POST TRAUMATIC STRESS DISORDER. FORENSIC REPERCUSSIONS

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Keywords: *road accident, mental disability, post-traumatic stress disorder*

Abstract: *Posttraumatic stress disorder (PTSD) is characterized by exposing an individual to a traumatic, stressful event or his exposure as a witness to such an event and beyond his ability to cope with the situation. As a consequence of these events, the subject exhibits extreme fear, nightmares, intrusion of thoughts and images associated with permanent anxiety, with depressive states, and insomnia. We exemplify by presenting the case of a 61-year-old man without a psychiatric background, victim of a road accident in June 2017 as a driver who presented no traumatic injuries and who shows three months after the event a subjective symptomatology with headaches, dizziness, anxiety, memory and concentration disorders requiring forensic expertise. It was concluded that the diagnosis of PTSD was grafted on an affective-emotional background, without posttraumatic organic substrate. This disorder is temporary, it can be treated under specialized treatment and it is not a mental disability.*

INTRODUCTION

Posttraumatic stress disorder (PTSD) is characterized by exposing an individual to a very stressful event of either short or continuous catastrophic, traumatic, life-threatening incident or exposure to such an event and beyond his ability to cope with the situation. This psychiatric condition usually occurs in previously healthy people as a result of the event. Types of situations involved can cause major stress in most exposed persons, so the major traumatogenic situations include: violent sexual or mechanical aggression, physical torture, natural or industrial disasters, severe work-related or road traffic accidents. An increased risk of developing PTSD is presented in women, children, the elderly, low levels of living, social deprivation, low intelligence, the presence of personality traits, especially the neurotic background, various mental illnesses and people suffering at the same time from a psychological trauma and a physical trauma.(1,2)

As a result of these traumatic events, the subject exhibits extreme fears, indignation, nightmares, intrusion of thoughts and images associated with permanent anxiety tension, with depressive states, phobic avoidance of reminders of the traumatic situation, hypervigilance, overstimulation, and insomnia.(1,2) These manifestations may become evident after a certain period of time, typically ranging from few weeks to several months, as opposed to the acute reaction to stress where immediate short-term responses occur and last for several hours or days, characterized through great anxiety, agitation and disorientation, having a self-limiting character or can install a PTSD.(3,4)

The post-traumatic stress disorder is manifested by re-experiencing events with the spontaneous occurrence of memories of the traumatic event, repetitive dreams, so-called flashbacks (intense and very lively retrospective episodes that suddenly occur during an ordinary day) or other stressful, repeated, prolonged mental manifestations. There are thoughts followed by bad moods, dominated by depressive symptoms, persistent anxiety, decreased concentration, insomnia, increased irritability with anger, difficulty concentrating, exaggerated reactions to stimuli, feelings of guilt or blame towards others, the significant diminution of interest in daily activities. Disability of the patient occurs through the behaviour of avoiding any situations closely related to the traumatic event until the amnesia of the trauma.(5,6) There is also a state of affectional indifference manifested by detachment from reality, entourage, from his own previous motivations, diminishing the amplitude of his emotions, abandoning the important activities.(7)

The sufferer feels slightly offended, exhibits aggressive manifestations, reacting quickly to external stimuli.(8,9)

PURPOSE

The purpose of this article is to demonstrate that the PTSD is not in this situation a mental disability.

CASE REPORT

We present the case of a 61-year-old man without a psychiatric pathological history, the victim of a road accident in June 2017 as a driver who suffered minor injuries, consisting of a calf escoriation for which he required 1 -2 days of health and life-threatening care, according to the medical certificate issued by the Institute of Forensic Medicine (IML) Tg. Mures. Since three months after the aforesaid road event, the suspect presented a subjective symptomatology consisting of (headache, dizziness, anxiety, memory and concentration disorders) at the request of the Mureș County Police Inspectorate, in October 2017, he was re-examined by the psychiatric forensic committee.

The person showed himself in front of the forensic psychiatric commission at Institute of Forensic Medicine Târgu-Mureș dressed in clean, neat clothes. Visual and verbal contact has been easily accomplished, is temporo-spatially oriented to

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Article received on 01.05.2018 and accepted for publication on 29.05.2018
ACTA MEDICA TRANSILVANICA June 2018;23(2):24-26

one's own person.

He has Romanian citizenship, Hungarian nationality, graduated 12 classes, worked as a driver, and he retired four years ago. Non-psychiatric pathological antecedents: not known. The man reported that he has the B, C, E categories of driving license since 1976, he worked as a driver both in the home country and abroad, and was not involved in any road accident for 41 years. However, on June 18, 2017 while driving his personal car that was stationary at the time of the impact, a van bumped into the back of his car. At the moment of impact, he affirmed that he has lost consciousness. The road accident only resulted in material damages of the man's car, which was totally damaged. The man sadly describes the fact that he owned a 29-year-old Audi, an old car, but very well-maintained, that he bought from Germany in 1992 and which after the accident was declared total damage, being valued by the insurance company at 850 Euros. The man mentions that he has not driven since the accident, because he has a permanent fear of driving or taking other means of transport, preferring to walk. He mentions that he has nightmares, "I dream that I am fighting dwarfs", and he is sweating having insomnia, and moments of easy crying. In terms of toxic consumption: he denies alcohol, consumes coffee occasionally, and gave up smoking 2 years ago.

Psychiatric examination: At our request, he was admitted to the Psychiatryc I Târgu-Mures Clinic for a period of two weeks, where the establishing diagnostic was: "Posttraumatic stress syndrome, posttraumatic cerebral syndrome, oscillating HTA (arterial hypertension)".

From the epicrisis it appears that the suspect does not know of any pathological psychiatric antecedents, but four months ago he suffered a car accident from which, he suffered a cranio-cerebral trauma affirmative with the loss of short-term knowledge. He presented a psychopathological picture dominated by: psychomotor anxiety, irritability, depressed mood, rumming about the road accident, easy crying, low vitality, low tolerance to frustration and mixed insomnia (nightmares). At the psychical examination, he showed: cooperative attitude, relatively easy to establish visual and verbal contact, plurisensorial hyperesthesia (is disturbed by light and noise), selective focused attention of the theme of the accident and the illness of the wife (attention disorders); memory disturbance, good orientation in time and space, ideological flux consistent with normal rhythm, irritability, anxiety, depressed mood, increased instinct of defense, psychomotor restlessness, impulsivity, mixed insomnia.

The general clinical examination included: hypomobile facies, normostenic constitution, lumbar and cervical spine contusions, right calf escoriations, sporadic post-accident scars in the neck and bilateral calf's. During treatment he received treatment: endovenous perfusion (PEV) with solutions of sodium Chloride (NaCl) + vitamin B1, B6 + Aspatofort, Alprazolam 0.5 mg, Silimarin, Folic Acid, Tanakan, Zolpidem 10 mg, and the evolution of the therapy was favourable. At the discharge it was recommended: balanced life regime, to avoid psych trauma, conflict situations and toxics of any nature (coffee, alcohol, tobacco), monthly psychiatric control, continuing the medical treatment according to the recommendations: Tanakan 3x1, Carbamazepine, Mirzaten 30 mg, Alprazolam 0.5 mg, Zolpidem 10 mg, Silimarin, Folic Acid, B9-Vitamin.

Psychological examination: reveals a psychoemotional status dominated by intrapsychic tension, difficulty in comforting, low tolerance to frustration, change in sensory thresholds, easy crying, depressive affective resonance and according to the Hamilton Depression Scale (HAM-D) = 22, anticipatory anxiety, exacerbation of situational emotional states related to psychotrauma four months ago (road accident) with implications for global operation, and according to Hamilton Anxiety Scale (HAM-A) > 25, and Global Assessment of functioning Scale (GAFS) = 50.

The neurological examination established the diagnosis of Craniocerebral Syndrome. Electroencephalography (EEG): alpha activity without pathological changes.

DISCUSSIONS

The psychiatric forensic expertise is a complex one that analyzes and interprets all the medical records related to the trauma suffered, the intensity, the nature and the localization of the lesions, respectively the immediate or evolutionary psychiatric displays, the objectification of the symptoms through clinical and paraclinical examinations that can reveal a posttraumatic organic substrate of the psychic condition, the possibility of their improvement under treatment, the establishment of the causal relationship between the trauma and the psychological condition diagnosed, respectively the state of permanent psychiatric disability. Consideration will be given to the patient, his personality type (especially the neurotic background) and environmental factors (conflictual, frustrating, hostile) in the psychogenic generation of symptoms.(10,11)

The forensic interpretation of post-traumatic psychiatric pathology has important legal implications in deciding a post-traumatic psychiatric disability state. This is represented by all the psychological modifications, being deteriorative, cognitive and psycho-behavioral, conditionally caused by the existence of a cerebral traumatic brain injury with objectively cerebral lesion substrate, to a person without psychiatric antecedents.(10)

In traumatized subjects, certain genetic risk factors confer vulnerability to psychiatric disorders, so the probability of developing posttraumatic stress disorder (PTSD) is higher in people with a history of heredocolateral affective, anxious or substance-related disorders. An important role is played by self-esteem, optimism, humor, self-efficacy, positive reporting to one's own abilities and resources, a place of internal control, spirituality, problem solving, and interpersonal relationship management. Resilience in the context of exposure to a traumatic event. Also, a series of post-traumatic factors related to the subjective contextual and objective perceived especially relational, interpersonal and social in which the impact of trauma reverberates prevents extinction of the physiological posttraumatic response: nightmares, insomnia, and impairment of everyday functions, reactions and attitudes of others towards to the post-traumatic symptomatology of the person.(12,13)

Infirmity is quantified binary by being present or absent, it is not quantified in degrees or percentages and cannot be temporary. Due to the permanent character, infirmity is appreciated only after the exhaustion of all the usual recovery therapeutically means. In order to establish a potential psychiatric disability, a series of 6 to 12-month examinations, for an extended period of time between 2-5 years, annual psychological assessments based on cognitive assessment are performed.(10)

Treatment requires a complex approach in which cognitive-behavioral psychotherapy doubles pharmacotherapy. It is used selective serotonin reuptake inhibitors and tricyclic antidepressants, and it is been demonstrated that they contribute in overcoming the patient's tendency to avoid contact with reminders of the traumatic event. Benzodiazepines reduce the hyper excitability reaction but should be administered with caution in order not to induce dependence. In most situations, time is the most effective treatment.(14-16) Consideration should be given to the type of personality of the patient

(especially the neurotic background) and environmental factors (conflictual, frustrating, and hostile) in the psychogenic generation of symptoms.

CONCLUSIONS

It was concluded that the diagnosis of "Posttraumatic stress disorder" was grafted on an affective-emotional background, without posttraumatic organic substrate (no traumatic important lesions). This disorder is temporary and can be resumed under specialized treatment. Given the major legal implications of the diagnosis of PTSD, this must be considered subjectively from a forensic perspective, considering the presence of traumatic injuries, the circumstances in which they occurred, and following the evolution of the psychiatric symptomatology in conjunction with the personality of the patient, his age, level of intelligence and social condition.

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