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Modeling Activity: Quality Conversations With Patients About Suboptimal Management of PTSD Symptoms and Emerging Treatment Options

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. McIntyre:
This is CME on ReachMD and I'm Dr. Roger McIntyre. Here with me today is a good friend and colleague, Dr. Joe Goldberg. Welcome, Joe.

Dr. Goldberg:
Thank you, Roger. Good to be here.

Dr. McIntyre:
We are discussing how we approach conversations with our patients who are experiencing less than optimal outcomes with current therapeutic approaches and focus on how we decrease a patient's anxiety and the potential use of unapproved treatments, and more so introduction of newly emerging treatments into the therapeutic approach.

Joe, how do we go about this?

Dr. Goldberg:
Delicately. So I think first and foremost, any clinician who is probing information about a history of trauma and its sequelae wants to be mindful of what are the things you want to ask about? You want to ask about did trauma occur, and, if so, what was the nature of it? And that's easier said than done. So it's asked with great delicacy. It's probably an appropriate question to ask someone for whom you are aware that a traumatic experience occurred. I just survived a natural disaster, I had an attack, I had a serious medical illness. Some unfortunate event that occurred. You would be delicately mindful in asking about permission first and foremost. This sounds like it was a very difficult experience for you. Is it okay if I ask you more about it? And then to talk about, trauma is really an aversive experience that happens to someone. It is distressing. It causes all kinds of bodily reactions. So letting patients know that your brain and your body respond to trauma in unique kinds of ways, and then to gently and delicately ask about some of the ways in which a potential traumatic experience could impact their sleep, their thinking, their mood, their startle response or their sense of vigilance about the environment.

Sort of laying these things out as domains that are affected, I think, normalizes the experience, desensitizes it in a way because it's telling the person, well, not just, tell me all the nitty-gritty details about the awful thing that happened, but rather the ramifications. We're interested in what actually happened, but we're especially interested in these domains of intrusive thoughts, avoidant behaviors, hyperarousal, and mood and cognitive symptoms that occur. Patients may be much more comfortable talking about those things, first and foremost, and then tying it back to what the event was, because then this leads us to treatment.

So treatments for PTSD. It's message we want to impart to the patient. We're not just asking for the sake of asking. We're saying, well, if these are symptoms that are there, there are things we can do about it. We can target some of these domains. There are treatments that may be specific for helping with nightmares and flashbacks, for example. There may be treatments that can downregulate the fight or flight or freeze response. There are behavioral approaches that can help someone basically unlearn an overlearned aversive response to an experience, a kind of an extinction process. So you can almost put it in very medical terms for the patient that your brain has learned something and we're trying to help it unlearn.

It's also destigmatizing for patients to say to them, "When something awful happened to you, your brain responds to it." Some people might wrongly blame themselves for that or think that they caused this to happen when in fact, let's blame your hippocampus or let's blame the reactivity within your brain that's going on.

We also want to make sure a patient's not going down the wrong avenue. So, well, alcohol helps me with this, or lots of benzos help me with this. So we want to steer them toward the knowledge that once we've recognized the syndrome, when it's there, we have treatments that can be effective.

And the overarching message, I think, is with delicacy, trust, asking permission, and trying to truly impart a sense that, once we've recognized the syndrome and we can name it, we can do something about it. We have new and emerging options that hopefully will make for better outcomes than we've ever seen in the past.

Dr. McIntyre:
Joe, so well put. And I think the theme that emanates from your comments is the importance of patient centricity, the shared decision-making. And I might even say the word perseverance. I mean, if we can persevere, if we have inadequate response to a first-level therapy, keep persevering. There's investigational treatments, there's off-label treatments. There's also treatments on the horizon for people with PTSD. So I often hear the refrain, I've been treated for PTSD, the treatments didn't work. No point in considering it further. Well, I would say there are treatments that one should consider and that should be done empathically as part of a shared-decision model with our patients.

Joe, our time is up, unfortunately. What a great discussion. And thanks to all of you for tuning in to today's program.

Dr. Goldberg:
Thanks everyone. See you next time.

Announcer:
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