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DIAGNOSTIC CHALLENGES IN ASSESSING POST-TRAUMATIC STRESS DISORDER

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SUMMARY

Post-traumatic stress disorder (PTSD) is one of those psychiatric disorders that are still away from our attention, understanding, assessment and proper management. What could be the reason as by its name and diagnostic criteria an etiological fact is specified, namely a specific traumatic event.

In our paper we aim to share and elicit some difficulties that we have met in consulting, diagnostic and management of people, who have suffered a traumatic event.

On the base of a review of current psychiatric classifications and ongoing discussions we briefly summarize and discuss important key points.

The definition of the event, associated with PTSD is different in DSM-III (introduced for the fist time in a classification of mental disorders), DSM-IV and ICD-10. DSM-IV is less restrictive and includes events that occur more frequently. In DSM-5, PTSD is placed in chapter "Trauma and Stressor-related disorders" and the accent is on the variable clinical characteristics of psychological distress. Emotional reactions to the traumatic event are no longer part of Criterion A. The clinical presentation varies and a number of intrusive psychological and physiological reactions of distress are described. Here comes a problem- the assessment of the trauma itself and the determination of the basic symptoms, when such an event happens. So, the skills to assess the trauma, to determine and competently attribute these symptoms to the specific event and cluster are of great importance.

We conclude that a number of risk and prognostic factors should be considered in the process of assessment, diagnosis and management.

Key words: post-traumatic stress disorder, classification, ICD, DSM

Post-traumatic stress disorder (PTSD) is one of those psychiatric disorders that are still away from our attention, understanding, assessment and proper management. According to the national representative epidemiological study (EPIBUL) on the common psychiatric disorders in Bulgaria, conducted during the period 2003-2007, the lifetime prevalence of PTSD is 1.9%, twelve-month- 1,1% [1].

In our study we aim to share and elicit some difficulties that we have met in consulting, diagnostic and management of people, who have suffered a traumatic event.

On the base of a review of current psychiatric classifications and ongoing discussions we briefly summarize and discuss important key points.

From a historical point of view descriptions of traumatic syndromes resembling PTSD have been described early 20th century. The need for such a diagnostic category was extremely felt among the Vietnam veterans. The initiative to recognize distinct stress-related syndromes and their inclusion in the third edition of Diagnostic and Statistical Manual of Mental Disorders [2] came from the Vietnam Veterans Working Group (VVWG) and was supported by some professional and humanitarian organizations [3]. Post-traumatic stress disorder was grouped under anxiety disorders. One of the most distinctive symptoms of PTSD included frequent intrusive recollections of the traumatic event and dissociative flashbacks [4].

Further development of psychiatric classifications helped professionals to be more precise in assessing PTSD. The DSM-IV refined some diagnostic criteria concerning definition of a traumatic event and included instances of witnessing trauma to others Diagnostic criteria for PTSD included a history of exposure to a traumatic event and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerned duration of symptoms and, a sixth criterion insisted significant distress or functional impairment [5]. The definition of traumatic event in ICD-10 is narrower and more conservative [6].

Some features of PTSD, as re-experiencing, arousal, avoidance, are seen in anxiety disorders [7]. Frequent intrusive recollections of stressful and unpleasant events, many of them traumatic, are found in different psychopathological states [8].

The DSM-5 has made a number of important evidence-based revisions to PTSD diagnostic criteria, with both important conceptual and clinical implications [9]. Proposed revisions are expected in ICD-11. There is much discussion with regard to diagnostic criteria for posttraumatic stress disorder (PTSD), subthreshold PTSD, a dissociative subtype described in the DSM-5, complex PTSD, included in the ICD-11, bereavement-related disorders and adjustment disorders.

In DSM-5, PTSD is no longer classified as an anxiety disorder, but falls under a new chapter, "Trauma- and Stressor-Related Disorders". Thus, the accent is on common etiology i.e. exposure to a traumatic event (actual or threatened death, serious injury, or sexual violence), and several scenarios (A1-A4) are defined [9]. ICD-11 has removed PTSD out of the anxiety disorders group, too.

As Friedman (2014) comments clinical experience with the PTSD diagnosis has shown that different people appear to have different trauma thresholds, but events such as sexual abuse, torture, genocide, being kidnapped, being taken hostage, terrorist attack are experienced as traumatic events by most people [10]. Criterion A is rather sharpen. Emotional reactions to the traumatic event are no longer part of Criterion A, since the personnel of some services are trained in disaster situations and is not expected to experience an immediate emotional reaction after the traumatic event [11]. ICD-11 definition of a traumatic stressor is much more general.

Four clusters of characteristic symptoms that could develop after experiencing one or more traumatic events are defined in DSM-5.

Former clusters *re-experiencing* and *arousal* are defined as *intrusion symptoms* (criterion B), respectively *alterations in arousal and reactivity* (criterion E). *Avoidance and numbing* have been split into two clusters*, avoidance* (Criterion C) and *negative alterations in cognitions and mood* (Criterion D). All clusters give descriptions of symptoms included. Two new symptoms were added to Criterion D–*persistent and exaggerated negative beliefs and expectations* about oneself, others, or the world; *persistent and distorted blame of self or others* for causing the traumatic event or for resulting consequences. Reckless and self-destructive behaviour are also newly included in DSM-5 (Criterion E2).

Two subtypes of PTSD have been added, the preschool subtype (PTSD in children 6 years and younger) and the dissociative subtype (PTSD with prominent dissociative symptoms- depersonalization and derealization).

Maercker and Perkonigg (2013) support the simpler diagnostic algorithm of ICD-11, which would to their opinion, provide greater clinical utility [12].

It is a matter of time to see whether the changes improve the diagnostic accuracy. To our opinion there are several key points, discussed in DSM-5 and profoundly argued by some authors, which we've found to be useful in everyday clinical practice [4, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20].

The assessment of the trauma itself. Definition of trauma for PTSD in DSM-5 is more explicit and no longer requires reaction of intense fear, helplessness, or horror. Criterion A requires exposure to actual or threatened death, serious injury or sexual violence in different ways. A symptom pattern of PTSD in response to a stressor that does not meet PTSD Criterion A should exclude PTSD but might be classified as Adjustment disorder. A life-threatening illness or medical condition, leading to incapacity is not necessarily considered a traumatic agent except in cases of sudden catastrophic events. Non-violent death or injury to a loved one is excluded in DSM-5.

Competence to attribute the symptoms to the relevant cluster. The clinical presentations could be various and some symptoms concerning the four symptom clusters may predominate or combinations of the symptom patterns could be experienced by some individuals.

Competence to assess the symptoms- i.e. to differentiate some intrusive symptoms from depressive ruminations (Citerion B1). The emphasis is on the content and the relationship of the distressing dreams or of intrusive memories with the major threats of a certain traumatic event. The reliving in the present distinguishes intrusive memories in PTSD from those in other disorders [21].

Determination of dissociative reactions (flashbacks) (Criterion B3). Such states could be of different duration during which components of the event are relived without loss of reality orientations and can be associated with prolonged distress and heightened arousal. On the other hand, the "loss of awareness" of present surroundings is supposed. Flashbacks in PTSD should be distinguished from perceptual disturbances that occur in psychotic disorders. Furthermore, due to considerable comorbidity between PTSD and other mental disorders some overlapping symptoms may impede diagnosis.

Trauma-related stimuli could evoke images and physiological reactions associated with the trauma.

PTSD patients also use behavioral strategies like avoidance of any thoughts, places, objects, activities or situations which are likely to trigger distressing traumatic memories or even avoiding to leave the house (Criterion C), a state that needs to be differentiated from agoraphobia. At least one avoidance symptom should be present.

Cluster "D" symptoms *negative alterations in cognitions and mood* reflect persistent alterations in beliefs or mood that have developed after exposure to the traumatic event. People with PTSD often have distorted cognitions about the causes or consequences of the traumatic event which leads them to blame themselves or others. This is due to inability to remember an important aspect of the traumatic event (dissociative amnesia) but not to head injury or psychoactive substances. People with PTSD have a wide variety of negative emotional states such as fear, horror, anger, guilt, or shame, but are unable to experience positive feelings such as love, pleasure, satisfaction, happiness. Other symptoms of this cluster include diminished interest in significant activities and feeling detached from others.

Other important differentiations are between *alterations in arousal and reactivity* (Criterion E) from those seen in panic and generalized anxiety disorders. Hypervigilance and startle are more characteristic of PTSD, while insomnia and cognitive impairment are symptoms from the anxiety spectrum. Hypervigilance is characterized by a heightened sensitivity to potential threats, including those that a

related to the traumatic experience. Exaggerated startle response is expressed through a strong reaction to loud noises or unexpected movements. Irritable and angry outbursts with little or no provocation and reckless and self-destructive behavior such as impulsive acts, excessive alcohol or drug use, reckless driving and suicidal behavior should be considered.

Criteria F, G and H specify duration of the disturbance, functional impact and exclusion issues.

Levin et al. (2014) profoundly discuss the potential impact of the new and broader criteria on the prevalence of PTSD in clinical studies and the impact on forensic psychiatric assessment and eligibility for disability. They conclude that increase of claims in civil and employment cases is anticipated [22].

Despite the number of critical issues the full DSM-5 manual has a good deal of information in addition to the basic diagnostic criteria. We find the DSM-5 text discussion useful for some notable additions concerning sub-threshold PTSD and Risk and Prognostic Factors (temperament, environment, genetic and physiological course modifiers).

Risk factors are those variables that contribute to a person developing a particular psychiatric disorder. These variables in PTSD can be related to person's childhood emotional problems, to person's environment such as lower socioeconomic status, lower education, cultural characteristics, female gender, younger age, etc. One of the greatest predictors of emotional distress following a traumatic event is having suffered a traumatic event sometime in the past. One of the biggest protective factors is social support (family, friends, specialized services, etc).

Getting effective treatment after PTSD symptoms develop can be critical to reduce symptoms and improve function.

Further research based on the DSM-5 and clinical experience data should prove whether the changes lead to improvement in diagnostic accuracy.

REFERENCES:

1. Okoliyski M, Zarkov Z, Broshtilov A, Hinkov H, Nakov, V, Dinolova R, et al. National Representative Epidemiological Study of Common Psychiatric Disorders in Bulgaria (2003-2007): Twelve-month and lifetime prevalence, severity and co-morbidity. *Bulgarian Journal of Public Health,* 2010 Apr-Jun;2(2):2-13. [in Bulgarian]

2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, (3rd ed.). Washington, DC, 1980.

3. Shalev A. Post-traumatic stress disorder: diagnosis, history and life course. In: Nutt D, Davidson J, Zohar J eds, Post-traumatic stress disorder: diagnosis, management ant treatment (Martin Dunitz Ltd, 2000): 1-15.

4. Brewin CR. Re-experiencing traumatic events in PTSD: new avenues in research on intrusive memories and flashbacks. *Eur J Psychotraumatol*. 2015 May 19;6:27180. [PubMed] [CrossRef]

5. American Psychiatric Association. Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC, 2000.

6. World Health Organization. The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines. Geneva: World Health Organization, 1992.

7. Bryant RA, O'Donnell M, Creamer M, McFarlane AC, Silove D. Posttraumatic intrusive symptoms across psychiatric disorders. *J Psychiatr Res*. 2011 Jun;45(6):842-847. [PubMed] [CrossRef]

8. Brewin CR, Gregory JD, Lipton M, Burgess N. Intrusive images in psychological disorders: Characteristics, neural mechanisms, and treatment implications. *Psychol Rev.* 2010 Jan; 117(1):210-232. [PubMed] [CrossRef]

9. American Psychiatric Association. Diagnostic and statistical manual of mental disorders, (5th ed.). Washington, DC, 2013.

10. Friedman MJ. PTSD History and Overview. *National Center for PTSD* (25. 03. 2014) [Internet]

11. Friedman MJ, Resick PA, Bryant RA, Brewin CR. Considering PTSD for DSM-5. *Depress Anxiety.* 2011 Sep; 28(9):750-769. [PubMed] [CrossRef]

12. Maercker A, Perkonigg A. Applying an international perspective in defining PTSD and related disorders: Comment on Friedman (2013). *J Trauma Stress*. 2013 Oct;26(5):560-562. [PubMed] [CrossRef]

13. Herman JL. Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *J Trauma Stress.* 1992 Jul;5(3):377-391. [CrossRef]

14. Prigerson HG, Horowitz MJ, Jacobs SC, Parkes CM, Aslan M, Goodkin K, et al. Prolonged grief disorder: Psychometric validation of criteria proposed for *DSM-V* and *ICD-11. PLoS Medicine.* 2009 Aug; 6(8):e1000121. [PubMed] [CrossRef]

15. Shear MK, Simon NM, Wall MM, Zisook S, Neimeyer RA, Duan N, et al. Complicated grief and related bereavement issues for DSM-5. *Depress Anxiety.* 2011 Feb;28(2):103-117. [PubMed] [CrossRef]

16. Strain JJ, Friedman MJ. Considering adjustment disorders as stress response syndromes for DSM-5. *Depress Anxiety.*2011 Sep;28(9):818-823. [PubMed] [CrossRef]

17. Lanius RA, Brand BL, Vermetten, Frewen PA, Spiegel D. The dissociative subtype of posttraumatic stress disorder: Rationale, clinical and neurobiological evidence, and implications. *Depress Anxiety.* 2012 Aug; 29(8):701-708. [PubMed] [CrossRef]

18. Friedman MJ. Finalizing PTSD in DSM-5: Getting here from there and where to go next. *J Trauma Stress*. 2013 Oct;26(5):548-556. [PubMed] [CrossRef]

19. Brewin CR. "I wouldn't start from here"-An alternative perspective on PTSD from *ICD-11:* Comment on Friedman (2013). *J Trauma Stress*. 2013 Oct;26(5):557-559. doi: [PubMed] [CrossRef]

20. Kilpatrick D. The *DSM-5* Got PTSD Right: Comment on Friedman

(2013). *J Trauma Stress*. 2013 Oct; 26(5):563-566. [PubMed] [CrossRef]

21. Brewin CR. Episodic memory, perceptual memory, and their interaction: Foundations for a theory of posttraumatic stress disorder. *Psychol Bull*. 2014 Jan;140(1):69–97. [PubMed] [CrossRef]

22. Levin AP, Kleinman SB, Adler JS. *DSM-5* and Posttraumatic Stress Disorder. *J Am Acad Psychiatry Law*. 2014; 42(2):146–158. [PubMed]

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