

Post Traumatic Stress Disorder and Other Clinical Conditions

Summarized by Thomas T. Thomas

At our May 24 meeting, **Kumar Vedantham, MD**, discussed his psychiatric and clinical work as medical director of the Oakland Veterans Administration (VA) Mental Health and Substance Abuse Clinic. His talk included post traumatic stress disorder (PTSD), covering advances in treatment and new medications.

Dr. Vedantham has been a psychiatrist with the Veterans Administration clinic in Oakland for six years. “The population trends at our clinic are changing rapidly,” he said. “For one thing, we now have more women veterans, and for another, veterans are now returning from the Iraq war. The Oakland clinic also has a methadone program, which has given me a chance to understand how addiction and mental health interact. And, of course, we see a lot of post-traumatic stress disorder, which is the bread-and-butter of the VA’s work.”



KUMAR VEDANTHAM, MD

The VA has been progressive with its formulary, Dr. Vedantham said, which has enabled him to gain clinical experience with many of the new medications. In this regard, he discussed the recent findings of the CATIE1 study, which was funded by the National Institute of Mental Health and conducted by Jeffrey Lieberman, MD, chair of the Columbia University Department of Psychiatry and Director of the New York State Psychiatric Institute. The study included 1,400 people taking antipsychotic medication for schizophrenia at 57 sites around the country between 2000 and 2004. The results were released in September 2005.

The CATIE researchers compared an older medication, perphenazine (brand name Trilafon), which has been available since the 1950s, to four newer medications: olanzapine (brand name Zyprexa), quetiapine (brand name Seroquel), risperidone (brand name Risperdal), and ziprasidone (brand name Geodon)—all of which are known as “atypical” antipsychotics and were introduced in the 1990s. (A fifth atypical, aripiprazole with the brand name Abilify, was too new to be included in the study.)

“Antipsychotic drugs are double-edged with side effects,” Dr. Vedantham said. The atypicals are so called because at first they presented fewer side effects, especially those usually found with the older medications—most notably the involuntary muscle movements of tardive dyskinesia. However, psychiatrists have since discovered that the atypicals do have metabolic side effects, including weight gain, susceptibility to diabetes, and elevated cholesterol. People with schizophrenia

¹ CATIE stands for Clinical Antipsychotic Trials of Intervention Effectiveness.

usually have a high incidence of these kinds of health problems already, and the medications tend to make them worse.

The CATIE study tried to present a real-life picture of patients and medication, Dr. Vedantham said. Unlike research efforts focused on a particular medication and usually funded by the drug company, there was no attempt to screen out patients due to addiction, tendency to suicide, previous noncompliance with medication, or other reasons. Also, most drug studies use a fixed dosage and forbid drug switching. The CATIE study ran the participants for 18 months on one medication that was randomly assigned and then allowed them to switch to a different medication for another 18 months. The intent was to see how long the patients stayed with a medication and what they experienced in terms of effectiveness and side effects.

“As a psychiatrist,” Dr. Vedantham said, “you would hope that the medication with the cleanest side effects profile would also be the best drug. I had hoped that ziprasidone or Geodon, which has no weight gain or diabetes issues, would come out on top. What the study discovered is that olanzapine or Zyprexa, which was the worst for metabolic side effects—weight gain, diabetes, cholesterol—was the best for compliance, which indicates that it was working for the patient.”

Ziprasidone or Geodon was the newest of the medications in the study and, although it had the fewest side effects, was not very effective, and in fact some patients did worse on it. Quetiapine or Seroquel was the least effective of the medications and had the most side effects.

The study found that overall compliance with any of the medications was low. Only 27%—just about a quarter of participants—stayed with the first medication for the full 18 months. The average length of compliance was only three months, although patients on olanzapine stayed with it for an average of nine months. “Surprisingly,” said Dr. Vedantham, “the older drug, Trilafon, was not too bad in terms of effectiveness and was fairly clean of side effects like tardive dyskinesia, especially at a reasonable dose. However, the side effects did show up over time. This medication was also the cheapest, averaging 75 cents per day, compared to \$6 or \$7 per day for the newer drugs.”

At the switch point in the CATIE study—when clozapine (brand name Clozaril) was admitted as a choice—the results were reassuringly similar to the first 18 months. Risperidone performed somewhat better, however, and clozapine was found to be clearly superior to all the other atypical antipsychotics.

From the CATIE study, Dr. Vedantham concluded, first, that if someone is taking Zyprexa and doing well, the patient would be reluctant to switch. Second, that if someone is taking Seroquel, Dr. Vedantham would encourage him or her to switch. Third, that he would start a patient on Risperdal with Zyprexa as a second choice. “But that’s just my own opinion,” he said. “Other doctors may have different opinions.

“But finally, we need to pay more attention to whether the patient is actually taking the medication—and if not, find out why not. There are many reasons why a patient will stop taking his or her medication. The psychiatrist needs to partner with the patient in choosing the medication.”

During his talk, Dr. Vedantham took many of the audience's questions. Here are a sample.

Q. What about compliance with injectable, timed-release medications?

A. This form of a medication is called "decanoate" and can usually be taken every two weeks rather than once a day. The decanoate allows for smoother blood levels, fewer side effects, and is easier to monitor. Decanoates are widely used in Europe, where they are popular with patients. In the U.S., there is a feeling of stigma—that they are for people who have a history of noncompliance and therefore are "bad patients"—because a doctor must administer them. Dr. Vedantham said he actually likes decanoates because the patients seem to enjoy the interaction, and it gives him a chance to chat with them and "feel like a doctor."

Q. Regarding the weight gain with olanzapine, can a patient take a weight loss medication to counter it?

A. People have tried this, although in the CATIE study there is no indication that this worked better than any other medication.

Q. The trend today seems to be away from personal therapy and toward just doling out medications. Is this because no one is going into psychiatry? I felt that talking one-to-one with my psychiatrist was good for me.

A. There has always been a shortage of psychiatrists. But then, in the past, we did not have a good model of care. Psychiatry was authoritarian and control oriented. The patient was incompetent and needed to be locked away. Now attitudes are changing. Mental health care has become consumer oriented and recovery driven. The patient is a person with a disability who has rights. The physician forms a partnership with the patient. If the patient can work and wants to, it is incumbent on the employer to adapt the environment to the patient's needs.

U.S. presidents have the authority to create commissions to address problems, Dr. Vedantham went on. George W. Bush created the New Freedom Commission on Mental Health, which summarized in its report that our mental health system is a shambles; treatment is frequently inadequate; and it lacks input from consumers. Most commission reports remain just that—reports—but this one has teeth, because the Veterans Administration is required to implement it. There is a top-down emphasis on changing our mental health system. For example, the VA is focusing on homelessness, because housing is a mental health issue. There is also a focus on compensated work therapy, so that people can function in a work setting, get the services they need, and earn money that will lead to independence. Mental health care will become like wheelchair access to public places—we as a society will provide it because it is the appropriate response.

One of the issues raised by this question is specialization. Psychiatrists have become the people who prescribe medications after a twenty-minute consultation, while social workers and psychologists provide therapy in a remote location, and sometimes the two never talk to each other. This is different from the 1950s, when the psychiatrist provided therapy to heal the whole person because there were not many psychotropic medications.

The emphasis now should be how to help the patient stay in treatment and how to engage him or her in a productive life, which means helping the patient find a dwelling, find work if possible, and manage his or her finances. Assertive case management is one model; it focuses on function instead of symptoms. Patients don't just want relief of symptoms but a better life.

Q. How do you organize treatment to promote function?

A. You do this through peer support. Dr. Vedantham said he was struck by the methadone program at the VA clinic, how it was like a community. Mental illness is isolating. But the methadone community—and other self-help groups, like Alcoholics Anonymous—take the premise that if you think you can solve your problems on your own, you're lying to yourself. Other addicts become the mirror held up to help you see yourself. In a way, NAMI is a community like this. In mental health treatment, peer support needs to become more systematic.

Q. What is the treatment for Post-Traumatic Stress Disorder?

A. First, Dr. Vedantham said, trauma is common. Seventy percent of Americans have experienced a traumatic event. Most people recover, because humans are remarkably resilient. When people don't recover, they often have different reactions to the event: depression, or anxiety which may present itself as agoraphobia, or sometimes substance abuse. Traumas are different, too, and generally human-based trauma, such as sexual abuse, is harder to deal with than naturally occurring trauma, like a hurricane. Human trauma changes a person's sense of human nature. An event like Katrina is easier to live with because people usually form groups and help each other.

For PTSD, there are four criteria:

1. The patient must have experienced—objectively and subjectively—a trauma.
2. The patient must have intrusive thoughts, which means he or she keeps thinking about the event.
3. The patient must have arousal, which means he or she is constantly vigilant against a recurrence and cannot relax.
4. The patient must suffer from avoidance, which means the he or she won't talk about the event, may not want to be with people, especially those associated with the event, and avoids situations that led to the event.

Treatment usually involves use of an antidepressant such as paroxetine (brand name Paxil), sertraline (brand name Zoloft), or fluoxetine (brand name Prozac). Then the patient receives cognitive therapy to help him or her integrate the experience into his or her life by recalling the incident and remembering it in a calm way.

Q. Can you use antipsychotic medications for PTSD?

A. The way we diagnose disorders is changing. Psychiatrists are now finding more overlaps than differences, and traditional labels like "schizophrenia" may one day go away. For example, people with schizophrenia can experience anxiety, and people with depression can have hallucinations. So the way we label medications will also change. And it's a bad idea to begin with: if you give a patient an "antipsychotic" medication, he or she may conclude, "I'm psychotic."

We have discovered that dopamine, a substance in the brain, is associated with psychosis when there's a lack of it. But dopamine is also associated with

pleasure, which is the basis for many addictions. Significantly, people with schizophrenia are marked by a lack of pleasurable experiences. But this is a complicated issue.

The short answer is that some of the newer antipsychotic medications have been prescribed for PTSD, but there is still the metabolic side effect to be dealt with.

Q. What about taking multiple medications?

A. The CATIE study raised questions of compliance, but there the patients were taking their medications singly, not together. However, combination of medications is probably the rule rather than the exception in treatment. A doctor will often have a patient on three or four medications at once. As the symptoms and diagnoses overlap, so the medications overlap.

Q. What clues are there that a patient needs help?

A. The first clue is when the patient refuses help, shuts off, or expresses a sense of pseudo independence, rejecting his or her support system. The second clue is depression.

Having a mental illness can be traumatizing in itself. First, the experience of an episode is traumatic, and then the forced hospitalization is traumatic. The patient's instinctive approach to these events—avoidance, similar to someone suffering PTSD—doesn't work. The therapist needs to help the patient recall and handle the experience in a non-distressed way.