

Spotting—and treating—PTSD in primary care

Combat, sexual assault, and random violence have left millions of Americans with PTSD. A 4-question screen can help you determine if your patient is among them.

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PRACTICE RECOMMENDATIONS

➤ *Adopt a staged screening approach to PTSD, starting with a validated 4-question screen for patients with risk factors, and following up, as needed, with a longer (17-item) symptom checklist. (C)*

➤ *Prescribe SSRIs as first-line medication for PTSD, augmented by other agents, if necessary, for symptom control. (A)*

➤ *Enhance your ability to recognize and respond to patients with PTSD through continuing education, psychotherapy, participation in a Balint group, and/or expert consultation. (C)*

Strength of recommendation (SOR)

- A** Good-quality patient-oriented evidence
- B** Inconsistent or limited-quality patient-oriented evidence
- C** Consensus, usual practice, opinion, disease-oriented evidence, case series

CASE. Maureen S,* a patient in her late 50s with chronic pain due to severe degenerative disc disease and early-stage chronic obstructive pulmonary disease (COPD) from years of smoking, was referred to me (JRF) 5 years ago after her physician relocated. Because of her chronic health problems, I began scheduling monthly visits. But she rarely followed through on my recommendations, whether for smoking cessation, physical therapy, pain management, or mammography screening. As I got to know Maureen, it was clear that she was chronically depressed and anxious. I began asking her why she didn't take better care of herself.

Gradually, she provided the answers. Throughout her childhood, Maureen confided, her mother had subjected her to severe corporal punishment. From the time she was 7 until she reached her teens, Maureen's "uncle" had sexually abused her. As an adult, she'd had a series of abusive relationships. The patient's poor health and failure to care for herself, I suspected, were related to chronic post-traumatic stress disorder (PTSD).

CASE. Dominic T,* a 46-year-old construction worker, had always been in good health and remained active, both on the job and off. He came to my office (JRF) for the first time because he was "a little down" and suffering from insomnia.

As I examined Dominic and took a medical history, it was easy to understand why. Three months earlier, he had been involved in an industrial explosion. Dominic had sustained burns on his arms, neck, and upper torso; his buddy, who had been working beside him, died. Upon questioning the patient further, I discovered that he was also having nightmares and panic attacks, often triggered by loud noises. I suspected that he, like Maureen, suffered from PTSD.

*Patients' names and certain details of their cases have been changed to protect their privacy.

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PTSD AND SUICIDE PREVENTION

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Sexual assault is the leading cause of PTSD in women; violence, often combat-related, is the chief cause in men.

The lifetime prevalence of PTSD in the general population is estimated at 7% to 8%, with about 10% of women and 5% of men developing the disorder at some point in their lives.¹ But in primary care settings, where patients often seek medical care related to the situations or experiences that are associated with PTSD, it is generally believed that the rates are 2 to 3 times higher.^{2,3}

In women, rape is the leading cause of PTSD.³ Nearly 13% of US women will be sexually assaulted at some point in their lives,⁴ and 25% to 50% of them will develop PTSD as a result.³ In men, violence—often combat-related—is the No. 1 cause.³

Overall, PTSD costs an estimated \$3 billion a year in lost productivity in the United States—similar to that of major depression.³ A more recent estimate, based solely on PTSD among US troops and on the assumption that 15% of those who return from deployment will develop PTSD, projects a 2-year cost of \$3.98 billion for this population alone.⁵ Clearly, PTSD is not a condition we can afford to overlook.

Untreated PTSD: The impact is severe

The effect of PTSD on patients, families, and society is profound. Mental health comorbidities, including depression, other anxiety disorders, alcohol abuse, and suicidal ideation commonly complicate treatment.^{2,3} PTSD is associated with functional impairment—underachievement in school and work, and relationship difficulties—and behaviors that represent health risks, such as smoking, overeating, inactivity, and nonadherence to treatment. In addition, PTSD often goes hand-in-hand with chronic conditions such as diabetes and COPD.^{2,6}

While patients with PTSD are often hesitant to talk about psychological symptoms, they often present with vague, and persistent, physical complaints.^{2,6} Experienced primary care physicians sometimes discover that their most troubling patients—those who are chronically depressed, anxious, or preoccupied with somatization, and nearly impossible to console—may actually be suffering from chronic PTSD.^{3,7}

Diagnostic criteria and PTSD risks

There are 6 diagnostic criteria for PTSD (TABLE 1).⁸ In addition to 1 or multiple traumatic precipitating events, the patient must suffer from intrusive thoughts or reactions (re-experiencing), detachment or other withdrawal (avoidance/numbing), and sleep disturbance, hypervigilance, or other disturbing reactions (arousal) as a result. In addition, the symptoms must persist for 1 month or more and impair the patient's academic, occupational, or social functioning.⁸

The time that has elapsed since the traumatic event is also a factor in diagnosis (TABLE 2).⁸ While PTSD can be acute (lasting months prior to full resolution), symptoms more often follow a chronic, recurrent course,^{2,3} as in Maureen's case.

However, the 4 categories—acute, chronic, delayed, and subclinical PTSD—are not mutually exclusive; an acute case may become chronic if it is unrecognized and untreated; subclinical PTSD may be reactivated by recent reminders of a past traumatic event.² Several years after Dominic returned to baseline function, for example, a fire in a neighbor's home triggered another acute episode.

When to suspect PTSD: A review of risk factors

A history of trauma (particularly rape or other forms of sexual assault, physical assault involving weapons, severe injury or perceived life threat, or combat exposure); personal or family mental health problems; substance abuse; vague, persistent medically unexplained physical symptoms; physical injuries; and pregnancy (4%-8% of US women are physically abused during pregnancy⁹) are key risk factors for PTSD.^{2,3,10-12}

Straightforward as that may seem, physicians frequently fail to consider PTSD in the differential diagnosis—and patients often fail to discuss symptoms. Some patients avoid talking about their problems because of the stigma of mental illness. Others, like Maureen, know little about PTSD and are unaware that events that occurred many years ago can have a profound effect on them now.¹³

Barriers to detection

There are no specific recommendations for

TABLE 1

Diagnostic criteria for PTSD

Diagnostic criteria	Distinguishing features
Traumatic event	Experienced, witnessed, or was confronted with an event involving actual or threatened death or serious injury, or threat to physical integrity; responded with intense fear, helplessness, or horror
Reexperiencing trauma (≥1 feature)	Intrusive thoughts, nightmares, flashbacks, intense psychological distress to internal/external cues; physiologic reactivity to cues
Avoidance/numbing (≥3 features)	Avoidance of internal/external cues; trauma-related amnesia; diminished interest or participation, social detachment/estrangement; restricted affect; sense of foreshortened future
Arousal (≥2 features)	Sleep disturbance, irritability/anger, concentration difficulty, hypervigilance, exaggerated startle response
Duration	Symptoms persist ≥1 month
Functional impairment	Academic, occupational, social

PTSD, posttraumatic stress disorder.

Adapted from: American Psychiatric Association. *DSM IV-TR*. 2000.⁸

screening for PTSD in primary care, at least in civilian settings. The US Preventive Services Task Force (USPSTF) recommends that physicians address health behaviors that are potential outcomes of violence—tobacco and alcohol use, depression, illicit drug use, and suicidal ideation among them—but does not address PTSD itself.¹⁰

A number of other factors work against routine screening for trauma and PTSD, some on the provider side and others on the part of patients.

Provider barriers^{7,10,14-16} include:

- Education deficit. (The medical aspects of, and sequelae to, violence are not sufficiently addressed; violence is not seen as a medical issue.)
- Time constraints
- Physician discomfort addressing violence. (Repeatedly victimized patients typically display a sense of vulnerability that can induce negative feelings in physicians, potentially causing them to act counterproductively.)
- Misunderstanding of patient needs. (The physician may not realize the importance of providing a psychologically safe environment in which the patient is neither shamed for his or her behavior nor excused from responsibility for self-care.)

- Lack of awareness/limited knowledge of PTSD resources and treatment.

Physicians who have little experience with serious mental health issues may need to take steps to develop the knowledge and skills to work with patients with PTSD—continuing medical education and professional reading, participation in Balint groups (small groups of physicians who meet, typically for 1-2 years, for the purpose of learning to better manage doctor-patient relationships), psychotherapy, and/or professional consultation. You can learn more about Balint groups from the American Balint Society (<http://www.americanbalintsociety.org>). Information about PTSD and lists of clinicians who specialize in treating it are available at the National Center for PTSD (www.ncptsd.va.gov), National Crime Victims Research and Treatment Center (<http://colleges.musc.edu/ncvc>), and Eye Movement Desensitization and Reprocessing Institute, Inc. (www.emdr.com).

Patient barriers^{13,17} include:

- Fear of retribution. (Victims of violence are often threatened with further harm if they tell anyone about the abuse.)
- Embarrassment, guilt, and shame. (Ironically, refraining from talking about traumatic events can reinforce patients' sense of shame.)
- Low self-esteem



Risk factors for PTSD include a history of trauma; current or past mental health problems; vague, persistent medically unexplained physical symptoms; physical injuries; and pregnancy.

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TABLE 2

PTSD diagnosis: How time affects it

Diagnosis	Distinguishing features
Acute PTSD	Symptoms 1-3 months posttrauma; better prognosis than chronic PTSD
Chronic PTSD	≥3 months of symptoms; worse prognosis than acute PTSD
Delayed PTSD	< 5% of cases; symptom onset ≥6 months after trauma exposure
Subclinical PTSD	Symptoms may wax and wane; physical or psychological stress may reactivate symptoms

PTSD, posttraumatic stress disorder.

Adapted from: American Psychiatric Association. *DSM IV-TR*. 2000.⁸

- Learned helplessness
- Limited insight.

Many of these barriers were affecting Maureen: She had been threatened by the man who sexually abused her. And, because of repeated trauma, she suffered from learned helplessness; she did not consider herself competent enough to take steps to improve her health or otherwise help herself. Nor did she realize that her past continued to profoundly affect her—until she underwent screening for PTSD.

Suspect PTSD?

Start with a 4-question screen

Several brief screening instruments have been developed to minimize the time required to identify patients who have (or have a high likelihood of having) PTSD.¹⁸⁻²⁰ One of the most useful is the Primary Care PTSD Screen (PC-PTSD) (TABLE 3). This 4-item test was developed for a study of 88 men and women attending general medicine and women's health clinics at a Veterans Administration (VA) medical center.¹⁸ The questions address the reexperiencing, avoidance/numbing, and hyperarousal that are unique to PTSD.

Using a cutoff score of 3, the PC-PTSD showed 78% sensitivity and 87% specificity compared with the gold standard—the structured diagnostic interview.¹⁸ Other studies have confirmed similar results for the PC-PTSD among primary care patients in both VA and civilian primary care settings (JRF, North American Primary Care Research Group [NAPCRG] annual meeting, November 2009).²¹

Follow up with a more detailed screen or structured interview. A study in a civilian primary care setting found the PC-PTSD to

have a positive predictive value (PPV) of 36.7%. Adding a second PTSD screen—the 17-item PTSD symptom checklist, civilian [PCL-C],²²⁻²⁴ a self-administered test in which the patient rates the severity of a range of symptoms over a specified time period—increased the PPV to 47.3% and the negative predictive value to >99% (JRF, NAPCRG, November 2009).

VA and military settings use such a staged approach. All primary care patients in these settings undergo annual screening with the PC-PTSD, and anyone with a score of 3 or higher undergoes additional evaluation.²⁵ Such an approach might also be valuable in civilian primary care settings.

Some physicians resist the idea of a staged approach to identifying PTSD because of time constraints. This is a legitimate concern, considering that the USPSTF alone recommends nearly 100 areas for doctors to consider for screening or basic intervention.¹⁴ However, we would counter that argument by noting that PTSD often has such a profound impact on the patient's well-being and overall health that you can't afford *not* to conduct screening.

We recommend a systems-based approach, similar to scheduled HbA1C tests, for PTSD: Patients with any of the risk factors described earlier should be screened with the 4-item PC-PTSD; those with positive results on the brief screen should take the 17-item PCL-C. Nurses or other support staff can be trained to administer PTSD screening tests, with physicians following up on positive results.

Positive identification of PTSD: Then what?

When screening leads to a diagnosis of

Symptoms of subclinical PTSD may wax and wane, and may be triggered by physical or psychological stress.

TABLE 3

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*. 2003.¹⁸

PTSD—as it did for both Maureen and Dominic—the first thing you’ll need to do is provide patient education. Talk about the effects of trauma and the fact that PTSD is treatable. Answer questions directly and truthfully, but be calm and reassuring. You may also need to be somewhat directive—for example, stress the importance of adhering to a treatment plan and coming to you, rather than discontinuing treatment, if doubts or difficulties arise.

An important lesson in caring for patients with PTSD is that it is more important to listen empathically than to try to “fix” their problems. It will often be necessary to provide a referral to psychotherapy—primarily cognitive behavioral therapy (CBT)—and prescribe medication, as well.

■ **Evidence-based psychotherapeutic approaches** for PTSD include stress inoculation training, trauma-focused CBT, cognitive processing therapy, eye movement desensitization and reprocessing therapy, and exposure therapy. Using typical treatment protocols, the number needed to treat (NNT) for these proven psychotherapy approaches is approximately 12.²⁶

We recommend that primary care physicians work closely with 1 or more local mental health providers skilled in an evidence-based approach to PTSD; keep in mind, however, that no single form of CBT has been found to be superior to the other approaches.²⁶

■ **Selective serotonin reuptake inhibitors (SSRIs) are first-line agents** for both the acute and long-term management of PTSD. (For fluoxetine, paroxetine, or sertraline, the NNT=4-5).^{2,27} Research indicates that 12 weeks is the adequate time for a medication trial for a patient with PTSD (vs 6-8 weeks for major

depression), and 12 months is the minimal length of medication treatment.²⁸⁻³⁰

Research also supports the use of second-line medications to target specific PTSD symptoms. Other classes of antidepressants, benzodiazepines and nonbenzodiazepine hypnotics, atypical antipsychotics, and mood-stabilizing agents are typically used in addition to SSRIs, and in combination with psychotherapy.²

■ **Collaborative care is an ideal approach.** In addition to being the setting in which chronic mental and physical health problems are often managed,^{1,2} primary care is well suited for a collaborative approach to PTSD.^{2,31} In a collaborative care model, the efforts of the primary care physician might be extended with the help of midlevel providers and periodic consultation with a mental health specialist. Collaborative care management of depression in primary care has been found to be superior to the usual care, and this model is promising for PTSD.³²⁻³⁵

CASE. Maureen: It has now been 5 years since Maureen’s diagnosis: a moderately severe case of chronic PTSD. Since then, I have continued to see her regularly, and have been able to cut back on her pain medication, adjust her dosage of psychotropic medication, and convince her to enter psychotherapy. While Maureen still has multiple health problems, her functioning has improved and, for the first time, she has been able to undergo vital health screening, including Pap smears, mammography, and colonoscopy.

CASE. Dominic: After his PTSD diagnosis, it took Dominic nearly 18 months to return to baseline, with the help of frequent primary



In caring for patients with PTSD, it is more important to listen empathically than to try to “fix” their problems.

Research supports the use of second-line medications to target specific PTSD symptoms.

care visits, an SSRI, and CBT. He began feeling so much better that we stopped the medication after 2 years of treatment, and he didn't return to the office for 2 or 3 years, other than for flu shots and other routine health needs. When the fire in the house down the street reactivated his PTSD symptoms, we restarted the SSRI and I met with him monthly for about 6 months to monitor his PTSD symptoms and provide support. By the end of

6 months, Dominic's PTSD symptoms had largely resolved. Recognizing that PTSD can remain subclinical for a long time but that symptoms may wax and wane, we decided to keep him on antidepressant therapy indefinitely. Dominic is feeling well, and comes in for yearly follow-up.

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