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ACUTE POST-TRAUMATIC STRESS DISORDER IN PREVIOUSLY TRAUMATIZED PATIENTS

The importance of a comprehensive psychosocial history and consideration of the use of psychological defense mechanisms

It is the accepted premise of psychiatric theory that a comprehensive psychiatric evaluation involves consideration of all relevant "bio-psycho-social" factors. In addition to determining the presence of biological/constitutional factors and taking a full history of the presenting symptomatology, the evaluation of "psychological" factors also must include a full consideration of the psycho-social history of the patient, and an assessment of the patient's characterological structure, including the nature of underlying repressed or suppressed emotional issues and conflicts, and the manner in which psychological defenses are employed in the formation of personality traits.

Only through an integrated analysis of all of these factors can an accurate case formulation be constructed. The description and analysis of both clinical and forensic issues, related to diagnosis, etiology, and treatment of pathology must be based upon a comprehensive and accurate case formulation.

However, in current clinical practice, and particularly within the medical-legal arena (*especially in my experience working within the California Workers Compensation system)*, I have found that the documentation of comprehensive case formulations is rare. Even when the biological, psychological and psychosocial contributions to a person's problems are discussed within an evaluation report, most commonly, these issues are seen as independent variables rather being recognized as *interdependent* aspects of psychopathology, all of which need to be addressed therapeutically in an integrated fashion. Quite often evaluations are superficial, essentially based only upon acute symptomatology – not infrequently in the service of "plugging" a patient into a "standard" protocol of superficial counseling and/or psychopharmacological intervention (as per some type of promulgated "treatment guidelines" or "Utilization Review criteria").

This process leads to inaccurate clinical diagnostic conclusions, faulty medical-legal determinations, and inadequate proposals for and provision of mental health treatment.

Acutely traumatized patients often had suffered significant emotional traumatization due to earlier life experiences. Whether or not the patient previously developed overt post-traumatic symptomatology or was previously involved in any formal mental health treatment does not change the fact that the clinical determinations regarding acute psychopathology must be informed by an appreciation of the relationship of the presenting symptomatology to past emotional traumas, and the personality traits and psychological defenses present which developed in response to pre-existing issues.

The specific nature and severity of the symptomatology which has arisen is necessarily fully determined by the acute traumatic incident and mental health treatment cannot be effective if the focus of intervention is only upon the patient's emotional reaction to the most recent incident and related manifest symptomatology.

In many cases, taking a comprehensive history reveals that the patient presenting with acute post-traumatic symptomatology has experienced previous traumatization in the past – emotionally toxic events which may range from having suffered previous life-threatening illness or injury, to having witnessed traumatic or gory accidents or injuries, to having served in the military in theatres of combat, to (perhaps – unfortunately – most commonly) having been the victim of child abuse. Exploration at times reveals that these patients suffered previously diagnosable episodes of Post-Traumatic Stress Disorder, for which they may or may not have received significant or partial mental health treatment; but very often, they were never before evaluated, diagnosed or treated, and they relied on their own reasonably adaptive personality traits and psychological defenses to overcome the emotional impact of the prior incidents. At times, the emotional consequences of previous trauma were "reasonably" worked through, but more often than not, earlier episodes of trauma were merely repressed or suppressed and never actually resolved. In fact, often the containment of unresolved trauma has been supported by defenses which had been *adequate*, but not optimally effective, and very frequently, those defenses guard against still active emotional vulnerability to fear, anxiety, grief, anger, and distrust. At times, the issue of distrust may be the most complex issue to address, as it may involve a generalized distrust of people, strangers, particular segments of the population (racial, gender, etc.), and/or a universal existential ambivalence towards society, and a lack of trust in life itself. Often, those issues have been contained by denial, rationalistic defenses, heavy reliance upon religious belief, dissociative repression, a tendency towards social avoidance, or becoming involved in a rather dependent relationship (benign or malignant) which had been perceived as (superficially) offering "protection".

While those defenses may function "well enough" for years, it is not unusual that a further acute trauma disrupts those defenses, and what then emerges are affective

symptoms and emotional conflicts which conflate issues arising from the acute situation with long-repressed unresolved factors. In complex cases where the previous traumas were objectively severe or repetitive it may be difficult or impossible to determine at what point the acute symptomatology and impairment is directly related to the recent trauma, and at what point the difficulties which have emerged were "lit up" by the recent trauma. For example, a person may not have been overtly symptomatic with indications of Post-Traumatic Stress Disorder previous to the acute incident, but evaluation of their baseline level of functioning may reveal a long-standing pattern of avoidance and and/or dependency in their personal relationships, counter-phobic acting out, and/or episodes of dissociative phenomena – not infrequently with periods of affective dysfunction having "broken through" those less-than-optimal defenses.

This is most complicated in what I consider the "Pandora's Box" cases, or, to mix metaphors, the "Humpty-Dumpty" cases. These are individuals whose psychological defenses are so disrupted by the acute trauma that previously suppressed emotional conflicts flood into consciousness in such a manner that no short-term psychotherapeutic or psychopharmacological intervention will resolve the symptomatology or impairment, and in fact, defenses which previously were reasonably adaptive may not be able to be restored at all. It is also not uncommon that dangerous acting out arises, which may reflect increased impulsivity, self-destructive impulses and/or substance abuse issues. At times, the patient has the insight, motivation, and courage to therapeutically work through all of the disruptive emotions which have arisen (or are lucky enough to respond well to the prescription of psychotropic medications) – but often, those attributes are not sufficiently available, and the only ethical clinical alternative is on-going, long-term therapy, during which time there continues to be significant impairment, before an effective containment of pathology can be achieved.

From a clinical perspective, understanding that scenario is not particularly difficult; especially if one has initially performed a comprehensive evaluation and has been able to construct and document a case formulation which clearly describes all of the contributory factors – i.e., acute, recent and remote emotional conflicts or traumas, and/or the long-term presence of "adaptive" but less-than-optimally mature psychological defenses.