

TRAUMA RECOVERY CENTER PSYCHIATRY AND PSYCHOPHARMACOLOGY: THE ROLE OF THE PSYCHIATRIST

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Photograph by Ezme Kozuszek

“My friend is one who takes me for what I am.”

—Henry David Thoreau

The UC San Francisco Trauma Recovery Center Model: Removing Barriers to Care and Transforming Services for Survivors of Violent Crime. Edited by Stacey Wiggall, LCSW & Alicia Boccellari, Ph.D. Produced in collaboration with Allen/Loeb Associates
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The TRC psychiatrist is an essential member of the TRC treatment team, working closely with the TRC Clinician and other staff to provide comprehensive care to trauma survivors. TRC psychiatrists have special expertise in the area of treating Acute and Posttraumatic Stress Disorders and providing a more intensive level of services in a briefer period than usual care.

How are TRC Psychiatric Services Different?

In the TRC model, the Psychiatrist is involved in a more hands-on, time-intensive way than is usual in community mental health. They have the capacity to devote considerable time to meeting with clients and other members of the treatment team, and this has a greater impact than usual care. By providing an intensive level of services in a short period of time (normally 16 weeks), the Psychiatrist and other members of the TRC team bring about a major and lasting reduction in PTSD symptoms, helping prevent trauma survivors from developing chronic mental health problems. The Psychiatrist's intensive involvement may serve to reduce clients' potential reluctance to receive psychiatric services, to enhance adherence, and to optimize effective pharmacological treatment as quickly as possible. Many trauma survivors have never received mental health services before, and because of societal stigma around psychiatric medication, may feel considerable anxiety and shame about meeting with a Psychiatrist to consider medication. As will be discussed below, the TRC psychiatrist's accessibility and relationship to the team help to gently overcome a client's potential anxiety and facilitate engagement in psychiatric services.

TRC psychiatrist is on-site

The TRC psychiatrist is on-site, ideally in the same area as the TRC Clinician, not located on a different floor or in a different building. This co-location makes it possible for the Psychiatrist to participate as an active member of the multidisciplinary team. The Psychiatrist is available for consultation with the Clinician, and works collaboratively with him or her, sharing information about the client. The Psychiatrist and Clinician also meet jointly with the client when indicated.

Caseload

Because TRC is a brief, intensive program, Psychiatrists have a smaller caseload with clients being seen more frequently and with significantly higher client turnover than in a typical outpatient clinic. This smaller caseload size is essential for providing a higher level of care, especially at the beginning of a client's treatment.

Relationship to the TRC team

The TRC team is collaborative, not hierarchical. The TRC Psychiatrist participates as a member, with special expertise in pharmacological approaches and other medical aspects of trauma treatment. Because of the Psychiatrist's active involvement, the client soon becomes familiar with the Psychiatrist and comes to understand that he or she is a part of the team. This makes it much easier for the Psychiatrist to establish a therapeutic alliance with the client.

INTERFACE WITH THE TRC CLINICIAN. The Psychiatrist interfaces closely with the Clinician. At TRC, the Clinician is the client's central point of contact for psychotherapy, case management, and outreach, and is the source of the on-site referral of the client to the Psychiatrist. Clinicians should consider referring clients to the TRC Psychiatrist in the following circumstances:

- When a client is already taking a psychotropic medication prescribed by an outside provider
- When a client requests a psychiatric assessment
- When a client has been diagnosed with any of the following: Major Depressive Disorder (particularly when it is moderate to severe), Panic Disorder, Bipolar Disorder, Obsessive Compulsive Disorder, Schizophrenia or Schizoaffective Disorder
- When a client's PTSD symptoms are impairing their daily functioning and are not clearly improving with psychotherapy

During the beginning phase of treatment with psychotropic medications, the Psychiatrist and Clinician discuss the information that the Psychiatrist has shared with the client after the psychiatric assessment, including diagnoses, goals for treatment with the prescribed medications, target symptoms, potential side effects, assessment of efficacy, and medication compliance. The Psychiatrist monitors the client's medication adherence and response during medication management follow-up visits, and keeps the Clinician informed. The Clinician also regularly updates the Psychiatrist about any important additional observations that may help shape psychiatric treatment decisions. This close communication helps to ensure that the client receives individualized, effective treatment and that TRC providers function as a team providing care.

INTERFACE WITH OTHER TEAM MEMBERS. Although the Psychiatrist works most closely with the Clinician, she or he also interacts with the receptionists, paraprofessionals, supervisors, and other team members as an integral part of the TRC community of providers.

INTAKE TEAM MEETINGS. The TRC Psychiatrist participates in intake teams where new cases are presented. This allows the Psychiatrist to gain some familiarity with clients who may be referred for a psychiatric assessment prior to their first meeting. Additionally, the Psychiatrist can provide some initial orientation to other intake team staff about how psychiatry may be able to help each new client. In addition, the Psychiatrist gives the team the benefit of their expertise in considering medical conditions that may have a psychiatric interface, as well as in diagnosis and treatment planning.

STAFF MEETINGS. The TRC Psychiatrist participates in regular staff meetings. This participation keeps the Psychiatrist updated and on the same page with the rest of the team, and gives the team the benefit of the Psychiatrist's regular and timely input.

Meetings with the Client

It is important to be aware that the TRC model is a short-term, intensive treatment approach (therapy is generally planned for 16 sessions, with extensions as deemed appropriate by the team). In this model, the Psychiatrist does not see clients for a brief review on a regular (e.g., monthly) basis for an extended period of time. Rather, the Psychiatrist's initial session with the client will be a 90-minute evaluation, followed by weekly meetings for 2 to 4 weeks, with each session lasting about 30 minutes. After that, the sessions are bi-weekly or monthly, depending on treatment complexity and response, until the completion of the course of TRC treatment.

Initial informal meeting

Because the Psychiatrist is on-site, the Clinician may invite the client to meet the Psychiatrist briefly for an introduction and initial conversation. This introduction, with some unstructured discussion, can lessen a client's anxiety about working with a Psychiatrist, and make the idea of receiving psychiatric services more acceptable.

Initial 90-minute meeting

Once the client is officially referred to the Psychiatrist, they meet together for approximately 90 minutes. Prior to this meeting, the Psychiatrist carefully reviews the Clinician's chart notes and any additional available medical records. The Psychiatrist is sensitive to the fact that requiring the client to tell his or her trauma history over again in an initial meeting may be quite stressful for the client, and so refrains from doing so if adequate information is available from the medical record. During this meeting, the Psychiatrist performs a comprehensive diagnostic assessment to identify potential target

symptoms that may be amenable to psychopharmacologic intervention. The interview covers:

- The client's treatment priorities
- The client's questions and concerns about receiving treatment from the Psychiatrist
- Medical history, current health status, and current medications
- Client's psychiatric history and past psychiatric medications, if any

Following this assessment, if medication management is indicated, and the client is in agreement with this recommendation, the Psychiatrist will prescribe medication as appropriate and will communicate findings and recommendations to the client's Clinician.

Ongoing follow-up meetings

After the initial 90-minute evaluation session, the Psychiatrist schedules medication follow-up appointments to monitor treatment adherence, tolerability and response. To ease the burden on the client, these appointments are scheduled to coordinate with weekly therapy appointments whenever possible.

LOCATION OF MEETINGS. The TRC model requires flexibility in where clients are seen. The TRC Psychiatrist and Clinician may make home visits to clients who are homebound. Seeing the home environment can be very useful in assessing the client's functioning and needs, and in determining appropriate treatment goals. The Psychiatrist and Clinician may also make hospital visits to clients who are confined to a hospital bed.

If the client is monolingual non-English speaking, the inclusion of an interpreter may make the sessions longer, and this is factored into the client's scheduling.

Substance abuse issues

Severely traumatized clients are at increased risk for substance use disorders, either pre-dating the index trauma or developing subsequent to the trauma. The Psychiatrist addresses this issue by: 1) completing a thorough assessment regarding substance use and misuse; 2) providing psychoeducation about the substances identified including medical risks, and the relationship between substance use and PTSD and co-morbid conditions; 3) offering addiction-focused pharmacotherapy or referral for medical detoxification as indicated; 4) supporting the client in use of psychosocial treatments both within TRC and

through external treatment programs; and 5) coordinating management of substance use disorders with the client's primary care provider and their Clinician. A key aspect of the approach to substance use disorder treatment in TRC is the concurrent treatment of Substance Use Disorder, PTSD, and other co-morbid conditions.

NONJUDGMENTAL STANCE. The Psychiatrist takes a nonjudgmental, harm reduction approach to substance use, but this is far from enabling. Very often, the Psychiatrist lets the client know that they understand how drugs of abuse (e.g., alcohol, stimulants) may provide the client with temporary symptom relief. The Psychiatrist also makes sure to educate clients that self-medication with these drugs may lead to worsening of PTSD symptoms or those of co-morbid conditions such as major depressive disorder, or may lead to development of a substance use disorder.

INSOMNIA. Insomnia is probably the most frequent complaint presented by traumatized clients, as it interferes with their ability to function. For example, the Psychiatrist may see a woman who, until she experienced a recent physical assault, had no history of substance abuse. She had some history of exposure to interpersonal violence, and met criteria for diagnoses of PTSD and major depression. When she came to the Psychiatrist she had started drinking alcohol to fall asleep. The Psychiatrist provided education about how alcohol can temporarily reduce symptoms, but on the rebound, ends up making things worse. This is because alcohol can help in falling asleep, but at the same time results in frequent awakenings and decreased sleep quality. The client understood and cooperated with other, more effective approaches to her sleep problems.

SUBSTANCE USE: UNDERSTANDING WHY. It is essential that the Psychiatrist probe to understand exactly why the client is using a substance and what they hope it will do for them. Once this is understood, the Psychiatrist can help the client identify safe and more productive coping options. For example, sleep difficulties often relate to the client's experience of nightmares that directly disrupt sleep and may secondarily lead to sleep avoidance. Instead of the client using alcohol in this context, the Psychiatrist can directly reduce the nightmares with a medication known to be efficacious for this purpose.

AN EXAMPLE. Clients with PTSD and anxiety disorders may use stimulants such as methamphetamines and cocaine, which then worsen the symptoms of their anxiety. A recent instance of this occurred with a client who had a history of long-time poly substance abuse but had achieved abstinence. Then she was informed by the District Attorney's office that they did not feel they had a case against her perpetrator and were releasing him. Soon, she encountered the perpetrator in public. That event re-triggered her symptoms of PTSD and, in response, she used crack cocaine twice. The Psychiatrist provided education about how using a stimulant makes things worse overall by increasing

anxiety reactions, and helped the client make an informed choice about her use. With support from the Psychiatrist and the rest of the team, the client was able to return to abstinence from stimulants.

EDUCATING RESPECTFULLY. Education about the risks posed by substance use should be presented candidly but respectfully, with an appreciation of the fact that the client truly does have severe symptoms to deal with. The Psychiatrist recognizes that the client's desire to self-medicate with drugs of abuse is understandable, though acting on it is unhelpful. This education helps the client adjust to alternative ways of coping with symptoms such as insomnia, depression, or anxiety, including the use of psychotropic medications when warranted.

Consultation with primary care providers

Survivors of violent crime may have complicating physical issues. The Psychiatrist may need to consult with the client's primary care provider (PCP) to get more information about how the client is dealing with physical problems and to discuss the use of pain medications that may have potential for abuse under the circumstances. They also may discuss other medications the client is taking that may have complications or potential interactions with psychiatric medications.

After TRC treatment there is a need to establish continuity of care, since the Psychiatrist will not be seeing the client over the long term. Often the client will need continued management of psychiatric medications. In this case, the Psychiatrist coordinates the transfer of care to the client's PCP or a community psychiatrist, depending on the complexity of the client's treatment.

Co-morbid disorders

As mentioned previously, many TRC clients have co-morbid disorders. Of those with PTSD, 50% or more have major depression. By providing appropriate medications, Psychiatrists help clients manage major depression, as well as other disorders such as bipolar disorder and borderline personality disorder. These co-occurring issues can prevent the client from participating actively in the cognitive-behavioral therapy and psychoeducational programs they need to overcome their trauma. By helping clients manage or recover from these other issues, the Psychiatrist helps make trauma recovery possible.

How to discuss medications with clients

The TRC Psychiatrist understands that psychiatric medications can be frightening and stigmatizing for clients. The Psychiatrist educates the client about why the medications are being prescribed and the expected treatment duration. Clients are assured that they can choose to decline the recommended medication without impact on their eligibility to continue treatment with the Clinician. Providing options and allowing the client some choice and control in the medication decision-making process when possible is an important aspect of treating trauma survivors, who by definition had control taken away during the trauma. This can be empowering for clients and facilitates a positive therapeutic alliance with the TRC Psychiatrist.

Payment issues

When clients cannot self-pay for medications and do not have insurance, the TRC needs to mobilize case management services to help the client become eligible for Medicaid or access another program that will arrange payment for medications.

Psychopharmacology: Overview and Resources

TRC Psychiatrists prescribing medications for survivors of trauma and people suffering from PTSD are well-informed about medication guidelines for trauma, PTSD and co-occurring disorders. Evidence supports the use of selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) in PTSD treatment. The current evidence base is strongest for SSRIs, and currently only sertraline (Zoloft) and paroxetine (Paxil) are approved by the Food and Drug Administration for PTSD. All other medication uses are off label, though there are differing levels of evidence supporting their use. For example, there is strong evidence for the SSRI fluoxetine (Prozac) and for the serotonin norepinephrine reuptake inhibitor (SNRI) venlafaxine (Effexor) which are first-line treatments in the Veterans Administration/Department of Defense (VA/DoD) Clinical Practice Guidelines for PTSD (VA/DoD Clinical Practice Guidelines for PTSD.)

There are excellent technical resources that provide complete and detailed information on the recommendations and contraindications of medications for the TRC target population. A useful review chapter, Pharmacologic Treatment of PTSD (Raskind, 2009), is included in *Post-Traumatic Stress Disorder: Basic Science and Clinical Practice* .

ON-LINE RESOURCES. Many resources can be found at the Veterans Affairs PTSD web site <http://www.ptsd.va.gov/>

- For a more complete overview of PTSD psychopharmacology, see the *Clinician's Guide to Medications for PTSD* at <http://www.ptsd.va.gov/professional/treatment/overview/clinicians-guide-to-medications-for-ptsd.asp>
- *Psychopharmacology of PTSD* is a longer series of videos (90 minutes, in 6 parts) at <http://www.ptsd.va.gov/professional/materials/videos/emv-psychopharm-mhcp.asp>

Trauma Psychiatrists and Self Care

One of the concerns for anyone working directly with trauma survivors is *vicarious trauma*, which is discussed in another chapter of this manual (Vicarious Trauma and Staff Support). The TRC Psychiatrists at the UC San Francisco Trauma Recovery Center have found that working as part of a team is an essential element in preventing vicarious trauma and compassion fatigue. The program structure is very helpful, in that no one feels alone in dealing with traumatized clients or in crisis situations. For example, if a client is expressing suicidal ideation, there is a whole team and a structure for bringing in the support of the other team members.

SELF CARE GROUP. Self care is as important for TRC Psychiatrists as it is for other team members. At the UC San Francisco Trauma Recovery Center, where there are separate self care groups for line staff and supervisors, the Psychiatrists participate in the supervisors' self care group. Because the Psychiatrists see a larger caseload than the Clinicians, they are exposed to increased trauma information and self-care becomes very important in addressing vicarious traumatization and increasing resiliency.

TRC Psychiatrists as Fully Integrated Treatment Team Members

In summary, TRC Psychiatrists are fully integrated into the TRC treatment team, as co-providers, staff members, and supervisors. Close collaboration between Psychiatrists and Clinicians helps erase barriers to psychiatric care for TRC clients. The specialized training and knowledge that TRC Psychiatrists bring to their role of working exclusively with trauma survivors ensures that clients receive effective, individualized treatment that is complementary to the services provided by their TRC Clinician.

References

Raskind, M. A. (2009). Pharmacologic treatment of PTSD. In *Post-Traumatic Stress Disorder* (pp. 337-361). Humana Press.

Thoreau, H.D. (n.d.) QuoteAddicts.com. Retrieved November 7, 2016 from QuoteAddicts website: <http://quoteaddicts.com/908224>