Opening Access to Address Trauma and Treat PTSD in Primary Care

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Trauma and PTSD Prevalence in community

- Most people will experience at least one lifetime trauma
- 70.4% of adults worldwide reported a trauma with 3.2 average events per capita (Kessler et al, 2017)
- 3.9% Lifetime PTSD prevalence and 5.6% among those exposed to trauma (Koenen et al., 2017)
- Interpersonal traumas have the highest conditional risk for PTSD while traumatic loss of loved one is the most frequent trauma.
- Certain populations are at higher risk of trauma exposure including sexual assault survivors, people residing in military conflict (wars and displacement), military populations, police and firefighters, etc.
- While many people recover naturally, those with less access to social support, social resources (employment etc.), and mental health assistance are at higher risk of PTSD following trauma.

Rising Tide: Phased Approach to Covid-19 Mental Health Response (PAC)

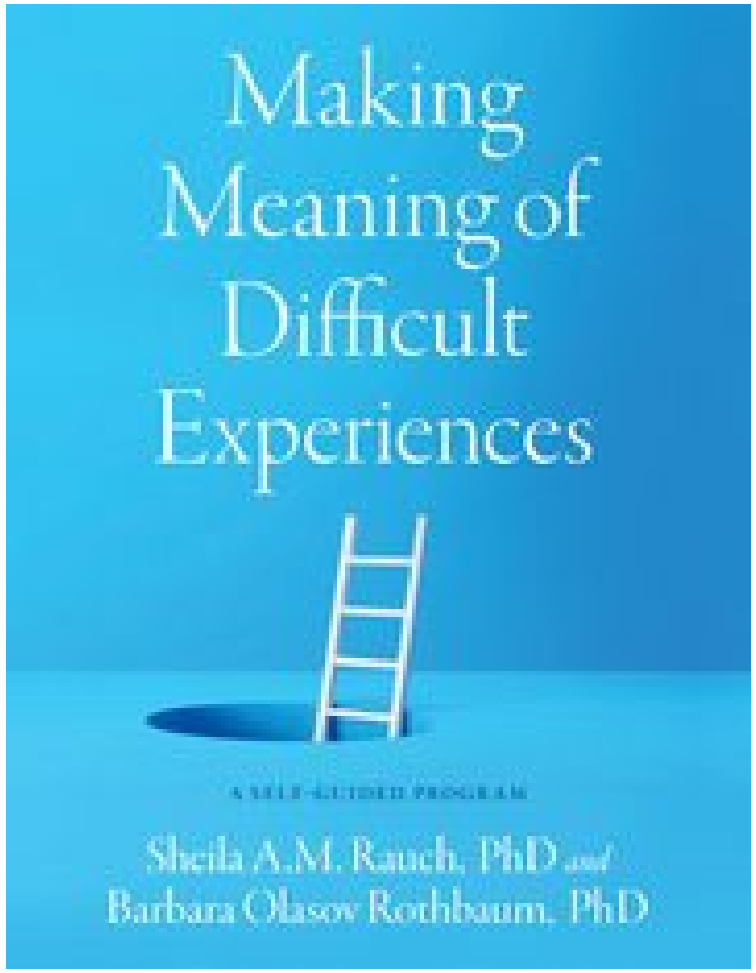
- Phases
  - Initial Phase- ongoing stressor
  - Post Phase- acute exposure to risk and loss is complete and the next three months
  - Long-term Phase- 3 months and more

Rauch et al, 2020

Rising Tide: Phased Approach to Covid-19 Mental Health Response (PAC)

- Levels
  - **Public Health/System Supported Level** recommendations for leadership and organizations
  - **Self-Directed Level** (includes Messy Memories and Making Meaning of Difficult Experiences)
    - self-assessment of need or as an initial intervention for those
    - mild to moderate distress and/or functional impairment without imminent risk to self or others
  - **Mental Health Supported Brief Intervention Level**
    - brief interventions provided with entry through primary care or mental health providers
    - higher level of need or for whom self-directed approaches are not possible and/or effective

Rauch et al, 2020



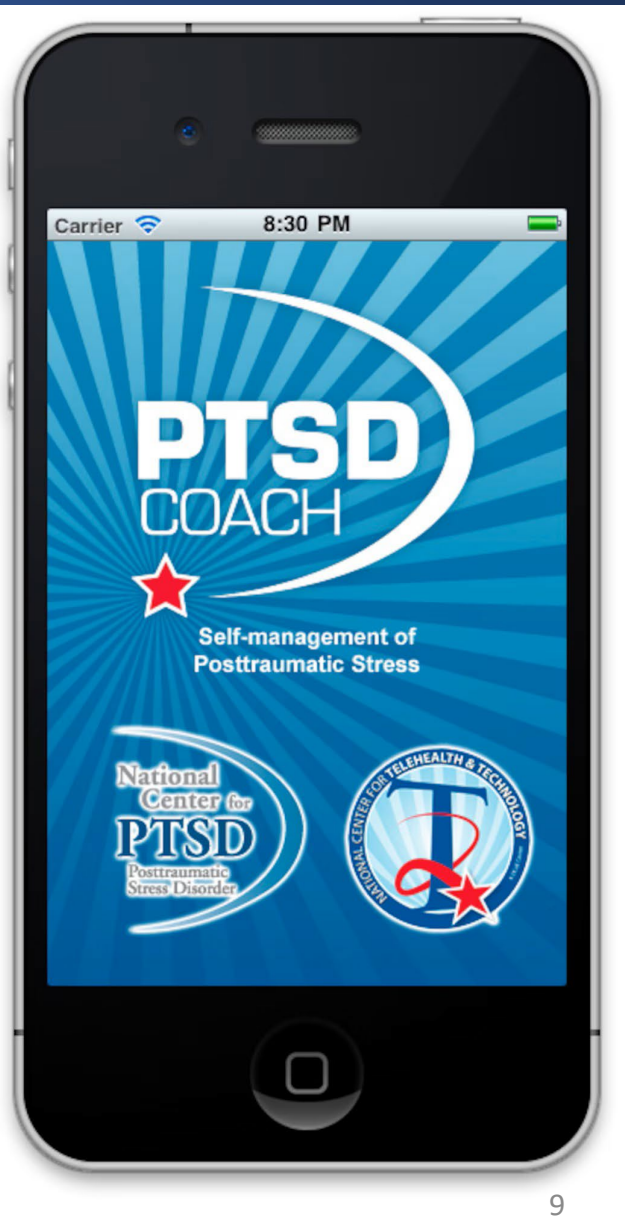
- **Self-directed model is currently being examined.**

PTSD Prevalence in Primary Care

- Overall, 12.5% of primary care patients meet criteria for PTSD (Spottswood, et al., 2017)
  - 11.1% civilian PC
  - 24.5% veteran PC
- Many PC patients prefer to receive MH treatment in PC
- PTSD increases risk for other medical conditions (heart and lung disease and even diabetes; Roberts et al, 2015)
- PTSD increases healthcare costs (Walker et al, 2003)

PTSD Coach vs. TAU (Possemato et al, 2023)

- Posttreatment (8 wk)
  - Self-reported PTSD significantly lower than TAU
  - Interview PTSD and self-reported depression were not significantly different
- PTSD Coach participants more likely to show reliable change in PTSD (34%) than TAU (18%)



Development of Processing Emotions in Primary Care (aka Prolonged Exposure in Primary Care; PE-PC)

Came out of expressed need from Primary Care Mental Health providers

Collaboratively developed with PC provider and patient input on the process

Modified based on feedback from providers to simplify

Flexible manual to fit variations in practice

In use in VA, DOD, and Federally Qualified Health Centers (FQHCs) with success

WHY PE-PC?

Most people with PTSD:

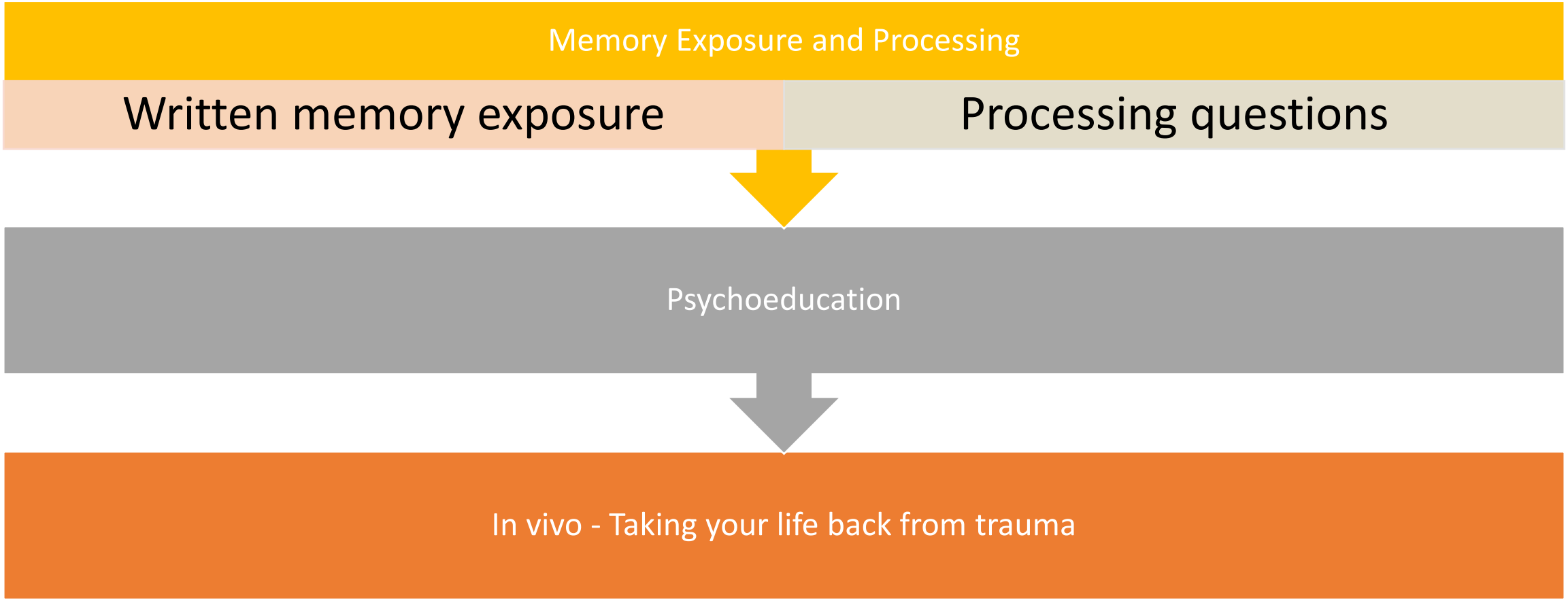
- never seek treatment,
- refuse treatment or specialty MH referral when offered,
- drop out early.

PE-PC can increase reach of effective therapy to PC

Pilot and RCT show efficacy in Military, VA and civilian primary care (Cigrang et al., 2017; Rauch et al., 2023a; Sripada et al.2022)

VA PCMHI Training Pilot showed effectiveness (NCPTSD & CIH; Rauch, et al, 2022; Rauch et al, 2023b)

PE-PC Components



PE-PC Protocol (30-minute visits)

Contact 0: (1) Assess patient, (2) Discuss treatment options

Contact 1: "Confronting Uncomfortable Memories" workbook.

Assign Homework: write a first-person detailed narrative of the traumatic event once a week.

Answer emotional processing questions.

Read trauma narrative and answers to questions 30 min. 3 x week

Contact 2 to 8:

During appointment: Read narrative and answers to questions out loud

Trauma-associated emotional processing using a focused discussion

At end of Contact 4, review progress & collaboratively decide next step:

- Conclude treatment
- Two to four additional contacts in primary care
- Referral to specialty care

Memory Exposure Exercise: Contact 1

Date of Exercise: _____

Use the following scale to rate your DISCOMFORT:

0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

Completely Relaxed	Mostly Relaxed	Noticeably Upset	Very Upset	Most Upset

Rate your discomfort **BEFORE** completing the memory exercise:

0-------1-------2-------3-------4-------5-------6-------7-------8--

Trauma Start Point: _____

Trauma End Point: _____

Write your traumatic memory below:

_____

Processing Questions: Contact 1

1) Why do you think this event happened to you?

_____

_____

_____

2) What caused it to happen?

_____

_____

_____

3) How has this event changed what you think about yourself?

_____

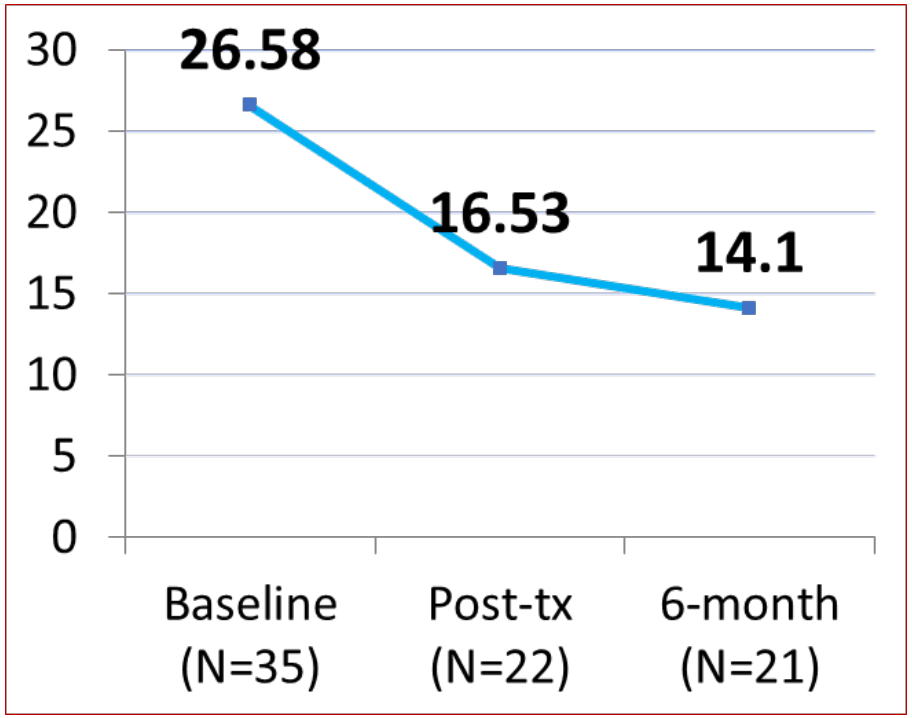
_____

Who can benefit from PE-PC?

- Experienced a trauma or traumas
- Haunted by a specific memory of a trauma
- Want to figure out how to take their life back from the trauma with your support in PC
- NOT in imminent risk of harm to self or others
- Not experiencing other mental health issues that require a higher level of care
- Do not need full PTSD as long as they are motivated to work on the memory

Pilot PE-PC reduces PTSD and Depression

Changes in PTSD (PSSI)



Table

Changes in Clinician-Rated PTSD Symptom Severity (PSS-I)

	EM Estimation (MIXED)		
	Mean	StdErr	ES
Baseline	26.58	1.76	
Posttreatment	16.53	2.00	1.17
6-month follow-up	14.10	2.19	1.45
1-year follow-up	18.35	2.33	0.95
Average posttreatment and follow-up	16.33	1.86	

Omnibus *F*-tests

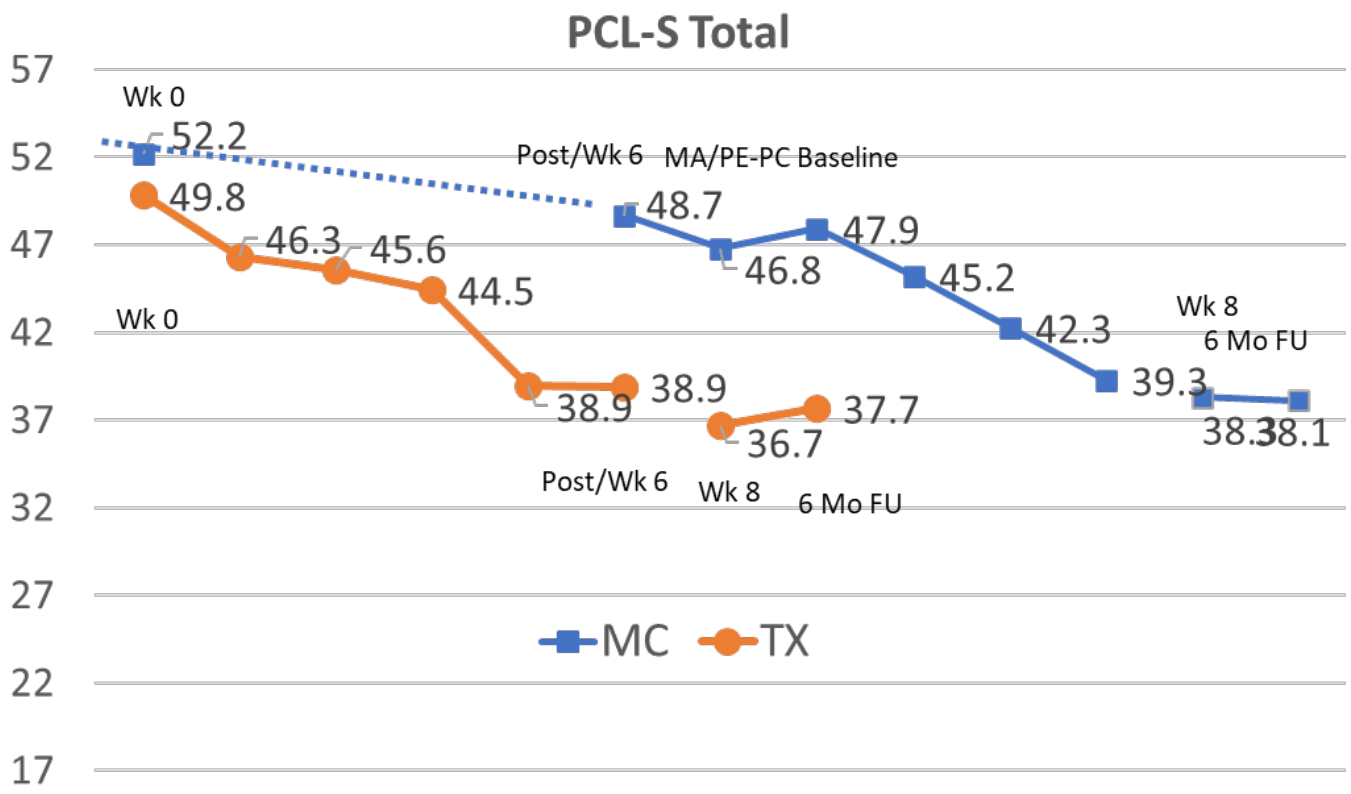
Effect	*F*	*df*	*p*
Time (Main Effect)	12.12	3, 23	<.0001
Among post baseline	1.98	2, 23	0.16

Cigrang et al., 2011, 2015; Brundige et al, 2012

What does PE-PC look like?

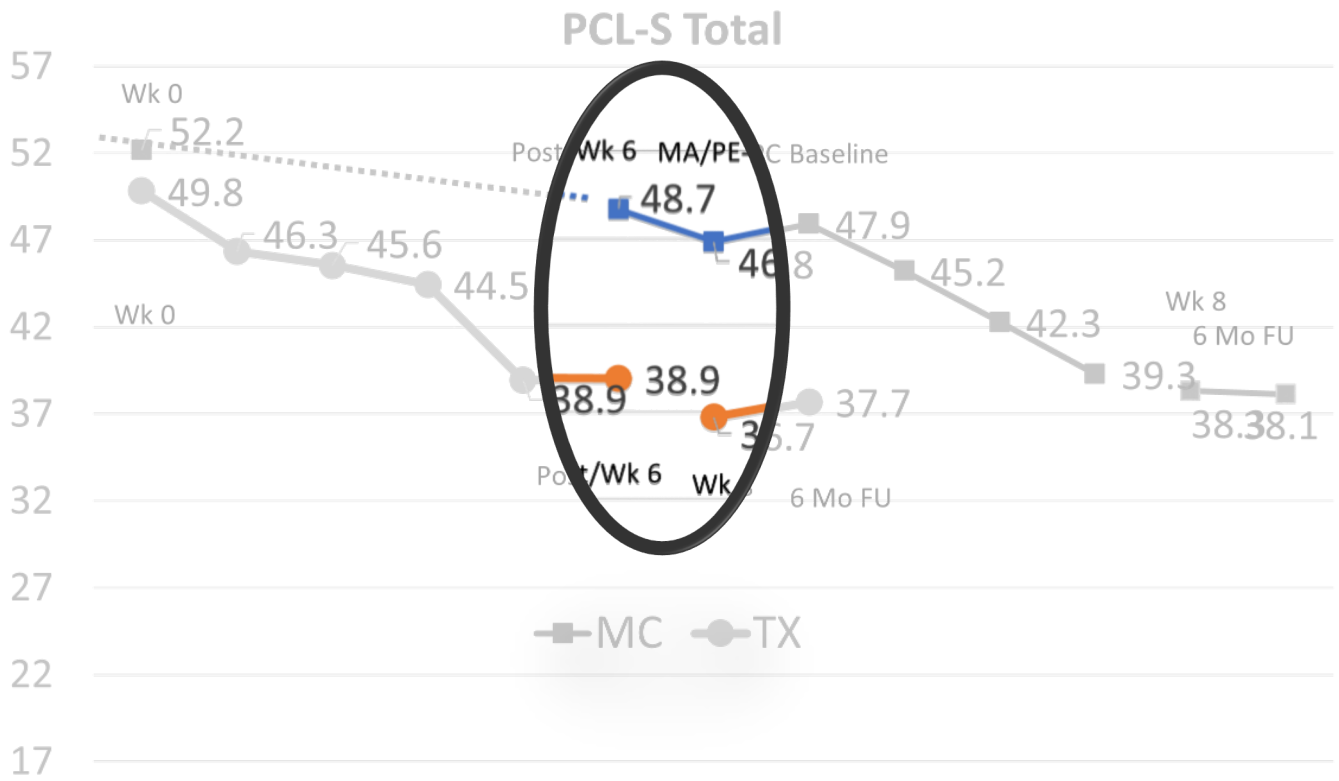
- https://bcove.video/3CEssyL

RCT: PE-PC vs. Minimal Contact



(Cigrang et al, 2017)

RCT: PE-PC vs. Minimal Contact



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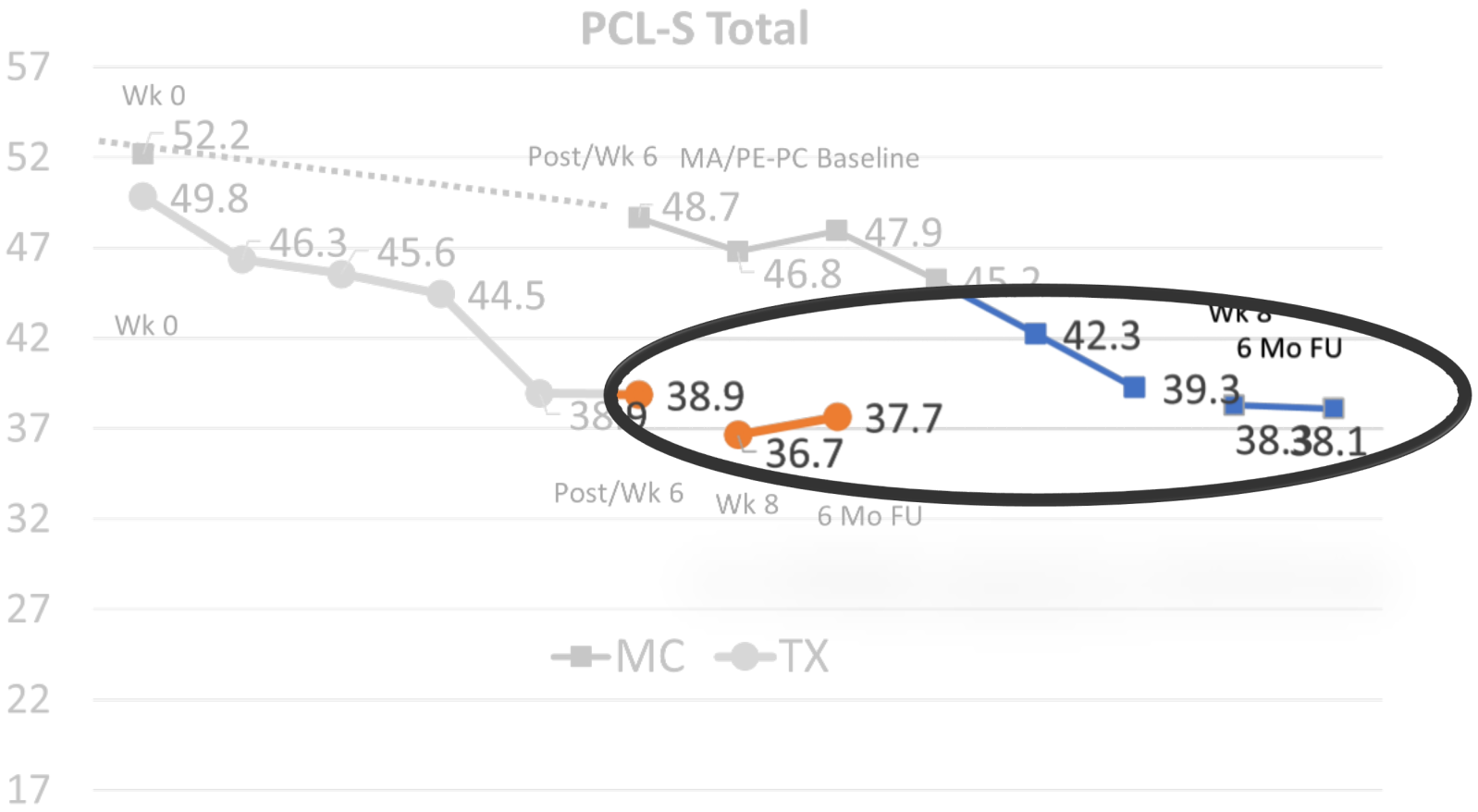
RCT: PE-PC vs. Minimal Contact



(Cigrang et al, 2017)

PE-PC Effectiveness & Predictors (N = 733)

	%		%
Male	84	OEF/OIF/OND era	47
White	67	Persian Gulf 1	25
Black	22	Post Vietnam/Pre-Gulf 1	9
Asian American	4	Vietnam	19
All other, unknown, mixed, and declined	6	Target Trauma-Combat	52
Not Hispanic/Latino	83	Target Trauma-MST	10
Hispanic or Latino	14	Target Trauma- Child sexual/physical Abuse	4
Unknown/Declined	3	Target Trauma- Other Military	27
Completers	64	Target Trauma- Other Non-Military	8

Rauch et al, 2023

PE-PC Effectiveness & Predictors

- Modal number of sessions = 5
- 85% Baseline PCL-5 greater than 33
- PE-PC is a veteran-centered intervention with inclusion determined by self-reported PCL5 symptoms and veteran reported motivation
  - 64% Completion
- Clinically significant change in 32% of all veterans who started PE-PC (PCL-5 change of 15 or more points)
- 81% of baseline depressed veterans were below clinical depression on PHQ-9 at posttreatment
- Referral on to specialty mental health is also a good outcome!

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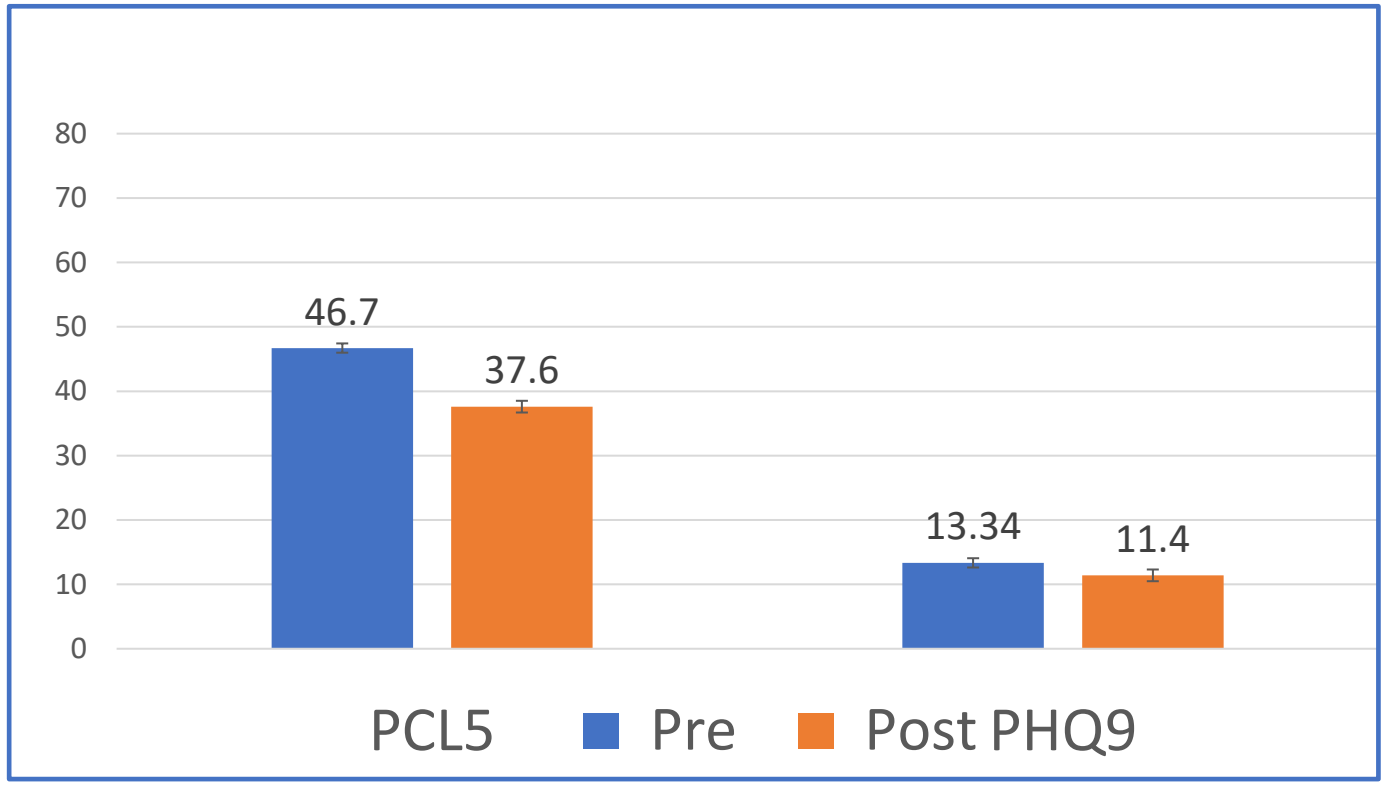
PE-PC Effectiveness and Predictors



Time, PCL scores [t (735)= -17.172, $p < .001$; ITT, $d = 0.63$; completers, $d = 0.79$)

Time, PHQ-9 scores (t (727)= -10.649, $p \leq .001$; ITT, $d = 0.40$; completers, $d = 0.51$)

Rauch et al, 2023

Predictors of PE-PC Magnitude of Change in PTSD and Depression

When examining the impact of:

Gender	Race/ Ethnicity	Trauma Type	Provider previous training	Age	Depression

No significant predictors emerged

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Predictors of Retention in PE-PC

When examining the impact of:

Gender	Race/ Ethnicity	Trauma Type	Provider previous training	Age	Depression

Age, race, trauma type and previous provider training impacted retention

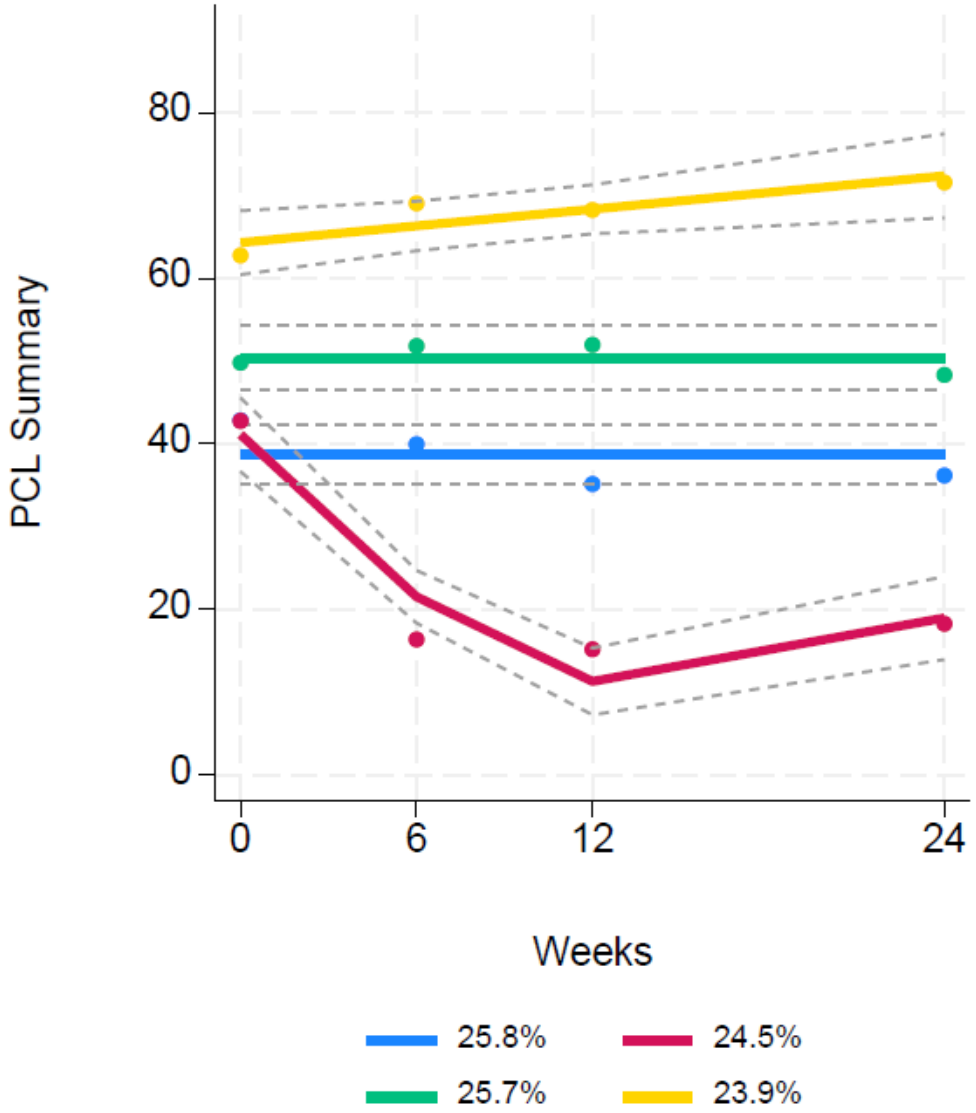
- Older veterans had better retention
- Providers with training in both PE and CPT had better retention than those with no previous PTSD EBP training
- MST as target trauma had lower retention than combat trauma
- Those who identified as Asian and Pacific Islander veterans had better retention than those who identified as white veterans

Rauch et al. 2023

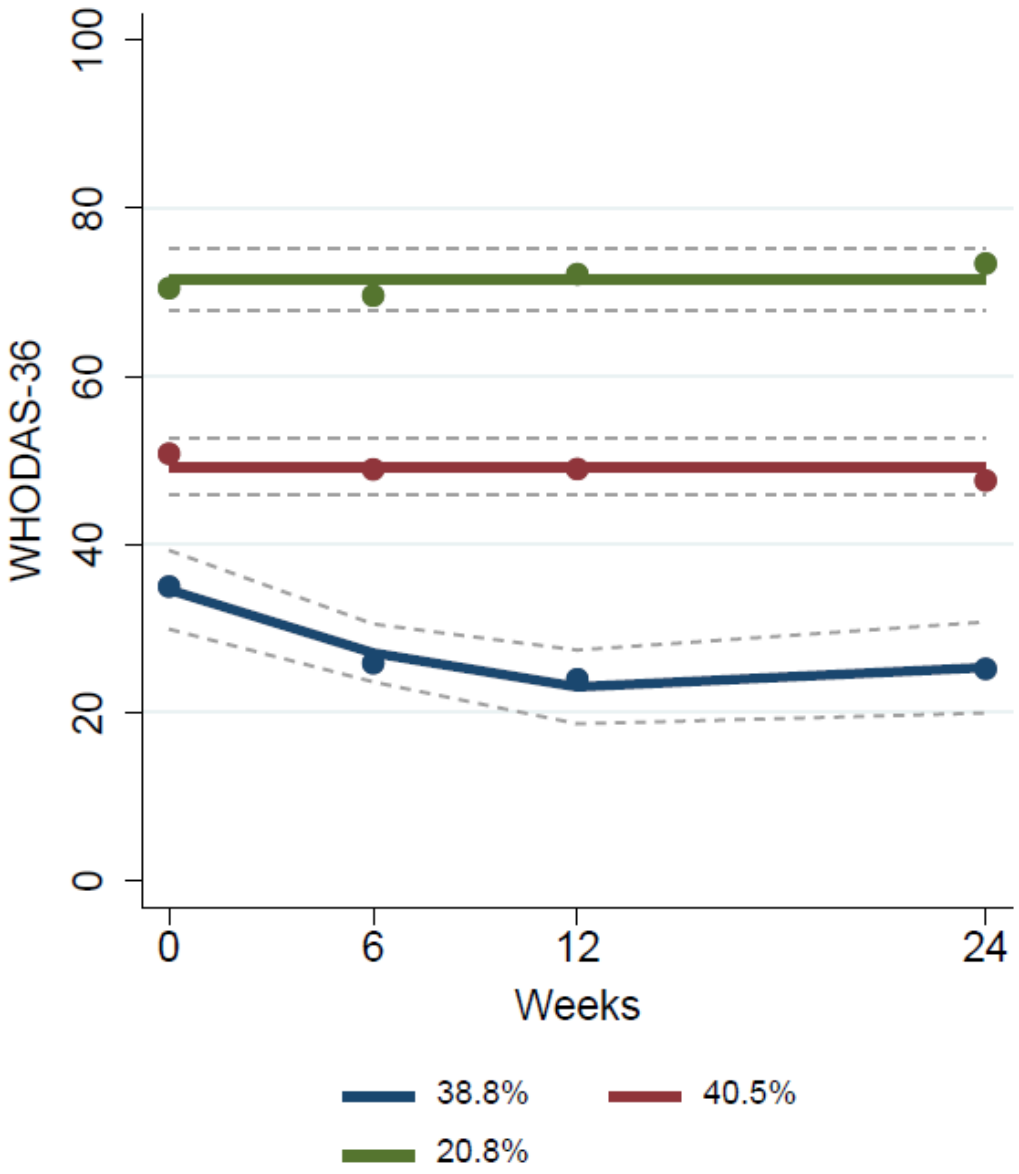
Patterns of Change in PE-PC

- Brief intervention may not fit the needs of all PTSD patients.
- Examination of possible factors that can predict who might benefit from brief, PC-based care may assist with treatment planning
- IMPACT PE-PC study in VA PCMHI (N = 59)
- We examined predictors of symptom response trajectories (PCL-5 and WHODAS 2.0) for veterans with PTSD presenting and receiving PE-PC in PCMHI
  - Demographics (race, ethnicity, gender)
  - Baseline PTSD severity
  - Baseline depression severity (PHQ-9; Kroenke et al., 2001)
  - Baseline functional impairment
  - Treatment Expectancy & Credibility [CEQ; (Devilly & Borkovec, 2000)]

PTSD Trajectories with PE-PC



Function Trajectories with PE-PC



Predictors of PTSD Trajectories

Neither age, race, sex, study site, expectancy, nor credibility were predictive of response trajectory

Baseline PTSD symptoms were highly predictive of latent PTSD trajectory classes.

Although we found baseline depression severity and level of functioning as measured by WHODAS to be predictive of these PTSD symptom trajectories, neither was independently predictive when baseline PTSD symptom level was included.

Predictors of Function Trajectories

Neither age, race, sex, study site, expectancy, nor credibility predicted function response trajectory.

Baseline function was highly predictive of latent function trajectory classes.

Although baseline depression and PTSD severity were predictive of functional impairment trajectories, neither was independently predictive, once baseline level of function was included in the model.

Trajectories Study Limitations

Sample size somewhat small for the predictive analysis	Currently looking in a large sample of veterans (over 700) treated as training cases in the PE-PC training program to see patterns and predictors
Only one VA facility is represented (Ralph H. Johnson VAMC)	See above
Veteran sample so not clear whether civilian or active duty show similar patterns of change	TRANSFORM and other ongoing studies will be able to examine this

Summary- UPDATE

- 25% of Veterans show sustained remission of PTSD
- 39% show sustained functional improvement
- PE-PC provides increased access to effective PTSD care
- Burden of care on the system is reduced
- For those veterans who present in PC with higher severity of PTSD and functional impairment at baseline, timely referral to specialty mental health may be warranted
- Caution against requiring referral based on a cut score for two reasons:
  - Need replication in a larger sample across VA
  - Veteran/Patient centered care is critical to PTSD treatment
  - Treatment planning discussion - get them started in PE-PC to bridge the transition to specialty mental health.

What Is The Implementation Status of PE-PC?

- 409 VA providers have completed PE-PC training as of June 2025
  - 43 providers currently in training
- Providers from every VISN and 233 different facilities
- 18 active Training Consultants, with 29 consultants certified to date
- 15 DOD providers and one currently in training
- 59 civilian providers have been trained in the VA PE-PC training program
  - 12 providers currently in training
- 32 counselors at 13 Employee Assistance Programs (EAPs) have been trained in the PRIME study with 3 currently in training.
- 22 civilian providers trained in the TRANSFORM study, with 12 additional currently in training now.

Training in PE-PC

- Therapy protocol is on the CIH Protocol Portal and shared with providers who are in the training program
- PE-PC training program
  - Designed for those working in PCMHI
  - Short didactic training
  - 4-month weekly 30-minute video consultation call
- Contact Ms. Mara Venners, MPH, MSW at Margaret.Venners@va.gov for enrollment and application information for VA providers
- Contact Mr. James Garlick at jgarlick@med.umich.edu for enrollment and application information for civilian providers.

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Thank you