SAMPLE Clinical Case about Trauma and Chronic Illness
THEN…The Center for Collaborative Study of Trauma, Health Equity & Neurobiology

Case History of Chronic Pain: JOHN

VISIT #1: John is a 38 y/o man with unrelenting neck pain - seeing you as a new clinician - requesting narcotics for pain.

PRESENT HISTORY: John reports his neck pain started 3 years ago after suffering neck whiplash in a minor car accident. Police were called to the scene but both cars were drivable and John refused medical care.
The day after the accident, John developed a severe headache (pain level 10 out of 10) and stiff neck, went to the ER where X-rays were normal. Sent home with Tylenol #3 and told to follow up with primary care.

Over the past 3 years, pain has never gone away. John has seen multiple specialists including orthopedics, neurosurgery, chiropractic, physical therapy, massage therapy and had multiple imaging studies - all normal except for minor degenerative changes consistent with his age. No prior head injuries, no prior car accidents or sports injuries.

John has taken narcotics or NSAID every day for 3 years. "Nothing helps."

PAST MEDICAL HISTORY: unremarkable. No hospitalizations, no surgeries, no chronic illness.

REVIEW OF SYSTEMS: unremarkable except for pain and constant fatigue. "Sleep terrible - how could I sleep with this pain?" Emotionally - feels "under a lot of pressure."

SOCIAL HISTORY: Married, 2 children. He and his wife are in marital counseling. His work (desk job) is demanding and he hates his boss. Never smoked, rare alcohol.

PHYSICAL EXAM: Well nourished, tall young man - appears stated age in good physical shape. Normal weight. BP 140/100. P 84. Exam - unremarkable except ++ spasm of neck and shoulder muscles with decreased neck range of motion in all directions. Painful for him to open his jaw - no clicking with jaw open/closure. Teeth, throat, palate all unremarkable.

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CASE DISCUSSION – QUESTIONS

1. In 2 or 3 sentences, describe John.

2. Should you order additional imaging tests?

3. Although John feels chronic pain is his big problem, name 2 other symptoms described above that are clues to the root of his distress?

4. What is your guess? When did the root of John's distress start - at the time of the car accident or before? What simple question could you ask to get to the root?

5. Using the LIFECOURSE chart, what is our guess about the path that led John to current illness?

Prenatal	Birth	Infant 0-3	Childhood Age 4-12	Puberty Age 13-19	Young Adult Age 20-40	Middle Age 40-65

6. What is John's Diagnosis List after your Visit #1?

7. What is your treatment plan?

Typical Trainee Responses:

DIAGNOSES:

1. Chronic musculoskeletal pain
2. History neck flexion/extension injury (whiplash) 3 years ago
3. Persistent neck stiffness
4. Borderline Hypertension
5. Normal diagnostic tests
6. Narcotic seeking behavior

TREATMENT PLAN

1. Explain to patient the potential harms of narcotic dependence
2. Ask patient to agree to written contract to taper narcotics
3. Prescribe gabapentin or other central-acting pain medication
4. Physical Therapy
5. No additional diagnostic tests
6. Return one month; recheck Blood Pressure

Preceptor Answers to Questions – Visit #1

1. *Describe the patient*: John is a 38 y/o man in generally good health with severe, unexplained chronic pain – unrelieved by narcotics. John has had multiple extensive evaluations with no identified pathology.

2. *Order additional imaging?* No

3. *2 symptoms that may be clues to cause of chronic pain*: Sleep disorder, emotional distress

4. *When did chronic pain probably start?* Very likely that pain syndrome started <u>before</u> car accident.
   Simple Question to probe root of illness: "How was growing up for you? Mostly OK or pretty difficult?"

5. *Using LIFE COURSE chart*, John likely had significant childhood adversity with difficulty sleeping, loss of interoception (ability to sense and respond to internal body sensations), emotional hyperarousal with difficulty navigating the challenges of life (job, marriage, parenthood).

6. *Diagnoses*: see Part 2

7. *Treatment Plan*: acknowledge pain, start with discussion and improvement of sleep, gradually explore childhood and emotional distress.

VISIT #2 with JOHN

After briefly discussing John's current pain status (actually worse off narcotics despite gabapentin), the clinician asks John "How was growing up for you?"

John replies that growing up was extremely stressful. He remembers his father drank a lot and had a bad temper. He witnessed his father repeatedly threaten his mother and sometimes actually hit her. As the oldest son, John was often beaten by his father who would come upstairs at night and pull John out of bed for a beating. Therefore, John has always been afraid to fall asleep at night. Even though he hasn't lived with his parents since age 17, he still has trouble sleeping. He often has nightmares. John estimates he sleeps 3-4 hours per night, never more than 2 hours in a row.

John states his father often made fun of all 3 children, calling them stupid. John's father was often out of a job – and not having money for food and clothes created more stress – and bullying from classmates. Growing up, John swore that he would never be like his father. However now he finds himself often short-tempered with his wife who he thinks might leave him. John feels miserable and afraid.

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8. **With this additional history**, revise John's Diagnosis List:

PRECEPTOR'S LIST:

1. Developmental Trauma (survivor of parental emotional, verbal and physical abuse, witness to domestic violence, familial alcoholism, poverty, food insecurity, bullying)
2. Severe, lifelong sleep disorder– inadequate hours of sleep, disrupted sleep, nightmares
3. Emotional distress – lifelong fear
4. Difficulty regulating his emotions and behavior at home and at work (anger, depression)
5. Social stress at home and at work
6. Chronic pain syndrome with longstanding muscle spasms; probable loss of interoception
7. Inadequate pain relief despite longterm narcotics

9. Revise John's Treatment Plan:

PRECEPTOR'S PLAN:

1. A Clinician Team approach is needed – ideally a team of 3 plus patient:
   - Primary Care (or specialist) Clinician who leads the case,
   - Trauma-Focused Mental Health provider [also consider trauma-focused family therapy],
   - an Occupational Therapist that can help patient regain interoception.
     [Other choices – body worker, physical therapist, art therapist]
2. All Clinicians should express to John that they believe he has real pain – and that with a broader approach, his pain can improve and resolve.
3. All the Clinicians must commit to a Patient-Led, Patient-Paced Approach – building on the principles of trust, attachment, and attunement: let John decide how much and when he reveals more of his trauma history – and let John decide which therapies to use and when. Communication among the Team about progress and setbacks.
4. Psychoeducation for John and his wife: sharing that his childhood experience and severe lifelong sleep disorder may be at the root of his chronic pain.
5. Every visit should include discussion of sleep. Consider sleep study. Discuss ways to improve sleep (regular sleep routine, sleep in the dark, deep breathing, etc.)
6. Later recommend other services: bodywork: massage, stretching, yoga, low impact sports, physical therapy; mindfulness training; art therapy or other expressive modalities.
7. Suggest that as John starts to feel better, Clinicianr and John can jointly plan to taper him off of pain medication.

Preceptor Reminders

- Remember that even a classroom CASE can cause Secondary Trauma or trigger memories of a trainee's own history.

- Create space for effective conversation with trainee about the potential emotional impact of case content on themselves and recommend Self Care. Offer further conversation as needed and referral if warranted.

- Remember to engage in your own Reflective Practice with a colleague or mentor, and practice your own Self Care.

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