POST TRAUMATIC STRESS DISORDER: An alternative approach.

By Rosemary Crouch PhD, Adj. Professor Therapeutic Sciences, Wits .

The objectives of the paper.

- To develop a better understanding of our clients with the diagnosis of PTSD.
- To consider a possible alternative diagnosis.
- The complications of mental illness facing the assessor.

The first Case

- Mr Divali,

His wife was murdered on the Cape Flats on their honeymoon, by a taxi driver who was jailed for murder.

He was hospitalised for PTSD at Falkenberg Hospital in Cape Town and also in England for a long period.

He was severely disabled by the condition and finally let off the murder.


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Oscar Pistorious.

Famous athlete.
He shot his girlfriend who died. He was diagnosed by a Wits Professor as having a Generalised Anxiety Disorder early in his trial for murder.

A later possibility in the trial was that he is now suffering from PTSD.

WHAT DO YOU THINK?

Clinical/ PTSD, Personality Disorder, General Anxiety Disorder or

MANIPULATION?

Alternatives

- It is possible that the client the occupational therapist is assessing, who is diagnosed as having post traumatic disorder, may have a personality disorder or may just be suffering from a depressive or anxiety disorder.
- P TD is very popular and trendy and as evidenced in the two cases I am quoting, may be involved in a manipulative procedure.

Anxiety Disorders

- According to the American Psychiatric Association (APA), the publisher of the DSM-5, the DSM-5 chapter on anxiety disorder no longer includes obsessive-compulsive disorder or PTSD.
- Instead, these disorders have been relocated to their own respective chapters.

Personality Disorder

- A deeply ingrained and maladaptive pattern of behaviour of a specified kind, typically apparent by the time of adolescence, causing long-term difficulties in personal relationships or in functioning in society.

POST-TRAUMATIC STRESS DISORDER - CURRENT FINDINGS

The DSM 5 criteria for PTSD:

- Diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms; the seventh assesses functioning; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition

CURRENT MEDICAL OPINION AS TO THE OUTCOME/PROGNOSIS OF PTSD

Longitudinal research has shown that PTSD can become a chronic psychiatric disorder and can persist for decades and sometimes for a lifetime. There are often remissions and relapses. People vary in the time that it takes (delay) to react after the event.

There appears to be a high rate of additional psychiatric co-morbidity diagnoses, such as major affective disorders, dysthymia, alcohol or substance-use disorders, anxiety disorders or personality disorders.

TREATMENT APPROACHES:

There is no cure and no definitive treatment.

The most successful interventions are cognitive behavioural therapy and medication. Excellent results have been obtained by combining cognitive-behavioural therapy, in particular cognitive restructuring and exposure therapy.

The best therapeutic option for mildly to moderately affected PTSD is group therapy. In such a setting the patient can discuss traumatic memories, PTSD symptoms and functional deficits with others who have had similar experiences.

Treatment procedures in occupational therapy are well documented by Jennifer Creek, 2002, and Carolyn Baum 2008.

WHAT IS MALINGERING?

Malingering is fabricating or exaggerating the symptoms of mental or physical disorders for a variety of secondary gain motives which may include financial compensation (often tied to fraud), avoiding school, work or military service, obtaining drugs , getting lighter criminal sentences or simply to attract attention to sympathy.

For the assessor:

Other conditions such as personality disorder and depressive and anxiety disorders must be taken into consideration by the occupational therapist assessing the client. Updated knowledge on the latest clinical and theoretical presentations and research about these very important conditions must be undertaken. Malingering is often very hard to detect.

The money (reward), the motivation and the background circumstances of every client must be taken into consideration. Mental illness complicates the issue for you.

WHAT IS YOUR OPINION ABOUT THE TWO CASES?

Are we talking about PTSD, personality disorder or straight forward manipulation/malingering with these two cases?

IT IS UP YOU TO DECIDE.

THANK YOU