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Conversations With Patients About PTSD, Screening, and Referral

Announcer:
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Dr. Goldberg:
Hello, everyone, this is CMD on ReachMD. I'm Dr. Joe Goldberg. I'm here today with my good friend and colleague, Dr. Roger McIntyre.

Welcome, Roger.

Dr. McIntyre:
Joe, great to be with you as always.

Dr. Goldberg:
Glad you're here. So we're here to talk about how primary care and obstetrics and gynecology physicians can improve their communication with their female patients, whom they suspect might be suffering from PTSD. And one of the questions, How should these clinicians approach their patients when seeking acceptance to screen and, if necessary, refer for psychiatric follow-up? How do we do this?

Dr. McIntyre:
Yeah, Joe, I think it's a really important question, and I think that, also, what is tacitly implied in the question is should we be screening for PTSD? And the answer is of course, yes, we should be thinking about this. Joe, it's been my usual practice throughout my entire career to ask all patients about trauma. We call trauma a cascade event, meaning it's an event that cascades into many different types of psychopathological conditions as well as medical conditions: obesity, heart disease, diabetes. So it's an important question to ask. I also recognize in my years of practice and, Joe, I'm sure you've noticed this as well, that there's different levels of comfort in talking about trauma and that needs to be acknowledged; that needs to be empathically registered with the patient. I would say, certainly in fact, it is an empathic question to ask about trauma. Patients want to be understood. That's certainly good for alliance-building with the patient, etc. But indeed, I think there needs to be recognition that for some people this is, for a host of reasons, not something they wish to talk about or they are able to talk about in the there-and-then or are able to talk about with me, particularly. Maybe there's someone else that they may be comfortable talking about. So I give patients opportunities to articulate that. So I do ask about a trauma history in patients. If they do say, yes, there's been a history of a trauma, as they've described it, I asked probing questions about if they're comfortable to talk about what's the nature of that trauma, when did it occur? What were the circumstances, what were some of the follow-up to that event, etc. But if the patient comes back and says, "You know, I have a trauma history, but I don't want to talk about it," I would certainly say I register that clearly and would recognize that that may not be the right time.

In some cases, what I might do, Joe, as a follow-up question, is there a way where this would be comfortable to talk about? If not, not a problem. We can revisit this another time, or what have you.

So I think, in fact, it really begins with 2 points. One is probing for trauma. The patient hearing that information being asked. And the patients, secondly, also hearing that you're aware of the fact that trauma has such a subjective experience for the person, a lived experience, that you're sensitive to the fact that in that moment, they may not be comfortable talking about it. At the same time, you have the professionalism, you have the empathy, you have the core competencies to discuss this further.

Joe, one final comment would be I often make the point of saying to patients, in one way or the other, that the purpose is to better understand that treatments are available for people living with trauma. So that's kind of how I generally go about this issue.

So for me as a clinician, I'm really registering a couple of points. I think, in fact, that it's empathic to ask patients about trauma history. That's never been described as un-empathic for a patient. It is un-empathic when they're not being better understood. But secondly, for the patient to have heard that you are recognizing that this is a sensitive topic, that you have the professionalism, you have the core competencies to describe this issue and work with them on this issue. And then finally, I also convey a hopeful message in the sense that there are therapeutics. This isn't just that navigating the patient psychopathology; we're doing it with a mind to set what our therapeutic priorities [are] and so on. So it's also good to know that there are treatments available, and in many cases, that might ease the patient, if you will, in discussing the topic. They may not know that there are treatments available to them.

Dr. Goldberg:
Terrific as always. It occurs to me, primary care doctors and ob-gyns may be especially natural and poised at being able to deal with problems that are delicate and to be able to say to a patient, I don't want to hurt you. So before I say or do anything, give me feedback. I want to make sure that this is comfortable for you. I'm going to probe. I'm going to ask about something. And let them know, I want to make sure that this is as comfortable as possible because I'm here to help, as you would with a physical injury. So I think clinicians in this area have a particular opportunity to establish that empathy, which is a cornerstone of a therapeutic alliance.

Well, this has been really helpful, Roger. As always, I want to thank you so much for your input. Hope you all find this helpful out there, and we hope to see you again soon. Bye for now.

Dr. McIntyre:
Thanks, Joe. Thank you everybody.

Announcer:
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