Secondary Traumatic Stress

Second Edition

Self-Care Issues for Clinicians, Researchers, and Educators

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Primary care providers see many trauma cases pass through the health care system. However, current health care pedagogy provides little training in traumatic stress. Consequently, primary care providers may find themselves faced with frustrating patients—patients they may even avoid out of the providers’ frustration. Stories of how these patients are shuffled from provider to provider with little or no truly helpful treatment abound. It is easy to side with the patient against the provider, but in doing so, we may miss the provider’s genuine distress. Lyndra Bills, trained both as an internist and a psychiatrist, offers a systematic approach with which the primary care provider can treat the unique health problems of the traumatized patient. This approach affords the primary care provider better options in treating the trauma patient while simultaneously supporting the provider’s need to be helpful.

Thanks to amazing technological advances in modern medicine, primary care practitioners can now more easily diagnose symptomatic coronary artery disease, hypertension, cerebrovascular accidents, meningitis, and many other physical illnesses that have plagued humankind. Modern technology has also improved psychiatric care thanks to some
very effective psychotropic medications like clozapine for schizophrenia, valproic acid, carbamazepine and lithium for bipolar affective disorder, and the serotonin-specific reuptake inhibitors like fluoxetine which are very effective for most major depressive disorders and many types of anxiety disorders. However, there are still numerous patients presenting to the primary care provider and to the mental health provider with complaints which are far more difficult to diagnose adequately.

Because primary care providers are trained to provide rapid and efficient relief of the patient's symptoms, an inability to diagnose correctly and relieve the patient's symptoms can be a major work-related stressor for a primary care provider. Most caregivers have identified patients that they consider problem patients. These patients continue symptomatic, regardless seemingly, of the caregiver's best efforts. These difficult patients may engender several different responses in the caregiver. For example, the caregiver may begin to reject the patient and assume the patient does not want to get well. Or the caregiver may refer the patient to a series of specialists who seem to do no better. Finally, the caregiver may begin to doubt his or her own competency, which may leave the caregiver vulnerable for secondary traumatic stress (See Stamm & Pearce, in this volume).

Interestingly, many of the complaints of the problem patient are stress related. Although providers know about the negative impact of chronic stress on the physical and emotional well-being of the patient, a coherent framework for understanding the effects of stress has not always been clearly articulated in medical training. As a preventive measure for the caregiver, this paper presents a trauma-based approach to psychiatry in a primary care setting.

Many patients will present to their primary care provider with somatic complaints like chest pain, chronic pain, chronic headaches, and gastrointestinal complaints, as well as anxiety, depression, sleep problems, nightmares, suicidal ideation, and memory disturbances. This complex array of symptoms does not necessarily meet criteria for a specific medical or psychiatric diagnosis. These in-between patients have physical and/or psychological complaints which are neither easily pegged into a diagnostic category nor felt clinically to be a condition which will present itself after proper testing and evaluation. And yet the suffering of the patients and their families is unmistakable. In cases such as these, a trauma-based approach may be helpful and the most important thing you can do for these patients is to ask them questions about what has happened to them recently or in the past.

Post-traumatic stress disorder (PTSD) describes the mind and body changes which occur after a traumatic event. Specifically, PTSD refers to someone who reacts with intense fear, helplessness, or horror to a major (or minor) trauma by developing (a) intrusive reexperiencing symptoms; (b) avoidance responses to evidence of the trauma and generalized psychological numbing and isolation; and (c) widespread physiologic arousal (Tomba, 1994). In other words, PTSD often causes biopsychosocial changes in patients. Thus, when care providers see someone in a clinic or an office with difficult and/or confusing constellations of complaints, they should consider the possibility of the PTSD diagnosis.

PTSD can be acute, chronic, or delayed. Furthermore, it is often co-morbid with many psychiatric and medical conditions. How and why some people develop a post-trauma reaction to a stressor is dependent upon the nature, intensity, and duration of the stressor; the person's history and vulnerability to previous trauma; and the treatment received following a traumatic event.
Patience Presentation and Assessment

Roberts (1994) estimates that up to 75% of all visits to primary care providers involve presentation of psychosocial problems through physical complaints. In one survey of a primary care clinic, the rate of childhood sexual abuse was 37% and the rate for adult sexual assault was 29% (Walker, 1993). The same survey revealed that only 4% of the patients had been asked by their primary care provider about a history of victimization. Another survey in a primary care setting correlated the number of unexplainable physical complaints with increasing prevalence of a potentially treatable anxiety or mood disorder—up to 60% for an anxiety disorder and 48% for a mood disorder (Kroenke, 1994).

The in-between patient's presentation may be explained through a trauma-based approach. Trauma can refer to physical, sexual, or emotional abuse, as well as events such as motor vehicle accidents, natural disasters, combat experiences, rape, witnessing assaults and violence, kidnapping, torture and/or terrorist attacks, and/or trauma from medical procedures (Stuber et al., 1991).

Consider the following case of a 21-year-old female college student who presented to the primary care office with recurrent complaints of vaginal infection, as well as pelvic and lower abdominal pain. She had a history of sexually transmitted disease, recurrent upper respiratory infections, and irritable bowel syndrome. She presented vaginal and pelvic complaints on three consecutive visits, but had normal physical and gynecological exams, negative pregnancy tests, and no evidence of urinary or gynecological infection. She nevertheless insisted on both a pelvic exam and the fact that she must have an infection. When asked about a history of victimization, she gave a history of childhood sexual abuse and adult sexual assault. The frequent gynecological symptoms without medical etiology turned out to be the somatic representation of her traumatic memories. These decreased in frequency once the abuse issues were recognized.

Another example is a 45-year-old male who presented to his primary care doctor for chronic pain in his right leg following a severe coal-mining accident. During the next 10 years he continued with frequent primary care visits and subsequent psychiatric hospitalizations for chronic pain and depression. No one, however, asked him about his accident during that 10-year period. When that vital information finally came out, he began to tell the story of his accident, which then reduced his pain, depression, and PTSD symptoms.

Research supports a definite connection for trauma as the etiology in many cases of somatization (Blank, 1994), dissociation, and mood disturbances. Two-thirds of patients diagnosed with a dissociative disorder also met criteria for a somatization disorder (Saxe, 1994). In a survey of general medical outpatients, the hypochondriac patients recalled more childhood trauma before age 17 (Barsky, 1994). In a population of adult psychiatric patients, 40% to 70% were survivors of abuse (Briere & Runtz, 1987). Prisoners of war consistently show increased mortality from suicide, homicide, and accidents (Segal et al., 1976). In a study of battered women, 42% had attempted suicide (Gayford, 1975). Dissociation and the disturbance of time sense, memory, and concentration are common to survivors of prolonged and repeated trauma and victimization (Putnam, 1989). These are many more statistics which will point to the same thing: the need for more health care providers to ask questions about traumatic experiences and be open-minded when routine treatment strategies fail to fix the problem.

A trauma-based approach, therefore, can assist primary care providers to understand some possibilities for the somatization complaints. This has at least two benefits. First, primary care providers can guide their patients to gain insights which may end the somatization. Secondly, and just as important, primary
care providers themselves can gain a measure of competency and thus relieve some of the uncertainties of dealing with *in-between* patients. Usually, patients who have a normal stress response to traumatic events do not suffer persistent or untreated symptoms, the kind which baffle, confuse, or otherwise challenge the competence of the provider. Knowledge of the trauma-based approach, however, alerts the primary care provider to the possibility that difficult or *in-between* patients often manifest a post-trauma stress response which causes some type of functional impairments. Thus the primary care provider is uniquely positioned to view the importance of the mind/body connection, which is an advantage for managing psychiatric problems generally and *in-between* patients particularly.

All patients presenting for help with a physical or psychological problem need a thorough history and physical. This should include gaining some type of trauma history. The following questions should be included as a minimum for a routine trauma history in a primary care setting.

1. What is the most traumatic incident that has ever happened to you?
2. What is the most traumatic incident that has ever happened to someone in your family?
3. Have you ever been the victim of a crime?
4. Have you ever been in an accident serious enough so that you had be examined medically?
5. Have you ever had excess fear concerning medical procedures or surgery?
6. Have you ever served in the armed forces? If yes, were you involved in combat? Explain.
7. Have you ever been sexually or physically assaulted as a child or as an adult?
8. At any point during this (these) experiences(s) did you think you were in danger of serious personal harm or losing your life? (Peterson et al., 1991).

As part of the history and physical, the mental status exam should include elements of orientation, appearance and behavior, mood and affect, thought content, cognitive function, judgment, and insight. Appropriate assessment should also include some fundamental laboratory tests such as a sensitive TSH (thyroid stimulating hormone), drug screens, chest X-ray, and an EKG when indicated. If the history and examination indicate the appropriateness of trauma-based intervention, several avenues of action should be considered.

**Self-Help Protocols**

Self-help and support are two treatment modalities available to the primary care provider in taking care of the *in-between* patient. They can be used for psychiatric problems generally, but are particularly good for patients recovering from post-trauma conditions. People who have been traumatized generally feel a sense of loss of control, isolation, and a tendency to become immobilized by a sense of victimization. Therefore, it is often therapeutic to allow them to do things for themselves and to lend them solid support.

Primary care providers can have an advantage in managing psychiatric problems because of their practical problem-oriented approach. The primary care provider can guide patients to do many things for themselves which will promote overall health. Also, patients who present to primary care providers generally have an understanding that they will be expected to contribute to improving their own health and will accept homework assignments or some of the responsibility to help themselves. One example of this is the behavioral contract—patients sign agreements and promise to make certain behavioral changes within a specified time (Neale, 1991). This has been successful in improving weight and cholesterol, but is also applicable to problems with decreased sleep, self-harm, and safety.
Health and safety are essential to everyone's overall well-being. The following protocols are guides which recognize the fact that there often is no place for patients to be referred or that the primary care provider and the patient must manage a crisis in a physically remote location. Thus, they are checklists for the health provider to engage patients in helping themselves.

1. The Healthy Protocol includes aspects of diet, exercise, stress management, sleep, hygiene, physical health, fun/relaxation, and preventive health. The stress management component can include meditation, self-hypnosis, controlled breathing, anger management, education, and exercise.

2. The Safety Protocol is meant primarily for patients who are suicidal and includes identification of risk factors, a contract for safety, and a phone contact/support list. Identification of risk includes items such as guns, alcohol, pills, gender, age, medical problems, and relative isolation (Beaumont, 1992). The contract for safety should have the patient agree to 24 hours of safety and contact; have the patient make phone or personal contact within 24 hours; be written in the patient's chart (with the patient's signature) and whenever possible, witnessed by a supportive family member. Patients should agree to have a friend or family member stay with them for a specified period of time. Finally, the phone/contact list should include five people or resources to whom the patient can turn for help when he or she feels overwhelmed or unsafe. This list also could include a list of places or homes to visit in the absence of phone resources.

3. The Self Harm Protocol includes behavioral monitoring, self-evaluation, and practical suggestions to increase patient safety. The patient should contract to remove all sharp or otherwise potentially harmful objects. Patients should be asked to focus on what may have precipitated the episode of self-harm by writing about how they were feeling, what preceded the self-harm, what they could do to prevent it next time, etc. Ask patients to monitor their time and activities by writing them on a time-sheet, with updates every 30 minutes. After 24 hours, intervals can gradually increase as patients exhibit safer behavior and decrease self-harming attempts. Patients should ask for help from family and friends until patients can keep themselves safe; the family and friends should be informed of their importance in this task. The primary provider should acknowledge that the main etiology for self-harming behavior is trauma, but the continuation of violence is the basis of the self-harming behavior. Patients need to learn to manage their anger and stress, but they also need to understand that their own self-harming behavior is violence to themselves. Provide support groups, therapy, journaling opportunities, etc., in order to help patients address their trauma issues. Finally, use a self-abuse scale to enable patients to monitor their own severity of self-harm.

The Self-Abuse Scale is simple—the meaning of severity by number should be agreed upon by the patient and provider. For example, a 5 on the scale might indicate the need for medical attention which may require inpatient treatment or more intense means of intervention, such as a mental health referral.

4. The Anti-Regressive Protocol is used to reduce regression, a common and serious manifestation of several psychiatric conditions. It refers to a loss of ego boundaries (Petersen, 1991). Regression occurs in severe depression, psychosis, delirium, dementia, and dissociation. Practically speaking, it refers to patients who are suffering with an inability to have a clear sense of their body and mind, who often are disoriented, and who have problems with routine sleeping and eating schedules.
anti-regressive protocol (Tinnin, 1990) is a guideline for the primary care provider and the patient to decrease and hopefully stop the regression. It includes attempts to restore ego boundary-orientation by regulating sleeping and eating schedules; b) maximizing physical safety, including closer observations by close friends or family members (who have well-defined ego boundaries of their own and who can provide positive social support); by removing dangerous items; and by resorting to grounding techniques to help restore the patient's sense of reality, orientation, eye-to-eye contact, physical grounding (feet on the ground), and object awareness (touching objects), etc.

5. Self-Help Books. Patient education is a valuable tool for the primary care provider in helping patients understand their problems more clearly. Below is a sample list of books that the provider may wish to consider suggesting to his or her patients; however, there are many patient education options available and providers should seek out books that he or she considers particularly good.

Mind Body Medicine, Daniel Goleman, Ph.D. and Joel Gurin, eds.
Ten Days to Self-Esteem, David D. Burns, M.D.
Feeling Good Handbook, David D. Burns, M.D.
Mastery of Anxiety and Panic, David H. Barlow, Ph.D. and Michelle G. Craske, Ph.D.
Courage to Heal, Ellen Bass and Laura Davis
Courage to Heal Workbook, Ellen Bass and Laura Davis
Victim No Longer, Michael Lew
The Castle of the Pear, Christoph Biffle
Workbook for Survivors of War, Joel Osler-Brende, M.D.
I Can't Get Over It: Trauma Survivors Handbook, Aphrodite Matsakis, Ph.D.

Adult Survivors of Childhood Abuse Workbook, Christine Courtois, Ph.D.

6. Support and Self-Help Groups. In addition to these self-help protocols, there are other useful self-help resources available for the primary care provider and the patient. A primary care provider can even facilitate the beginning of a patient-directed support group. Although the primary care provider may be too busy to lead many support groups, primary care practice can bring together patients with similar problems who could benefit from such groups. Primary care practitioners can play an important role in directing their patients towards each other, encouraging and supporting them sufficiently to engage their self-help skills. These self-help groups can serve all kinds of functions, but primarily serve as a means for mutual solace, education, and personal change (Self-Help Groups, "Harvard Mental Health Letter," March 1993). Such groups include Alcoholics Anonymous, Adult Children of Alcoholics, Veterans Centers, incest survivors and battered women support groups, local churches and/or religious centers, and provider-supported/guided groups.

GENERAL LIVING PROBLEMS

General living problems include common issues faced by nearly everyone at one time or another. Although they may be common, that does not necessarily mean that everyone is capable of handling the particular problem or that the problem does not cause significant stress. It is estimated that general living problems may explain up to 90% of psychiatry seen in the primary care setting (Kathol, 1988). In a study of 1,081 college students, nearly 50% of the participants reported stress-related problems in living (Stamm, 1993). These problems include marital stress, occupational problems, academic problems, uncomplicated bereavement, parent-child conflicts, financial stress, noncompliance with treatment, and religious or spiritual issues.
In a primary care setting, it is possible to provide brief but effective therapy for many of these general problems in living. The most important thing you can do as the primary care clinician is to ask questions about the patient’s problems and direct them to help or encourage their efforts to help themselves. It is very important to recognize that even though your health care resources may be limited, your community resources probably are not. Take advantage of local religious leaders like ministers, priests, rabbis, as well as friends of patients, local support groups, and local counselors. Also, as previously suggested, you could consider advising some of your patients with similar problems to get together and support each other.

In addition, stress management techniques can easily be taught and encouraged in a primary care setting. Antoni (1993) suggests four basic coping strategies for handling stress: (a) recognizing irrational thinking patterns or cognitive distortions; (b) receiving assertiveness training, which helps people to express wishes concretely but still respect the needs and desires of others; (c) providing information about the causes and signs of stress and aspects of specific illnesses; and (d) acquiring social support by recognizing the support available and augmenting the weak spots of a support network.

In the primary care setting, office visits are usually very brief and focused. For most patients, goal directed, brief therapy will be very effective. Just because you have only 15 or 20 minutes with a patient, do not assume that you will be ineffective. Primary care providers do a lot of bedside therapy—usually with very little training. There are several simple steps you can follow which will help you focus your brief therapy for general living problems. These are: (a) listen to and observe patients as they explain the problem; (b) ask patients how they are handling the specific problem; (c) educate patients about resources or ways to handle their specific problem; (d) explore alternatives with patients and help them to think about how to handle their problem; and (e) in some cases, give specific recommendations about what he or she should do. Remember, in terms of your qualities as a therapist, you need empathic ears, a willingness to be honest with the patient, a general positive regard for the patient as a human being, and a realization that medications are generally not necessary (Kathol, 1988). If these steps do not seem to be useful, you should consider referring the patient for psychiatric evaluation.

Practical Approach Algorithms

Algorithms are certainly no substitute for the art of clinical practice, but they can serve as useful guides to decisionmaking in patient care. What follows is a series of algorithms based on how the patient presents his or her primary complaint. It should be noted that they are not necessarily dependent on the primary psychiatric diagnosis. Within the algorithms, there are references to the self-help-protocols which have already been suggested.

In terms of the actual psychiatric symptomatology, references will be made for more detail. Remember, the approach here is simplified and geared for a busy primary care setting without access to many resources. The most important aspect of these guides is the ability to determine the etiology of the psychiatric symptoms and not just to treat them with psychotropic medication and stabilize. Of course, psychotropic medication can be helpful and may be an important part of the overall patient care. The primary care practitioner has an advantage in deciding on a course of treatment since he or she usually is already focused on overall mind/body health and getting the patient and patient’s family involved in taking care of themselves.

Many primary care clinicians are incredibly busy and overburdened with a large volume of patients who have all kinds of health problems. If you can ask the questions and provide direction for your patients to be able to take responsibility for
their own cases, both you and your patient will benefit. Shared responsibility can reduce the stress related to patient care for both the clinician and for the patient.

This shared responsibility may be particularly important for trauma-based patients. Asking the questions about trauma exposure can decrease the number of clinic/hospital visits which are confusing and reduce the number of misfires when the patient does not respond well to a standard medical treatment. Moreover, patients really appreciate that you want to know why they are having so many problems, which is a refreshing change from the “Take this pill” approach for both the patient and the caregiver.

The algorithms that follow include General, Depressed Patient, Anxious Patient, Substance Abusing Patient, Traumatized Patient, Somatizing Patient, Psychotic Patient, Suicidal Patient, and Self-Harming Patient.

**Conclusion**

The patients that many primary care practitioners have considered as problem patients or the patients “I just can’t help” may in fact be the part of our population who have suffered from trauma or significant stressors. These traumas could be dysfunctional family systems, childhood physical and sexual abuse, emotional and physical neglect, combat experience, earthquakes, floods, and other natural disasters, a random shooting in a subway, or any other of the major or minor traumas that we read about every day in the newspaper. One of the ways these patients try to correct the social, physiological, and psychological deficits they have experienced is by engaging the health care system.

Primary care providers are often on the front line and have a unique opportunity to recognize and treat many trauma-based problems for their patients. This opens many possibilities for education, prevention, and motivating patients to become involved in their own healing. Educational and preventive think-
**ANXIETY ALGORITHM CONTINUED:**

- Social Phobias
  - Educate
  - Support (groups, family, friends)
  - Behavioral approach
    - e.g., advise on exposure
    - Techniques like graded exposure to heights for acrophobia or graded exposure to people/crowds for social phobia

- Post-traumatic stress or stress induced problem
  - Refer to traumatized patient algorithm

- Continue evaluation
  - If you are unable to identify the anxiety problem or the methods you have used don’t seem to help, then consider referral to mental health specialist
  - Always remember to phone consult at any time you feel you need some guidance

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**SUBSTANCE ABUSE ALGORITHM**

- Substance abuse
  - Yes
    - Medically unstable
      - Detox if necessary
      - Addiction support
        - Groups: AA, ACOA, NA, OA, etc.
      - Healthy protocol
      - Safety protocol
      - Frequent drug screens
      - Family meetings/confrontation
      - Consider further evaluation to include organic work-up if patient’s mental status doesn’t clear or if there fails to be improvement after drug detox and treatment

  - No
    - Refer to traumatized patient algorithm
    - Continue treating substance abuse or refer to other algorithm

- Dual approach and refer to traumatized patient algorithm

**DUAL APPROACH**

- Refers to simultaneously needing to treat PTSD, trauma and substance abuse. If the patient has a trauma related problem, you may need to treat this first or along with stabilizing the substance abuse problem.

  - For example, using anxiolytic mods to reduce intrusive symptoms, treating trauma, using support and then focusing on the abuse problem.

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*Self-Care Issues for Clinicians, Researchers, and Educators*
SOMATIZING PATIENT ALGORITHM

ONE or MORE SOMATIC COMPLAINTS WITHOUT ANY OBVIOUS ORGANIC or PHYSICAL ETIOLOGY AFTER THOROUGH HISTORY and PHYSICAL EXAM

NO

REFER TO GENERAL ALGORITHM OR CONSIDER FURTHER ORGANIC WORK-UP and/or MENTAL HEALTH SPECIALIST CONSULTATION

YES

TRAUMA HISTORY

NO

REFER TO TRAUMATIZED PATIENT ALGORITHM REMEMBER THAT POST-TRAUMATIC SYMPTOMS CAN MANIFEST VERY SOMATICALLY. YOU SHOULD CONSIDER BODY MEMORIES AS THE SOMATIC REPRESENTATION OF FLASHBACKS AND THEY CAN LITERALLY REPRESENT THE SIGHT OF THE TRAUMA

YES

FOR SOMATIZING PATIENTS, THE USUAL RECOMMENDATION IS REGULAR FOLLOW-UP: MINIMIZATION of MEDICAL/SURGICAL TESTING and PROCEDURES, AND SUPPORT CONSIDER ADVISING THE PATIENT to DRAW or WRITE ABOUT the AREA or BODY PART CAUSING THE PROBLEM. ASK THEM to FOCUS ON HOW THIS IS DECREASING or INCREASING THEIR DAILY FUNCTIONING. ONCE THEY COMPLETE THIS TASK (remember to give them a specific time by which they should have completed the task), THEN ASK THEM to WRITE or DRAW ABOUT HOW THEY WANT to CHANGE THINGS or HOW THEY WANT THEIR BODY to CHANGE and WHAT THEY SHOULD DO in ORDER to GET THERE. THESE TASKS SHOULD BE ACCOMPLISHED ALONG WITH THE USUAL REGULAR SUPPORT.

TRAUMATIZED PATIENT ALGORITHM

PSYCHOLOGICAL TRAUMA (include MVA x. medical and surgical procedures. combat, sexual/physical/emotional abuse)

ACUTE, i.e. WITHIN 6 MONTHS

YES

RECURRENT, dysfunctional:
- Approach as with acute, however, more emphasis upon support and safety.
- Encourage patients to start support groups, volunteer speak to family, friends, community about their experiences—focus on their social/personal functioning
- Closely monitor for depression, anxiety symptoms, and ability to self-care

NO

YES

- REFER to OTHER ALGORITHMS
- CONTINUE EVALUATION: ONCE YOU ASK ABOUT TRAUMA, IT MAY TAKE A WHILE BEFORE THE PATIENT FEELS COMFORTABLE TELLING YOU ABOUT IT

- TREAT ACUTE TRAUMA
  - SAFETY PROTOCOL
  - HEALTHY PROTOCOL
  - TRAUMA NARRATIVE instruct the patient to write or draw the entire traumatic event from a safe point before the event and in a safe point after the event
  - REQUIRE the patient to tell 5 trusted family/friends over the next month
  - SUPPORT GROUPS
  - SELF-HELP BOOKS
  - ADVISE the PATIENT to REPEAT the NONVERBAL (writing or drawing) NARRATIVE 1-5 times a week to themselves until their intrusive symptoms like flashbacks, nightmares, poor sleep, etc. improve
  - You can go over the narrative with them, but only after they have completed the initial task of the narrative and telling 5 people
  - May really benefit from psychotropic meds like SSRI (Prozac), benzodiazepine, etc.
PSYCHOTIC PATIENT ALGORITHM

- Patient with auditory hallucinations, delusions, abnormal thought form like loose associations, etc. Remember, visual hallucinations are a sign for an organic etiology (e.g., brain tumor). Also, traumatized patients will often describe visual or auditory hallucinations which usually come from "inside" their head instead of "outside" their head as in schizophrenia.

- Trauma History
  - Yes
  - Refer to traumatized patient algorithm, should also consider antipsychotic medication like risperidone or more traditional halolol, navane (higher potency neuroleptic medication is more effective)
  - No

- Review Med Compliance
  - Assess for side-effects like EPS or tardive dyskinesia
  - Consider depot neuroleptic
  - Consider neuroleptic blood level monitoring
  - Consider phone consult with mental health specialist

- Anti-regressive regimen
- Safety protocol
- If too regressed, unable to keep self safe, enlist family/friends support for 24-hour monitoring
- Ask for support from church leaders, self-help groups, etc.
- If unable to enlist support, consider inpatient treatment until patient can use support and keep self safe
- Begin neuroleptic medication
- Consider anti-anxiety meds to augment neuroleptics and improve sleep schedule
- If first psychotic episode, need organic work-up like ct-head/mri-head/ee/psych testing and/or mental health specialist consultation
- Follow-up daily until psychosis starts to clear

REFER TO OTHER ALGORITHMS, MONITOR CLOSELY FOR REGRESSION

SUICIDAL PATIENT

- If the patient suicidal and regressed?
  - Yes
  - Anti-regressive regimen
  - 24-hour supervision (may be friends/family or in the hospital)
  - Evaluate source of suicidality and risk factors
  - Treat primary mood or thought disorders or trauma-based disorders

  - No

  - Assess chronicity, if chronic could evaluate for secess and sometimes good follow-up and support will reduce suicidal urges
  - Utilize support system for 24-hour supervision which may need to be visual i.e., watching the patient for 24-hour periods
  - If no support, may need to hospitalize
  - Advise patient to write 5-step safety plan to follow when not feeling safe e.g., phone numbers, action plan, emergency plan, etc.
  - Anti-regressive regimen
  - Safety protocol
  - Healthy protocol
  - Consult mental health specialist if patient does not improve or you have questions
ing is needed for medical and surgical procedures, stress management, preventive health care, social support, and a self-help viewpoint.

Patients do better when they take an active role in a medical or surgical procedure (Bennett, 1993) Thus, to help reduce the stress of caregiving for the provider and the stress of healing for the patient, you should encourage your patients to design their own pre-surgical or pre-medical procedure program. For example, they should be involved in gaining information and education about the procedure and why they are having it done. They should have an opportunity to learn ways that they could decrease pain, decrease heart rate and be able to influence bodily function like their immune system, bowel activity, as well as other autonomic functions (Bennett, 1993).

Primary care providers usually excel in the areas of preventive health care and patient education. This aspect of the primary care setting is advantageous for trauma-based problems. The primary care provider will expect the patient to have basic health care needs met and patients will expect their primary health care providers to know and understand the latest and best treatments. So, this too can be expanded to reflect the latest information about violence prevention, the dangers and consequences of childhood physical and sexual abuse, the effectiveness of rapid debriefing after a traumatic event, etc.

The nature of primary care offices or clinics involves an interaction between someone who has a lot of skill and information (the caregiver) with someone who has a need or problem (the patient) and the desire for it to get better or go away. People can be encouraged to begin to take responsibility for their own care and healthier lifestyles, but they must be given that responsibility. There is an enormous opportunity to take advantage of limited clinical resources and encourage the development of patient organized self-help or support projects. The primary care provider in the best-case scenario can become a guide, shaman, and mentor about how to become healthy.
Spiegel’s studies at Stanford on social support show that people who are the least connected socially have twice the death rate of a connected group, even after smoking, alcohol, physical activity, and obesity are considered (Spiegel, 1993). A decrease in immune function is noted for single, separated individuals, but an unhappy marriage is also a health hazard. Primate studies suggest that positive relationships may possibly decrease the flow of stress hormones, such as cortisol (Spiegel, 1993).

The more technically advanced health care becomes, the more primary care providers will need to pay attention to the potential healing value of the human-to-human interaction. The most important point about trauma-based psychiatry and primary care is the willingness to listen and hear about reasons for why “My chest hurts” when there is no cardiac problem or why “My head hurts” when there is no migraine. The reasons are obvious. It is a matter of listening to what the patient tells you and being willing to believe that their traumatic experiences really can cause somatic pain and symptoms. Just as you routinely try to isolate which bacteria is causing Mrs. Smith’s urinary tract infection, so too must you pursue what events or traumas preceded the onset of Mr. Jones’s persistent atypical chest pain. Instead of giving in to frustration when patients do not fit into the usual constellation of symptoms for a particular diagnosis, your challenge is to keep an open mind and be willing to ask the question “What happened to you?”, not just “What is wrong with you?” (Bloom, 1992).

References


Boston, MA: Harvard Mental Health Newsletter.


