

3 | Diagnostic dilemmas in assessing post traumatic stress disorder

Berthold PR Gersons and Miranda Olf

INTRODUCTION

The introduction of the Third Diagnostic and Statistical Manual (*DSM-III* (1)), International Classification of Diseases of the World Health Organization version 10 (*ICD-10*) (2) and Fourth Diagnostic and Statistical Manual (*DSM-IV* (3)) has helped psychiatrists to become more precise in assessing psychiatric disorders. In *DSM-III* the posttraumatic stress disorder (PTSD) has been introduced for the first time in psychiatry as a coherent profile of signs and symptoms related to the experience of a traumatic incident. Large epidemiological studies have contributed to the validity of this disorder.(4, 5, 6) In the assessment of PTSD two flaws however can interfere with the correct establishing of the diagnosis of PTSD. The first flaw is people do not tell easily about their traumatic experiences and doctors do not like to hear the terrible details. The accuracy of the information generated during the psychiatric interview concerning trauma depends on the level of skills used to establish a trustful relationship with the patient and a willingness to listen to horrifying details. Also, the patient is often unaware of any relationship between the symptoms of PTSD and the experience of the trauma. As we know in psychiatry the accuracy of the information that we get during the interview depends strongly on our willingness to listen. A nonjudgmental attitude in the interview is a necessary prerequisite. The second flaw in assessing PTSD is the overwhelming affect that accompanies the report of someone who experienced trauma. For the listener, therefore, it sometimes seems self-evident traumatic experiences must result in some kind of disorder, especially PTSD. Asking about symptoms after listening to the details of a traumatic incident can look like an unneeded burden. Here the epidemiology of PTSD (4, 5) helps us enormously to understand the limited relationship between the experience of trauma and the development of PTSD. While between 50% and 90% of the general population experience trauma at least once during lifetime, the lifetime prevalence of PTSD lies between seven and eight (6,7), which still means a huge burden on society. Men and women differ in terms of risk to develop PTSD after trauma; for men it is between 8% and 13%, and for women, between 20% and 30%.(6, 7) Differences in appraisal and coping mechanisms as well as psychobiological response patterns have been related to these differences.(8)

The initial response to a trauma can be characterized as a “normal reaction” toward an “abnormal” event that relates to sleep, nightmares, concentration, emotionality, and flashbacks. “Watchful waiting” is recommended when symptoms are mild and have been present for less than four weeks after the trauma. Early psychological intervention, often called debriefing, has no effect in preventing PTSD (9)—despite the high satisfaction. Instead, public information on psychological reactions and crisis intervention combined with practical support is useful for people to regain control over their situation.

Treatment is needed when severe early posttraumatic symptoms arise or when the disorder of PTSD is diagnosed. It should be noted that other disorders like depression, anxiety, or addictive disorders may also occur and are also often comorbid to PTSD. Before starting treatment, it is essential first to assess the diagnosis of PTSD. It is equally necessary to evaluate the effectiveness of the intervention after the treatment as well; here comes a dilemma: For patients it is often already very satisfactory to have experienced the intense emotions related to the trauma in the trusted setting with the therapist. The patient rarely judges the result of the treatment by evaluating the disappearance of symptoms. Whereas, for the therapist, sometimes the cathartic expression of emotions by the patient is often taken as proof of a well-established working through the traumatic experience. Also therapists do not always evaluate the treatment in a more objective fashion. Studies of debriefing after traumatic experiences, for instance, have shown a high satisfaction by the debriefed patients and by the therapist

themselves (10, 11, 12, 13), and those who were debriefed showed higher symptom profiles in the follow up compared to the nondebriefed. (14, 15) Therefore, the precise assessment of symptoms is important for the assessment of PTSD. It also helps the patient to understand that he or she is not only suffering from traumatic experiences but also from symptoms resulting from the experience.

The assessment skill sets for PTSD consist of the skills to assess trauma in all its gruesome details and to assess symptoms resulting from the traumatic incident(s). In this chapter, we will first pay attention to the assessment of trauma and its pre- and post-treatment dilemmas. Then we will continue with the symptoms of PTSD. There are specific structured interviews and self-report instruments developed for the assessment of PTSD. The chapter will only highlight these instruments but not discuss them in detail. There are also other techniques to help to establish the diagnosis of PTSD with psychophysiologic measures and neuroimaging and neurohormonal measures. These techniques will not be discussed here, however. Then we will discuss the issue of the trauma-spectrum disorders and comorbidity in PTSD.

DILEMMAS IN THE ASSESSMENT OF TRAUMA

In *DSM-IV*¹ diagnostic criteria for PTSD trauma is described as follows:

The person has been exposed to a traumatic event in which both of the following were present:

- (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- (2) The person's response involved intense fear, helplessness, or horror.

What follows from the definition is the distinction between the actual traumatic event and the person's reaction.

Traumatic event

The definition does not describe exactly what a traumatic event means. There are characteristics concerning the actual role of the person involved in the event:

- The person must be exposed to an event.
- The event can be an experience of the person him or herself.
- The event can be an experience of others in which the person is a witness.

The conditions that result from the definition, for instance, give the following examples. A person who has been a victim of an automobile accident and who lost consciousness for the incident itself did not consciously experience the traumatic incident. However, for instance, when the same person later on learns that her husband died in the incident and, as was the case in our hospital, also experienced her leg was broken has to cope with two traumatic events following the incident. This is important to understand because the reexperienced symptoms of the event can only evolve when someone consciously went through the incident. Another example was a police officer who could not work because of illness at a specific day, and another officer who worked in her place for that day was killed in the police car. She developed quite similar symptoms to PTSD and she tried to reconstruct the event. She felt guilty because she thought she should have been the one to be killed and not her fellow police officer. This assessment of the actual involvement in the incident is important in treatment when this implies imaginal exposure. It is another question if such exposure can be helpful in such situations, but the nature of reexperiencing is essentially different. For the assessment, it is important to analyze very precisely the actual involvement in the traumatic situation with the patient.

¹ Because *DSM-IV* favors a more precise description of symptoms compared to *ICD-10* we will quote from the *DSM-IV* definition of PTSD.

In the *DSM-IV* definition of trauma the examples mentioned are as follows:

- Actual death
- Threatened death
- Serious injury
- Threat to the physical integrity to self
- Threat to the physical integrity of others.

These events can become traumatic for the person who experienced, witnessed, or was confronted with the event. From our police studies (16, 17) we, therefore, made the distinction between *threatening* and *depressive* experiences. The threatening ones are those incidents in which the patient him or herself is the victim. The depressive experiences are those events in which the patient witnesses the traumatic incident. This distinction is important because it makes the traumatic experience very different. In a threatening experience, one's fight-flight stress responses are activated to reach safety. This is important, for instance, for survivors of fires, robberies, and rapes. But in the same instances, those who were not directly threatened but only witness the incident become overwhelmed by the helplessness to see others hurt, die, or suffer any other trauma. Here also the fight-flight responses can become activated but more to flee from the horrible experience and from the intense feeling of helplessness. An 18-year-old girl witnessed a robbery in daylight. Her office manager asked her to accompany her to put a cassette with the money of the day into the deposit box of the bank. The box was located outside the bank. When they approached the bank one of the two boys put a gun on the head of the office manager. She gave the cassette to the boy and the boys disappeared in the crowd. The girl was not threatened at all by the boys who actually did not take notice of her. But she witnessed the threat and later on started to get reexperiences of this scene. She was not used at all to such events. Ursano (18), for instance, wrote about the risk factor for emergency workers, for example, they seem to be more at risk to develop PTSD when the corpses resembled their family or children. The confrontation with death and destruction is in itself a frequent experience for rescue workers but when they associate the victims with their close ones the traumatic experience can result in PTSD. Here we are reminded of an aspect of the definition of the stressor criterion mentioned in the *DSM-III-R* description of PTSD: "... an event outside the range of usual human experience and that would be markedly distressing to almost anyone. ..." This criterion has been abandoned in *DSM-IV* because the stressors as we know from epidemiology are much more common human experiences, which is in contrast to what was thought before. However, it still is important because even one usual experience can make the difference.

By focusing on the definition of (threatening) death or injury, too much attention is sometimes only paid to the result of some act. In fact in the reexperiencing we know that not only the result of the act comes back in memory, for example, a dead body, but also the details of the actual happenings themselves. A man survived an air crash. The plane crashed on the landing lane because of storm. This was accompanied by an enormous noise. The plane turned around. Then the walls of the cabin started to crumble. One of the stewardesses fell over him. So the air crash in itself is of course a traumatic event. But the traumatic experiences, which can come back as symptoms in PTSD, are these specific aspects of the threatening happening. In this case, for instance, the trembling of the plane, the noise of the crash, the falling down of the stewardess, and the view of a crumbling cabin became the traumatic details. Also violent behavior of someone else can become the reminder of the incident. Here also specific moments are often reexperienced. This is also meant by the adjunctive serious to injury. Here the threat is the most important aspect of the event. A significant aspect of an incident is often that it is unexpected. A person driving came along an accident. He saw a tractor with a white stick behind it. A moment later he found out it was someone's leg with its flesh stripped of. Also, the adjective *serious*, in medical parlance, denotes the critical condition of the victim. To make a critical inquiry into a traumatic experience and to make an effective assessment, it is mostly the unexpected, unwelcome details that are essential. For instance, someone tried reanimation to keep an old man alive. However, under the pressure of the act, the rescuer had broken the ribs of the person he was trying to save. In the reexperiencing, he relives the noise of the moment the ribs broke, and the person's reaction—intense fear, helplessness, and horror.

In contrast to *DSM-III* not only the experience of a traumatic event is necessary for the diagnosis but also the response of intense fear, helplessness, and horror. For instance, threat to one's physical integrity will specifically result in these intense reactions, for example, in rape,

sexual abuse in childhood, and torture of any kind. Rape is always accompanied by threat and some kind of violence. Here also the reminders give a clue to the traumatic aspects of the experience, like the use of a knife or the threat, "I will kill you when you tell someone else." Here fear also plays an important role in the aftermath of the event. Though not mentioned for all traumatic events, shame is one factor that is usually very strongly felt in the three types of events. Here the assessment skills are important. Questioning about trauma not only involves facts but also extreme emotions associated with the incident. The traumatized person tries often to suppress the intense emotional reminders. The victim also protects the interviewer from being confronted with the repulsive details and the extreme emotions. For instance, a woman who has been raped by a group of youngsters had lots of difficulties telling all the terrible details of the experience. There had been moments that one of the boys had put the gun into her vagina and at other moments to her head. It is extremely difficult to not only tell these horrid details but also listen to them. These elements are most important in treatment. However, for the patient, it is important that the therapist listens without hesitation to these details. So one has to ask questions, for example, as given below:

- Did you feel fear?
- What were the most fearful experiences?
- Did you feel helpless?
- At which moments you felt most helpless?
- Did you feel horror?
- At which moments you felt most horror?
- Do you feel ashamed to tell these things?

Abuse in childhood is also often connected with violence and neglect. Here also shame and helplessness play an important role in the traumatization of the person. A critical factor in the assessment of sexual traumas is the trust to be established between the patient and the therapist. This is of course not self-evident. Judith Herman (19) calls our attention for a "stabilization phase" in which the patient can test the therapist about the safety of the treatment situation. It is good to realize the assessment phase can be complicated by the need for safety. The traumatized person not only suffers from the event that resulted in his or her trauma but also from the disappearance of trust he or she had in other human beings before the event. This is also the case with torture victims, whereas the safety of the consulting room for other trauma victims can resemble too much the torture room, disconnected from the outside world, sitting in the consulting room. Basoglu et al. (20) has paid attention to the development of psychological preparedness for torture. This office of the therapist can repeat this experience as well.

Horror is also an emotion that is often difficult to share. An example of such horror is the following example: In 1992, in Amsterdam, a plane crashed on a neighborhood.(21) This caused a fire as high as the apartment buildings that were struck by the plane. Eyewitnesses not only experienced this unbelievable scene but also heard the shouting and crying of burning people, some of them jumping off the balconies; thus, these details are horrible and difficult to tell. Such extreme emotions are characteristic of traumatic experiences. Fear is often presented this way, "I felt the adrenaline flow through my body." One remembers fear as a somatic experience of increased heartbeat, the trembling of the legs, being rooted to the ground, being unable to speak, cold hands, and so on.

For the therapist, there are risks connected to the listening about the events, especially when confronted with having to observe the extreme emotions of the patient in session. This is called secondary traumatization or vicarious traumatization.(22) It is well known in psychiatry, and it is also essential for a good interview that an empathic, understanding relationship with the patient is developed. The patient tells his or her story and details of symptoms only when he or she can trust the therapist. The right attitude, therefore, is one of willingness to listen and of acceptance. Such attitudes stimulate the patient to continue to tell; however, with trauma histories, this is much more complicated. The patient might worry that the interviewer will not take his or her story and the complaints serious or be afraid that the disclosure of gruesome details of the traumatic incident could scare the therapist him or herself. For instance, after listening to the story of burning people jumping from the balconies, even the therapist might be prone to dreaming about it. Treatment of a survivor of a plane crash can make the

therapist fearful of flying. Secondary traumatizing refers to a sort of 'infectious' effect of listening to trauma stories. One feels saddened and helpless. Especially the listening to the details can cause the interviewer to develop nightmares of such incidents. So PTSD can endanger the mental health of the interviewer. It is, therefore, advised to limit the number of trauma patients one has to interview or to treat. Also regular intervention between trauma-therapists is highly recommended to limit their risk of secondary traumatization.

Another dilemma lies in the discussion on whether the emotional response (A2 criterion) to trauma should get more weight than the type of event (A1).(23)

While some have argued that this definition is too narrowly defined and should be broadened to even include experiences that are distressing, but not necessarily directly associated with physical threat or injury (23, 24), others have been critical, stating that this definition is too inclusive.(25) The "conceptual bracket creep" (25) refers to the broadening of the stressor criterion in *DSM-IV*, especially to the inclusion of "second-hand exposure," such as learning about the unexpected death of a close friend/relative or watching atrocities on television . This seems to increase the eligible events by about 20%.(26) However, what is more important in this case is the question addressed in *DSM-IV*, that is, "whether or not to include reactions to the numerous stressors that are upsetting, but not life threatening or even to eliminate the stressor criterion altogether." The fear that more inclusive definitions will vastly increase the frequency of the diagnosis seems to be unrealistic. More minor stressors simply will not result in the other diagnostic criteria for PTSD.

SYMPTOMS ASSESSMENT

A variety of common symptoms are already covered in the assessment of the traumatic event. The symptom profile of PTSD has been divided into three sections:

- 1 Reexperiencing symptoms
- 2 Avoidance symptoms
- 3 Hyperarousal symptoms.

In the interview, a person often realizes the reexperience symptoms are related to the traumatic event. So they are more easily reported. The other two groups of symptoms are less well known to the sufferer and, therefore, are connected to the experience of the event. In the context of *DSM-IV* guidelines, a clear problem the therapist is faced with while asking about the different symptoms is a lack of frequency and intensity of the symptom mentioned. In the structured interviews for PTSD this is mostly better defined.

Reexperience symptoms

These are as follows:

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

- 1 Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
- 2 Recurrent distressing dreams of the event;
- 3 Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated);
- 4 Intense psychological distress during exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event;
- 5 Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

In the reexperience symptoms there are some important characteristics:

- The person involved does not have control over the occurrence of the symptoms.
- The reexperience is a perceptual one that resemble actual experience.
- The perceptual quality of the remembrance is essentially different from telling a story.

When a symptom is regarded persistent it means that nearly every week it occurs, and it is quite typical that the symptoms reoccur. Mostly specific episodes of the traumatic scene come back again and again. At moments of rest, for example, before sleep, when someone is most relaxed, he or she can be taken by surprise in reliving and seeing the terrible happening. They also come back in dreams. For instance, the partner can tell the bedclothes were wet and disordered or the person was talking and behaving in his sleep. The confrontations of cues that symbolize or resemble an aspect of the traumatic event are characteristic. Someone who survived an air crash bends down every time when a plane crosses the sky. After a rape by a colored person every time a woman sees a colored person she feels frightened even when knowing there is no real danger. Every element of the traumatic incident, such as sound, color, scene, and so on, can act as the trigger of the conditioned fear response, which is accompanied by some kind of reminder or reliving. It is hypothesized that this impaired extinction of fear conditioning may lie at the core of the development of PTSD and other anxiety disorders.(27)

The physiological reactivity means that the confrontation with cues result in increased heartbeat, transpiration, feeling cold, trembling, and so on. In psychobiological research trauma scripts are often used to examine, for instance, the heart rate response or changes in brain activation in response to the patient's own trauma story.(28, 29)

Avoidance symptoms

These are as follows:

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following:

- 1 Efforts to avoid thoughts, feelings, or conversations associated with the trauma;
- 2 Efforts to avoid activities, places, or people that arouse recollections of the trauma;
- 3 Inability to recall an important aspect of the trauma;
- 4 Markedly diminished interest or participation in significant activities;
- 5 Feeling detachment or estrangement from others;
- 6 Restricted range of affect (e.g., unable to have love feelings)
- 7 Sense of a foreshortened future (e.g., does not expect to have career, marriage, children, or a normal life span).

Here two kinds of reactions are described: actual avoidance or numbing of general responsiveness. These symptoms strongly relate to the general fight-flight response to stress. The numbing seems related to a third kind of response, which is known from animals: acting as if one is dead. In the interview one has to rigorously pursue and probe for avoidance behavior. Often a patient is so used to the avoidance that it is not perceived as an active strategy. In fact much of the normal activities before the traumatic events are not taking place anymore. Certain neighborhoods will not be visited anymore. Those who suffered war and camps avoid the scenes of endless streams of refugees on television. So in assessing avoidance symptoms one has to understand that the traumatic cue brings back the perceptual remembrances of the trauma. Also, the intense pain, grief, and helplessness are felt again. It feels like "an open wound." The wound will never completely close. Also fear is intense again, and behind it often extreme feelings of aggression are hiding. The avoidance can also involve (like in C1) social withdrawal. Here the following question helps: "Do others perceive you as being changed after the incident?" The answer is often this: "Yes, I was always actively involved but now I do not like to go out." An example of how complicated this can be is the following. An officer who shot a person was complemented after returning to the police station. He was seen as a hero. However, he felt terrible because he did not want to kill anybody. He felt guilty notwithstanding the rightness of the act in the terrible situation. He realized his colleagues had no idea about how lousy he felt. They could not understand his withdrawal and in a certain way they did not like to see their hero withdrawn. For the assessment of the inability to recall an important aspect of the trauma one has to investigate very carefully the traumatic incident. The traumatized person is not always aware of this symptom. A woman survived a killing in daylight while sitting in good weather with friends outside a cafe. She could only remember seeing coming near a group of men and then she remembers being in the hospital crying. She was not hurt herself.

But the actual traumatic moment has been lost because of dissociation. Another well-known aspect of the remembrance of traumatic incidents is the fact the one involved feels very convinced of the details of the happening. For instance I treated three persons who survived the same crash; each presented a different version in terms of recounting the incident and presenting the details of the incident. But they felt threatened after being faced with the probability their memory was not totally accurate. In the face of danger one must rely on few cues, which activates the stress response. From the work of le Doux (30) we know our brains work to perceive these threatening cues after which our fight-flight behavior becomes activated. Certain details are not taken into consideration or are lost. This is also defined by what is called "tunnel vision." The perception is restricted to endangering elements.

The symptoms listed under C4, 5, 6, and 7 overlap strongly with symptoms of depression. The interest in initiating activities or participation in something can be lost. The world that seemed normal and safe before the incident is no longer perceived that way and seems far less important after the incident. Here we see that the appreciation of the world of what is important, can have changed tremendously. A UN military officer went to Bosnia to identify the corpses of killed inhabitants. In one month he saw a 300 bodily remains of the dead in a devastated surrounding complete with burned and destroyed houses. Before this, in his homeland, the soldier was an active participant in local activities in the area where he was living with his family. After this trip, he felt everything was unimportant. He also felt detached from his partner and even his children, which is a terrible feeling. In the treatment it became clear as to what was the reason for this detachment; he felt he is no longer capable of safeguarding his family and he internally anticipated the possibility of losing them. Also, this symptom of detachment is difficult to express because the person involved feels very guilty about it. The restricted range of affect also becomes clear from the fact that the "shine" of normal experience has been lost. The sense of a foreshortened future relates to the loss of control over one's life and over the lives one feels responsible for.

A dilemma within the *DSM IV* classification is that research indicates that the avoidance cluster may need to be split into two distinct factors.(31) The first factor consists of actively avoiding thoughts or feelings about the event or doing things that remind the person of the event. The second factor describes emotional numbing as in having difficulty enjoying things or having sad or loving feelings, feeling distant from other people, or finding it hard to imagine fulfilling future goals. Foa et al. (32) already suggested that avoidance and numbing represent two separate factors reflecting different mechanisms. Previous models attempted to characterize PTSD based on the theoretical position that the clinical manifestations of PTSD follow a pattern of oscillations.(32-33) Avoidance would be an effortful and strategic process following distress associated with intrusive thoughts or episodes of reexperiencing the traumatic event, whereas numbing, that is, a lack of emotional responsiveness and social withdrawal, is a consequence of uncontrollable arousal as in hypervigilance and anger.

Hyperarousal symptoms

These are as follows:

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:

- 1 Difficulty falling or staying asleep;
- 2 Irritability or outburst of anger;
- 3 Difficulty concentrating;
- 4 Hypervigilance;
- 5 Exaggerated, startled response.

These symptoms are more easy to assess. The sleeping problem can relate to the fear that the traumatic incident can happen again. After the air crash in Amsterdam, we saw people who could only sleep with the light and TV on. Here the stimuli came in place of the increased need to scan the environment for endangering cues. Also waking up after two hours is common, as it seems dangerous to be not awake. To have no control over one's reactions becomes clear in the symptom irritability or outburst of anger. A shopkeeper was robbed at gun point just before closing time. He developed PTSD. One of the symptoms was his hypervigilance. He was afraid the robbery would happen again. He had much difficulty in being patient with his clients. His

normal humor had faded away. People no longer liked to visit his cheese shop. This change affected the family front as well; he became quite irritable toward his wife and children. He changed, so partners often told us. Children suffered because of the irritability of their parent. One can easily understand this irritability. The traumatized person seems to be constantly distinguishing dangerous stimuli from "unimportant" stimuli. This is in fact the description of hypervigilance. Also one sees this in the behavior. A person has taken the chair as close to the wall as possible that his back was against the wall and to feel safe that no one can be between him and the wall. A person who had been attacked very violently constantly slowed down when bicycling because he feared the persons bicycling behind him. Also normal stimuli like the closing of a door can startle the person extremely. The difficulty in concentrating corresponds also to this "scanning behavior." For example, recalling and describing the danger experienced is not difficult; on the contrary, a person might actively recall all sorts of details associated with the danger experienced. But if the same person were to read two pages of a book, he will likely forget the contents and start all over again. One might forget to what to buy during shopping. One needs to write down at home a list before going to the shop.

The hyperarousal symptoms are quite invalidating. Normal relations and normal activities become disordered. We see the person involved to cope with it in less adaptive ways by avoiding and withdrawal.

Dissociative symptoms

Apart from the symptoms B3, "dissociative flashback episodes," and C3, "inability to recall an important aspect of the trauma," dissociative symptoms are not very well specified in the *DSM-IV* description of PTSD. Spiegel and others (34) have argued that PTSD is a disorder of memory. From this viewpoint, more symptoms similar to the two mentioned above can be seen as distorting normal memory functions like encoding, storage, and retrieval of traumatic memories. Bremner et al. (35) have argued that dissociation is the main mechanism in the development of PTSD; an example is the lack of emotions while remembering traumatic events. Without such accompanying emotions, the incident according to the definition is not a traumatic one. Here we have a problem; dissociation could have negated such emotions. Thus, the person remembers the incident but cannot remember the intense emotions he felt while it happened. Brewin (36) has described different forms of memory: (1) verbally accessible memory (VAM) involving explicit, conscious, and hippocampally dependent memories, such as ordinary autobiographical memories, and (2) situational assessable memory systems (SAM), which involve implicit, image-based, cue-dependent, and nonhippocampally dependent memories at the amygdala level as when sensory memories of the traumatic event are reexperienced after being triggered by external cues. One of the aims of treatment is integrating the memories of the trauma into the totality of a person's memory system.

A specific accompanying symptom is often the depersonalization or derealization, which are dissociative symptoms. Especially from sexual child abuse, it is well known that the traumatic incident can be forgotten. This is part of a heavy debate, especially because some accuse that therapists "implant such memories." One has to be very careful in the interview not to suggest such experiences. But one cannot leave them out, particularly because when the therapist detects long periods of amnesia during childhood phase, as becomes evident during the session, the possibility that there was a childhood trauma must indeed be taken seriously.

Marmar et al (37) has described a set of specific dissociative features of the traumatic experience that are quite common. These symptoms are called peritraumatic dissociation. These symptoms are part of the traumatic experience of a person and come back while remembering the event. For instance, a traumatic situation feels "endless" in time, whereas it could have lasted only for a short moment. Also the incident can be experienced as a "slow-motion" scene in which the sound associated with the actual event can change or even be absent. Peritraumatic dissociation describes the changes in perception, especially in time-space relation. A police officer who was sitting in his car shot through the windscreen at a man who took a woman as the hostage. The window-screen splintered into thousand particles. He, however, saw them falling down slowly, as if they were water drops. It sounded like "Christmas bells." The traumatic value of an incident can, therefore, change the perception; thus, the perception concerning time, sound, place of the incident may not only vary but may instead regard the incident as unreal, as if it never happened.

STRUCTURED INSTRUMENTS

Structured interviews and self-report instruments have a definite advantage because they don't need much clinical skills while using them, as outlined before. Also they make the validity of assessment between groups better. Many instruments have been developed for epidemiological purposes and for research on PTSD. We will summarize a few here. The *Impact of Events Scale (IES)* of Horowitz et al (38) is not only well known but is also the oldest one in its category. It is more often used because it gives a fine presentation of the reexperience and avoidance characteristics. However, the disadvantage is it has been developed far before the formulation of PTSD in *DSM-III* and *IV* and may not cover many of the symptoms as presented in *DSM-III* and *IV*; for example, the hyperarousal symptoms are not part of this scale. The revised version now includes these hyperarousal symptoms (IES-R), though. The Structured Clinical Interview for *DSM-IV* (39) is also available with a PTSD part. Furthermore, in current research, the Clinician Administered PTSD Scale for *DSM-IV (CAPS-DX)* is also very often used. (40) For epidemiological research with trained lay interviewers (not clinicians), the Composite International Diagnostic Interview (41) is available for PTSD assessment. Breslau et al. (42) reported about a 7-item symptom list to discover PTSD in the community and later Brewin et al. (43) developed a 10-item instrument to screen for the presence of PTSD. Also, self-report instruments have been used in research and are sometimes recommended for use in clinical practice as well. These are the Davidson Trauma Scale (DTS) (44), the Self-Rating Scale for PTSD (SRS-PTSD) (45), the Self-Rating Inventory for Posttraumatic Stress Disorder (SID) (46) and the Posttraumatic Diagnostic Scale (PDS) (47). Most of the self-report instruments have been developed for special trauma populations, like Vietnam veterans (CAPS), police and disaster victims (46) and rape victims (47).

TRAUMA SPECTRUM AND COMORBIDITY

The ICD-10 classification (2) mentions that PTSD is often accompanied by anxiety, depression, or even obsessive-compulsive disorder. The consequence is that when a patient comes for assessment, one should not restrict assessment to only focus on PTSD but must instead look for other accompanying symptoms described previously. Comorbidity of PTSD with other disorders, including the dissociative ones, is quite common. Therefore, some have argued for the need of a so-called trauma spectrum of disorders (48, 49, 50). There are important overlaps with depression, other anxiety disorders and with dissociative disorders. Also, PTSD can become complicated by addiction. Acute stress disorder (ASD) has been recognized in *DSM-IV* (3). There is also much interest in subthreshold manifestations of PTSD-symptoms described as partial PTSD (51). Herman (52) and van der Kolk (53) have pleaded for adding complex PTSD to *DSM-IV* items of measure. Much attention has been given to a partial relationship between the borderline personality disorder and early trauma. Complex PTSD has been developed to describe the long-term effect of PTSD on the personality.

For future research, it will be necessary to pay more attention to trauma spectrum disorders, which, in the meantime, should not, however, stop clinicians from assessing PTSD alone.

CONCLUSION

In the assessment of the diagnosis of PTSD many dilemmas have been mentioned. Psychiatrists are mostly familiar with the difficulty of assessing, for instance, psychotic symptoms because having such skills is usually associated with one's bearing a professionally accomplished persona and professional pride, whereas for other doctors such assessment turns out to be extremely difficult. The disorders like PTSD that are related to traumatic events may at first seem more easy to detect. The improved classification of disorders in DSM and ICD over time has tremendously increased the in between reliability of making diagnosis of different disorders. However, behind the short descriptions, definitions, and sentences, much clinical expertise is hidden, which helps with precise diagnosis of PTSD and other disorder. A special aspect in the skills for assessing PTSD is the impact of any unpleasant stories divulged during the

diagnosis. It is important to understand that the patient often does not want to share his or her terrible experiences with the therapist, which he or she feels acts sometimes as a protection so that the therapist does not get bogged down with such details and extreme emotions. For the clinician, it is, therefore, necessary to realize how one should be prepared with knowledge and skills to start assessing PTSD. Those who argue for seeing PTSD as a dissociative disorder help us to understand the symptoms from the view of a memory disorder. The use of structured instruments and self-rating inventories can be helpful, but to what extent is not yet well known. The risk of secondary traumatization has to be taken very seriously.

REFERENCES

1. American Psychiatric Association. Diagnostic And Statistical Manual of Mental Disorders, third edition (DSM-III). Washington, DC: APA; 1980.
2. World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders; Clinical Descriptions and the Diagnostic Guidelines. Geneva; 1992.
3. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). Washington, DC: APA; 1994.
4. Kessler, RC, Sonnega A, Bromet E, Nelson CB. Posttraumatic stress disorder in the national comorbidity survey. *Arch Gen Psychiatry* 1995; 52, 1058–60.
5. Breslau N, Kessler RC, Chilcoat HD et al. Trauma and posttraumatic stress disorder in the community; the 1996 Detroit area survey of trauma. *Arch Gen Psychiatry* 1998; 55: 626–32.
6. Olff M, de Vries G-J. The epidemiology of PTSD in the Netherlands. 9th European Conference on Traumatic Stress, Stockholm. Stockholm: Sweden, 2005; 206.
7. Breslau N, Davis GC, Andreski P, Peterson EL, Schultz LR. Sex differences in posttraumatic stress disorder. *Arch Gen Psychiatry* 1997; 54(11): 1044–8.
8. Olff M, Langeland W, Draijer N, Gersons BPR. Gender differences in posttraumatic stress disorder. *Psychol Bull* 2007; 133(2): 183–204.
9. National Institute for Clinical Excellence. The management of PTSD in primary and secondary care. London: NICE; 2005.
10. Kenardy JA, Webster RA, Lewin TJ et al. Stress debriefing and patterns of recovery following a natural disaster. *J Trauma Stress* 1996; 9: 37–50.
11. Bisson JI, Jenkins PL. Psychological debriefing for victims of acute burn trauma. *Br J Psychiatry* 1997; 171: 583.
12. Bisson JI, Jenkins PL, Alexander J, Bannister C. Randomized controlled trial of psychological debriefing for victims of acute burn trauma. *Br J Psychiatry* 1997; 171: 78–81.
13. Carlier IVE, Van Uchelen JJ, Lamberts RD, Gersons BPR. Disaster-related posttraumatic stress in police officers; a field study of the impact of debriefing. *Stress Med* 1998b; 14: 143–8.
14. van Emmerik AA, Kamphuis JH, Hulsbosch AM, Emmelkamp PM. Single session debriefing after psychological trauma: a meta-analysis. *Lancet* 2002; 360: 766–71.
15. Sijbrandij MJ, Olff M, Reitsma JB, Carlier IVE, Gersons BPR. Emotional or educational debriefing after psychological trauma: Randomised controlled trial. *Br J Psychiatry* 2006; 189, 150–5.
16. Carlier IVE, Gersons BPR. Partial PTSD; the issue of psychological scars and the occurrence of the PTSD symptoms. *J Nerv Ment Dis* 1995; 183, 107–9.
17. Carlier, I.V.E., Lamberts, R.D., Gersons, B.P.R., Risk factors for posttraumatic stress symptomatology in police officers: a prospective analysis. *J Nerv Ment Dis* 185(8):498-506, 1997.
18. Ursano RJ, Fullerton CS, Vance K, Kao TC. Posttraumatic stress disorder and identification in disaster workers. *Am J Psychiatry* 1999; 156, 353–9.
19. Herman J. Trauma and Recovery; the Aftermath of Violence - From Domestic Abuse to Political Terror. Basic Books; 1992.
20. Basoglu M, Mineka S, Paker M et al. Psychological preparedness for trauma as a protective factor in survivors of torture. *Psychol Med* 1997; 27: 1421–33.
21. Carlier IVE, Gersons BPR. Stress reaction in disaster victims following the Bijlmermeer plane crash. *J Trauma Stress* 1997; 10: 329–35.
22. Figley CR. Compassion fatigue as secondary stress disorder: An overview. In: Figley CR, ed. *Compassion fatigue: Secondary Traumatic Stress Disorder in Treating the Traumatized*. New York: Brunner/Mazel, 1995: 1–20.
23. Avina C, O'Donohue W. Sexual harassment and PTSD: is sexual harassment diagnosable trauma? *J Trauma Stress* 2002; 15: 69–75.
24. Olff M, Gersons BPR. What is a traumatic event? *Br J Psychiatry* 2005; 187, 189–90.
25. McNally RJ. Progress and controversy in the study of posttraumatic stress disorder. *Annu Rev Psychol* 2003; 54: 229–52.

26. Breslau N, Kessler RC. The stressor criterion in DSM-IV posttraumatic stress disorder, an empirical investigation. *Biol Psychiatry* 2001; 50: 699–704.
27. Knight DC, Smith CN, Cheng DT, Stein EA, Helmstetter FJ. "Amygdala and hippocampal activity during acquisition and extinction of human fear conditioning", *Cogn Affect Behav Neurosci* 2004; 4(3): 317–25.
28. Lindauer RJL, Van Meijel EPM, Jalink M et al. Heart rate responsivity to script-driven imagery in posttraumatic stress disorder: specificity of response and effects of psychotherapy. *Psychosom Med* 2006; 68(1); 33–40.
29. Lindauer RJL, Booij J, Habraken JBA et al. Cerebral blood flow changes during script-driven imagery in police officers with posttraumatic stress disorder. *Biol Psychiatry* 2004; 56(11): 853–61.
30. LeDoux J. *The emotional brain. The mysterious underpinnings of emotional life.* New York: Simon and Schuster; 1996.
31. Olf M, Sijbrandij M, Opmeer BC, Carlier IV, Gersons BP, The structure of acute posttraumatic stress symptoms: 'Reexperiencing', 'Active avoidance', 'Dysphoria', and 'Hyperarousal', *J Anxiety Disord*, 2009 Jun;23(5):656-9.
32. Foa EB, Riggs DS, Gershuny BS. Arousal, numbing, and intrusion: symptom structure of PTSD following assault. *Am J Psychiatry* 1995; 152(1): 116–20.
33. Litz BT. Emotional Numbing in combat-related posttraumatic-stress-disorder: a critical-review and reformulation. *Clin Psychol Rev* 1992; 12(4): 417–32.
34. Butler LD, Spiegel D. *Trauma and memory*, in: American Psychiatric Press, Washington. *Review of Psychiatry* 1997; 16(2): 13–53.
35. Bremner JD, Marmar CR. *Trauma, memory, and dissociation.* American Psychiatric Press, Washington; 1998.
36. Brewin CR. A cognitive neuroscience account of posttraumatic stress disorder and its treatment. *Behav Res Ther* 2001; 39: 373–93.
37. Marmar CR, Weiss DS, Schlenger WE et al. Peritraumatic dissociation and posttraumatic stress in male Vietnam theater veterans. *Am J Psychiatry* 1994; 151: 902–7.
38. Horowitz MJ, Wilner N, Alvarez W. Impact of event scale: a measure of subjective stress. *Psychosom Med* 1979; 41: 209–18.
39. Spitzer RL, Williams JBW, Gibbon M. *Structured clinical interview for DSM-III-R, Version NP-V.* New York: Biometrics Research Department, New York State Psychiatric Institute; 1987.
40. Blake D, Weathers F, Nagy D. A clinician administered PTSD scale for the assessing current and lifetime PTSD: the CAPS-I. *Behav Ther* 1990; 18: 187–8.
41. Kessler RC, Andrews G, Mroczek D, Ustun B, Wittchen HU. The world health organization composite international diagnostic interview short-form (CIDI-SF). *Int J Methods in Psychiatry Res* 1998; 7: 171–85.
42. Breslau N, Peterson EL, Kessler RC, Schultz LR. Short screening scale for DSM-IV posttraumatic stress disorder. *Am J Psychiatry* 1999; 156: 908–11.
43. Brewin CR, Rose S, Andrews B et al. Brief screening instrument for post-traumatic stress disorder. *Br J Psychiatry* 2002; 181: 158–62.
44. Davidson JR, Book SW, Colket JT et al. Assessment of a new self-rating scale for posttraumatic stress disorder. *Psychol Med* 1997; 27: 153–60.
45. Carlier IVE, Lamberts RD, van Uchelen JJ, Gersons BPR. Clinical utility of a brief diagnostic test for posttraumatic stress disorder. *Psychosom Med* 1998a; 60: 42–7.
46. Hovens JE, Van der Ploeg HM, Bramsen I. The development of the self-rating inventory for posttraumatic stress disorder. *Acta Psychiatrica Scandinavica* 1994; 90: 172–83.
47. Foa EB, Hearst-Ikeda D, Perry KJ. Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. *J Consult Clin Psychol* 1995a; 63: 948–55.
48. Bremner JD. Editorial: Acute and chronic responses to psychological trauma: where do we go from here? *Am J Psychiatry* 1999; 156(3): 349–351.
49. Horowitz MJ. *Stress-response Syndromes* (2nd ed.). Northvale, NJ: Jason Aronson; 1986.
50. Van der Kolk BA, McFarlane AC, Weiseth L, eds. *Traumatic Stress: the Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press; 1996.
51. Carlier IVE, Gersons BPR. Partial posttraumatic stress disorder (PTSD): The issue of psychological scars and the occurrence of PTSD symptoms, *J Nerv Ment Dis* 1995; 183(2): 107–9.
52. Herman JL. Sequelae of prolonged and repeated trauma: evidence for a complex posttraumatic syndrome (DESNOS). In: Davidson JRT, Foa EB, eds. *Posttraumatic Stress Disorder: DSM-IV and Beyond.* Washington, DC: APA; 1993.
53. Van der Kolk B.A, McFarlane AC, Weiseth L eds. *Traumatic Stress: the Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press; 1996.