

## Opinion and Debate

### **Post traumatic stress disorder: Is it under or over recognized in clinical practice?**

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According to observations, in the western world, Posttraumatic Stress Disorder (PTSD) is being liberally diagnosed as either Axis I diagnosis or an adjunct morbidity. Many a times, the magnitude of an event, faced by a particular patient, is much more trivial and not falling into the category as per the manual for psychiatric diagnoses.

"The kinds of events that can trigger PTSD were traditionally limited to the most violent and frightening situations, such as being involved in a plane crash, a shooting incident, or the collapse of a building after an earthquake or bomb. The main source of such trauma is war, and in North America the largest category of PTSD sufferers are Vietnam War veterans. Much of what we know about this syndrome comes from studies involving former soldiers.

More recently, the definition has broadened. People who suffer rape or physical or sexual abuse may react in much

the same way as those who have witnessed carnage or been threatened by violent death. In this context, PTSD among children has become a major focus because they are particularly likely to develop the symptoms associated with this condition."<sup>1</sup>

For clarity of diagnostic criteria, the DSM IV description is being reproduced:<sup>2</sup>

Re-experiencing phenomena (at least one is required): recurrent and intrusive distressing recollections, recurrent distressing dreams, acting or feeling as if the events are recurring and intense psychological distress to cues. Avoidance and numbing (at least three required): avoidance of thoughts, feelings, and conversations, avoidance of reminders, psychogenic amnesia, greatly reduced interest in related activities, detachment or estrangement feelings, restricted range of affect, sense of a foreshortened future.

Increased arousal (at least two required): difficulty sleeping, irritability or outbursts of anger, difficulty concentrating, exaggerated startle response.

The PTSD describes the symptoms that result when a person experiences a short lived trauma but for long term traumatic experiences, the diagnosis of Complex PTSD has been suggested by Dr. Judith Herman of Harvard University.<sup>3</sup> The symptoms may not fall fully in the category of either PTSD in general or Complex PTSD in particular and may not qualify for a full diagnosis, such symptoms may well be labeled as Subthreshold PTSD. This type of disorder was found to be associated with greater impairment, co morbidity and suicidal ideation. Disability and impairment found in previous studies of subthreshold PTSD symptoms may be related in part to the presence of co morbid disorders.<sup>4</sup> Having said this, a number of patients that do present themselves in psychiatric clinics may not be suffering from pure PTSD; it could be rather depression with anxiety features, phobic disorders or any other neurotic condition. It may however be the presentation of sub threshold or complex PTSD. It is also known that not everyone who lives through a dangerous event gets PTSD as a number of resilience factors may reduce this risk. Some of these factors are: seeking support from other people such as friends and family, finding a support group, feeling good about one's own actions in the face of danger, or having a coping strategy.<sup>5</sup> Ironically, the trend for diagnosing PTSD is common in the western world. One wonders what could be the magnitude of PTSD in countries that are terror-stricken. Pakistan has been in the grip of terrorism and violence for so many years and hence the magnitude of PTSD must be higher. Experts have started talking about the magnitude of this problem, though without strong empirical evidences. Studies mainly mention selected episodes of natural disaster while we wait for large scale studies as a result of suicide attacks and bomb blasts. In a local study<sup>6</sup> conducted on earthquake survivors in NWFP reveals the prevalence of 37% when the responses of participants were evaluated on 17 PTSD items of scale. The same study also found 23% suffered from PTSD with co morbid depression. In another local study, it was found that frequency of PTSD was markedly increased in people who had suffered from physical injuries as compared to those who did not.<sup>7</sup> A study<sup>8</sup> on 75 destitute women who survived the earthquake in NWFP, revealed that 81% of the women suffered from depression and over all 94% met the diagnosis of PTSD. It is not known whether PTSD or depression was a co morbid condition. Even the Foreign Service employees serving on dangerous posts in Pakistan, and at a high risk of being targeted by terrorists, experience symptoms of PTSD.<sup>9</sup> In view of limited studies, it is safe to assume that PTSD among the general population

must be of a high magnitude in the current circumstances. It is also important to recognize, that PTSD can go undiagnosed or can be misdiagnosed as refractory depression. Moreover, substance misuse and eating disorders often mask underlying PTSD and flashbacks may be erroneously labeled as psychotic symptoms.<sup>10</sup> Co morbidity patterns suggest that when PTSD is associated with other psychiatric illness, diagnosis is more difficult and overall severity of PTSD is considerably greater. Traumatic grief, somatization, acute stress disorder and dissociation, personality disorders, depressive disorders and other anxiety disorders all have significant associations with PTSD.<sup>11</sup> It appears that still PTSD is not fully understood and is being over diagnosed in the western world and under diagnosed in the developing countries particularly those under the constant threat of terrorism. In Pakistan, there is a need for a lot of work on this issue as so far we are looking into natural disasters more closely rather than the man-made disasters. Do we need to re-educate and re-train ourselves in order to understand the complexities of PTSD? Can we focus on the resiliency factors in order to prevent this disorder? Should we review our diagnostic and management strategies in clinical practice? Do we need to include psychodynamic psychotherapy along with other therapies in order to look deeply into the dynamics of risk as well as resiliency factors?

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