

# **Integrative Awareness in PTSD Treatment: Avoiding Unseen Risks of a Provider-Initiated Drug Withdrawal**

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## **SUMMARY:**

In "The Integrative Clinician" series, the author discusses the importance of exercising integrative awareness when treating patients with PTSD. Through integrative approaches, clinicians can develop a heightened awareness of the various ways in which their treatments interact dynamically (1) with patients, (2) with patients' environments, and (3) with other disciplines and professional providers. In this segment, the author presents a case study in which a provider's

prescription of sleep-inducing medication intersected with environmental and interdisciplinary factors. The provider's failure to exercise integrative awareness of these factors led to the patient's experience of sudden and complete withdrawal from a multiple drug regimen. Analysis of the case demonstrates how integrative approaches, had they been adopted, could have improved the patient's outcome and protected her from potentially lethal risks.

In an increasingly complex society, it is easy for practitioners and clinicians to overlook the elemental. When professionals have devoted years to attaining expertise in the nuances of their fields, they can easily become hyper-focused and attentive only to what they perceive as falling within their own clinical lane. When this occurs, they may disregard important peripheral factors affecting the patient.

As we continue to use *complexity* as a measure of professional *competency*, we may lose sight of simplicity and the important role it plays in our approach to clinical problems. Risks may arise when a provider takes a self-oriented approach to patient treatment, without adequate consideration of how a treatment plan may interact with factors outside of the provider's own discipline. In an effort to attend to complex aspects of treatment, clinicians can easily bypass simple factors that play a key role in the quality of care. As one who has frequently been in the position of serving as a care coordinator between multiple providers, I have seen how patient outcome can become compromised by clinicians' inadvertent disregard of factors so elemental that they weren't considered worthy of attention.

In this segment, we explore a case in which a dangerous discontinuation of a complex multiple-medication regimen occurred as a result of the dynamic interaction between (1) a single, newly added prescription, (2) the circumstances of the patient's home environment, and (3) the provider's disregard of collateral aspects of the patient's interdisciplinary care and medication. Readers are advised that the clinical details of the case study are factual. Identifiers have been changed to protect the medical confidentiality of those involved.

**THE CASE OF "MARY":** Mary was a 45 year-old, widowed, Air Force retiree suffering from severe post-traumatic stress disorder. She was transferred to the care of Dr. Jones, a psychiatrist serving in a government healthcare facility. His treatment style emphasized aggressive use of medication but incorporated minimal dialogue with the patient. Mary's treatment included antidepressant, anxiolytic and benzodiazepine drugs. Despite the use of these medications, Mary continued to experience post-

traumatic stress reactions, often several times daily. Her symptoms would include 'triggering' in response to external stimuli, terrifying flashbacks associated with traumatic events of her deployment, heightened anxiety and hypervigilance. In addition, Mary would experience a racing and pounding heartbeat, throbbing headaches and intense fear that she would have a heart attack.

Mary brought her cardiovascular symptoms to the attention of Dr. Jones, but he declined her request for a cardiovascular consult. By virtue of the fact that she was a psychiatric patient, Dr. Jones viewed her cardiovascular symptoms as a strictly anxiety-related feature of her PTSD. He advised Mary that, for this reason, he did not feel that her symptoms merited a cardiovascular referral.

Unable to obtain the desired consult within the hospital facility, Mary self-referred to Dr. Smith, a well-respected interventional cardiologist. His complete cardiovascular workup reflected that (1) Mary was severely, chronically hypertensive and tachycardic, (2) that these conditions were a cardiovascular expression of post-traumatic stress disorder, and (3) that she was at resultant high risk for stroke. Dr. Smith managed the cardiovascular aspects of Mary's PTSD through a balance of oral propranolol and clonidine administered in six doses, carefully spaced throughout the day and evening. His cardiovascular care, when added to her ongoing psychiatric management, significantly improved her overall psychiatric and medical status.

Several months later, Mary experienced sleep difficulties coinciding with the anniversary of her late husband's death. In response to this, Dr. Jones dispensed a hypnotic sedative to induce sleep. The downstream events of the patient's case were unexpected and disturbing, and - most importantly - preventable.

1. Disregard of the patient's social circumstances: Dr. Jones viewed his prescriptive authority as purely unilateral - a function which he routinely performed thousands of times a year without feeling the need to stop and investigate the social circumstances of the patient. He assumed that social *factors* were the sole concern of social *workers*,

and not pertinent to his dispensing of medication. In keeping with this 'siloed' mindset, Dr. Jones failed to do one simple thing: *he failed to inquire whether or not the patient lived alone.*

As it turned out Mary did, indeed, live alone. She was not only alone, but depressed, fatigued, withdrawn and bereaved. In addition, she was unaware of how susceptible she was to hypnotic medication, whose sedative effect was potentiated by several other medications Dr. Jones had also previously prescribed. Exhausted and unable to sleep all Thursday night, Mary took the hypnotic 'z-drug' early Friday morning. Alone in the house, without anyone to awaken her, Mary entered into a drug-induced stupor from which she did not awaken until late Sunday night. This, as we shall see, created unintended and potentially serious risks to her life and health.

### 2. Failure to integrate with collateral providers and treatments:

Prior to the incident in question, Mary had provided copies of her cardiology workup, progress notes and prescriptions to her psychiatrist. She sought to discuss these with Dr. Jones and found him unreceptive. Dr. Jones, in fact, criticized Mary for having consulted with a provider from another facility and another discipline. After expressing his opinion that her problems were strictly psychiatric, Dr. Jones felt threatened that his assumptions had been proven incorrect. Dr. Jones did not collaborate, nor communicate, with Dr. Smith. Additionally, Dr. Jones refused to list Mary's propranolol and clonidine prescriptions in her patient drug list. As a result, these cardiovascular prescriptions (which were administered for the control of both cardiovascular and PTSD symptoms), were not included in Mary's electronic medical record. This omission would later expose her to exacerbated medical risk.

### 3. Disregard of risk-producing factors: Dr. Jones' lack of integrative awareness led to the creation of several serious risks, which not only affected Mary's health but could have potentially jeopardized her life.

First, despite his knowledge that Mary was receiving other medications prescribed by her cardiologist, Dr. Jones remained focused solely on the psychotropic and psychoactive drugs which he himself

prescribed. In particular, he failed to consider that the hypnotic sedative that he added to Mary's regimen would *inhibit* the action of propranolol, and thereby lead to a dangerous resurgence of cardiovascular symptoms.

Second, Dr. Jones failed to consider how susceptible Mary might be to the effects of the hypnotic, and how vulnerable to over-sedation she could become in circumstances where there was no one at her home to monitor her response to the medication.

Third, Dr. Jones did not consider that a prolonged, drug-induced period of sleep or stupor could actually prevent Mary from awakening to take her other, regular medications, thereby resulting in *sudden, total withdrawal from her entire medication regimen.*

Fourth, Dr. Jones did not consider the risk that a sudden, total withdrawal of Mary's cardiovascular medication would initiate 'rebound' symptoms. These could place the patient at risk of stroke, and also lead to a resurgence of her post-traumatic psychiatric symptoms.

## A "Perfect Storm" of Downstream Risk

By the time Mary was found by a concerned neighbor, *she had slept through 18 skipped doses of cardiovascular medication.* She was in the midst of full blown drug withdrawal, and her symptoms included a soaring heart rate and acutely elevated blood pressure which placed her at risk of stroke. Unfortunately, the risks created by her situation did not end there. Despite her psychiatrist's belief that cardiovascular medication did not contribute to the management of PTSD, that was not the case. When 'on board', propranolol and clonidine helped remediate Mary's PTSD symptoms. Similarly, their sudden withdrawal had significant effects. When suddenly roused by her neighbor and EMS, she was already experiencing heightened anxiety, rage and aggression - all symptoms of sudden, total propranolol withdrawal. When police charged into Mary's house in response to the 911 call, their uniformed and armed presence triggered her flashbacks of traumatic events of her deployment. Without proper medication in her system, Mary became terrified, combative

and disoriented to time, place and surroundings. Police misperceived her reactions and responded by physically tackling, restraining, and transporting her in handcuffs to a psychiatric 'lockdown' ward. The experience left her severely traumatized.

On Mary's arrival at the psyche ward, medical personnel erroneously assumed that Mary was suicidal and believed she was guilty of an intentional *drug overdose*, when in fact she was in the midst of an accidental *drug withdrawal* - one that was physician initiated. She was stigmatized and disbelieved when she attempted to explain her situation. In response to her explanations, providers consulted her electronic medical record. Thanks to the earlier omissions of her psychiatrist, it contained no reference to the propranolol and clonidine which she needed to achieve re-stabilization. As a result, her withdrawal from these essential medications continued for days, during her inpatient hospitalization. Not until the fourth day of her medical incarceration was Mary's true situation discovered and rectified by the unit psychiatrist. By that time, irreparable damage had been done.

## EPILOGUE

Once Mary's proper medication regimen was discovered and restored, it still took several weeks for her to return to her former level of stability. Emotionally and psychologically, however, she never recovered from the incident. In response to the fear and vulnerability which she suffered as a result of her doctor's actions, Mary removed himself from his care. Unfortunately, her levels of fear prevented her ever re-entering psychiatric treatment again.

In retrospect, it appears that Mary's psychiatrist did not act out of the desire to do harm. Rather, Dr. Jones behaved in accordance with a clinical mindset that was so narrowly focused that it caused him to ignore the real world circumstances of his patient, as well as the downstream potential consequences of his prescriptive decisions. *He failed to foresee the manner in which the addition of one single drug could result in the total*

*cessation of Mary's entire medication regimen*, and thereby expose her to risks associated with profound drug withdrawal.

## SUGGESTED INTEGRATIVE APPROACHES

Mary's experience is something which could conceivably affect many PTSD patients. The following are some integrative approaches, which this author suggests to clinicians, involved in PTSD treatment, who desire to avoid the risks which Mary suffered.

1. Inquire and maintain awareness about the environment in which a patient takes medication, including their degree of access to assistance, or their lack of it. Ask yourself: once a patient has taken this medication, will he/she be able to awaken, ambulate, and continue their normal meds regimen? Or will he/she be likely to remain asleep and skip dosages? Even if drugs are in reach, will an opposite risk be created, e.g., will the patient be so disoriented that he/she may accidentally overdose or take the wrong medication?
2. Consider not only the patient's physical susceptibility to becoming over-medicated, but also any accompanying psycho-social-emotional factors that might induce physical lethargy and immobility, such as depression, grief, withdrawal and social isolation. These factors may enhance the risk that medication will be skipped.
3. Whenever possible and permissible, coordinate with other providers. If other providers are prescribing drugs which your patient is taking, you must maintain awareness not only of your prescriptions, but theirs also. Determine the effects of the TOTAL DRUG REGIMEN, including drug action, interaction, potentiation and discontinuation. If you disagree with the treatment conducted by a collateral provider, by all means discuss it with the patient and the other provider, but do not simply ignore it.
4. Find a means of ensuring that the patient's complete drug list can be accessed by providers in the event of an emergency.

5. Remember that prolonged episodes of sleep can result in skipped dosages of medication, resulting in sudden and dangerous drug discontinuation.

6. Be open to the fact that certain illnesses, including PTSD, have both psychological and physiological components. Optimal management may require the use of medications associated with several clinical disciplines, including cardiology, endocrinology and others.

7. Whether you are a physician or a therapist, develop integrative awareness not only about the effects of the drugs which the patient is prescribed, but also about the signs of withdrawal from those drugs. The patient's life may depend upon your ability to recognize signs of drug discontinuation.

8. Be aware of circumstances which may 'trigger' a patient's post-traumatic stress reactions, including flashbacks. Recognize that their reactions are tied to a past incidence of trauma, and not directed at you personally. Avoid the temptation to retaliate.

Sadly, Mary's story is not unique. This author has witnessed the repetition of her nightmarish experience in a number of cases. In all of them, providers were so hyper-focused on their own agendas that they ignored the totality of the patient's circumstances. As a result, they developed 'tunnel vision' at the patient's expense.

By expanding our peripheral clinical vision, and by replacing tunnel vision with *integrative awareness* of ALL factors that impact treatment, we can help to ensure that our own patients receive the safe and compassionate care that Mary was so unfortunately denied.