

WB07: The Hidden Face of PTSD: How to Identify and Approach PTSD in Primary Care

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PTSD resources and teaching tools

1. **NIMH:** good basic information on PTSD, patient handouts. Concise summaries of recent research.

<http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>

2. **National Center for PTSD (VA):** excellent listing of treatments, training videos, handouts for patients. The site is not entirely geared toward veterans.

<http://www.ptsd.va.gov/>

3. **ISTSS** (International Society for Traumatic Stress Studies): an international, interdisciplinary professional organization that promotes advancement and exchange of knowledge about traumatic stress. Guidelines on treatment for PTSD, teaching section with best practice parameters.

<http://www.istss.org/EffectiveTreatmentsforPTSD2ndEdition/2673.htm>

4. **NAMI** (National Alliance on Mental Illness). NAMI is the major national advocacy organization for persons with mental illness, and contains a lot of useful patient education information. It is also very helpful for providers to be able to direct patients (and their families) to local chapters and meetings.

www.nami.org

PTSD in print and the news (some faculty find using literary or entertainment references useful in teaching students):

http://www.newyorker.com/reporting/2008/09/29/080929fa_fact_finnegan

Selected References :

Review articles:

Nakell, L. Adult Post-Traumatic Stress Disorder: Screening and Treating in Primary Care. *Prim Care Clin Office Pract.* 2007; 34: 593–610. Provides an overview of how patients present, challenges for PCPs and brief detection methods.

PTSD and Physical Health

Schnurr PP, Green BL. *Trauma and health: Physical health consequences of exposure to extreme stress.* Washington, D.C.: American Psychological Association; 2004.

Gill JM, Szanton S, Taylor TJ, Page GG, Campbell JC. Medical conditions and symptoms associated with posttraumatic stress disorder in low-income urban women. *J Womens Health (Larchmt).* Feb 2009;18(2):261-267.

Dennis MF, Flood AM, Reynolds V, et al. Evaluation of lifetime trauma exposure and physical health in women with posttraumatic stress disorder or major depressive disorder. *Violence Against Women.* May 2009;15(5):618-627.

PTSD in primary care:

Liebschutz J, Saitz R, Brower V, et al. PTSD in urban primary care: high prevalence and low physician recognition. *J Gen Intern Med.* Jun 2007;22(6):719-726.

Lowe B, Kroenke K, Spitzer RL, et al. Trauma exposure and posttraumatic stress disorder in primary care patients: cross-sectional criterion standard study. *J Clin Psychiatry.* 2011; 72 (3): 304-12.

Stein MB, McQuaid JR, Pedrelli P, Lenox R, McCahill ME. Posttraumatic stress disorder in the primary care medical setting. *Gen Hosp Psychiatry.* Jul-Aug 2000;22(4):261-269.

Alim TN, Graves E, Mellman TA, et al. Trauma exposure, posttraumatic stress disorder and depression in an African-American primary care population. *J Natl Med Assoc.* Oct 2006; 98(10):1630-1636.

Brief screening tool:

PC-PTSD (4 items)

The 4-question Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:*

1. Have had nightmares about it or thought about it when you did not want to?	Yes or No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes or No
3. Were constantly on guard, watchful, or easily startled?	Yes or No
4. Felt numb or detached from others, activities, or your surroundings?	Yes or No

*A score of 3 or higher should prompt additional evaluation.

Source: Prins A et al. *Prim Care Psychiatry*. 2003.

Comparison of brief screens for PTSD

Screens for PTSD	# of items	Time to Admin. (in min.)	Allows Multiple Trauma	Corresponds to DSM-IV Criteria
BAI-PC	7	3	Yes	N/A
Primary Care PTSD Screen (PC-PTSD)	4	2	Yes	N/A
Short Form of the PTSD Checklist	6	2	Yes	N/A
Short Screening Scale for PTSD	7	3	Yes	N/A
SPAN	4	2	Yes	N/A
SPRINT	8	3	Yes	N/A
Trauma Screening Questionnaire (TSQ)	10	4	Yes	N/A

(Excerpted from <http://www.ptsd.va.gov/professional/pages/assessments/screens-for-ptsd.asp>)

Cases for Breakout sessions

Case 1 (25 minutes)

HH* is a 28 yo woman who comes for a visit to establish care with a new primary care provider. She has recently moved back from out of state to live closer to her family especially an elderly father, age 80. She states that her most pressing problems are getting enough sleep and pain in her back and all over her body for the last few years.

The patient feels extremely anxious and watchful all the time. She cannot sleep more than 3-4 hours per night. She wants to go back to school but cannot sleep more than 3-4 hours per night. She is tearful when talking about her physical pain. She says it is so severe she even has pain with dressing and bathing. She also says that her pain makes it hard for her to sleep. She is evasive when asked about her sexual history. She has never seen any specialists for these problems. She has no other medical problems and was only prescribed depo-provera and clonazepam by her prior PCP.

1. *Could she have PTSD, what features in the history are consistent with this diagnosis? What is the differential?*
2. *What other history should you gather now, what would be useful to know?*

When you ask about nightmares, she answers “sometimes.” She reports being watchful, but attributes this to recently moving to downtown Boston, she remains evasive about trauma/sexual assault, IPV. She states she is not in a relationship at this time and mostly just sees a cousin and her father. On the way out, she asks you to refill the clonazepam prescription that her prior internist prescribed, saying it is the only medication that helps her sleep.

1. *Should/would you renew her benzodiazepine?*
2. *What evidence based treatment can you offer her at this point?*

At the end of your last visit, you agree to refill her clonazepam, but request that she make an appointment with a mental health specialist and explain that you will only refill it until she is seen by a specialist. You also agree to refill her depo-provera and ask that she return for a screening pap smear.

In the subsequent months, she schedules then cancels mental health intake multiple times. In between appointments, she continues to call for benzo refills and complains of severe sleep problems. On one visit, you prescribed trazodone, but she says it “did nothing.” She readily agreed to do a urine toxicology screen which came back positive for benzodiazepines, but nothing else.

She also continues to request depo provera but is a no-show for her pap smear appointment. Despite your request to reschedule in one month,, she returns 3 months later. When you ask HH why she is not going to appointments, she states that her elderly father has been in the hospital for bypass surgery.

1. *How would you address her repeated mental health cancellations (that are frustrating to you)?*
2. *Is there anything more you can do to help her sleep?*
3. *How can you explore her reluctance to have a pap smear? Should you?*

What if you discovered that HH is a veteran? How would this change your management or the way you counsel her?

Case 2 (25 minutes)

SH is a 51 y.o. man seen in residents' clinic. He was recently incarcerated and arrives with prison medical records. He told the front desk staff that he refuses to see male physicians. The medical assistant noted that he "didn't look right" and that he was jumpy, agitated and impatient when she tried to take his vital signs. His chief complaint was noticing blood in his stool over the past several weeks. He also told the resident that his father had colon cancer in his 50s. His own past medical history is notable for hypertension and hyperlipidemia. His medications include lisinopril, simvastatin, and fluoxetine. The PGY-3 resident comes to speak with you because the patient got very upset during the examination, raising his voice and acting suspicious of the need for this exam. She has asked him to get undressed from the waist down for a rectal exam.

1. *What is your differential for this patient's behavior?*
2. *What do you do next as a preceptor?*

Your resident comes back after she has tried to examine the patient. He declined the exam and she describes him as "odd and a little bit scary." She states he seems to be unable to focus his eyes on her and seems to be agitated and looking around the room. He has said a name she doesn't recognize a few times. She thinks things got worse when she asked him questions about his father's cancer or possibly when she started discussing the need for a colonoscopy with him.

1. *What could be going on?*
2. *What were possible triggers for this episode of strange behavior? Could they have been avoided?*
3. *What do you do next?*

You accompany the PGY-3 resident back into the exam room and interview the patient. He answers your questions in a vague tangential manner and has great difficulty making eye contact. He jumps when the door closes behind you.

1. *How can you help this patient feel better right now?*
2. *What skills can the resident learn from the encounter to better manage this kind of patient in the future?*

After you have spent some time conversing with the patient about his hobbies and favorite sports teams, he seems to be calmer and in better contact.

1. *How should we proceed with this patient now? What are some strategies to help him obtain this needed invasive test?*
2. *How do you know if the patient is safe to leave clinic that day? If there is no MH colleague available, how will you decide if he be sent to the E.D.?*

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