Chapter 5
The Case of Daniel Terzi: Trauma with Clinical Care

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Case

Daniel Terzi, a 26-year-old third-year medical student, presented to student health at the strong encouragement of his girlfriend for evaluation of poor sleep and decline in function over eight weeks.

While Daniel passed his pre-clerkship rotations, he did not do as well as he wanted. Specifically, he struggled with test-related anxiety. Testing was always stressful for Daniel, but this mushroomed during his first two years of medical school. Daniel was determined to perform at the top of his class during his clinical clerkships. Clinical care, he reminded himself, was the reason he wanted to become a physician. Daniel's first rotation was psychiatry. He was assigned to the acute psychotic disorders inpatient unit at a busy public hospital.

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He was excited about his assignment and within his first week, already felt part of a team treating challenging and interesting patients.

At the start of the second week of this rotation, Daniel began working with Mr. L, a 40-year-old man with schizophrenia. Mr. L was admitted over the weekend following an unprovoked verbal altercation with a group of women on the street. Since his presentation to the emergency room, Mr. L was noted to be paranoid and irritable. He refused all medications, but considering his disorganization and agitation, he required emergency intramuscular medications and restraints on multiple occasions. The attendings on Daniel's unit emphasized that the experience for psychotic patients was scary and the level of their paranoia could provoke unpredictable and aggressive behaviors. Medications were part of his treatment.

Mr. L's treatment team knew that he required ongoing neuroleptic medications to treat his psychosis and address his associated dangerousness. He continued to refuse medications, and his treatment team began legal proceedings for treatment over objection. The day before Mr. L was to go to court, Daniel met with Mr. L in his room and attempted to persuade Mr. L to take medications without involving the legal system. He believed that they had developed a nice rapport seeing each other during rounds every day and nodding hello to each other regularly on the inpatient unit. Daniel imagined that approaching Mr. L individually in his room, Mr. L would feel less scared. On approach, Mr. L was initially calm, but as Daniel broached the topic of medication, Mr. L's behavior shifted and became threatening. Daniel started to leave Mr. L's room when Mr. L lunged at him, knocking him to the ground with a punch to his nose. Daniel raced out of Mr. L's room and left the unit without any staff witnessing the aftermath of a bloody nose. Daniel went home and reached out to his attending to say that he had "food poisoning" and would be back at work the following day.

Daniel was primarily concerned that his decision to meet alone with Mr. L and Mr. L's aggression reflected his futility

as a health-care provider. He believed he would fail the clerkship and perhaps face disciplinary action. Daniel did not inform his attending nor did he report the incident to the medical school; instead, he continued to work on the unit as a member of Mr. L's treatment team. Following the incident, Daniel started to have significant trouble sleeping, with frequent nightmares that woke him from sleep with accompanying palpitations and the image of Mr. L knocking him to the ground. It was difficult for him to concentrate in both social and academic settings. Furthermore, he was anxious when he attempted to do required readings and on edge when asked to present during rounds. In fact, he had called out sick multiple times over subsequent weeks, as he felt significantly more uncomfortable when in the hospital building. Daniel's girlfriend was concerned about his low mood, lack of interest in doing activities together, and overall decline in functioning. She finally insisted that he seek psychiatric evaluation after he became furious with her when she accidently startled him while they were studying together in the library.

Daniel insisted that his girlfriend accompany him to his initial evaluation at student health where he met with a psychiatrist, Dr. Mada, a recent graduate of his medical school's psychiatry residency program. Daniel was scared. He scanned Dr. Mada's office throughout the session. He was reluctant to talk about the assault and focused on his poor sleep as a result of his recurrent nightmares.

Principles of Diagnosis and Management

Diagnosis

Daniel presented to student health with symptoms of anxiety that started after a potentially fatal experience. This traumatic experience prompted the re-experiencing of the event via nightmares, as well as hypervigilance, with poor concentration, difficulty sleeping, and increased startle response. The most appropriate diagnosis for Daniel is post-traumatic stress

disorder (PTSD) [see Table 5.1]. Patients with PTSD have experienced or witnessed a traumatic event that is life-threatening or potentially life-threatening in nature. Following such a catastrophic trauma, such individuals experience intrusive symptoms including unwanted memories, flashbacks, emotional distress or physical reactivity when reminded of the traumatic event. Individuals may also demonstrate avoidance behavior which can include avoidance of trauma-related stimuli [1]. As exhibited in Daniel's case, PTSD can also impact one's mood and inhibit their daily functioning. While Daniel meets criteria for PTSD, other possible diagnoses should be considered. Adjustment disorder with anxious features is on the differential; however, such a diagnosis typically applies to stressful life events that are not life-threatening in nature. In the case of Daniel's physical assault, his life was, in fact, threatened. Another possible diagnosis is major depressive disorder (MDD). Daniel's poor sleep, diminished concentration, and low mood over a period greater than 2 weeks are suggestive of MDD; however, in order to firmly make this diagnosis, more information about recent symptoms is necessary. Given Daniel's current level of hyperarousal and anxiety

Table 5.1 Post-traumatic stress disorder: core features

Exposure to a traumatic experience involving threat to one's life or safety (physical or sexual), through direct exposure, witnessing, on behalf of a loved one, or in a recurrent way
At least 1 month of:
Intrusion symptoms related to the trauma (e.g., memories, dreams, dissociative symptoms, or other distressing emotional or physical symptoms)
Avoidance of thoughts or cues related to the trauma
Problematic changes in thinking or emotions (e.g., altered memory of the event, negative thoughts about oneself, low mood)
Changes in arousal and behavior (e.g., irritability, recklessness, heightened attention, impaired sleep)

(with associated difficulty concentration and sleep disturbances), combined with his previous history of anxiety during pre-clerkship years, an anxiety disorder should also be considered. In order to make this diagnosis, more information would have to be obtained about the nature of his anxieties beyond that related to traumatic event. A diagnosis of complex PTSD should also be considered. This is relevant for patients concurrently experiencing emotional dissociation, emotion deregulation, somatization, and strained relationships. Daniel's symptoms have persisted for over a month following the event, and as such, acute stress disorder is not on the differential, which is a transient state and passes within one month. Furthermore, the possible role of alcohol and other substances should be considered as a possible diagnosis. While his case presentation does not specifically reference signs or symptoms that are directly suggestive of substance use, his rather sudden change of behavior could be explained by acute intoxication and/or withdrawal.

Management and Treatment

PTSD diagnosis and treatment begin with a thorough evaluation. Treatment options include psychopharmacologic management and/or psychotherapy. This decision is largely based on patient's individual preference and treatment availability. If medication is indicated, antidepressants, usually serotonin reuptake inhibitors (SRIs), are prescribed. SRIs can help a patient feel less on edge, decrease irritability, and help lift one's mood. In addition to antidepressant medications, other classes of medications, such as benzodiazepines (fast-acting anxiolytics) to target moments of panic and hypervigilance, are beneficial when use cautiously and judiciously. Alpha-1 adrenergic receptor blockers (to address nightmares) can also be considered as augmentation agents. Psychotherapy can be used in place of, or in addition to, medications. Possible therapy modalities to consider include trauma-based therapy, cognitive behavioral therapy, eye movement desensitization

and reprocessing (EMDR), or supportive psychotherapy [2]. Previous studies have shown that trauma-focused psychotherapies can help decrease the severit of one's symptoms. For example, a meta-analysis found that trauma-focused cognitive behavior therapy led to greater reduction in PTSD symptoms than usual care [3]. In individuals such as Daniel, therapy can play a crucial role in addressing ongoing symptoms while also promoting coping skills necessary to tolerate future distressing circumstances.

Principles for Doctors Treating Doctors

Upon initial presentation to Dr. Mada, Daniel expressed ambivalence about receiving psychiatric care. On the one hand, he recognized the recent changes in his level of functioning, subsequently negatively impacting his academic performance and relationship with his girlfriend. That said, he was preoccupied that seeking mental health treatment would influence his standing in medical school. Daniel was concerned he would be penalized not only for his clinical judgment prior to the assault but also because he could not control his symptoms. It was also very uncomfortable to recount the details of the event. He wondered if others would fear him as a psychiatric patient in the way others perceived Mr. L on the inpatient unit. In fact, Daniel's fear of stigma played a large role in his decision not to tell supervisors about the assault when it occurred. Daniel shared the events with Dr. Mada as well as the changes he noticed about himeslf over the last two months. His major concern was difficulty sleeping, as he awoke from nightmares multiple times per night. Lack of sleep was leading to exhaustion during the day and decline in his academic performance. Furthermore, he was having a substantial level of anxiety when in the hospital for required hospital rotations; he shared that he recently had to leave a patient's room during rounds, as a patient suddenly moved in his bed to reach for his cell phone, leaving Daniel sweaty, breathing quickly, and panicky. Daniel was unsure how he would continue with his clerkships.

Dr. Mada proceeded with a comprehensive review of symptoms, including substance use, mood symptoms, psychotic symptoms, and suicidality, as PTSD is often associated with high rates of psychiatric comorbidities [4]. Daniel denied symptoms concerning for an additional condition. Dr. Mada diagnosed Daniel with PTSD related to his assault. While Daniel acknowledged he was "stressed," he did not agree that he met diagnostic criteria for such a serious mental illness. He was also concerned that the details of the event would travel from Dr. Mada to the inpatient psychiatry attending on the unit. Dr. Mada emphasized the benefits of beginning treatment right away in order to avoiding long-standing impairments. He recommended initiating both medication and therapy. Daniel was hesitant to commit to treatment, especially weekly therapy, as he felt like his busy academic schedule precluded him from such intensive care. Dr. Mada impressed upon Daniel that addressing his well-being was an essential element of professionalism. He needed to care for himself in order to care for others. Ultimately, Daniel agreed to begin a medication trial. Escitalopram, a selective serotonin reuptake inhibitor (SSRI), was started at a low dose and subsequently increased to the higher end of therapeutic doses. Daniel noted some improvement in his baseline level of anxiety and isolation but continued to experience sleep disturbances and hypervigilance, especially when in the hospital setting. In addition to the escitalopram, Dr. Mada recommended Daniel to take prazosin at bedtime to target ongoing nightmares and sleep disturbances [5]. While on this medication regimen, Daniel had a partial response but continued to have difficulty spending time alone with patients. He agreed to augment medications with trauma-focused cognitive behavioral therapy.

Dr. Mada referred Daniel to a therapist, Dr. Guy, who was trained specifically in trauma-focused cognitive behavioral therapy (TF-CBT) [6]. The goal of TF-CBT is to help individuals reconceptualize their traumatic experiences, their capacity for resilience and the ability to cope following the trauma [7]. Daniel had weekly individual sessions, where he was encouraged to re-evaluate his automatic thoughts about

the assault that were often catastrophic and negative in nature. He was asked to participate in a range of different exposure activities that directly addressed his avoidance behaviors. For example, in order to challenge anxieties related to spending time in the hospital, and specifically alone with patients, Daniel composed a graded exposure hierarchy in which he was alone with patients across a variety of settings. During such exposures, his therapist asked him to keep detailed thought records, where he identified automatic thoughts, as well as associated emotions, adaptive responses, and outcome to exposures. As part of Daniel's exposure heirarchy, Daniel reached out to his inpatient attending to discuss the event. Reflecting on this exposure with Dr. Guy, Daniel reconceptualized his experience on the inpatient unit as a wish to appear capable as a medical student and empathic as a provider to Mr. L. Because his intervention with Mr. L, did not go as planned he felt shame and this inhibited him from reaching out for supervision at the time of the episode. This was one example of reconceptualizing his experience and understanding alternative ways of coping with the trauma. With ongoing therapy, Daniel challenged his thinking patterns related to patient care and the possibility of a subsequent assault. He focused on building skills to tolerate patient encounters and time in the hospital.

Outcome

Daniel continued to work with both Dr. Mada for medication management and Dr. Guy for therapy. He was maintained on escitalopram 20 mg daily to target anxiety. Prazosin was tapered off over subsequent months, as his sleep improved. After completing the course of trauma-focused cognitive behavioral therapy, Daniel continued to meet with Dr. Guy weekly, but the focus of therapy shifted to more supportive and dynamic in nature. Goals included addressing Daniel's baseline anxiety and develop a better understanding why he did not disclose the assault or associated difficulties to his

medical school administration. Specific emphasis was placed on exploring his tendency to avoid asking for support from others, given the concern that doing so would make him seem less capable or intelligent. Over the following year, Daniel gained insight into his perfectionistic tendencies and desire to present himself as infallible regardless of the circumstances. He was able to reflect on the fact that the unrealistic expectations he was placing on himself led to anxiety that was inhibiting his ability to succeed. Daniel was able to complete all of his clerkships and is now preparing to apply for a position in a pediatrics residency program.

Pearls

- Post-traumatic stress disorder (PTSD) is a psychiatric condition that can affect any individual exposed to a trauma that involves an actual or threatened injury to oneself or others. Symptoms include intrusive thoughts, nightmares, and flashbacks, as well as hypervigilance, avoidance of reminders of the trauma, and sleep disturbance.
- Psychiatric comorbidity is high in individuals with PTSD, and therefore careful attention must be paid to evaluating for comorbid mood disorders, anxiety disorders, and substance use disorders.
- PTSD is best managed when treatment begins as quickly as possible after a person is diagnosed with this condition; that being said, many individuals are resistant to receiving care.
- Treatment of PTSD can include medications and psychotherapy. These two approaches can be used individually or in conjunction with each other. Deciding which modality to begin with depends on the specifics of the individual case (i.e., patient's preference, availability of therapy, severity of symptoms).
- If an individual participates in therapy, attention should be paid to targeting symptoms specific to

PTSD but also to gaining better insight of other comorbid psychiatric conditions. Such an approach can help an individual understand underlying difficulties that contributed to the development of PTSD; with such an improved understanding, it is hopeful that the patient can enhance overall functioning and resilience in the future.

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Suggested Reading

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