Integrated Diagnostic and Treatment Approach for the Medical Patient Who Has Had Psychologic Trauma

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ABSTRACT

Background. Physicians often treat patients with physical illnesses that have a functional component. Investigators have discovered that many of these patients have unresolved emotional problems associated with histories of trauma and abuse.

Methods. Abused and traumatized patients with medical complaints often seek medical help. Empathic nonpsychiatrist physicians play an important role in the care of these patients. The physician's efforts can be augmented by a trained RN to provide supportive stress training and nutrition education and by a mental health professional to provide psychotherapy when needed.

Results. In the case presented, the patient had symptomatic improvement when her physician empathically provided medical treatment, involved the staff and a trained RN in the healing effort, and made an appropriate referral to a mental health professional.

Conclusion. This unified diagnostic and treatment approach for traumatized patients with medical problems can be rewarding, efficacious, and cost effective.

APPROXIMATELY 12 million people are victims of domestic violence,[1] nearly 3 million children are abused each year,[2] and the incidence of sexual abuse has escalated to alarming levels.[3-5] Many physicians may not be aware of the magnitude of this problem, particularly since victims do not always talk openly about being abused. However, it has been reported that 22% to 35% of women who visit emergency rooms have physical or emotional symptoms related to an abusive relationship. The majority of these women are not asked whether they have been victims of trauma or abuse, and most are afraid or ashamed to discuss it.[6] Most certainly physicians, particularly emergency care doctors, internists, pediatricians, surgeons, and primary care physicians, should know about the emotional and physical symptoms that accompany trauma and abuse, ask appropriate questions to be able to diagnose posttraumatic disorders, and make appropriate referrals for additional help when needed.[7] In this paper, we present the varieties of posttraumatic symptoms and some interventions associated with patients' experiences of trauma and abuse.

CASE REPORT

A 32-year-old single white child care worker sought help from a gastroenterologist for irritable bowel syndrome (IBS) and gastroesophogeal reflux of 10 years' duration. The medical evaluation confirmed these diagnoses, treatment was initiated, and the symptoms improved. Over the next 13 months, she had additional medical problems, including fibrocystic breast disease and hyperthyroidism. She became anxious and depressed and was treated with a mild anxiolytic and tricyclic antidepressant. Although she was appropriately treated for these medical problems, the IBS worsened. She called the office nurse to report that she was more depressed and her diarrhea had become so incapacitating that she was unable to leave the house. At the time of her medical appointment, she reported feeling as if she were "going crazy" and was having nightmares, sleep disturbance, weight loss, and profound depression. Making a diagnosis of major depression, her gastroenterologist recommended psychiatric treatment, which she refused. Despite rejecting appropriate psychiatric treatment, she trusted her gastroenterologist enough to return weekly for medical treatment.

At the gastroenterologist's suggestion, the patient was

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asked to meet with the office Registered Nurse, whom she had previously learned to trust. A special room in the office complex was set aside and furnished with wicker furniture. Within this home-like environment, the RN met with the patient weekly for life-style education and stress management. During these "teaching" sessions, the patient talked openly about nightmares, dysphoric emotions, and fragmentary memories of sexual abuse from age 8 to 12. At that point, her physician referred the patient to a support group for survivors of sexual trauma. This therapeutic intervention was successful in fostering eventual recovery from her posttraumatic stress disorder.

POSTTRAUMATIC SYMPTOMS AND MEDICAL PROBLEMS

There are predictable emotional responses after life-threatening trauma or abuse. If asked, survivors will often report the psychologic symptoms of posttraumatic stress disorder (PTSD).[8] These symptoms include sleep disturbance, nightmares, irritability, disturbed interpersonal relationships, physiologic hyperarousal, emotional detachment, and intrusive memories of traumatic events or "flashbacks" of dissociated abusive experiences.[9-11] The severity of these complaints is likely to reflect the intensity of the trauma and associated stigmatization.[12,13] Trauma survivors may frequently have a variety of medical complaints, including headaches, nausea, diarrhea, vomiting, muscle aches, chest pain, restlessness, tremors, sweating, and general fatigue.[14] Physical symptoms have been reported to be the primary complaint in 66% of survivors,[15] even though they do not always consult their physician.[16]

Although no single theory can adequately explain somatization completely,[17] somatic symptoms may often be manifestations of emotional pain related to unresolved traumatic experiences. Sexually abused children, for example, have been found to have high incidences of somatization disorder.[18]

Researchers studying 100 women with somatization disorder found that more than 90% had been abused, with 80% reporting sexual abuse as a child.[19] In another study of 50 female medical patients with gastroesophageal reflux disease, noncardiac chest pain, and functional gastrointestinal (GI) symptoms including irritable bowel syndrome, the incidence of previous sexual or physical abuse was 56%.[5] In fact, several studies revealed high correlations between a history of childhood trauma and irritable bowel syndrome (50% to 80%)[20-24] and between childhood sexual abuse and eating disorders (40% to 60%).[25]

Trauma survivors often suffer from physiologic manifestations of sympathetic hyperarousal,[26,27] thought to be associated with functional GI symptoms,[28] panic and anxiety disorders,[29] and stress-related somatic symptoms[30,31] in the form of palpitations, chest pressure, and hyperventilation. Chronic hyperarousal has also been associated with a variety of somatic disorders: hypertension, stress-related ventricular fibrillation, nonischemic myofibrillar degeneration, stress-related coronary artery disease, migraine headaches, Raynaud's disease, muscle contraction headaches, non–head-related muscle contraction dysfunctions, peptic ulcer, and irritable bowel syndrome.[30]

Although researchers are not in complete agreement about the significance of authenticity of traumatic memories,[32] trauma victims often have physical symptoms that they do not associate with previous trauma.[33] In fact, they may recall only part or even none of their frightening encounters, particularly if these occurred many years before.[13,34-40] However, it has been discovered that previously traumatized patients can have forgotten or distorted traumatic memories in the form of somatic symptoms,[41,42] such as chronic pelvic pain.[43,44] Abused children often have alexithymia (inability to verbalize one's emotions)[41] and develop physical symptoms and somatization disorders as a way of expressing their emotional needs.[45-47]

Although patients may not always remember traumatic experiences, their memories may be expressed physiologically,[42] in the form of dysesthesias,[48] abnormal visceral sensations,[49,50] noncardiac chest and esophageal pain,[51,52] dyspepsia,[53] unexplained pelvic pain,[54,55] headaches,[56] muscular or joint pain, fibromyalgia, and other "psychosomatic" symptoms.[57] Trauma survivors' alterations in pain thresholds may also be related to lower available levels of the brain's own internal pain killers, endogenous opioids,[58,59] causing lower pain thresholds and chronic pain.[44,60]

LOWER PAIN THRESHOLDS AND CHRONIC PAIN

What are the implications of these findings, particularly since patients with persistent physical symptoms and functional disorders seek help from nonpsychiatrist physicians? How should physicians approach these patients? Should anything be unique about the office milieu? Is it helpful to ask such patients about past traumatic experiences? If so, how should

physicians and their staff members pursue this delicate task?

The anxiety associated with these patients' physical and emotional symptoms often fosters unhealthy dependency and fear of separation, explaining why abused children fear exposing the deeds of neglectful or exploitive parents and battered spouses frequently cannot leave their abusive partners.[61]

First, medical patients with a history of traumatic events often initially seek help from medical doctors,[62] particularly if their symptoms are medical in nature. Physicians who understand this will be motivated to become better able to patiently tolerate their patients' aloofness and sometimes hostile ways of interacting, since previously abused patients find it difficult to trust others, including care providers. Such individuals are often reluctant to depend on anyone, yet if they have been abused, continuously or repetively, they often cling to abusive parents or spouses because of their fears of losing these relationships.[63,64]

Second, victims of abuse who have physical symptoms sometimes find it difficult to talk about their emotional distress. They seek treatment for physical symptoms, since they may be unable to translate somatic sensations into basic emotions.[65] Their medical doctors often struggle to understand their emotional problems[66] and may not understand the interaction between physiologic, emotional, behavioral, and interpersonal symptoms.

Third, patients with a history of abuse feel more at ease in a safe medical environment. The entire medical team—physician and office staff—should establish a trusting environment with sensitivity to potential anxiety triggered by removal of clothing and potentially invasive procedures. Patients should feel safe and be able to talk about emotional trauma and current symptoms when feeling comfortable to do so. Such patients will benefit from sensitivity that begins with the first telephone call, extends to the in-office contact with the receptionist and billing personnel, and continues, especially with the nurses. In such an environment patients will look forward to subsequent appointments.[67]

Fourth, it is important for the nonpsychiatrist physician to pursue all three functions of the medical interview, particularly emphasizing the second one: (1) gathering diagnostic information. (2) establishing a relationship with the patient, and (3) recommending and instituting treatment.[68] This effort will enhance the diagnostic process and facilitate "active listening"[69] through appropriate open-ended questions including: "How are you feeling?" More specific questions can follow, such as: "Have you suffered from any traumatic events in your life?" To be more focused, the physician can ask about explicit traumas: "Have there been any deaths among your family or friends?" "Have you had any life-threatening experiences?" or "Have you been a victim of sexual abuse or assault?" It is important to offer the patient an opportunity to keep painful information private with a question such as: "If so, would you like to tell me about it?" or "Are you comfortable telling me the details about what happened to you?" or "You don't have to talk about it now if it's too painful."

Fifth, it is important for physicians to be sensitive to patients' shame and distrust by being aware of the "human side of medical care"[70] and the "healing power of the doctor-patient relationship."[71] Novack[72] listed the following factors as comprising an empathic, healing relationship: conveying empathy, encouraging emotional expression, giving encouragement, offering hope, touching (when appropriate), facilitating self-forgiveness, and giving reassurance.

It is always best to recognize that providing effective treatment for traumatized patients is a team effort, particularly since it is often difficult for physicians to find time to spend with patients in this era of managed care. As a result, physicians may wish to augment their skills and add trained staff. A trained registered nurse can aid the physician through "scheduled nurse visits" during which times she provides information to patients about (1) posttraumatic stress disorder, (2) proper rest, (3) medications, (4) appropriate exercise, and (5) nutrition.[67] The physician may also consider setting up a scheduled nurse visit to obtain relevant information before the physician's evaluation.

Sixth, an empathic physician, not trained as a psychiatrist, can provide a therapeutic experience for the patient by listening to the emotionally charged memories of painful traumatic experiences. "The clinician needs to hear the patient's story with all its associated emotional distress . . . ranging from fear to sadness, to joy, to anger, to shame. The patient's verbalizing these feelings in the presence of someone who can tolerate them and

not be frightened . . . is in itself therapeutic," often resulting in improvement and compliance with treatment.[67]

Physicians may, over a period of time, help patients with a history of abuse to gain a sense of cognitive and physical mastery and to become aware of the connection between their physical and emotional symptoms. In many cases, psychiatric intervention or additional counseling is recommended. However, after specialized psychologic intervention has begun, it is still important for physicians and nurses to remain involved with patients and avoid abandoning them.

USE OF MEDICATION

Not infrequently, nonpsychiatrist physicians may choose to initiate the prescription of anxiolytic and antidepressant medications for target symptoms of anxiety and depression, while being aware that medications may provide only partial or temporary relief. Follow-up medication visits are also helpful in developing a trusting relationship with the patient and can reinforce the message that talking is an important component of treatment. Antidepressants are considered to be the "first line drugs in PTSD pharmacotherapy."[73] They are useful in treating not only the depression, but also the associated symptoms of anxiety and panic. More recent data point to the likelihood that serotonin activity is disturbed in PTSD, warranting the use of selective serotonin reuptake inhibitors (SSRIs) such as fluxetine, sertraline, paroxetine, fluvoxamine, and the mixed serotonin and norepinephrine reuptake inhibitors, venlafaxine, and nefazodone.[74] Although they have all been prescribed, research studies were initially conducted with fluoxetine, which was reported to reduce PTSD symptoms, particularly "numbing" and depression,[75,76] though it was less effective in war veterans.[42] Daily total doses for the SSRIs (as found in the PDR) are generally as follows: fluoxetine—10 to 40 mg, sertraline—50 to 150 mg, paroxetine—10 to 30 mg, nefazedone—150 to 600 mg, venlafaxine—75 to 375 mg, and fluvoxamine—100 to 300 mg.[77] When in doubt, physicians should initiate a low dose, review it every 2 weeks, and raise the dose to maximum benefit, in accordance with side-effect profile and efficacy. It is important for physicians to know that in some patients the required dosage is lower than expected. In those patients, higher doses of SSRIs sometimes cause worsening side effects (ie, sleeplessness, nausea, agitation, more depression or anger, numbing, etc), requiring discontinuing or reducing dosage to a minimal level.

Tricyclic antidepressants such as imipramine, norpramine, doxepin, and amitriptyline can be prescribed when there is no concern about weight gain, cardiac condition, anticholinergic side effects (constipation and bladder outlet restriction), or suicidal risk (an overdose may be fatal).[77] Their dosages usually range from 25 mg to 300 mg daily. Bupropion hydrochloride, prescribed in a dose range of 75 to 300 mg daily, has also been found useful for some patients.

The adrenergic system modulating agents including clonidine and propranolol have been found helpful in reducing the severity of fear-enhanced startle reactions, intrusive thoughts, and irritability associated with posttraumatic stress disorder.[73] The short-acting benzodiazepines are effective in controlling symptoms of tension, panic, anxiety, and sleeplessness. However, because of the risk of physiologic dependency, particularly in patients with a history of substance abuse, this group of medications is best prescribed intensively for short durations up to 4 weeks and intermittently thereafter unless the patient's symptoms respond only to this group. For patients who have a physiologic dependency on benzodiazepines, abrupt cessation may cause withdrawal symptoms, and the medication should not be discontinued unless there is a slow withdrawal process, and then only when the patient is in full agreement. Finally, mood and behavioral stabilizers,[74] including lithium, the long-acting benzodiazepine clonazepam, and the anticonvulsants valproic acid and carbamazepine, have been prescribed for individuals with chronic symptoms, including mood swings, aggressive outbursts, dissociative symptoms, "behavioral" seizures, and sometimes panic attacks. All of these medications have potential side effects and should be monitored closely.

DEVELOPING A FORMAL DIAGNOSTIC AND TREATMENT PROGRAM

Because many similar patients had sought treatment for functional GI disorders from this physician (J.E.D.), he and his staff developed the following formal program for patients with medical symptoms and psychosocial problems.

(1) *Initial and Follow-up Physician Evaluation*

This evaluation consisted of a medical history and a relationship-based medical-psychosocial interview during which the physician asked questions to ascertain the patient's emotional needs, relationship difficulties, and possible history of any physical or sexual abuse obtained by the nurse in an earlier interview. Selected patients were referred to the nurse for symptom monitoring, life-style education, and supportive counseling.

(2) *Patient Education*

A 30-minute period was set aside each month for nutrition education and stress management with the RN. These sessions, which were primarily educational, were scheduled to coincide with physician office hours, permitting third-party reimbursement and facilitating adequate nurse and physician communication about the patient's medical needs.

(3) *Referral*

If it became apparent that the patient's emotional symptoms were not responding to this supportive approach or if the patient began to have trauma-related intrusive thoughts, memories, or nightmares, she was referred for mental health counseling or therapy.

DISCUSSION

Increasing number of patients with physical illnesses related to psychosocial factors are seeking medical help from nonpsychiatrist physicians. A high percentage of these patients have been victims of trauma, including childhood physical and sexual abuse. These individuals have a variety of complaints, including somatization and "functional illnesses," chronic pain with unclear physical etiology, panic attacks, episodic depression, sleep disturbance, nightmares, relationship problems, a recurring stressful life-style, and dependency on alcohol and other "self-medication."

Their various physical symptoms often worsen with stressful circumstances. They may be emotionally withdrawn, secretive, depressed, and resistant. Although there may be a need for referral to a mental health professional, in many cases these patients are unwilling to see a psychiatrist or other counselor, particularly if they fear losing their physician.

As vital as psychiatrists may be, nonpsychiatrist physicians may have an even more important role to play in the care of these patients. Because they often have the most contact with such patients, nonpsychiatrist physicians can provide appropriate medical management while enhancing trust, further diagnostic efforts, and ongoing support. It is understandable, however, that because these patients can be emotionally draining, time consuming, untrusting, and resistant to being referred to a psychiatrist, nonpsychiatrist physicians may choose to broaden responsibility and share it with other team members. Drossman[77] has recognized that sexually abused women, in particular, may not trust a male physician enough to provide either a good history or opportunity for therapeutic support and will more often trust a woman—a female physician, nurse, psychologist, or social worker. Properly educated office personnel, including skilled nurses, can be trained to provide ongoing empathic support, symptom monitoring, life-style education, stress management, and supportive counseling. In most cases, treatment is not complete without psychiatric consultation and the inclusion of individual and/or group psychotherapy provided by a trained professional. When successful, the comprehensive diagnosis and treatment of these patients is rewarding, efficacious, and cost effective.[67]

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