

Grieving Over Complications Associated with Neuro-Endovascular Treatment

K. GOTO, M. NODA*

Neuro-Endovascular therapist, Ohta Memorial Hospital, Fukuyama; Japan
President of the 15th Annual Meeting of the Japanese Society of Neuro-Endovascular Therapy
*Psychopathologist, Kyoto Women's University, Kyoto; Japan

Key words: interventional neuroradiology, complications ethics

Summary

Neuro-endovascular therapy is regarded as one of the greatest achievements of modern medicine because of its effectiveness and low-invasiveness in the treatment of difficult neurovascular diseases. On the other side of the coin however, occasionally complications may occur which not only have a profound neurological effect, but also have a severe effect on the vital prognosis. The nightmare of a neuro-endovascular therapist is a catastrophe resulting from a preventive treatment for an asymptomatic or minimally symptomatic patient with a potentially dangerous disease. Therefore, grave psychic distress tends to occur on both sides of the patient-doctor relationship. Once severe complications occur, we have simultaneously to take care of not only the psychic trauma of a patient and/or family but also our own psychic trauma. If treatment is not appropriate, we might invite malpractice suits or end up in occupational burnout.

In order to study the adaptive mechanisms that allow our continued survival in this new specialty of medicine, we administered a questionnaire survey to members of the Japanese Society of Neuro-endovascular Treatment. 51% of 300 respondents stated that they had been the targets of severe recriminations by patients and/or families as a result of complications. 284 respondents had multiple (2.5 on average) signs and symptoms of psychic trauma. Also 23% of respon-

dents were unable to continue the clinical practice of neuro-endovascular therapy or resorted to conservative treatment. Only 7% of respondents had medical curriculum or residency program training on the psychological problems of complications. There is no systematic approach to education regarding physician grief in clinical practice. Many respondents tend to focus their attention solely on the details of failed interventional procedures and repeatedly "undo" actions and relive past events. However, the study showed that intellectualization of the tragic experiences without accepting and working through grief only adds to the physician's grief. The correlation was evaluated between the respondents' initial response to grieving and their change of attitude regarding their ability or willingness to performing the procedure after they had experienced devastating complications. It may be said that by facing the emotional truths of responsibility and grief, physicians can develop the ability to empathize with patients and their families. Mention is also made of the patient-doctor relationship, medical education, and the relationship with fellow physicians and medical lawsuits.

Introduction

In modern medicine, it is well known that in areas where treatment results are excellent, the possibility of tragedy is also high. This is very

true in our specialty, where complications occasionally may not only have a profound neurological effect, but also have a severe effect on the vital prognosis¹. However, patients and families are emotionally unprepared for complications despite their apparently "complete" informed consent, because:

1) Treatment is usually performed as a preventive measure on asymptomatic or minimally symptomatic diseases.

2) Treatment is less invasive and performed at the 'center of excellence'.

Therefore, grave psychic distress tends to occur on both sides of the patient-doctor relationship. Once grave complications occur, we have simultaneously to take care of not only the psychic trauma of patients and families but also our own psychic trauma. If treatment is not appropriate, we might invite malpractice suits or end up in occupational burnout.

Very little attention has been paid to psychological problems related to catastrophic results of neuro-endovascular treatment. In order to rectify this omission, we prepared a questionnaire on grieving and surveyed the members of the Japanese Society of Neuro-Endovascular Treatment. Analyses of the results caused us to ponder the question what maturation as a physician really means.

Material and Methods

The Questionnaire Survey (Appendix 1) was designed according to the one prepared for the attendees of the 6th Annual Morbidity and Mortality Conference by Grant Hieshima. This was greatly supplemented taking the diagnostic criteria of post-traumatic stress disorder (PTSD) into consideration (Appendix 2). The Japanese Society of Neuro-endovascular Treatment directory for 1999 lists 1113 physicians. Questionnaires were mailed to all members of the society by the president (KG), one of the authors. The questionnaire survey consisted of 17 questions with 75 choices concerning, for example, the experience of being a target of severe recriminations after causing severe complications, psychosomatic presentations of psychic trauma, the respondent's point of view on grieving, how the respondent overcomes the stress resulting from complications, the respondent's point of view on informed consent, the patient and/or family's ability to understand

explanations, and education about psychological aspects of malpractice, etc. A profile of the respondents is also given. Anonymity was optional and respondents were encouraged to comment freely on each question.

In order to analyze the correlation between the respondents' attitudes to about complications and the manner of accepting and working through grief, the correlation between relevant questions was evaluated statistically, for example:

1) Differences in the rates of the affirmative responses to Q3, Q4 and Q7 and the affirmative responses to options a) and b) of Q5, and

2) Differences in the rates of the affirmative responses to Q3, Q4 and Q7 and the affirmative responses to options c) and d) of Q5 were tested for significance using Chi-Square analysis and, when appropriate, Fisher's Exact Test.

Differences were considered significant when $P < 0.05$.

The physician's psychodynamic process caused by devastating failure was compared with the mourning process of patients and/or families and mass catastrophe victims studied through interview by one of the authors (MN).

Results and Discussion

There were 306 replies. As six of these were from the members of the society who are not engaged in neuro-endovascular treatment, we analyzed responses from 300 respondents. Although anonymity was optional, most of the respondents signed their names.

51% of respondents stated that they have been the targets of severe recriminations by patients and/or families as a result of complications (Q1). 284 out of 300 respondents had multiple (2.5 on average) signs and symptoms of psychic trauma (Q2). And 23% of respondents were unable to continue the clinical practice of neuro-endovascular therapy or resorted to conservative treatment (Q3).

After such devastating failure, are our colleagues suffering from posttraumatic stress disorder (PTSD)? Most are not, judging from the diagnostic criteria of PTSD (Appendix 2). A decisive difference from those suffering from PTSD is that physicians feel that they are wrongdoers and at the same time victims. Regretting hurt caused to patients entrusted to them brings about feelings of incompetence and a sense of guilt. There is also serious damage

Table 1 **Physician's Psychodynamic Process Caused by Devastating Failure**

- 1) *Intellectualization and searching for procedural mistakes*
- 2) *Emotional measures trying to recall:*
 - a) the image of the physician as a competent specialist
 - b) the motivation that made the physician want to become a specialist
- 3) *Finally work through grief focusing on new patients seeking treatment.*

caused to the physician's personal and professional self-esteem. In the study of the impact of perceived mistakes on physicians, Christensen noticed that physicians employed two types of strategy to cope with the consequences of their mistakes: problem focused and emotion focused. And he stated that physicians for the most part viewed the mistake as an unfortunate situation from which knowledge emerged².

The physician's psychodynamic process caused by devastating failure is regarded as a strategy to return to his/her positive condition (table 1). The initial step is intellectualization and the search for procedural mistakes, but this is not effective when deeply hurt. Then he/she seeks emotional measures and finally works through grief focusing on new patients seeking treatment. The patient and/or family's psychodynamic grieving process is radically different from the physician's (table 2). Their psychic trauma is much more intense, because lost lives, physical capabilities and time cannot be restored to them. The mourning process is an adaptive advantage that allows maximum survival characteristics when human beings are placed in situations of extreme stress. However, judging from the responses to Qs 2,3 and 5, physicians often fail to complete the mourning process - thus failing to release the emotion of the situation and attain catharsis. This is because of the common belief that because doctors are medical problem solvers, it is only natural that they should want to focus their attention on a perceived problem or mistake instead of their own grief 1.

Also, we have to realize that when patients and/or families are working through the grieving process, before facing up to reality they tend to wish to bring the responsible physicians

to justice, primarily in order to effect procedural changes to ensure the deceased did not die in vain (phase IV, table 3). For them, the anticipation of the trial may become something to live for. Hence, informed consent becomes a central issue here. With regard to question Q 8, most physicians regard informed consent as a necessary functional element (a: 57%) or a protective device (b+c: 62%) in performing procedures. We should notice that the patient's self-determination can only be achieved after the patient-physician relationship matures. However, only 29 % of the respondents regard informed consent as a record of dynamic interaction between patient and physician before achieving the patient's self-determination.

Many of the respondents experienced communication breakdown in the patient-doctor relationship despite apparently complete informed consent (Q6). As a reason for this, 13% of the respondents mentioned that the treatment was consented to without the unanimity of family members. And 19% of the respondents felt that the patient and/or family members regretted having consented to the treatment. As to the patient and/or family's ability to understand explanations (Q12), 67% of the respondents regarded patients and families as their allies in combating disease, but 55% of them were pessimistic about their ability to understand explanations. These facts might suggest that the higher the risk of the treatment, the more patients and/or families fail to appreciate the magnitude of the risk by psychologically refusing to hear what they are being told. The following key points of recommendations by the Assistance Publique des Hopitaux de Paris are most relevant to the matter discussed here³:

- 1) Oral information is the priority and must be clear, fair, understandable and ordered.
 - 2) The practitioner should always verify that the information imparted has been properly understood.
 - 3) On patient admission, details of the family members to be informed must be systematically collected.
 - 4) Any information given to the patient must be in the medical file. It is to be presumed that only the details noted have been communicated.
 - 5) Obtaining written patient consent is neither compulsory nor recommended.
 - 6) In the event of litigation centering around failure to inform, whether information has been correctly imparted or not will be assessed on the basis of a range of elements such as: the period allowed the patient to take an informed decision, the number of visits, practitioners consulted before proceeding, the systemic provision of information leaflets and the notes made on the patient record.
- The followings are problems frequently encountered in the medical field in Japan, and were pointed out by many respondents:
- 1) *Doctor-Patient Relationship*
 - Traditionally a patient and/or family cannot talk with a physician on an equal footing because of naiveté on the patient and/or family side and paternalism on the physician side.
 - 2) *Patients and/or Families*
 - They cannot accept the risks associated with treatment because they expect medical treatment to effect a cure.
 - They do not attach importance to informed consent, and family members who are not informed often make complaints when complications occur.
 - 3) *Physicians*
 - They do not know how to cope with medical malpractice, and they are not well prepared to tackle emotional problems especially.
 - 4) *Hospital Environment*
 - Difficult to do comprehensive analyses of

Table 2 Patient and/or Family's Psychodynamic Grieving Process

- I) *Shock Phase*
Never thought that complications would happen in reality.
Illusory denial of the fact.
Feeling of remorse for giving consent for treatment.
- II) *Hyperactive Phase*
Mourning process often disturbed by the necessary practical arrangements following the incident.
Punctuated with phase of hope and illusion followed by desperation and anger.
Hostility to culpable physicians and the hospital.
- III) *Depressive Phase*
Numbing of general responsiveness.
Markedly diminished interest or participation in significant activities.
Restricted range of affections(e.g., unable to have loving feelings).
- IV) *Facing Up To Reality Phase*
Acceptance of handicap/loss
Conducting a spiritual dialogue with the deceased.
The wish to effect procedural changes to ensure the deceased did not die in vain.
The bringing to justice of the responsible physicians.

medical malpractice because of the tendency to each speciality to dispose of problems exclusively.

– The working environment is always understaffed because of budget limitations.

5) *Graduate and Postgraduate Medical Education*

– Japanese medical schools give more weight to basic research than raising good clinicians.

– Faculties are generally more concerned with keeping up on technological improvements than with teaching medical students about the human aspects of clinical medicine.

– There is no teaching system that includes medical malpractice and no faculty specialized in this subject.

One of the special problems we have to face when we have a devastating failure is that we have to treat our own wounds while sharing the agony with the patient and/or family. But only 7% of respondents had medical curricula or residency program training concerning the psychological problems of complications (Q14). There is no systematic approach or education on physician grief in clinical practice: 36% of respondents replied that they are personally trying to overcome a sense of incompetence (Q9), and 52% of respondents admitted that “seeing how their seniors handle the problems” or “talking with their senior about grief” is helpful (Q14).

The results of statistical analyses to assess the correlation between the respondents’ initial response to grieving (Q5) and their change of attitude regarding their ability or willingness to performing the procedure after causing a permanent deficit or losing a patient (Q3), their ability to handle grief (Q4), and their way of overcoming hardships after a tragic experience (Q7), were as follows: Those who responded affirmatively to either Q5 a or b responded more affirmatively to Q3 d than those who responded negatively to Q5 a or b ($P=0.002$). Those who responded affirmatively to either Q5 c or d responded more affirmatively to Q3 e than those who responded negatively to Q5 c or d ($P=0.001$). Those who responded affirmatively to either Q5 c or d responded more affirmatively to Q4 c than those who responded negatively to Q5 c or d ($P=0.039$). Those who re-

sponded affirmatively to either Q5 c or d responded more affirmatively to Q7 c than those who responded negatively to Q5 c or d ($P=0.014$). It may be said that physicians who took a defensive attitude to complications from treatment significantly remained unmoved after tragic experiences, but those who reacted to tragic experience affirmatively and acceptably acquired an ability to empathize with patients and families, felt able to deal with their own grief and were able to reconcile with patients and families. In a study on managing medical mistakes, Mizrahi identified three major devices the housestaff often utilized both for defining and defending the mishap itself. They are as follows: 1) denial, 2) discounting and 3) distancing. He concluded that coping mechanisms are seen as “healthy adaptations under stress, while defense mechanisms are commonly viewed as adaptive devices gone wrong, so that the cognitive field is either partially blocked out or subjected to a major interpretive distortion”⁴.

The circumstances of neuro-endovascular treatment are dramatically changing. With marked advance and diffusion of diagnostic imaging, more and more potentially high-risk cases of asymptomatic or minimally symptomatic neurovascular disease are being found and subjected to endovascular treatment. And when complications result from this treatment, patients and/or families are attempting to talk with physicians on an equal footing armed with medical information obtained through the World Wide Web. Both physicians and patients and/or families should accept the fact that medical malpractice keeps happening because medicine is an underdeveloped field as a science, and we should create a system that allows free and creative talk about the indications and risk of the treatment. Establishing a scientific way of deciding indications and treatment method can reduce medical malpractice. By establishing guidelines for neuro-endovascular treatment, we can standardize treatment and intensively examine its effectiveness and any problems that may result⁵.

Why is physician grief important? A considerable number of respondents regarded maturation as a human beings more important than being a complete physician with special technology and they stressed the importance of family education. After causing permanent

deficits or losing a patient as the result of neuro-endovascular procedure, many respondents tend to focus their attention solely on the details of the failed procedures and repeatedly "undo" actions and relive past events. But intellectualization of the tragic experiences without accepting and working through grief only adds to the physician's grief¹. By facing the emotional truths of responsibility and grief, physicians can develop the ability to empathize with patients and their families. Only mature physicians can help patients make a mature decision in the informed consent process.

Conclusion

We physicians are engaged in a very happy profession (a calling from God) in which we do not need to doubt our motivation to help our diseased fellow human beings. However, when treatment results are bad, we can receive grave psychic trauma when facing a patient and/or family's deep sense of loss and desperation, or by being severely criticized by them, despite a strong psychological defense mechanism acquired in the course of our career. Even if we do not receive psychic trauma stemming from a severe sense of incompetence, the death or disability of a patient whom we were sure we would be able to save causes us acute grief. The psychology of physicians engaged in neuro-endovascular therapy when there are severe complications was compared with that of patients and/or families. The patient and/or families' grieving and mourning are so grave that they often desire to die, and observing their grief reminds us of and intensifies our own grief. Therefore, we tend to avoid intimate contact with them and seek support from our colleagues. Or we might estrange ourselves from our surroundings by repeatedly reviewing DSA and MRI and rationalizing the poor results. Or we might even try to overcome our sense of loss by improving our techniques or the material we used for the operation. However, all of these activities, regarded as intellectualization to overcome our sense of loss, have great limitations. To face a patient and/or family in the mourning process helps them to grieve thoroughly. This is especially important today, because often there is no consolation from the operating physician who may be a different person from the physician in charge. Some-

times it is an important part of a physician's job to accept the anger and recriminations of the patient and/or family. At the same time, it is necessary to recognize our masked grief and reveal it.

Through this study, it became apparent that the main issue is "What is maturation as a physician?" It could be said that the acquisition of technical skills is only one aspect of growth as a physician. It is obvious that through the grief of a patient and/or family suffering from severe complications and through their own grief, physicians can mature emotionally. This is because to live through the grief of a patient and/or family thoroughly enriches the physician's life, in the same way as celebrating the cure of the diseased does.

References

- 1 Hettis S, Werne A et Al "...and Do No Harm." *Am J Neuroradiol* 16: 1-5, 1995.
- 2 Christensen JF, Levinson W, Dunn P: The heart of darkness: the impact of perceived mistakes on physicians. *J Gen Intern Med* 7: 424-431, 1992.
- 3 Lasjaunias P: Recommendations of the Assistance Publique des Hopitaux de Paris, AH-PH (Paris Public Hospitals Group) France: The role of medical and non-medical staff in providing information to patients. *Interventional Neuroradiology* 6: 269-276, 2000.
- 4 Mizrahi T: Managing medical mistakes: ideology, insularity, and accountability among internists-in-training. *Soc Sci Med* 19: 135-146, 1984.
- 5 Lasjaunias P: Towards European standards in neuroradiology. *Interventional Neuroradiology* 6: 173-176, 2000.

Acknowledgement

First of all, the authors express their heartfelt appreciation to our Japanese colleagues who cooperated with this questionnaire survey by truthfully responding to multiple difficult questions. Also, editing work performed by Mr. Steve Cotton from the International Training Program of Iizuka Hospital and statistical analyses performed by epidemiologists Dr Matsui from Kyoto University School of Medicine and Dr. Imura from Iizuka Hospital is appreciated.

APPENDIX 1

Questionnaire Survey for the Members of the Japanese Society of Neuro-Endovascular Therapy about Grieving Over Complications Associated with Neuro-endovascular Treatment
Questions and Answers from 300 Respondents

Q1 *Have you had the experience of being a target of major recriminations after causing a severe complication of neuro-endovascular procedure performed as a preventive measure for a potentially dangerous disease on an asymptomatic or minimally symptomatic patient?*

- a) Yes: 51%
- b) No: 49%

Q2 *Which of the following happened to you after causing permanent deficit or losing a patient as a result of the neuro-endovascular procedure performed by you?*

- a) Became depressed and to some extent lost incentive to work: 35%
- b) Felt a sense of incompetence and guilt and suppressed it: 32%
- c) Became irritable and assumed a defensive attitude towards the patient and/or family: 6%
- d) Felt sharp pain associated with sense of incompetence and guilt, "like an arrow through the heart": 15%
- e) When alone, felt nausea, sighed, cried and found myself mumbling words of regret without knowing the reason why: 13%
- f) Had flash back of the moment of the incident: 26%
- g) Obsessively reviewed patients' DSA and MRI in order to recall the details of the procedure and try to understand the cause of the incident: 47%
- h) Repeatedly undid the procedure in the mind thinking that the mistake might have been avoided if the procedure had been performed in some other way: 66%
- i) Felt grief at the recriminations of the traumatized patient and/or family, but tried to absorb myself in my work reminding myself that grief is one of the hazards of my profession: 15%

Q3 *Which of the following represents a change in your attitude to performing the procedure after causing a permanent deficit or losing a patient?*

- a) Became unable to perform the procedure

because of the fear of seeing the anguish of patient and/or family again: 3%

- b) Became unable to perform the procedure after being the target of severe recriminations by patient and/or family or colleagues for having caused a severe complication: 1%
- c) Able to continue the work, but tended to limit myself to conservative treatments: 19%
- d) Did not make any change because it is statistically unavoidable for a percentage of complications to occur: 14%
- e) Grieved deeply, but able to continue in the profession after working through grief. Felt better able to understand the psychology of the patient/family: 71%

Q4 *What is your strong point compared with general physicians in dealing with grief?*

- a) Able to handle grief better, because I am not so intimate with patients and/or family as general physicians: 1%
- b) Unable to handle grief well, because patients were entrusted to me as an "expert": 8%
- c) Able to handle grief as well as general physicians, because every physician is doing his/her best to help patients: 22%
- d) Whether one is a specialist or a general physician does not matter, because everybody is trying to handle grief based upon one's faith and strength: 69%

Q5 *Do you have enough time for grieving after causing permanent deficit or death by procedural complication?*

- a) No, because I am too busy in clinical practice, research and education to have time for grieving: 28%
- b) No, I do not think it necessary, because I always try to keep some psychological distance from such circumstances: 7%
- c) Yes, I think that to cope with such distress caused by a sense of guilt and loss is important for my learning and growing process: 52%
- d) Yes, I think by grieving deeply, empathy with

the mentality of the patient and/or family can be attained: 9%

Q6 *Why did the relationship with the patient and/or family become difficult after major complications?*

- a) A defect in the informed consent form was pointed out by a patient and/or family: 14%
- b) Though there was no defect in the consent form, consent was not obtained from the appropriate members of the family: 13%
- c) A patient and/or family deeply regretted giving consent: 19%
- d) The operating physician and/or his assistants engaged in the treatment did not deal appropriately with a patient and/or family after the incident: 10%
- e) The attitude of physicians and/or paramedical staff not engaged in the procedure was inappropriate: 6%

Q7 *Which of the following helped you to overcome hardships after causing permanent deficits or losing a patient?*

- a) Training as a scientist or a professional: 29%
- b) Complete informed consent: 22%
- c) Given patient and/or family's forgiveness, reaching an amicable settlement with them: 27%
- d) By totally absorbing myself in work or hobby: 7%
- e) By the consolation of spouse or friends from outside of medicine: 10%
- f) Support from colleagues or senior physicians: 40%
- g) By obtaining a mentor: 5%

Q8 *Which of the following represents the function and style of the informed consent you have been using?*

Informed consent is:

- a) To outline the procedure, and to detail the probability of normal side effects and complications: 57%
- b) A kind of permission given by a patient and/or family after thorough discussion about the risks and benefits of the procedure: 36%
- c) A physician's promise to do his/her best in treating disease, making it clear that a physician is not a miracle-maker: 26%
- d) A document of dynamic interaction between a physician and a patient and/or family who

have considered the possibility of various complications prior to treatment: 29%

Q9 *Which of the following represent the relationship between you and your colleagues/staff members during hardships related to complications?*

- a) Helping each other, at the same level, to cope with a sense of incompetence: 28%
- b) You, as a physician, leading your colleagues/staff member to cope with a sense of incompetence: 14%
- c) Your colleagues/staff members are helping you by dealing with a sense of incompetence threatening your team: 17%
- d) Everybody is taking care of a sense of incompetence, individually: 36%
- e) My colleagues/staff members were totally indifferent to my hardship: 7%
- f) My colleagues/staff members deepened my wound by blaming me: 3%

Q10 *As you acquire more experience, how do you feel about your grieving over permanent complication or losing patient?*

- a) It is becoming easier: 12%
- b) More accepted by my colleagues/staff members: 11%
- c) Both a) and b): 11%
- d) It is getting more and more difficult as the numbers of bad results increase: 10%
- e) No change is seen as I get more experience: 43%

Q11 *I cannot grieve over complications because of the fear of major financial loss or of my mistake becoming widely publicized if the case is filed.*

- a) Yes: 12%
- b) No: 81%

Q12 *What is your point of view regarding the patient and/or family's level of understanding of your explanation?*

- a) They cannot understand the possibility of catastrophic results resulting from preventive treatments for asymptomatic or minimally symptomatic patients with potentially dangerous diseases: 16%
- b) They tend to remember only the part of my explanation convenient to them: 39%
- c) Any result will be accepted if I perform what I consider to be the best treatment to the best of my ability: 1%

d) I do my best to let my patient and/or family understand everything as I believe my patient and/or family are allies in the fight against disease: 67%

Q13 Do you agree with the following statement?

The reason for the lack of debate concerning how to deal with emotional problems related to medical malpractice in postgraduate education and clinical practice is that the medical field is an extremely competitive environment.

- a) Yes: 20%
- b) No: 71%

Q14 Did the medical education you received (undergraduate and graduate) deal with the psychological problem of causing pain to a patient and/or family by being responsible for permanent deficits or death resulting from complications?

- a) Yes: 7%
- b) No: 93%

Q15 If you answered "yes" to the Q14, which of the following was part of the medical education you received? If you answer "no" to the Q14, which of the following do you think is useful?

More than one choice is permitted.

- a) Lectures and readings on grief during the general education course: 12%
- b) Seeing senior physicians cooperating with a patient and/or family in grief in order to overcome hardships: 25%
- c) Discussing grief with experienced physicians: 27%

Q16 How much of your working time is devoted to neuro-endovascular therapy?

- a) 100%: 28%
- b) More than 75%: 9%
- c) 50-75%: 11%
- d) 25-50%: 17%
- e) Less than 25%: 35%

Q17 What was your motivation to be a physician?

- a) No obvious reason: 9%
- b) As a successor to my physician parent(s): 5%
- c) Wanted to be a specialist: 32%
- d) Longed to be a physician as a profession: 48%
- e) Wanted to be someone who shared both the affliction and the celebration of the cure of the disease with patients: 20%

APPENDIX 2**Diagnostic Criteria of Post Traumatic Stress Disorder -PTSD
(Diagnostic Criteria issued by the American Society of Psychiatry DSM-IV, 1994)**

A. *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.

B. *The traumatic event is persistently re-experienced 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 at 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

C. *Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before 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 of detachment or estrangement from others
 - 6) Restricted range of affection (e.g. unable to have loving feelings)
 - 7) Sense of 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 trauma), as indicated by two (or more) 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 Criteria B, C, and D) is more than 1 month.*

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

Specify if:

Acute: If duration of symptoms is less than 3 months

Chronic: If duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

K. Goto
Ohta Memorial Hospital
Fukuyama
Japan