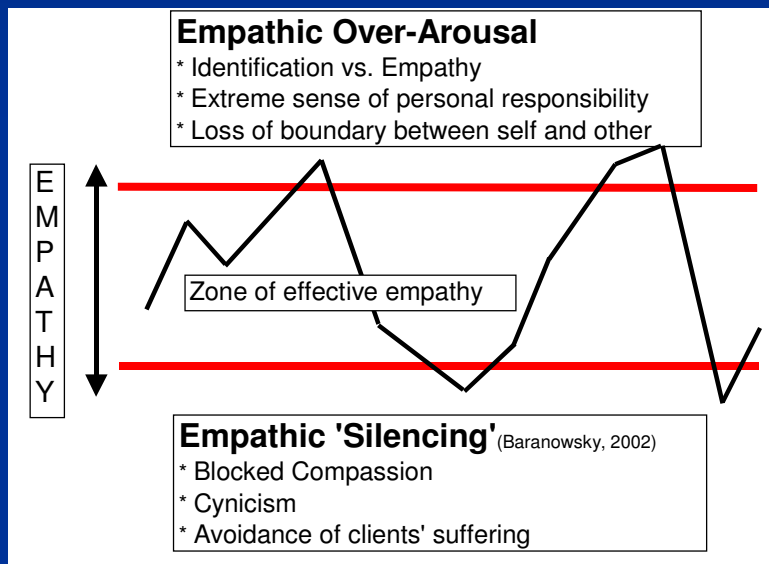
Window of Effective Empathic Engagement



Window of Effective Empathic Engagement

Over-Arousal

- Activation of personal trauma history
- Transfer of intensity/anxiety from self to other



Silencing Response

- Minimizing others' distress
- Avoiding the topic/Fearing what the other person has to say
- Blaming others for their experiences
- Feeling numb

Mediating Factors

Self

- Life stage
- Current personal stressors
- Stress Hardiness
- Spiritual Connection
- Resolution of personal trauma history

Work

- Supervision: Skill based/Support based
- Degree of isolation/Agency
- Experience: History/Training/Skill Level
- Quality of working relationships
- Ecological context

Pre-Trauma Risk Factors

- Female gender
- Prior exposure/ younger age at time of trauma
- Witness past trauma
- Childhood abuse
- Trait neuroticism / coping style
- Past psychiatric history
- Family psychiatric history
- Low SES, less education

Peri-Traumatic Risk Factors Influencing PTSD

- Nature of trauma (known/unknown, personal/group)
- Severity of trauma / chronicity of trauma
- Severity of acute symptoms / physiological reactivity
- Dissociation at time of trauma (chemical and non-chemical)
- Perceived agency
- Potential for mortality

Post-Trauma Risk Factors

- Social support
- Appropriateness of early treatment or access to services
- Shame / guilt / self-doubt
- Recovery-related secondary stressors (secondary trauma)
- Ongoing life stressors

In-office assessment and observation

Assessment Tools

Interview-Based Scales

- Clinician Administered PTSD Scale (CAPS) Blake et al 1990(b)
- Structured Interview for PTSD (SIP) Davidson et al 1997
- Treatment Outcome PTSD Scale (TOP-8) Connor and Davidson 1999
- Short PTSD Rating Interview (SPRINT) Connor and Davidson 2001

Assessment Tools cont'd.

Self-Rating Scales

- Trauma Symptom Inventory (TSI) Briere, 1995
- Impact of Event Scale (IES) Horowitz et al 1979
- Mississippi Combat and Non-Combat Scales Keane et al 1988
- PENN Inventory Hammerberg 1992
- Foa PTSD Symptom Scale - Self-Report (PSS) Foa et al 1993
- Davidson Trauma Scale (DTS) Davidson et al 1997

Clinical Presentation to the Physician

- Sleep complaints
- Somatic symptoms
- Depression
- Other comorbid anxiety disorders
- Substance use
- Suicidal ideation / ER visits
- High rate of medical service consumption
- Isolation
- Anger/Irritability (family/relationship concerns)
- other coping mechanisms (seeking excitement, overworking)

Hidalgo & Davidson, J Clin Psychiatry 2000

In Office Concerns

- Awkwardness asking certain questions
- Patient triggered by certain examination
- Retraumatize patient
- Compliance
- Personal trigger from patient
- Challenging therapeutic rapport
- Referral sources
- Others?

Treatment

PTSD TX

Noncomorbid
Children, Adults,
Geriatric Patients

Mild PTSD

Psychotherapy first

More severe PTSD

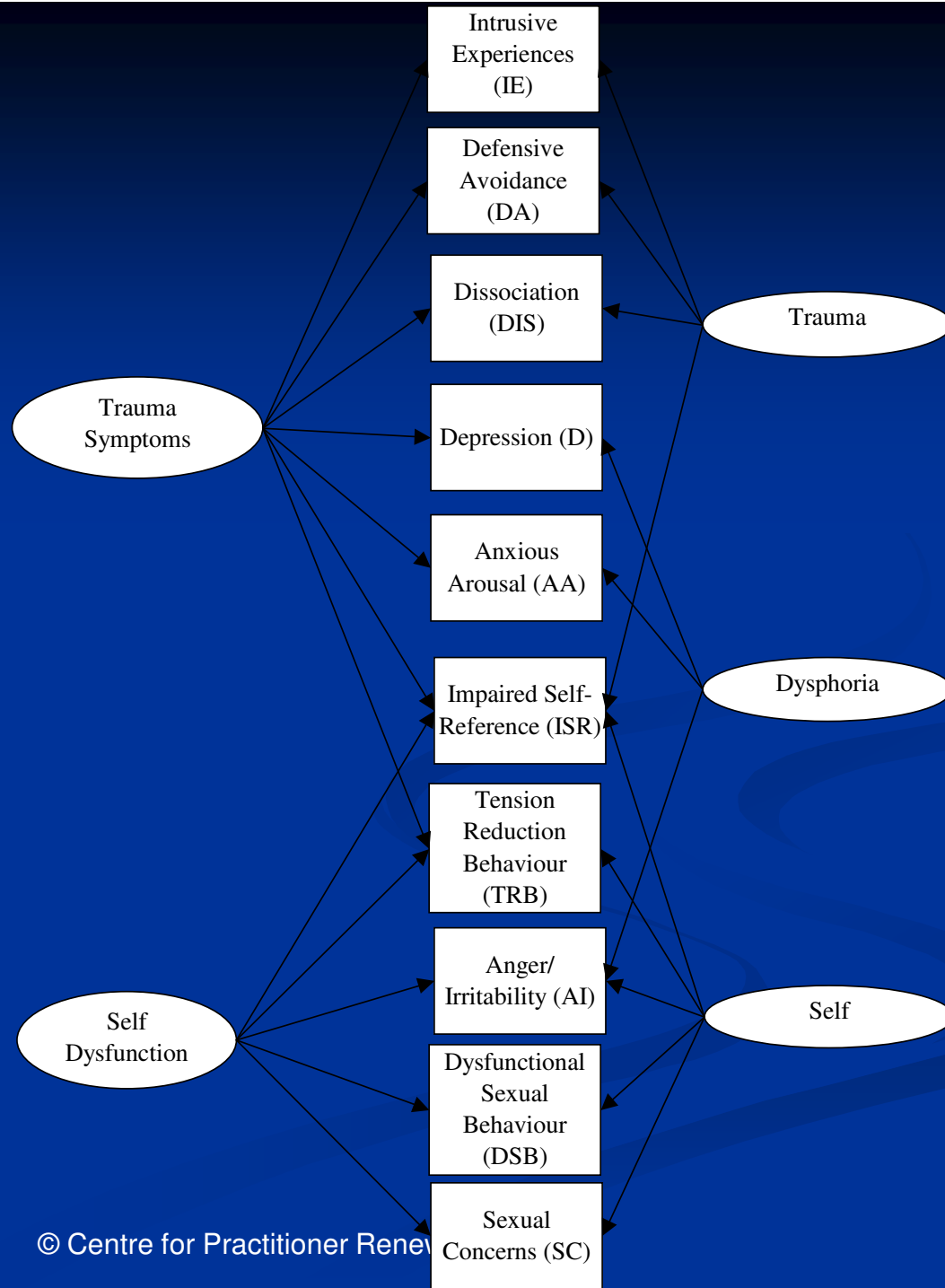
Psychotherapy first
or combine
meds/psychotherapy

Treatment Goals

- Reduce core symptoms
- Improve stress resilience
- Improve quality of life
- Reduce disability
- Reduce comorbidity
- Prevent relapse
- Isolation
- Balanced emotional expression
- Reduce unhelpful tension reducing behaviours

Davidson, J Clin Psychiatry 2000

**Briere, J. (1995).
Trauma
Symptom
Inventory:
Professional
manual.**



Psychopharmacological Treatment

Pharmacotherapy Goals

- Manage Sx
- Medication suppress activation of traumatic memories and affects
- With time trauma-related reactions may lessen, returning to more adaptive experiences
- Pharmacotherapy can help reduce core symptoms, improve stress resilience, and improve quality of life

Limitations of Pharmacotherapy:

- Impossible to provide new experiences to modify complex schema violation and influence future behaviour

SSRIs for PTSD

- Effective in PTSD
- Improved all core PTSD clusters
- Effective with:
 - Both genders
 - Effective in All trauma types
 - Co-morbid type

Benzodiazapine

- Do not eliminate global PTSD Sx
- Beta- and Alpha-blockers treat anxiety related Sx of PTSD, but not the global Sx

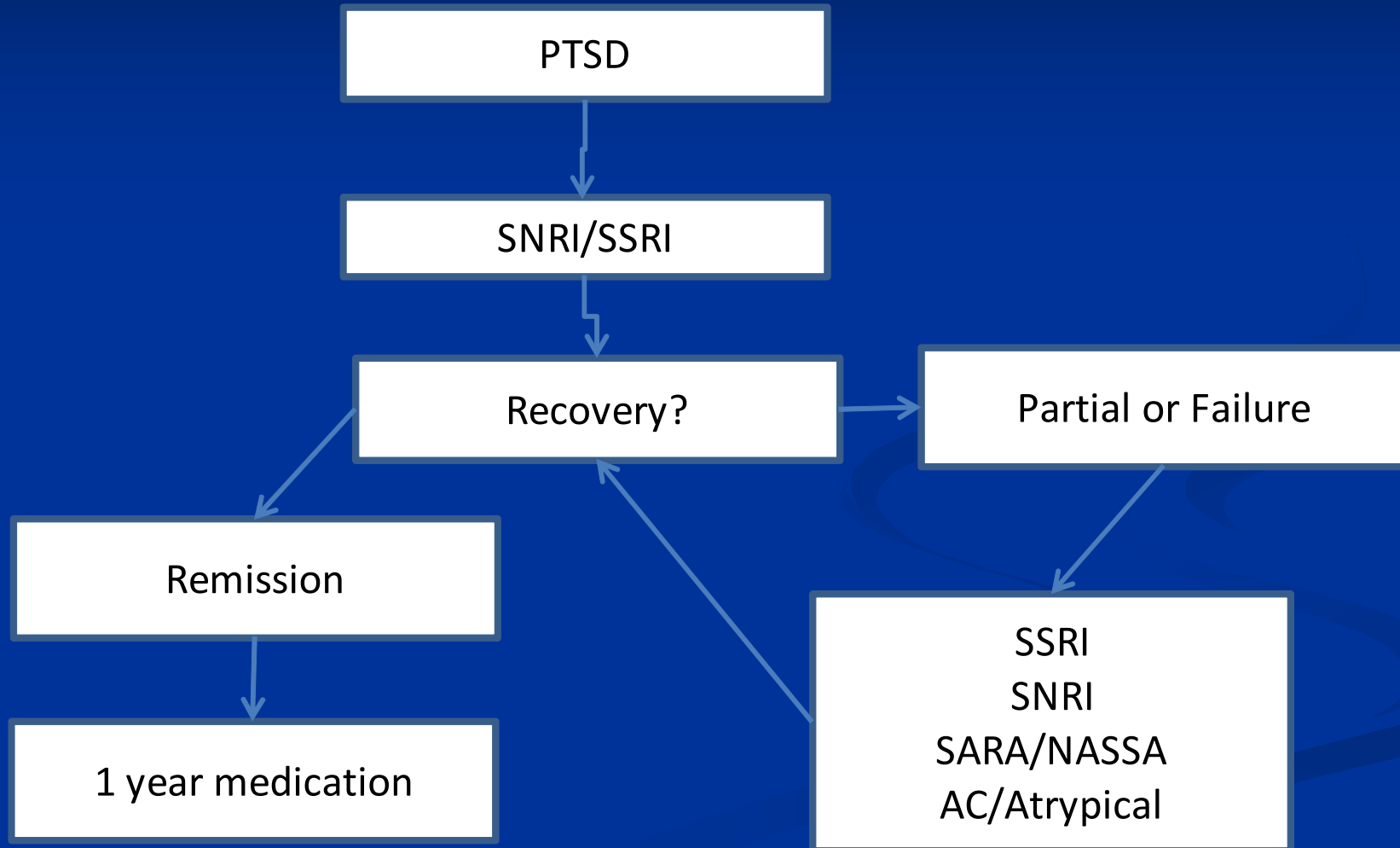
Rationale for Mood Stabilizers and Antikindling Agents

- Limbic structures including the amygdala and hippocampus have a low threshold for sensitization and kindling
- Hypothesized to contribute to increased physiologic reactivity in PTSD
- Intrusive imagery and flashbacks may be consequences of sensitization and kindling

Dosing Considerations

- Start low (50% of usual dose)
- Go slow
 - Titrate to maximum dose over 4-8 weeks
 - Titrate to side effects
- Aim sufficient (mid to upper dose ranges)
- Wait long enough for response (8-12 weeks)

Medication Strategy



Conclusion

- SSRIs are the most studied drug treatments for PTSD and remain the treatment of choice
- Paroxetine is indicated in the treatment of PTSD in Canada while Paroxetine and Sertraline are indicated in the U.S.
- While SSRI treatment does improve symptoms of PTSD, patients often remain symptomatic
- Several new uses of psychotropic agents, alone or as adjunct treatment, require further study

Psychological Treatment

Treatment Model

1. Safety
2. Remembering/Mourning
3. Reconnection

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Treatment Modalities

- Interpersonal – foundation for all approaches (safety)
- Exposure (in vivo/imagined)
- CB restructuring (cognitive needs to be addressed with behaviour/emotion)
- EMDR
- Self-soothing – self regulation
- Action (therapeutic enactment/sensory motor)

In office activities

In Office Activities

- Grounding
- Normalizing (universality)
- Psychoeducation (handouts, books)
- Psychological treatment preparation (normalizing)

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