



PTSD


Improving patient care by integrating medical
and mental health care treatment.

- ▶ Introduction
 - ▶ What is integrated care.
 - ▶ What is Complex PTSD and/or Chronic PTSD.
 - ▶ What is the relationship between physical health and PTSD.
 - ▶ How to improve clinical practice.
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Introduction

- ▶ Identifying the complex interplay between psychological and medical symptoms that may present with PTSD.
 - ▶ Integrating care is the only way patients can receive effective overall treatment.
 - ▶ Making a case that more research needs to be done.
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Integrated care

- ▶ Combining medical and behavioral health services to fully address patient needs.
 - ▶ Artificial divisions that fragment health care delivery systems become significant barriers to patient care.
 - ▶ Evidence grows regarding the relationship between the mind and the body.
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Barriers to integrated care.


- Biological basis of mental health disorders are poorly understood
- Separate educational systems
- Time and money

Top reasons patients present to a primary care physician:


- ▶ Fatigue
- ▶ Back pain
- ▶ Dizziness
- ▶ Headaches
- ▶ Abdominal pain
- ▶ Shortness of breath
- ▶ Numbness
- ▶ Insomnia

Top reasons patients present to a primary care physician:

All of these symptoms can be exacerbated by PTSD making it difficult for the provider to know if the disease is mental, physical or both.



Integrated care may included:


- 1) Screening by both providers
 - 2) Patient education by both providers
 - 3) Medication monitoring; collaborative
 - 4) Psychotherapy; primarily by mental health
 - 5) Coordinated care with both providers
 - 6) Clinical monitoring; primarily by medical
 - 7) Follow up by both providers
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Department of Veterans Affairs

Over the last several decades there have been numerous studies showing the efficacy and feasibility of providing integrated care. These studies routinely show that integrated care models enhance the outcomes of veterans with PTSD.

DSM-IV diagnostic criteria for PTSD

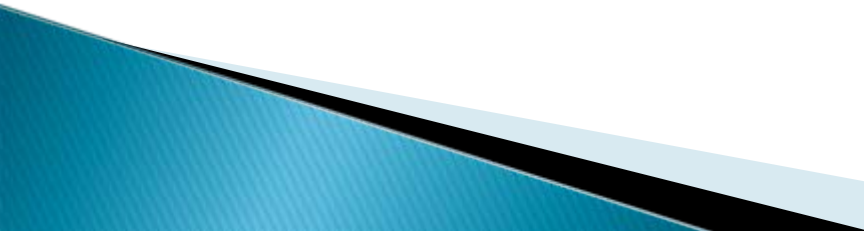
- a) Exposure to a traumatic event involving a threat to safety or an intense fear response.

 - b) Experience of intrusive recollections, dreams, flash backs, distress at exposure to triggering cues, psychological reactivity.
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c) Three symptoms of the following; avoidance of thoughts, feelings, activities, places or people that recall the event, memory loss, loss of interest in life, inability to feel love or a sense that life will be short.

d) Two persistent symptoms of the following; difficulty falling or staying asleep, anger outbursts, trouble concentrating, hyper-vigilance or an exaggerated startle response.


Predisposing factors

- ▶ History or acute stress
 - ▶ Presence of other psychiatric disorders
 - ▶ Past trauma
 - ▶ Family psychiatric history
 - ▶ Lack of social, family and peer support
 - ▶ Recent stressful life changes
 - ▶ Presence of childhood trauma
 - ▶ Being female
 - ▶ Borderline, paranoid, dependent or antisocial personality disorder traits
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Problems with PTSD criteria

- DSM-IV does not distinguish between the types of PTSD that can develop from chronic, long-lasting traumatic events as compared to PTSD from short-lived events.
- Complex PTSD refers to the set of symptoms that commonly follow exposure to chronic PTSD

Complex PTSD

- ▶ The criteria for PTSD works well for those experiences that happen 1–2 times but do not capture the psychological and physiological impact of repetitive exposure to trauma.
 - ▶ Difficulty for clinicians is that the severity of PTSD varies greatly and somewhat dependant on the developmental phase when the trauma occurred.
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Dr. Vanderkolk

- ▶ “Uncontrollable disruptions or distortions of attachment bonds precede the development of PTSD. People seek increased attachment in the face of danger. Adults, as well as children, may develop strong emotional ties with people who intermittently harass, beat, and threaten them. The persistence of these attachment bonds leads to confusion of pain and love. Trauma can be repeated on behavioral, emotional, physiologic, and neuro–endocrinologic level. Repetition on these different levels causes a large variety of individual and social suffering. Anger directed against the self or others is always a central problem.... Compulsive repetition of trauma usually is an unconscious process that ultimately perpetuates chronic feelings of helplessness and subjective sense of being bad and out of control ”


Coordination of care

- Unattached patients may try and sabotage treatment.
- Over attached patients may want multiple office visits and if needs are not met, validated, or diverted, decomposition frequently happens.


How to Improve Clinical Practice

1. Emotional regulation problems
2. Changes in consciousness
3. Changes in how a persons views themselves
4. Changes in how the victim views the perpetrator
5. Changes in personal relationships
6. Changes in how one views the world


Emotion regulation problems

- ▶ Severe depression
 - ▶ Thoughts of suicide
 - ▶ Controlling anger
 - ▶ Heart palpitations
 - ▶ Chronic fatigue
 - ▶ Adrenal and cortisol regulation
 - ▶ Frequent visits to ER
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Changes in consciousness

- ▶ Repress memories
 - ▶ Flashbacks
 - ▶ Dissociation
 - ▶ Substance abuse
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Changes in how a person views themselves

- ▶ Helplessness
 - ▶ Shame
 - ▶ Guilt
 - ▶ Detachment from others
 - ▶ Abandonment
 - ▶ Loyalty
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Changes in how the victim views the perpetrator


- ▶ Powerless
 - ▶ Preoccupied with relationship with perpetrator
 - ▶ Thoughts of revenge
 - ▶ Dysfunctional help seeking behaviors with provider
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Changes in person relationships

- ▶ Isolation
- ▶ Distrust


With personal relationships and clinicians.

Changes in how one views the world


- ▶ Lose faith in humanity
 - ▶ Hopelessness about the future
 - ▶ Medication compliance
 - ▶ Somatization of symptoms
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All of these changes require careful coordination of care and integration of treatment protocols so trust can be built.

Physical health and PTSD

- ▶ Trauma brings about neurochemical changes
 - ▶ Increased infections and immunological disorders
 - ▶ Adverse outcomes
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Hypothalamic–pituitary–adrenal (HPA)


- ▶ Long term stress changes hormones.
 - ▶ Cortisol increases at first with any stress but long term exposure can cause the body to decrease production and become insensitive to it.
 - ▶ Circulation T–cells then increase causing immune dysfunction.
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2,490 Vietnam veterans

- Increase prevalence of common autoimmune diseases;
 - Rheumatoid arthritis
 - Psoriasis
 - Insulin dependent diabetes
 - Thyroid disease
- Because of the increased immune system and inflammation response this caused cardiovascular disease.

Symptoms

Because of the change in hormones and immune functions the following symptoms can be seen before the onset of disease:

- Back pain
 - Insomnia
 - Swollen joints
 - Dizzy spells
 - Chronic fatigue
 - Hypertension
 - Heart palpitations
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Abnormal tests

- Higher T cell counts
- Higher immunoglobulin M levels
- Lower dehydroepiandrosterone (DHEA)
- Lower cortisol
- Hyper reactive immune responses on standardized delayed cutaneous hypersensitivity tests

Abnormal tests

The abnormal tests concluded the presences of biological markers consistent with a broad range of inflammatory disease and hence decreasing life span.


2009 women's health study

The following medical conditions were associated with a lifetime diagnosis of PTSD:


1. Chronic pain
2. Hypertension
3. Coronary artery disease
4. Thyroid disorder
5. Insomnia
6. Back pain
7. Swollen joints
8. Dizzy spells
9. Chronic fatigue
10. Difficulty concentrating
11. High blood pressure
12. Heart palpitation
13. Depression
14. Angina

2009 women's health study


Concluded that “if women with PTSD are not recognized, the pattern of continued health visits without improvement in symptoms is likely to continue. Assessment for PTSD has been suggested in patients who experience somatization, chronic pain, or unexplained medical symptoms or general distress...Treatment of PTSD in primary care settings involves recognizing symptoms as early as possible in traumatized individuals and subsequent treatment of symptoms with psychotropic medication or referral for psychotherapy.”



Outcomes can be improved

- Primary care providers must be able to recognize symptoms and signs of PTSD and refer appropriately and coordinate care.
 - Mental health providers must be able to recognize symptoms and signs of co-morbid diseases associated with PTSD and refer appropriately and coordinate care.
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How to improve outcomes

- ▶ Increase collaboration with care providers.
 - ▶ Screen for PTSD in medical settings.
 - ▶ Understand relationship between PTSD and other health problems.
 - ▶ Integrated clinics with mental health providers and primary medical services.
 - ▶ More research.
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Never

- **Overlook psychiatric/physical comorbidity.**
- **Underestimate the potential severity of this disorder.**

Good patient care as well as the need for protecting limited primary care medical resources, are both essential reasons for accurate PTSD diagnosis and collaborative referral and treatment protocols between providers.

Case studies

50 yo female PTC after referral from Loren Meltzer.

History: Married x 25 yrs with 2 children, unhappy but stayed in it because of kids, works as medical transcriptionist and enjoyed job until 2 years ago not sure what changed. Pt complains of anxiety and depression that started 10 yrs ago with some family trouble and she was started on xanax but the depression has always been there. Several attempts at suicide over the years.

Review of symptoms: Diarrhea alternating with constipation, hotflashes, insomnia (tried several medications with only little effect), poor long and short term memory, vaginal dryness but not had intercourse x 2yrs, headaches daily, chronic back pain with radiation into right leg, pelvic pain.

Past medical history: Hepatitis C, hypertension, hyperlipidemia, hysterectomy 98, multiple psychological hospitalizations.

Medications: Wellbutrin, triameterene/HCTZ, prilosec, ativan, fish oil, multivitamin.

Physical exam: BP 160/94, Pulse 92, Temp 97.8,

HEENT– erythematous post pharynx, diffuse swelling around thyroid

CV–RRR, no murmurs noted

Resp–wheezes all lobes (pack a day smoker)

Neuro–+3 reflexes bil ext. Cranial nerves WNL

MSK–numerous trigger pts, +SLR right at 40 degrees, hypertonic hamstrings and GL's,

ABD–TTP epigastric and R costal margin, liver palpated 2 inches below costal margin.

Labs–Elevated AST/ALT, Trig 333, chol 177, glucose 122, chol 99, sodium 132, WBC 11, mcv 100, estradiol <5, progesterone <.02, DHEA 22, sed rate 88, CRP 12.5, U/A wnl.

MRI–Annular bulge L4–5 and L5–S1, lower lumbar facet arthropathy, left L5 neural foraminal narrowing.

Footnotes

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