Session # A1

Treating Post-Traumatic Stress Disorder with a Prolonged Exposure within Primary Care Behavioral Health: A Case Example

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- Understand the importance clinical pathways within the Primary Care Behavioral Health (PCBH) model to identify patients who would benefit from a specific treatment;
- Describe how distrust of the healthcare system related to PTSD in vulnerable populations impacts the Quadruple Aim; and
- Describe the features of the PE-PC PTSD protocol.

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

Prevalence of PTSD in Primary Care

Prevalence of PTSD in Primary Care

- PTSD is something that can happen to ANYONE
- Over 90% of adults in the United States have experienced at least one traumatic event in their life (Breslau & Kessler, 2001).
- As many as 8% of such individuals will develop posttraumatic stress disorder (PTSD; Kessler, Sonnega, Bromet, & Hughes, 1995).

US Department of Veterans Affairs-National Center for PTSD

Men

- 6 of every 10 men experience at least one trauma in their lives.
  - Men are more likely to experience accidents, physical assault, combat, disaster, or to witness death or injury.
- 4% of men develop PTSD at some point

Women

- 5 of every 10 women experience at least one trauma in their lives.
  - Women are more likely to experience sexual assault and child sexual abuse
- 10% of women develop PTSD at some point

PTSD in Primary Care

- A systematic review of over 10,613 titles were screened
  - 41 studies met criteria and the included studies assessed the prevalence of PTSD in a total of **7,256,826** primary care patients
  - Conclusion of the study was that **PTSD is common** in primary care.
    - 11.1% civilian population
    - 12.5% special population
    - 24.5% veteran population

Race/Ethnic Differences

- 2011 study compared trauma exposure, risk for PTSD among those exposed to trauma and treatment seeking in Whites, Blacks, Hispanics and Asians.
- Marked racial and ethnic differences in the lifetime risk for PTSD and treatment seeking for PTSD symptoms
    - There is a large disparity in treatment
        - May be due to accessibility of services
        - Culturally sensitive treatment options

Lifetime Prevalence

- **African Americans: 8.7%**
- Whites: 7.4%
- Hispanics: 7.0%
- Asians: 4.0%
- African Americans and Hispanics had a higher risk of child maltreatment and witnessing domestic violence
- Asians, African American men, and Hispanic women had a higher risk for war-related events than whites

Exposure to Trauma

- PTSD risk is slightly higher among African Americans and lower among Asians compared to Whites
- **ALL** minority groups were less likely to seek treatment for PTSD than Whites and fewer than half of minorities with PTSD sought treatment
- Race/ethnic differences in <u>type of event exposure</u>, particularly elevated rates of exposure to violence, may account for possible differences in PTSD by race/ethnicity

PTSD, Health Status, and Impact on Health System

PTSD and chronic health conditions/health behaviors

- Patients with PTSD have known increased risk of obesity, cardiovascular disease, dyslipidemia, smoking, and type 2 diabetes.
- There is an association with poor lifestyle facilitating chronic disease development and poor health behaviors.
- Increased prevalence of psychiatric disorders such as major depressive disorder, anxiety disorders, and substance abuse.
- At least one additional psychiatric disorder is present in 88.3% of men and 79.0% of women who gave history of PTSD.
- Some studies also show modest association with increased risk for Alzheimer's and vascular dementia[2].

Greenberg, Tanev, Marin, & Pitman, 2014; Grinage, 2003

PTSD and the Health System

- A growing body of research is beginning to demonstrate a robust connection between PTSD and frequent emergency room (ER) visits.
- Vu and colleagues (2015) found that over a 12-month period, those with PTSD frequently visited the ER (> 4 times) and reported psychological distress as their primary reason for visiting.
- Further, in a sample of 350 homeless participants, almost a third (32.6%) screened positive for PTSD and close to half (49.7%) reported at least one ER visit, with over a fourth (27.2%) reporting two or more visits (range = 2 to 32) in the last 6 months (Raven et al., 2017).
- After the events of 9/11, those living with PTSD were 6.6 times more likely to visit the ER for asthma related symptoms (Fagan, Galea, Ahern, Bonner, & Vlahov, 2003).

PTSD and the Health System

- Cohen et al. (2010) also found that returning Iraqi and Afghanistan veterans with PTSD were 1.55 times more likely to use ER services over an 8-year period.
- This connection also extends to posttraumatic stress symptoms (PTSS), otherwise known as subthreshold PTSD.
- Over a three-month period, those with PTSD and PTSS utilized healthcare services (including ER visits) at a greater rate on average (3.37 vs. 2.54) compared to those who did not (Gillock, Zayfert, Hegel, & Ferguson, 2015).

PTSD and the Health System

- A paucity of research suggests that PTSD might result in increased hospitalizations.
- When controlling for the effects of age, gender, income, substance use, depression, and comorbidity, patients with PTSD had over twice as many hospitalizations and spent a greater number of nights in the hospital (2.99 vs. 1.01) over a 12-month period (Kartha et al., 2008).
- Finally, those with PTSS and probable PTSD, on average had higher ER costs ($17 per person) and greater total adjusted health care costs (e.g., inpatient care, outpatient care, medications, physician fees; $838 per person) over the last 12 months (Lamoureux-Lamarche, Vasiliadis, HPréville, & Berbiche, 2016).

Importance of treating PTSD in PC

Why treat PTSD in PC?

- Effective evidence-based psychotherapies for PTSD are available in specialty mental health settings, however many patients do not receive treatment due to barriers such as limited time, provider accessibility, long wait times, stigma, and hesitancy to discuss trauma and emotional concerns (Davis, Ressler, Schwartz, Stephens, Bradley, 2008; Vogt, 2011; Ede et al, 2015).
- EBT: Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT)
- Those that do seek treatment in the community often do so after significant delays (Sayer et al, 2009: Trusz, Wagner, Russo, Love, & Zatzick, 2011).
- Furthermore, not all specialty mental health providers in the community have the experience or the training to provided evidence-based psychotherapy for PTSD (Finley et al, 2017; Rosen et al., 2017).

Why treat PTSD in PC?

- With PTSD-focused services not located on site, PCP’s are often hoping that the referral leads to treatment and often receive limited feedback or communication from any specialty service (Zuchowski et al., 2015).
- On site treatment increases the likelihood that patients will engage in treatment, enabling primary care to have a greater impact on patient who would not accept a referral to specialty mental health services (Engel, 2005; Ogbeide, Landoll, Nielsen, & Kanzler, 2018).
- **Considering these barriers to care, it is important that PCP’s and BHC’s work together to address PTSD in the primary care setting.**

The Prolonged Exposure for Primary Care Procotol (PE-PC)

The PE-PC Protocol

- Brief treatment protocols for PTSD have been used successfully in military PC clinics, but these results are not necessarily generalizable to other patient populations.
- No large studies with civilian populations (yet…)
- Developed by Jeff Cigrang, PhD and Sheila Rausch, PhD

The PE-PC Protocol

- Protocol content was consistent with emotional processing theory, drawn from the PE model (Cahill & Foa, 2007) and designed to fit within the context of four 30-minute primary care appointments.
- 5 visits, every 2 weeks
- Appointment 0*:
  - The BHC will conduct a 30-minute visit that includes a functional assessment/contextual interview, patient education about factors that contribute to the development and maintenance of PTSD symptoms, with an emphasis on the role of avoidance.
  - The appointment will end with the BHC presenting treatment options, which will include the brief PTSD intervention (5, 30-minute visits), a referral to specialty mental health or self-help material.

*BH screening tools administered at each visit

The PE-PC Protocol

- Appointment 1:
  - Patient is provided a “Confronting Uncomfortable Memories” activity workbook to be completed at home and brought back for use in subsequent appointments.
  - Patient will write a first-person, detailed narrative of the stressful event associated with the greatest level of current distress and preoccupation, including recollection of personal thoughts, feelings, and physical reactions.
  - Patient will also answer emotional processing questions, such as, “How has this event changed what you think about yourself?” and, “How has this event changed how you think about others?”
  - Patients are asked to record their level of distress before and after the writing exercise using a 0-100 subjective units of distress scale (SUDS) with 0 = no distress and 100 = highest possible distress.
  - Patients were instructed to write and then read the trauma narrative and their answers to the emotional processing questions for at least 30 minutes three times per week.
  - In vivo exposure exercise

The PE-PC Protocol

- Appointments 2-4:
  - BHC asks about the experience of writing and reading the memory. The BHC reviews the pattern of SUDS ratings and discussed habituation and variability with the patient, praises the patient for having done whatever they could do, and problem-solved any issues that may have arisen.
  - Patients are then asked to read the narrative and their answers to the emotional processing questions out loud. The remainder of each 30-minute appointment was devoted to trauma-associated emotional processing that includes review of exposures and the patient's thoughts and emotions related to those exposures and how that impacts beliefs about themselves and world at the time of the trauma and now.
  - In vivo exposure exercise

The PE-PC Protocol

- End of Treatment
  - At the conclusion of the fourth appointment the BHC engags the patient in conversation about their perception of treatment gains using the record of BH screening scores and discussed whether a referral to the specialty mental health clinic is indicated.

A Case Example….

The patient…"Jane Doe"

- 36 yo Hispanic female
- Married (18 years) – states it is "okay" but "rocky"
- 5 children (15, 14, 13, 11, 10); also 30 yo DD sibling
- No social support and limited family support
- "Spiritual" (does not follow specific faith/attend services)
- Not working (wanting to get into nursing school)
- No hobbies
- ETOH use (2-3 mixed drinks on weekends); no other substance use
- Sedentary
- Poor sleep (nightmares/insomnia)

The patient…

- PTSD sxs (and MDD) started in adolescence (sexually abused by a family member as a child)
- Sxs worsened 1 year ago when she found out that two of her daughter were sexually abused
- What makes sxs worse: school (wants to get into nursing school), overwhelmed with children's needs; marital stressors (infidelity in past)
- Better: "distraction"
- Pt reports sxs significantly impacting QoL

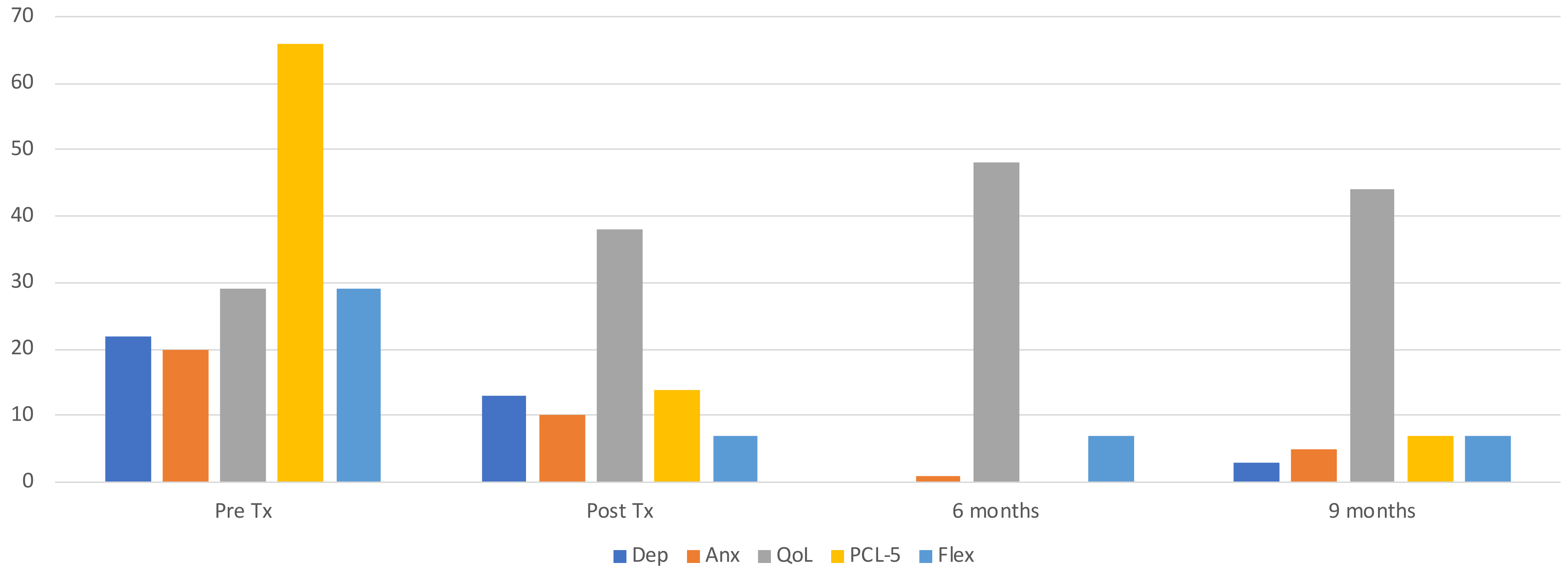
What we tracked…

- PTSD severity was monitored with the PTSD Symptom Checklist for the DSM-5 (PCL-5).
- Additional outcome measures were tracked:
  - Depressive symptoms were monitored with the Patient Health Questionnaire-9 (PHQ-9);
  - Anxiety symptoms were measure with the Generalized Anxiety Disorder-7 (GAD-7);
  - Quality of life was measured with the Quality of Life and Enjoyment Scale – Short Form (QLES-SF); and
  - Psychological flexibility was measured with the Acceptance and Action Questionnaire-II (AAQ-II) questionnaire.
- Outcomes were tracked pre-and-post treatment as well as 6 months post-treatment and 9-months post-treatment.

Outcomes

- The patient reported a clinically significant decrease in PTSD, depression, and anxiety symptoms.
- Overall, the PCL-5 score decreased from a 66 (significant impairment; 30 or above indicative of probable PTSD) to a 14 (minimal impairment) at the end of treatment.
- The PCL-5 score 9 months post-treatment = 7.
- Depression scores decreased from a 22 (severe) to a 13 (moderate), at 6 months was a 0, and 9 months, a 3.
- Anxiety scores decreased from a 20 (severe) to a 10 (moderate), at 6 months was a 1, and at 9 months = 5.
- Quality of life increased from a 29 to a 38 (scores range from 11 to 55 with higher scores = improved quality of life). At 6 months, quality of life was a 48. At 9 months = 44.
- Psychological flexibility was assessed post-treatment as well as six months post-treatment and decreased from a 29 to a 7 (scores range from 49 to 7 with lower scores = improved psychological flexibility). At 9 months, score = 9

Outcomes



Qualitative patient feedback

- **What was the most helpful thing you learned about yourself going through the PTSD treatment protocol in primary care?**
- *"Learning to accept my trauma and not allowing the trauma to have a hold on my life."*
- **If there was a patient who was nervous about starting this treatment protocol for PTSD, what advice would you give them?**
- *"I would tell them that at first, it will be difficult. But once they are able to accept what happened to them, life does become much easier once we understand our emotions and our triggers."*

Qualitative patient feedback

- **What do you want behavioral health providers or medical providers to know about introducing this treatment protocol to patients in primary care?**
- *“To have patience, because each story is different.”*

Conclusions

- The PE-PC PTSD treatment protocol for PTSD can be delivered in a primary care setting and is consistent with the PCBH model, a population-health approach to care.
- Such treatment may result in improved quality of life for patients, and the brief approach has the potential to reduce overall cost of care.
- This case encourages increased identification and treatment of PTSD within primary care settings, in order to increase access of care for patients with this debilitating condition (e.g., clinical pathways development)

Future Directions…

- Apply for a grant for civilian, underserved populations in primary care…

Questions???

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Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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