

PTSD and the practitioner

Darold Treffert, MD

Part of the art of medicine, like in Goldilocks and the Three Bears, is getting it “just right” when it comes to under-diagnosing or over-diagnosing conditions—providing false negatives or false positives—in day-to-day practice. This is especially important, but problematical, when a new diagnosis appears on the scene because, in my experience, such new conditions often either continue to be unrecognized by some practitioners, or are over-recognized by others. Post-traumatic Stress Disorder (PTSD) is one such relative newcomer to “official” diagnoses. PTSD first appeared officially coded as such in DSM-III in 1980, although it had been known by various names before that: “soldiers heart,” “shell shock,” “traumatic neurosis,” or “Gross Stress Reaction,” to name several.

Two papers in this issue of the *Wisconsin Medical Journal* deal with the under-recognition problem. Weis and Grunert point out that early identification and timely referrals of persons who develop PTSD following traumatic injuries results in better outcomes overall—not just in terms of symptom relief and recovery, but also in terms of reduced medical and mental health

expenses, disability payments, lost wages, and other costs. The authors provide a brief, useful physician screening tool to help in such early recognition efforts, and a case example. They also provide a concise summary of contemporary treatment techniques for PTSD.

A paper by Clardie outlines similar early identification techniques with a different group of patients in whom sexually traumatic experiences have triggered a Post-traumatic Stress Disorder, a highly emotionally charged and sensitive topic for both patient and doctor. The author suggests some specific questions, and ways of asking those questions, that the primary care physician, or OB-GYN specialist, can use in day-to-day practice so as not to miss clues to a possible PTSD aftermath to traumatic sexual events in the lives of these patients, yet at the same time do so in a non-threatening, empathic manner. The point of such inquires is to effect early identification and referral of these persons for treatment to minimize traumatic aftermath.

But PTSD can also be over-diagnosed. While it is true that some victims of traumatic accidents, natural disasters, and sexual trauma develop PTSD, many do not, and that is a credit to the overall resiliency in most persons. Accidents, natural disasters and other traumatic events happen often. Victims respond to those traumatic events

in a variety of ways. Some seem unfazed and life continues almost uninterrupted and unchanged. Others, in fact most, slowly process the event, put it in perspective and gradually let its memory fade over time. For those persons time is kind and a pretty good therapist too. For some other persons, though, tincture of time and support from those around the person are not enough and healing proceeds more slowly. Anxiety, reliving the experience, avoidance, and arousal continue as intrusive symptoms longer than usual, along with insomnia, nightmares, tension, and depression. In my view such a more prolonged healing might more correctly be called Post Traumatic Adjustment Disorder, rather than Post Traumatic Stress Disorder, since it is the equivalent of more typical anxiety and depressive disorders, and responds to treatments typically effective in those conditions.

For those patients who do go on to develop Post Traumatic Stress Disorder, however, with a clinical picture as described in these two papers, specialized treatments can be very effective, and, as elsewhere in medicine, the earlier the treatment the better the outcome. Papers such as these help the clinician to be alert to the possibility of PTSD following an identified traumatic event or injury, and to consider PTSD as a possibility in the face of certain unexplained presenting symptoms

Doctor Treffert is a Clinical Professor on the faculty of the University of Wisconsin Medical School in Madison, Wisconsin and is a psychiatrist affiliated with St. Agnes Hospital, Fond du Lac, Wis.

even when the traumatic event is more buried and not so evident.

A supported diagnosis of PTSD requires a stressor or event, which includes experiencing or witnessing actual or threatened death or serious injury, or threat to the physical integrity of self or others and resulted in intense fear, helplessness, and horror. Then there must be a number of very specific re-experiencing, avoidance, and increased arousal symptoms. These are high threshold events or stressors, and specific symptom constellations. Clinicians in all specialties need to be aware of both.

Unfortunately the term Post Traumatic Stress Disorder has lost its specificity, particularly in the

courtroom setting, where the term is a favorite in personal injury suits because, unlike many other psychological and psychiatric conditions, it is so incident specific and leaves aside the psychiatric vagaries and legal minefields of pre-existing illness, comorbid disorders, and multi-factorial stressors. As a result, the stressors for PTSD in legal proceedings are often down-graded and trivialized from the fairly high threshold required to precipitate the condition, to now include being turned down for public housing, or being harshly reprimanded by a supervisor, for example. This trivializes PTSD as a disorder, and undermines the identification and treatment of those persons who

have been exposed to a high-threshold stressor and have a bona fide subsequent reaction to it.

The first step in treatment is to make a diagnosis. Papers such as these help at a time when we seek the proper balance between over-diagnosis and under-diagnosis of PTSD. It is said "the beginning of wisdom is to call things by their right name." And that's what proper diagnosis is: calling things by their right name. There is a spectrum of individualized responses to trauma and distress. Not all end in formal PTSD. Some do. The "art" of skillful practice is being able to recognize the difference.

Editor's Note: Dr Treffert is a member of the Wisconsin Medical Journal's Editorial Board.



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