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PTSD Diagnosis and Treatment for Mental Health Clinicians

Matthew J. Friedman, M.D., Ph.D.

ABSTRACT: This article focuses on four issues: PTSD assessment, treatment approaches, therapist issues, and current controversies. Important assessment issues include the trauma history, comorbid disorders, and chronicity of PTSD. Effective intervention for acute trauma usually requires a variant of critical incident stress debriefing. Available treatments for chronic PTSD include group, cognitive-behavioral, psychodynamic, and pharmacological therapy. Therapist self-care is essential when working with PTSD patients since this work may be functionally disruptive and psychologically destabilizing. Current controversies include advocacy vs. therapeutic neutrality, eye movement desensitization and reprocessing (EMDR), the so-called false memory syndrome, and the legitimacy of complex PTSD as a unique diagnostic entity.

PTSD is an easy diagnosis to make when the patient tells you that s/he has been badly traumatized and believes that such exposure has precipitated current psychological problems. Thanks to a massive psychoeducational program provided by the print and electronic media, the public has become familiar with the concept of PTSD and recognizes that it can be caused by war trauma, domestic violence, sexual assault, industrial accidents, and natural disasters. Media coverage of major recent events such as the Persian Gulf War, Hurricane Andrew, cases of child abuse, and the genocide in Bosnia have often underscored the psychological impact of such events thereby contributing to

Matthew J. Friedman is Executive Director of the National Center for PTSD, VAM & ROC, White River Jct., VT and is affiliated with the Departments of Psychiatry and Pharmacology, Dartmouth Medical School, Hanover, NH.

Address correspondence to Matthew J. Friedman, M.D., Ph.D., VA Medical Center (1160), White River Junction, VT 05009.

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the growing sophistication of a public that knew little about PTSD until the late 1980's. Furthermore, PTSD is an attractive explanatory model for many people because it places responsibility for their suffering on factors outside themselves, factors over which they often had neither responsibility nor control.

Clinicians have also found the PTSD construct attractive and useful. It provides an explanatory model that is easy to address therapeutically and that promotes empathic patience, even with the most difficult and demanding clientele. Although the growing acceptance of trauma-focused assessment and treatment strategies has created clinical options that were not exercised as recently as ten years ago, such options have also generated a number of potential problems. In this article I will address four issues: PTSD detection and diagnosis; treatment approaches; therapist issues; and current controversies.

MAKING THE DIAGNOSIS

The switch from DSM-III-R (American Psychiatric Association, 1987) to DSM-IV (American Psychiatric Association, 1994) will bring few changes in the diagnostic criteria for PTSD. As shown in Table 1, the stressor criterion (A_1) will no longer characterize trauma as outside the range of normal human experience since we have been forced to recognize that exposure to catastrophic stress is an unwelcome but not unusual aspect of the human condition. Furthermore, the stressor criterion (A_2) now requires that in addition to exposure, the patient need also have an intense emotional reaction to the traumatic event such as panic, terror, grief, or disgust. (In DSM-III (American Psychiatric Association, 1980) and DSM-III-R, Criterion A was restricted to exposure per se [A_1] and did not address the subjective response [A_2].) Otherwise, the B, C, and D symptoms have remained the same with the exception of a slight rearrangement such that D_6 in DSM-III-R has become B_5 in DSM-IV.

PTSD patients are stuck in time and are continually re-exposed to the traumatic event through daytime recollections that persistently interrupt ongoing thoughts, actions, or feelings. They are assaulted by terrifying nightmares that awaken them and make them afraid to go back to sleep. They cannot tolerate any reminders of the trauma since these often trigger intense fear, anxiety, guilt, rage, or disgust. In some cases, they suffer PTSD flashbacks, psychotic episodes in which reality dissolves and they are plunged back into the apparent reality of a

TABLE 1

DSM-IV Criteria for PTSD

A. The person has been exposed to a traumatic event in which both of the following have been present:
   (1) the person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others
   (2) the person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in at least one of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed
   (2) recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
   (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 upon awakening or when intoxicated). Note: in young children, trauma-specific reenactment may occur
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

TABLE 1 ***(Continued)***

(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 of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:
(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specifiy if:
Acute: if duration of symptoms in less than three months
Chronic: if duration of symptoms is three months or more

Specifiy if:
With Delayed Onset: onset of symptoms at least six months after the stressor

traumatic event that has haunted them for years or decades. During such episodes they find themselves fighting off rapists, being attacked by enemies, or fleeing from explosions with the same intense feelings they experienced during the initial trauma. Such intrusive recollections (Criterion B) can persist for over 50 years (Schnurr, 1992) and may get worse, rather than better, with time (Archibald and Tuddenham, 1965).

PTSD patients develop avoidant/numbing symptoms (Criterion C) to ward off the intolerable emotions and memories recurrently stirred up by these intrusive recollections. Sometimes they develop dissociative or amnestic symptoms which buffer them from painful feelings and recollections. They also adopt obsessional defenses and other behavioral strategies such as drug and alcohol abuse, eating disorders, sexual acting out and workaholism, to ward off intrusive recollections.

Finally, PTSD patients suffer from autonomic hyperarousal (Criterion D). Such symptoms include insomnia, irritability that may progress to rage, agitation and jumpiness manifested by an exaggerated startle response, and hypervigilience that may become indistinguishable from frank paranoia. PTSD patients are always on guard, dedicated to avoiding ever being re-exposed to the terrifying circumstances that changed their lives forever. It is difficult for them to trust other people or the environment. The need for safety and protection may outweigh all other considerations including intimacy, socialization and other pleasurable pursuits.

In other words, the clinician attempting to engage the PTSD patient in treatment is asking the patient to take a tremendous risk. S/he is asking the patient to give up all the protective behaviors and psychological strategies that have emerged to ward off intrusive recollections and hyperarousal symptoms. Therefore, the therapist must recognize that assessment and treatment are potentially destabilizing. Therapy can only succeed in an environment of sensitivity, trust, and safety (Herman 1992). Therapists must recognize that it may take a long time for patients to shed the many layers of protective symptoms that have evolved over countless years since the trauma. It is important for the therapist to let the patient know as soon as possible that s/he recognizes that the prospect of therapy is frightening and painful. It is also important that therapists suppress their own need to get a trauma history as soon as possible and set a pace that the patient can tolerate. In my own work, I always tell patients to signal me when our trauma-focused therapy has become too upsetting. I promise to back off whenever they signal me that therapy has become too distressing. And I always keep my promise. In this way, I fortify the atmosphere of trust and safety and preserve the forward momentum of therapy despite a momentary pause or two.

Some patients may be so relieved that they finally have an opportunity to discuss long-suppressed, painful, and possibly shameful past events, that they cannot wait to review such material with a therapist. A second group may be equally motivated but may appear resistant because of fears that therapy will stir up intolerable feelings. They

require the safety mentioned earlier. A third group may have sought treatment for depression, anxiety, chemical dependency, eating disorders, somatic complaints, or adjustment disorders rather than for PTSD. Indeed, among cohorts of treatment seeking PTSD patients, up to 80% have at least one additional psychiatric diagnosis including affective disorders (26–65%), anxiety disorders (30–60%), alcoholism or drug abuse (60–80%), or personality disorders (40–60%) (Friedman, 1990; Jordan, et al., 1991; Kulka, et al., 1987). For such patients, PTSD sometimes emerges as a diagnostic possibility only after the clinician has obtained a careful trauma history as part of a comprehensive assessment. Finally, there is a group of difficult patients who present because of disruptive or self-destructive behaviors and who initially appear to suffer primarily from a personality disorder. Patients in this latter category may be adult survivors of protracted childhood sexual abuse whose trauma history may be obscured by DSM-IV labels such as borderline personality disorder (BPD), dissociative identity disorder, and somatoform disorder. In addition to PTSD symptoms, they often present with problems of affect regulation, impulsive behavior, dissociative symptoms, problems of trust, inappropriate sexual behavior, and a wide variety of somatic complaints (Herman, 1992). These latter problems may demand the lion's share of therapy. Treatment of these patients may be further complicated by fragmented thought processes, incomplete memories, and dissociative symptoms.

The trauma history is essential. Given high rates of comorbidity mentioned earlier, and given a significant amount of overlap between symptoms seen in PTSD, depression, and other anxiety disorders, the trauma history is the major vehicle through which PTSD can be diagnosed and distinguished from other major mental disorders. There are many anecdotes about severely traumatized patients whose therapists never bothered to ask about childhood or adult trauma. They followed their therapists' leads and spent countless hours reviewing Oedipal conflicts, family dynamics, or here-and-now interpersonal conflicts. Belated discovery of the centrality of sexual abuse, combat stress, or domestic violence provided the key to understanding their current symptoms and became a productive focus for therapy.

It is usually not difficult to obtain a trauma history. Patients are generally forthcoming and frequently pleased to finally have an opportunity to tell their trauma story to someone who appears sufficiently knowledgeable and sensitive to ask about it. For all the reasons mentioned earlier, however, telling the trauma story can be difficult. The first trauma story to emerge is often only the tip of the iceberg. More distressing material will come later after the therapist has es-

tablished trust and safety and has shown that he or she has the courage, wisdom, and empathy to listen to such material and sufficient positive regard for the patient to encourage further disclosure. Therapists can signal patients through their questions and responses that they understand the behavioral and emotional impact of a rape, natural disaster, or war. Such signals are readily perceived by patients who usually respond positively now that they have been reassured that it will be safe and productive to tell the full trauma story to this therapist at this time.

As with other medical and psychiatric disorders, PTSD patients may exhibit a wide spectrum of impairment. At one extreme, affected individuals may exhibit a high level of interpersonal, social, and vocational function. At the other extreme, some PTSD patients may be totally incapacitated by this disorder and may appear to have a chronic mental illness. Such patients may be misdiagnosed as having chronic schizophrenia and may be indistinguishable from such patients unless the clinician has undertaken a careful trauma history and diagnostic assessment. Two reports on psychotic female state hospital inpatients (Beck & van der Kolk, 1989; Craine et al., 1988) indicate that those with a history of childhood or adolescent sexual abuse were more likely than non-abused patients to have intrusive, avoidant/numbing and hyperarousal symptoms associated with the abuse. In fact, 66% of these previously abused and currently psychotic patients met criteria for PTSD although none had ever received that diagnosis. Furthermore, they could be distinguished from non-abused state hospital patients by the prominence of sexual and abusive themes in their thoughts and behavior.

To summarize, detection of PTSD can be difficult because of patient fears that therapy will reactivate intolerable symptoms, because of the many comorbid Axis I and Axis II DSM-IV disorders that frequently accompany PTSD, and because some patients may be too fragmented, amnestic, dissociative, and otherwise impaired to participate in therapy. Assessment can only succeed in a safe therapeutic environment that promotes a comprehensive review of each patient's trauma history at a pace and intensity that is tolerable.

TREATMENT

Many therapeutic approaches have been advocated for PTSD. The reader is referred to a number of comprehensive reviews of the most prominent treatments for PTSD including psychodynamic therapy

(Marmar, et al., 1994), cognitive-behavioral therapy (Foa, et al. (1994), pharmacotherapy (Friedman & Southwick, 1995), group, family, couples, and inpatient treatment (Williams & Sommer,1994), and treatment for patients dually diagnosed with PTSD and alcoholism/ substance abuse (Kofoed, et al., 1993). Therapists working with patients who have survived a variety of traumatic events (war, natural disasters, etc.) generally agree that therapy can be divided into three phases: a] establishing trust, safety, and "earning the right to gain access" to carefully guarded traumatic material (Lindy, 1993; p. 806); b] trauma-focused therapy: exploring traumatic material in depth, titrating intrusive recollections with avoidant/numbing symptoms (Horowitz, 1986); and c] helping the patient disconnect from the trauma and reconnect with family, friends, and society. It should be noted that patients who reach the third phase have integrated post-traumatic events and are ready to concentrate, almost exclusively, on here-and-now issues concerning marriage, family, and other current issues (Herman, 1992; Lindy, 1993; Scurfield, 1993).

Marmar, et al. (1993; 1995) have suggested that there are five identifiable post-traumatic syndromes, each requiring a different treatment approach: normal stress response; acute catastrophic stress reaction; uncomplicated PTSD; PTSD co-morbid with other disorders; and post-traumatic personality. The *normal stress response* occurs when healthy adults who have been exposed to a single discrete traumatic event in adulthood experience intense intrusive recollections, numbing, denial, feelings of unreality, and arousal. Such individuals usually achieve complete recovery following individual or group debriefing (Armstrong, et al., 1991) derived from critical incident stress debriefing, CISD, models initially developed by Mitchell (1983) and Raphael (1986). Often a single two hour group debriefing experience is all that is needed. Such sessions begin by describing the traumatic event. They then progress to exploration of survivors' emotional responses to the event. Next, there is an open discussion of symptoms which have been precipitated by the trauma. Finally, there is a resolution in which survivors' responses are normalized and adaptive coping strategies are identified.

Acute catastrophic stress reactions are characterized by panic reactions, cognitive disorganization, disorientation, dissociation, severe insomnia, tics and other movement disorders, paranoid reactions, and incapacity to manage even basic self care, work, and interpersonal functions (Marmar, 1991). Treatment includes immediate support, removal from the scene of the trauma, use of anxiolytic medication for

immediate relief of anxiety and insomnia, and brief supportive aggressive dynamic psychotherapy provided in the context of crisis intervention.

Uncomplicated PTSD may respond to group, psychodynamic, cognitive behavioral, pharmacological, or combination approaches. During the past ten years we have come to appreciate the powerful therapeutic potential of positive peer group treatment as practiced in Vet Centers for military veterans and in rape crisis centers for sexual assault and domestic violence victims. It can be argued that the peer-group setting provides an ideal therapeutic setting for trauma survivors because their post-traumatic emotions, memories, and behaviors are validated, normalized, understood, and de-stigmatized. They are able to risk sharing traumatic material in the safety, cohesion and empathy of fellow trauma survivors. It is often much easier to accept confrontation from a fellow sufferer who has impeccable credentials as a trauma survivor than from a professional therapist who never went through those experiences first-hand. As group members achieve greater understanding and resolution over traumatic themes, they are remoralized. As they climb out of the pit of trauma-related shame, guilt, rage, fear, doubt, and self-condemnation, they prepare themselves to focus on the present rather than the past (Herman, 1992; Scurfield, 1993).

Brief psychodynamic psychotherapy focuses on the traumatic event itself. Through the retelling of the traumatic event to a calm, empathetic, compassionate and non-judgmental therapist, the patient achieves a greater sense of self-cohesion, develops more adaptive defenses and coping strategies, and more successfully modulates intense emotions that emerge during therapy (Marmar, et al., 1995). The therapist needs to constantly address the linkage between post-traumatic and current life stress. S/he needs to help the patient identify current life situations that set off traumatic memories and exacerbate PTSD symptoms.

There are two cognitive-behavioral approaches, exposure therapy and cognitive-behavioral therapy. Exposure therapy includes systematic desensitization on the one hand and imaginal and in-vivo techniques such as flooding, on the other. In general, flooding has been much more effective than systematic desensitization. The second approach, cognitive-behavioral therapy, includes a variety of anxiety management training strategies for reducing anxiety such as relaxation training, stress inoculation training, cognitive restructuring, breathing retraining, biofeedback, social skills training, and distraction techniques (see Hyer, 1993; and Foa, et al., 1995 for references).

Foa and associates (Foa, et al., 1991; Rothbaum, et al., 1992) have shown flooding and anxiety management training (stress inoculation therapy) are both effective for rape victims with PTSD. They have also speculated that a combination of both treatments might be more effective than either treatment alone.

Given our expanding understanding of the many neurobiological abnormalities associated with PTSD (see Friedman, 1991; Southwick, et al., 1992; Murburg, 1994; Friedman, Charney, & Deutch, 1995), pharmacotherapy appears to have a place in PTSD treatment. From a practical perspective, there is no question that drugs can provide some symptomatic relief of anxiety, depression, and insomnia, whether or not they ameliorate core PTSD intrusive and avoidant/numbing symptoms. In most but not all trials, improvement has been achieved with imipramine, amitriptyline, phenelzine, fluoxetine, and propranolol. A quantitative analysis by Southwick, et al. (1994), suggested that tricyclic antidepressants and monoamine oxidase inhibitors are generally efficacious in PTSD patients, especially with regard to intrusion and avoidant symptoms, although fluoxetine, amitriptyline, and possibly valproate have shown efficacy against avoidant symptoms (Fesler, 1991; Davidson, et al., 1990; van der Kolk, et al., 1994). At this time no particular drug has emerged as a definitive treatment for PTSD although medication is clearly useful for symptom relief thereby making it possible for patients to participate in group, psychodynamic, cognitive-behavioral, or other forms of psychotherapy.

PTSD comorbid with other DSM-IV Axis I disorders is actually much more common than uncomplicated PTSD. As noted earlier, PTSD is usually associated with at least one other major psychiatric disorder such as depression, alcohol/substance abuse, panic disorder, and other anxiety disorders (Friedman, 1990; Jordan et al., 1991; Breslau and Davis, 1991; Kofoed, et al., 1993). Sometimes the co-morbid disorder is the presenting complaint that requires immediate attention. At other times, the PTSD appears to be the major problem. In general, the best results are achieved when both PTSD and the co-morbid disorder(s) are treated concurrently rather than one after the other. This is especially true for PTSD and alcohol/substance abuse (Abueg & Fairbank, 1991; Kofoed, et al., 1993). Treatment previously described for uncomplicated PTSD should also be used for these patients.

Post-traumatic personality disorder is found among individuals who have been exposed to prolonged traumatic circumstances, especially during childhood, such as childhood sexual abuse. These individuals often meet DSM-IV criteria for diagnoses such as borderline

personality disorder, somatoform disorder, and dissociative identity disorder. Such patients exhibit behavioral difficulties (such as impulsivity, aggression, sexual acting out, eating disorders, alcohol/drug abuse, and self-destructive actions), emotional difficulties (such as affect lability, rage, depression, panic) and cognitive difficulties, (such as fragmented thoughts, dissociation, and amnesia). Treatment generally focuses on behavioral and affect management in a here-and-now context with emphasis on family function, vocational rehabilitation, social skills training, and alcohol/drug rehabilitation. Long-term individual and group treatments have been described for such patients by Herman (1992), Koller, et al. (1992), and Scurfield (1993). Trauma-focused treatment should only be initiated after long therapeutic preparation. Inpatient treatment may be needed to provide adequate safety and safeguards before undertaking therapeutic exploration of traumatic themes. The three phases of treatment, described earlier, apply to these patients as well as those with uncomplicated PTSD, but treatment may take much longer, may progress at a much slower rate, and may be fraught with much more complexity than with other traumatized patients.

THERAPIST ISSUES

Trauma work is difficult. Traumatized patients have suffered greatly and the therapeutic process often opens old wounds with alarming intensity. It is difficult, if not impossible, to maintain a stance of therapeutic neutrality when a patient tells you how s/he was brutally abused as a child, tortured by political enemies, or was forced to watch loved ones be murdered. Such narratives generate powerful emotions in therapist as well as patient. Therapists sometimes find themselves having intrusive thoughts or nightmares about the events recounted by their patients. Therapists may experience guilt that they were personally spared from such horrors. They may feel profoundly powerless because they could not protect patients from previous trauma and present distress. Such feelings can produce a number of inappropriate responses that interfere with therapy and disturb the therapist on a personal level. Herman (1992) notes that powerful emotions generated during therapy may prompt the therapist to engage in rescue attempts, boundary violations, or attempts to control the patient. Therapists may also activate a number of avoidant/numbing coping strategies such as doubting, denial, avoidance, disavowal, isolation, intellectualization,

constricted affect, dissociation, minimization, or avoidance of traumatic material (Danielli, 1988; Herman, 1992; Lindy, 1988). McCann and Pearlman (1990) have called this phenomenon "vicarious traumatization," while Figley (1995) has called such secondary traumatization "compassion fatigue."

In my opinion, it is useful to separate out three different, but not mutually exclusive, circumstances in which therapists working with traumatized clientele may become distressed, immobilized, and symptomatic. First, therapists who have never been traumatized themselves may become overwhelmed by the material generated during the course of treatment with PTSD patients. They may experience (secondary) traumatic nightmares, guilt, feelings of powerlessness, rescue fantasies, or avoidant/numbing behavior as described above. This can set up a vicious cycle in which the more symptomatic, maladaptive, and ineffective therapists become, the more they plunge themselves into their work. When this occurs they are less likely to recognize that they have a serious problem and, unfortunately, are less likely to seek supervision or assistance from colleagues. Second, therapists experience a bona fide countertransference reaction in which the patient's material triggers intrusive recollections of traumatic experiences that happened to them in the past. Since exposure to trauma is not a rare event and since mental health professionals have no more immunity from such exposure than anyone else, such countertransference reactions should be expected to arise often enough to warrant careful monitoring by therapists and supervisors alike. Third, therapists are themselves exposed to the same kind of traumatic experiences for which they attempt to assist others. An example would be offering treatment to survivors of a natural disaster to which the therapist him or herself has also been exposed. Under such circumstances, the therapist must seek debriefing or treatment for his or her own post-traumatic symptoms before s/he can expect to assist others.

It is not enough for therapists to recognize these occupational hazards. They must make a conscious sustained and systematic effort to prevent such secondary traumatization through self-care activities. Such measures include developing a supportive environment, monitoring case loads in terms of size and number of trauma cases, making boundaries between personal and professional activities, having regular supervision, and establishing an institutional structure that will address this problem (Courtois, 1993; Gusman, et al., 1992). For example, Yassen (1993) has recommended time-limited group treatment for therapists and human service professionals who work with victims

of sexual abuse and who themselves have previously been exposed to sexual trauma.

CONTROVERSIAL ISSUES

Although the PTSD diagnosis, itself, was controversial when it first appeared in 1980, that is no longer the case. However, there are currently four controversies in the trauma field that are worth noting: advocacy, eye-movement desensitization and reprocessing (EMDR), the false memory syndrome, and complex PTSD.

Many trauma patients have been victimized by an overpowering aggressor such as a rapist or terrorist. Most therapists are privately outraged by the violence that has been perpetrated on their clientele. Under such circumstances it can be exceedingly difficult to balance one's stance as a neutral professional with one's humanistic values concerning justice and abusive power. Some argue that advocacy is an essential component of the therapist role when your clientele are victims, while others insist that one must always maintain therapeutic neutrality despite one's personal beliefs. It is crucial for each clinician to acknowledge this issue and to strive to achieve the proper balance for him or herself.

EMDR is a controversial therapy developed by Shapiro (1989) in which the patient is instructed to imagine a painful traumatic memory while visually focusing on the rapid movement of the therapist's finger. Shapiro believes that such saccadic eye movements reprogram brain function so that the emotional impact of the trauma can finally be integrated. She and her followers are convinced that patients can achieve resolution of previously disruptive trauma-related emotions through this procedure. Others have suggested that EMDR is really an exposure therapy in disguise and that eye movements may be irrelevant (Foa et al., 1995, Pitman, et al., 1993). Well-controlled empirical support for EMDR is lacking, the few completed controlled studies have been equivocal, and methodological questions have been raised (Boudewyns et al, 1993; Foa et al., 1995; Pitman et al, 1993). What's remarkable, however is that a number of seasoned PTSD clinicians are convinced that EMDR is the most effective available treatment for PTSD despite the fact that many others are highly skeptical of this approach.

Therapists working with adults who had been sexually assaulted as children have reported that such patients have sometimes had no

memories of these childhood assaults at the start of treatment. During the course of therapy, however, such repressed traumatic memories reportedly emerge so that patients regain access to discrete recollections of childhood events such as father-daughter incest (Herman & Schatzow 1987). Patients who claim to have regained traumatic memories of this nature have confronted parents whom they now regard as perpetrators of childhood sexual trauma. In some cases they have taken parents to court for these alleged abuses. Sometimes the accused parents vehemently deny that such events ever occurred and maintain that these "traumatic memories" are really emblematic of a "false memory syndrome" that has been manufactured in the course of therapy. Loftus (1993) has written extensively about the problem of authenticating such rediscovered previously repressed memories. Williams (1994), on the other hand, has shown that women who were sexually assaulted during childhood, (documented by recorded visits to hospital emergency rooms), are sometimes unable to recall that traumatic event. This hotly debated issue has theoretical, clinical, and forensic implications which will need to be sorted out in the future.

Finally, clinicians who work with victims of prolonged trauma such as incest and torture argue that such patients suffer from a clinical syndrome that is not adequately characterized by the PTSD construct (Herman, 1992). Although most patients in this category meet PTSD diagnostic criteria, it is argued that their primary problem is not PTSD. Instead, Herman (1992) has proposed that their major problems concern impulsivity, affect regulation, dissociative symptoms, self-destructive behavior, abnormalities in sexual expression, and somatic symptoms and has called this syndrome, complex PTSD. Identification and treatment of these patients has been described previously (post-traumatic personality). The controversy is whether complex PTSD is distinct from PTSD and whether it should have its own diagnostic identity. After much discussion, it was decided not to include complex PTSD in the DSM-IV. The controversy has stimulated a number of research initiatives. It is expected that this issue will be revisited during development of the next revision of the DSM-IV, the DSM-V.

SUMMARY

PTSD is not difficult to detect if the clinician includes a careful trauma history as part of his or her comprehensive assessment. The major current diagnostic questions concern the possibility that there are a num-

ber of acute and chronic post-traumatic syndromes of which PTSD is the most distinct and identifiable example. Complex PTSD has been suggested as another post-traumatic syndrome which affects individuals who have protracted exposure to trauma, especially childhood sexual trauma. Another diagnostic issue concerns the relative importance of PTSD when it is associated with other co-morbid diagnosis such as depression, alcohol/substance abuse, anxiety disorders, and Axis II diagnoses. A third but related diagnostic issue concerns the fact that PTSD can progress to a chronic mental illness. Such patients are so impaired that they are superficially indistinguishable from other chronic patients and can often be found on the fringes of society, in homeless shelters, and enrolled in programs designed for patients with chronic mental illness such as schizophrenia.

The most widely used treatment for acute traumatic exposure is some CISD-type approach administered in an individual or group format. Among the treatments for chronic PTSD, group, psychodynamic, cognitive-behavioral, and pharmacologic approaches are used widely although few randomized clinical trials have been conducted on any of these treatment approaches. When PTSD is associated with Axis I disorders, both PTSD and the co-morbid problems should be treated concurrently. When PTSD is associated with a personality disorder, treatment usually needs to be long-term and complicated.

There are a number of issues that must be acknowledged and addressed by therapists who work with traumatized clientele, which stem from the powerful emotions generated in the therapists during treatment. Inappropriate coping strategies by therapists may interfere with treatment and produce a disturbing syndrome which has been called vicarious victimization or compassion fatigue. Therapist self-care is an essential priority for these reasons.

Four controversies in the trauma field have attracted considerable attention. They are the proper balance between advocacy and therapeutic neutrality, the efficacy of EMDR as a treatment, the so-called false memory syndrome, and the possibility that complex PTSD is a unique diagnosis in its own right that is distinct from PTSD.

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