

# CHAMP

## Depression, Trauma and Collaborative Care

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## Land Acknowledgment





*The University of Washington acknowledges the Coast Salish people of this land, the land which touches the shared waters of all Tribes and bands within the Suquamish, Tulalip and Muckleshoot nations.*

Photo Credit: Paul J Barry

<https://native-land.ca/>

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### • CHECK IN

- Any questions or concerns about CMTS/REDCap/consenting or other research activities?
- Anything else on your mind?

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## Learning Objectives

By the end of this session, participants should be able to:

- List ways in which trauma can impact each stage of the Collaborative Care workflow
  - Recognize patients with trauma history
  - Assess impact of trauma on current functioning and ability to engage in depression treatment
  - Initiate treatment for depression even in the presence of trauma history
  - Identify patients who need to have more intensive trauma treatment

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## Trauma-Informed Care



- A trauma-informed approach can be implemented in any type of service setting or organization
- It is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing. (SAMHSA)
- MAIN GOAL: we aim not to re-traumatize patient or add to their trauma

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## Collaborative Care within a Trauma-informed Framework



- Provides low-barrier care in the primary care setting, that may be more familiar and preferable to the individual
- Approach that has been shown to be effective for people with PTSD (SPIRIT study)
- Patient-centered treatment planning and outreach is part of the model
- Behavioral interventions that build strengths for self-care and resilience e.g. BA, PST

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## Distinction between Trauma/PTSD?



- Trauma: an incident or series of events that are emotionally disturbing or life-threatening. with lasting adverse effects on individual's functioning and mental, physical, social, emotional and/or spiritual well-being.
- Not necessarily the same thing as PTSD, which refers to a specific set of symptoms.
- The effects of early neglect can permanently impact psychological / emotional functioning without meeting criteria for PTSD.

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## Examples



- Physical, sexual, and emotional abuse
- Childhood neglect
- Living with a family member with mental health or substance use disorders
- Sudden, unexplained separation from a loved one
- Poverty
- Racism, discrimination, and oppression
- Violence in the community, war, or terrorism

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## Does Trauma always Lead to PTSD?

**Most people *do not* get PTSD as a result of trauma**  
 (i.e., post Katrina, 9/11 studies, combat)  
 70-90% of people report having had at least one traumatic experience  
(Breslau, 2002; Kessler et al., 1995)

<b>NCS-R (2001-2003) US lifetime prevalence:</b> <ul style="list-style-type: none"> <li>• 6.8% of all adults;</li> <li>• 3.6% men, 9.7% women</li> </ul>	<b>Among Vets lifetime prevalence:</b> <ul style="list-style-type: none"> <li>• Vietnam War: 30.9% men, 26.9% women</li> <li>• Gulf War: 10.1%</li> <li>• OEF/OIF (2008): current prevalence 13.8%</li> </ul>	<b>35-50% of patients with chronic pain</b>
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## Resilience: A Positive Approach to Trauma

- “The capacity to withstand, recover and grow in the face of stressors and changing demands.”
- Helps people recover from adverse incidents
- Higher resiliency makes a patient less likely to develop PTSD
- Restoring these in treatment for depression may restore their ability to cope with trauma

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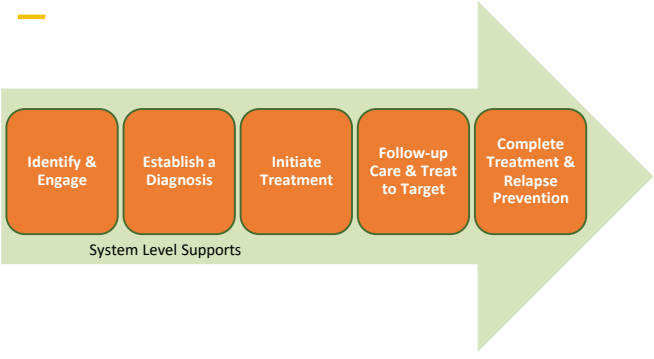
## Building RESILIENCE: The tendency to adapt to risk or adversity

- *Characteristics of resilience include*
  - optimism,
  - sense of control
  - perseverance despite obstacles
  - sense of humor,
  - ability to cope with misfortune and stress
  - self-esteem

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## Episode of Collaborative Care




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## Identify and Engage




- How to assess but not re-traumatize
- Focus on function
- PC-PTSD-5
- PCL-5



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## PC-PTSD-5 Screening Tool



**PC-PTSD-5**

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES      NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

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**In the past month, have you...**

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?
 


YES      NO
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
 

YES      NO
3. been constantly on guard, watchful, or easily startled?
 

YES      NO
4. felt numb or detached from people, activities, or your surroundings?
 


YES      NO
5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?
 

YES      NO




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## PCL-5 Screening and Monitoring



- The total score is the sum of all 20 items (0-80)
- A cutoff score of 31-33 suggests the presence of a significant level of symptom severity
- **Goal: 50% drop in score or <30**



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**PCL-5**

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little	Quite a bit	Very much	Extremely
1. Repeated thoughts or memories of the stressful experience?	(0)	(1)	(2)	(3)	(4)
2. Repeated distressing dreams of the stressful experience?	(0)	(1)	(2)	(3)	(4)
3. Suddenly feeling as if the stressful experience were happening again (as if the event were actually back there again)?	(0)	(1)	(2)	(3)	(4)
4. Feeling very upset when something reminded you of the stressful experience?	(0)	(1)	(2)	(3)	(4)
5. Feeling strong physical reactions when something reminded you of the stressful experience (e.g., sweating, trembling, heart racing)?	(0)	(1)	(2)	(3)	(4)
6. Avoiding or escaping people, places, or things related to the stressful experience?	(0)	(1)	(2)	(3)	(4)
7. Feeling very nervous or on edge about the stressful experience, the situation, people, places, or things related to the stressful experience?	(0)	(1)	(2)	(3)	(4)
8. Trouble remembering important parts of the stressful experience?	(0)	(1)	(2)	(3)	(4)
9. Feeling very irritable, angry, or easily annoyed when people, places, or things remind you of the stressful experience? (e.g., did you have trouble in controlling yourself, getting angry with others, or having outbursts of anger?)	(0)	(1)	(2)	(3)	(4)
10. Feeling guilty or ashamed about the stressful experience?	(0)	(1)	(2)	(3)	(4)
11. Feeling very sad or hopeless about the stressful experience?	(0)	(1)	(2)	(3)	(4)
12. Loss of interest in activities you used to enjoy?	(0)	(1)	(2)	(3)	(4)
13. Feeling alone or cut off from other people?	(0)	(1)	(2)	(3)	(4)
14. Trouble concentrating on things (e.g., reading, watching TV, listening to the radio)?	(0)	(1)	(2)	(3)	(4)
15. Trouble sleeping (e.g., trouble falling asleep, trouble staying asleep, or waking up too early)?	(0)	(1)	(2)	(3)	(4)
16. Trouble feeling calm or peaceful?	(0)	(1)	(2)	(3)	(4)
17. Trouble feeling safe or secure?	(0)	(1)	(2)	(3)	(4)
18. Trouble feeling confident about the future?	(0)	(1)	(2)	(3)	(4)
19. Trouble feeling hopeful about the future?	(0)	(1)	(2)	(3)	(4)
20. Trouble feeling or staying motivated?	(0)	(1)	(2)	(3)	(4)

PCL-5 © April 2013 National Center for PTSD Page 4 of 4

## Tips for Asking about Trauma



**#1**

To prevent re-traumatizing/dissociation and triggering of PTSD symptoms...

Encourage short, concise descriptions of the trauma

- ✓ ask for 2-3 sentences or 25 words or less to get a general sense of the trauma
- ✓ be directive and feel free to stop the telling if you see the patient getting upset
- ✓ Normalize the extreme difficulty patients often have in re-telling their stories

**#2**

Because patients...  
-Often have unique post-injury concerns  
-Interpret trauma uniquely  
-Post injury distress may be described differently

Don't start with a checklist


- ✓ Encourage them to tell their story in their own words
- ✓ Use open-ended questions

Remember, you don't need the details to make the diagnosis or treat depression

**#3**

If patient dissociates...

- ✓ Help the patient ground themselves by directing them to engage in their immediate environment
- ✓ Once grounded, educate on dissociation



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## Establish a Diagnosis



- Diagnosis of PTSD symptoms vs past history of trauma
- Use Systematic Caseload Review to help differentiate
- Screen for comorbid depression

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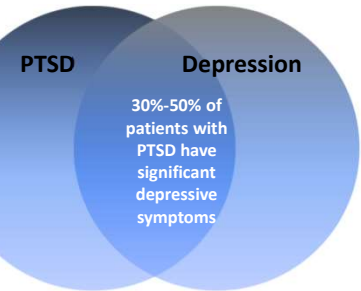
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## PTSD & Depression



Patients with PTSD & MDD in primary care:  
Campbell et al. (2007)

- More severe depression
- Lower social support
- More likely to report suicidal ideation
- More frequent health care visits



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## Initiate Treatment



- First step is most often focus on depression
- BA and PST can be used to help the avoidance symptoms
- Antidepressants can also help PTSD symptoms
- Special considerations if patients have PTSD
  - Consider prazosin (antihypertensive) to target nightmares
  - Avoid benzodiazepines

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## WHO Treatment Guidelines



- Trauma-focused treatments should be provided to adults with Acute Stress Disorder (ASD) or PTSD only if provider is specifically trained
  - otherwise, focus on stress management
- If moderate-severe depression is concurrent, provider should follow WHO depression guidelines as well

• World Health Organization. Guidelines for the management of conditions specifically related to stress. Geneva: WHO, 2013.

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## VA/DOD Clinical Practice Guideline for PTSD, 2017



- For patients with PTSD who are treated in primary care, collaborative care interventions are suggested that facilitate active engagement in evidence-based treatments.
- Comorbid treatment can usually be provided in PC setting, but more severe comorbidities should be referred to specialty or at least seek consultation.

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## Evidence Based Treatments for PTSD



- Trauma-Focused
  - Cognitive Behavioral Therapy (CBT)
  - Cognitive Processing Therapy (CPT)
  - Prolonged Exposure Therapy (PE-PC)
- Non-Trauma Focused
  - Depression: BA, PST
  - Anxiety management tools
    - Breathing, relaxation, preparing for a stressor
  - Insomnia: CBT-I
- Pharmacological Interventions

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## BA for PTSD



### Goals

- Increase activity levels
- Prevent avoidance behaviors
- Increase positive and rewarding behaviors

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## BA for PTSD



### What to do?

- Identify current avoidance behaviors and activities that are valued and rewarding
  - Depressive avoidance: do behaviors result from feeling depressed and is anxiety reduced
  - Do behaviors function to reduce anxiety/fear
  - Do behaviors lead to functional impairment and depression
- Evaluate barriers for doing these activities
- Set goals for number and frequency of activities and track in session

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## Role of BHCM

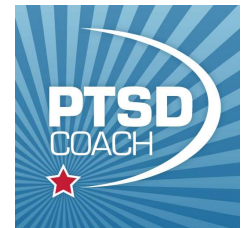


- Provide psychoeducation about PTSD & Depression
- Address depression first
- Coach in anxiety management tools
  - Breathing, relaxation, preparing for a stressor
- Build resilience
  - Encourage a predictable and controllable routine
  - Daily structure, Family meals, limits on social media
  - Exercise, Reach out/help others, Sleep hygiene

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## Resources/Tools



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## Consultation and Considerations for Referral for Specialty Care



- Patient has a high PTSD symptoms
  - PCL-C score above 45
- Patient is not improving in PCL and PHQ over a period of time
- You are not trained in an evidenced-based approach for this trauma and patient needs more specific care
- Patient is responding but will need longer term care

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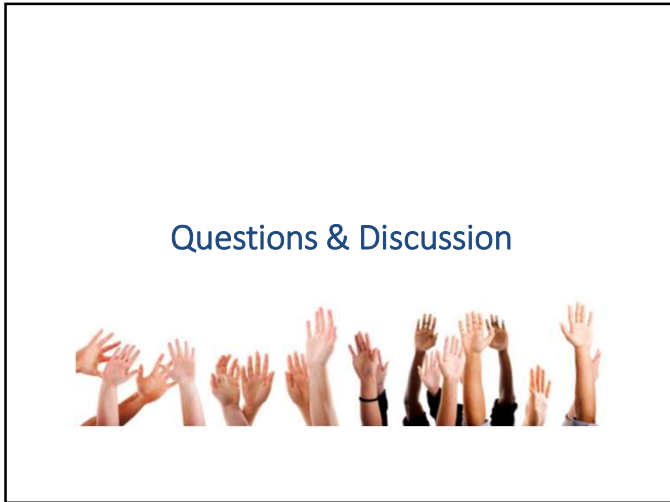
## Relapse Prevention Plan



- Consider both depression and trauma triggers
- Highlight the cognitive and relaxation techniques that have been helpful - making specific connections when you can

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