Posttraumatic Stress Disorder and Adherence to Medications in Survivors of Strokes and Transient Ischemic Attacks

Ian M. Kronish, MD, MPH; Donald Edmondson, PhD; Judith Z. Goldfinger, MD; Kezhen Fei, MS; Carol R. Horowitz, MD, MPH

Background and Purpose—Posttraumatic stress disorder (PTSD) can be triggered by life-threatening medical events such as strokes and transient ischemic attacks (TIAs). Little is known regarding how PTSD triggered by medical events affects patients’ adherence to medications.

Methods—We surveyed 535 participants, age ≥40 years old, who had at least 1 stroke or TIA in the previous 5 years. PTSD was assessed using the PTSD Checklist-Specific for stroke; a score ≥50 on this scale is highly specific for PTSD diagnosis. Medication adherence was measured using the 8-item Morisky scale. Logistic regression was used to test whether PTSD after stroke/TIA was associated with increased risk of medication nonadherence. Covariates for adjusted analyses included sociodemographics, Charlson comorbidity index, modified Rankin Scale score, years since last stroke/TIA, and depression.

Results—Eighteen percent of participants had likely PTSD (PTSD Checklist-Specific for stroke ≥50), and 41% were nonadherent to medications according to the Morisky scale. A greater proportion of participants with likely PTSD were nonadherent to medications than other participants (67% versus 35%, P<0.001). In the adjusted model, participants with likely PTSD were nearly 3 times more likely (relative risk, 2.7; 95% CI, 1.7–4.2) to be nonadherent compared with participants without PTSD (PTSD Checklist-Specific for stroke <25) even after controlling for depression, and there was a graded association between PTSD severity and medication nonadherence.

Conclusion—PTSD is common after stroke/TIA. Patients who have PTSD after stroke or TIA are at increased risk for medication nonadherence. (Stroke. 2012;43:00-00.)

Key Words: behavior ■ psych & behavior ■ stroke care ■ TIA
stroke survivors even after accounting for depression and other established correlates of nonadherence.

Methods

Participants

Participants were recruited between March 2010 and January 2012 as part of a clinical trial—Preventing Recurrence of All Inner City Strokes (PRAISE)—which tests the effectiveness of a peer-led educational workshop at improving risk factor control in community-dwelling survivors of strokes and TIAs. Participants were eligible for the trial if they were at least 40 years of age and if they self-reported a history of stroke or TIA in the prior 5 years. Participants were excluded if they did not have capacity to provide informed consent, if they did not have the physical or mental capacity to participate in classes, if they were non-English- and non-Spanish-speaking, if they resided in nursing homes or other institutionalized settings, if they were pregnant, or if they were unable to meaningfully participate in the workshop as a result of aphasia or severe cognitive impairment.

Participants were identified through screenings at senior centers, churches, and health fairs; by contacting patients with a history of stroke on hospital registries of an academic medical center, a federally funded neighborhood health center, and the Visiting Nurse Service of New York; and through advertising the study in clinics and local organizations and newspapers in northern Manhattan and southern Bronx, NY. The data collected for the analysis presented in this article were collected as part of the baseline interview for the trial; no study-related interventions had occurred before collecting information for this analysis. The design of all study procedures was made with the input of a community action board comprised of individuals from east and central Harlem. Ethics approval was obtained from the Institutional Review Board of the Mount Sinai School of Medicine. All participants provided written informed consent.

Outcome Measure

Adherence to overall medications was measured using the 8-item Morisky Medication Adherence Questionnaire (Morisky).16 The Morisky is a self-report measure of adherence that has good internal validity. Each of the 8 items assesses specific medication-taking behaviors such as forgetting medications or stopping medications when one perceives one’s medical condition to be under good control. Summary scores on the questionnaire can be used to classify patients into low and high adherence groups and these groupings are concordant with objective measures of medication adherence including pharmacy refills. To reduce social desirability effects, the questions related to medication adherence were preceded by the statement: “We want to know how you feel, not how you think doctors or other people you know feel.” According to the cut points recommended by the developers of the Morisky, participants who scored <6 points on the Morisky were categorized as nonadherent to medications and participants who scored 6 to 8 points on the Morisky were categorized as adherent to medications.16

Predictor Variables

PTSD symptoms were assessed with a modified version of the PTSD Checklist Specific for a stressor (PCL-S) using the stressor “stroke or ministroke.”18 The PCL-S is an extensively validated 17-item scale that corresponds to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria for PTSD. Participants were asked to rate whether they had specific PTSD symptoms as a result of their stroke or ministroke. To make the PCL-S more homogenous with the rest of the survey and easier to complete for participants of low health literacy, the instrument was modified from a 5-point (“not at all,” “a little bit,” “moderately,” “quite a bit,” “extremely”) to a 4-point response scale (“not at all,” “a little bit,” “somewhat,” “very much”). In addition, 3 items (loss of interest, trouble falling or staying asleep, difficulty concentrating) from the Patient Health Questionnaire (PHQ)19 were used in place of PCL-S items because there was substantial content and wording overlap between these items on both instruments. Confirmatory factor analysis verified that these 3 PHQ items performed as predicted, loading on first-order PTSD symptom factors with standardized factor loadings equivalent to PCL-S items. To allow our scoring to be comparable to other studies using the PCL-S, we recoded PCL-S scores to reflect the standard 5-point response scale (1 = 1; 2 = 2.33; 3 = 3.67; 4 = 5) so that the range of the total PCL-S score was the same as that used with the unmodified instrument. Although studies of PTSD in civilian populations have used cut points from 30 to 44 for diagnosing PTSD, we used the more stringent cut point of 50 to categorize participants as having likely PTSD as recommended by the developers of the scale. This cut point has corresponded to a sensitivity of 60% and specificity of 99% in relation to a clinical diagnosis of PTSD due to a breast cancer diagnosis.20

Depressive symptoms were measured using the 8-item PHQ (PHQ-8). The PHQ-8 has similar discriminant properties for diagnosing depression as the 9-item version,21 and the 9-item version has been validated for use in poststroke patients22 and in minority populations.23 A score of ≥10 on the PHQ-8 signifies at least mild to moderate depressive symptoms.

Demographic information including age, sex, race/ethnicity, annual household income, and insurance status was also collected by patient interview. For cases when data were missing on annual household income (n = 40), participants were categorized as having “low income” if they had Medicaid insurance. Three participants were missing information on both income and insurance status and were not included in the adjusted logistic regression models. Stroke severity was measured by asking patients the modified Rankin Scale24; a score of 3 or higher on this scale signifies at least moderate disability as a result of the stroke. Stroke timing was measured by asking the year of their most recent stroke or TIA.25 Comorbidity was measured using the Charlson comorbidity index.26

Analysis Plan

PTSD was not normally distributed and was dichotomized into PTSD versus no PTSD using PCL-S score of 50 as a cut point for the primary analysis. Chi-squared and t tests were used to compare characteristics of participants according to whether or not they had PTSD. To determine whether there was a graded association between PTSD and medication adherence, PTSD was also divided into 3 groups: no PTSD (PCL-S < 25), possible PTSD (PCL-S 25–50), and likely PTSD (PCL-S ≥50). We chose these cut points based on a review of predefined cut points in the literature.

We then used unadjusted and adjusted logistic regression to calculate the ORs and 95% CIs of medication nonadherence associated with PTSD. We chose covariates for adjusted analyses based on a review of the literature for important patient-level predictors of poor adherence to cardiovascular medications.27,28 Given the high comorbidity between depression and PTSD in prior samples and the potential for confounding by depression status, we tested separate models with and without depression. Because there was a high nonadherence rate, we used the GenMod procedure with a modified Poisson regression approach to estimate the adjusted relative risks.29 All analyses were performed using SAS statistical software, Version 9.2 (SAS Institute, Inc, Cary, NC).

Results

We surveyed 535 participants for this study. The mean age of participants was 63 years, 59% were women, 80% were black or Latino, 30% never completed high school, and 56% earned <$15 000 yearly (Table 1). Eighteen percent of participants had symptoms consistent with a diagnosis of PTSD, and 56% of participants had possible PTSD (PCL-S 25–50). Compared with participants without likely PTSD (PCL-S <50), those with PTSD were younger and were more likely to be women, minorities (black and Hispanic), low income, unmarried, and unable to work. Participants with PTSD also had a higher
Charlson comorbidity score and higher stroke-related disability as measured by the modified Rankin Scale. In addition, participants with PTSD were more likely to have elevated depressive symptoms (PHQ-8 ≥ 10) than those without PTSD (78% versus 19%, P < 0.001).

Forty-one percent of participants were nonadherent to medications according to the Morisky. Nearly twice as many participants with PTSD were nonadherent as compared with participants without PTSD (67% versus 35%, P < 0.001).

There was also a graded association between PTSD symptom severity and medication nonadherence (Figure).

In both unadjusted and adjusted logistic regression analyses, PTSD was associated with medication nonadherence (Table 2). In the model adjusted for demographic and clinical predictors of nonadherence, likely PTSD was associated with a nearly 3-fold increase in the risk for nonadherence (relative risk, 2.90; 95% CI, 1.92–4.42) as compared with stroke/TIA survivors without PTSD (relative risk, 1.86; 95% CI, 1.26–2.74) and 2.69 (95% CI, 1.71–4.23, respectively).

**Discussion**

To date, the understanding of PTSD’s association with medication adherence has been confounded by its association with depressive symptoms. We aimed to determine whether

---

**Table 1. Characteristics of Participants With Prior Stroke or Transient Ischemic Attack With and Without Elevated Symptoms of Posttraumatic Stress Disorder***

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Overall (N=535)</th>
<th>PTSD (PCL-S ≥50) (N=95)</th>
<th>No PTSD (PCL-S &lt;50) (N=440)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y, mean±SD</td>
<td>63.0±11.3</td>
<td>57.2±8.5</td>
<td>64.2±11.5</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Women</td>
<td>317 (59)</td>
<td>65 (68)</td>
<td>252 (57)</td>
<td>0.05</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>210 (40)</td>
<td>40 (42)</td>
<td>170 (40)</td>
<td>0.002</td>
</tr>
<tr>
<td>Hispanic</td>
<td>212 (40)</td>
<td>48 (51)</td>
<td>164 (38)</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>76 (14)</td>
<td>2 (2)</td>
<td>74 (17)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>27 (5)</td>
<td>5 (6)</td>
<td>22 (5)</td>
<td></td>
</tr>
<tr>
<td>Income ≤$15 000/y</td>
<td>300 (56)</td>
<td>74 (79)</td>
<td>226 (52)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Less than high school education</td>
<td>157 (30)</td>
<td>25 (27)</td>
<td>132 (30)</td>
<td>0.53</td>
</tr>
<tr>
<td>Preferred language Spanish</td>
<td>127 (24)</td>
<td>22 (23)</td>
<td>105 (24)</td>
<td>0.88</td>
</tr>
<tr>
<td>Married/lives with a partner</td>
<td>192 (36)</td>
<td>21 (22)</td>
<td>171 (39)</td>
<td>0.002</td>
</tr>
<tr>
<td>Live alone</td>
<td>185 (35)</td>
<td>40 (42)</td>
<td>145 (33)</td>
<td>0.09</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full- or part-time</td>
<td>76 (14)</td>
<td>7 (7)</td>
<td>69 (16)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Unable to work</td>
<td>205 (38)</td>
<td>64 (67)</td>
<td>141 (32)</td>
<td></td>
</tr>
<tr>
<td>Retired, in school, or other</td>
<td>252 (47)</td>
<td>24 (25)</td>
<td>228 (52)</td>
<td></td>
</tr>
<tr>
<td>No. of prior strokes and TIs, mean±SD</td>
<td>1.7±1.2</td>
<td>1.8±1.3</td>
<td>1.6±1.2</td>
<td>0.13</td>
</tr>
<tr>
<td>Years since last stroke or TIA, mean±SD</td>
<td>1.9±1.4</td>
<td>1.7±1.4</td>
<td>1.9±1.5</td>
<td>0.17</td>
</tr>
<tr>
<td>Charlson score, mean±SD</td>
<td>3.7±2.2</td>
<td>4.4±2.3</td>
<td>3.5±2.1</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Stroke impact severity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modified Rankin 0,1, or 2</td>
<td>287 (54)</td>
<td>23 (24)</td>
<td>264 (60)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Modified Rankin 3 or 4</td>
<td>248 (46)</td>
<td>72 (76)</td>
<td>176 (40)</td>
<td></td>
</tr>
<tr>
<td>Depressed (PHQ-8 ≥10)</td>
<td>159 (30)</td>
<td>74 (78)</td>
<td>85 (19)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Nonadherent to medications (Morisky 0–5)</td>
<td>218 (41)</td>
<td>64 (67)</td>
<td>154 (35)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

PTSD indicates posttraumatic stress disorder; PCL-S, PTSD Checklist Specific for Stroke; TIA, transient ischemic attack; PHQ-8, Patient Health Questionnaire–8 Item.

*Data are presented as no. (%) unless otherwise specified.

---

![Figure](http://stroke.ahajournals.org/Downloaded from stroke.ahajournals.org)
this would be the case for a group of individuals who were at high risk for PTSD and who had a strong need to adhere to medication to prevent future catastrophic health events, namely stroke and TIA survivors from diverse communities. We found that, indeed, elevated symptoms of PTSD were common in stroke or TIA survivors up to 5 years after their most recent stroke or TIA with 18% of participants having symptoms consistent with a likely PTSD diagnosis and nearly 3 of 4 participants with elevated symptoms of PTSD. Furthermore, stroke/TIA survivors with likely PTSD had nearly 3 times the risk of medication nonadherence in adjusted analyses, and the association between PTSD and medication adherence remained significant even after controlling for depressive symptoms. Furthermore, even participants with more modest elevations in PTSD symptoms were at increased risk of medication nonadherence, broadening the relevance of this risk factor for nonadherence to a large number of stroke/TIA survivors.

A large percentage of participants in our sample (41%) were nonadherent according to the Morisky questionnaire. For comparison, in the Adherence eValuation After Ischemic stroke–Longitudinal (AVAIL) Registry, only 14% of participants self-reported being nonadherent to medications.30 In the AVAIL study, low socioeconomic status was associated with lower adherence. Hence, the high prevalence of patients from a low socioeconomic background may help explain the higher prevalence of nonadherence in our sample.

Prior studies assessing the relationship between PTSD triggered by acute medical events and medication nonadherence have not always found an independent association after adjusting for covariates.10,12 There are several possible explanations for why our results differed. First, we had a relatively large sample size and a high proportion of participants was nonadherent to medications. These factors increased our statistical power to detect independent associations in multivariable analyses. However, the large magnitude of the relative risks we found suggests that power was not the only difference between our study and previous investigations. The severity of PTSD may have been higher in our poststroke/TIA sample as compared with other populations.31 Our finding that symptom severity is associated with medication nonadherence suggests that greater PTSD severity in our sample may account for the difference between our findings and previous studies. Strokes and TIAs may be especially conducive to PTSD as a result of the acute, frightening nature of the stroke/TIA-related symptoms.

Finally, the fact that the triggering event for the PTSD symptoms was a medical event as compared with other sources of trauma may have resulted in a distinct association between PTSD and self-management of medical illness. For example, one of the defining clusters of PTSD symptoms is avoidance of reminders of the triggering event. Accordingly, when symptoms of PTSD are triggered by medical events, PTSD may cause patients to avoid stroke medications if they serve as reminders of the PTSD-inducing event.

A number of other potential mechanisms might explain the relationship between PTSD and medication nonadherence. PTSD has been directly associated with deficits in cognitive

---

**Table 2. Unadjusted and Adjusted Relative Risks and 95% CIs for Associations Between Posttraumatic Stress Disorder and Nonadherence to Medications in Survivors of Stroke or Transient Ischemic Attack**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Model 1 (N=535)</th>
<th>Model 2 (N=532)</th>
<th>Model 3 (N=532)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely PTSD (PCL-S ≥50)</td>
<td>3.42 (2.36–4.96)</td>
<td>2.91 (1.92–4.42)</td>
<td>2.69 (1.71–4.23)</td>
</tr>
<tr>
<td>Possible PTSD (PCL-S 25–50)</td>
<td>2.10 (1.45–3.04)</td>
<td>1.92 (1.31–2.80)</td>
<td>1.86 (1.27–2.74)</td>
</tr>
<tr>
<td>No PTSD (PCL-S &lt;25)</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Age</td>
<td>...</td>
<td>0.99 (0.98–1.00)</td>
<td>0.99 (0.98–1.00)</td>
</tr>
<tr>
<td>Sex</td>
<td>...</td>
<td>1.12 (0.91–1.38)</td>
<td>1.10 (0.90–1.36)</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td>...</td>
<td>1.20 (0.79–1.21)</td>
<td>1.19 (0.77–1.83)</td>
</tr>
<tr>
<td>Income</td>
<td>...</td>
<td>0.98 (0.79–1.21)</td>
<td>0.97 (0.79–1.20)</td>
</tr>
<tr>
<td>Stroke impact severity</td>
<td>...</td>
<td>1.04 (1.00–1.08)</td>
<td>1.04 (1.00–1.08)</td>
</tr>
<tr>
<td>Modified Rankin 0–2</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Modified Rankin 3–4</td>
<td>0.92 (0.74–1.14)</td>
<td>0.92 (0.74–1.14)</td>
<td>Reference</td>
</tr>
<tr>
<td>Years since last stroke/TIA</td>
<td>...</td>
<td>1.06 (1.00–1.14)</td>
<td>1.06 (1.00–1.14)</td>
</tr>
<tr>
<td>Depressive symptoms (PHQ-8 ≥10)</td>
<td>...</td>
<td>1.12 (0.88–1.42)</td>
<td>...</td>
</tr>
</tbody>
</table>

PTSD indicates posttraumatic stress disorder; PCL-S, Post-Traumatic Stress Disorder Checklist-Specific for Stroke/Transient Ischemic Attack; TIA, transient ischemic attack; PHQ-8, Patient Health Questionnaire–8 Item.
function both in patients with and without traumatic brain injury.32,33 Accordingly, cognitive dysfunction may be a mechanism linking PTSD with medication nonadherence due to forgetfulness or other cognitive factors. Some investigators have hypothesized that participants with elevated PTSD symptoms may hold different beliefs about treatment that may impact on medication adherence.14 Wagner et al15 showed that among black HIV-infected individuals, perceived discrimination by the healthcare system partially mediated the relationship between PTSD and nonadherence to antiretroviral medications. Given the high proportion of participants at risk for discrimination in our sample on account of their minority and low income status, it would be important to test this mechanism in future studies. This mechanism, however, may not be generalizable to other patient populations.

There were several limitations to the interpretation of our findings. The cross-sectional nature of the data prevents us from ascribing causal attributions to the association of PTSD to medication adherence. The recruitment of a high proportion of minorities from low socioeconomic backgrounds and of individuals who were motivated to participate in an educational workshop may have limited the generalizability of the study’s findings to other populations. The PCL-S and PHQ-8 measure symptoms of PTSD and depression, respectively, but these do not replace diagnoses based on a psychiatric interview. Furthermore, a modified version of the PCL-S was used and this may have influenced its discriminant properties. Nevertheless, we used the most conservative cut point for categorizing participants as having likely PTSD and may have underestimated the true prevalence of PTSD diagnosed by a psychiatric interview. Medication adherence was measured using self-report and no objective measures of adherence were available to confirm responses. Although the Morisky has been validated with objective adherence measures in other studies, patients tend to overreport how well they adhere to medications such that the prevalence of poor adherence to medications may be underestimated by this study.

Summary/Conclusions

The results of this study suggest that not only is PTSD common after strokes and TIAs, but that PTSD may be putting stroke/TIA survivors at increased risk for recurrent cerebrovascular events as a result of decreased medication adherence. Although the impact of PTSD on subsequent prognosis remains unknown, PTSD after acute coronary events has previously been associated with worse cardiovascular prognosis.36,37 Hence, the results of this study suggest that poor medication adherence may, at least in part, mediate the relationship between PTSD and poor medical outcomes in patients with cardiovascular disease. Future studies should seek to elucidate the mechanisms linking PTSD with poor adherence in stroke/TIA survivors and should test approaches to improving adherence in this population.

Acknowledgments

We gratefully acknowledge the East and Central Harlem Community Action Board and the study participants for their generous contributions.

Sources of Funding

Dr. Kronish received support from the National Heart, Lung and Blood Institute (K23 HL098359), Dr Horowitz, Dr Goldfinger, and Ms. Fei received support from the National Institute of Minority Health and Health Disparities (P60MD00270) and Dr Horowitz received funding from the National Center for Research Resources (UL1RR029887).

Disclosures

None.

References


Posttraumatic Stress Disorder and Adherence to Medications in Survivors of Strokes and Transient Ischemic Attacks
Ian M. Kronish, Donald Edmondson, Judith Z. Goldfinger, Kezhen Fei and Carol R. Horowitz

Stroke. published online May 22, 2012;
Stroke is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2012 American Heart Association, Inc. All rights reserved.
Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://stroke.ahajournals.org/content/early/2012/05/22/STROKEAHA.112.655209

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Stroke can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Stroke is online at:
http://stroke.ahajournals.org/subscriptions/