TRAUMA-AND STRESSOR-RELATED DISORDERS

Dr. Rawan Masri

DSM-5 TRAUMA-AND STRESSOR-RELATED DISORDERS:

- Post Traumatic Stressor Disorder (PTSD).
- Acute Stress Disorder.
- Adjustment Disorder.

POSTTRAUMATIC STRESS DISORDER(PTSD) AND ACUTE STRESS DISORDER

Mrs. M sought treatment for symptoms that she developed in the wake of an assault that had occurred about 6 weeks prior to her psychiatric evaluation. While leaving work late one evening, Mrs. M was attacked in a parking lot next to the hospital in which she worked. She was raped and badly beaten but was able to escape and call for help. On referral, Mrs. M reported frequent intrusive thoughts about the assault, including nightmares about the event and recurrent intrusive visions of her assailant. She reported that

she now took the bus to work to avoid the scene of the attack and that she had to change her work hours so that she did not have to leave the building after dark. In addition, she reported that she had difficulty interacting with men, particularly those who resembled her attacker, and that she consequently avoided such interactions whenever possible. Mrs. M described increased irritability, difficulty staying asleep at night, poor concentration, and an increased focus on her environment, particularly after dark.

POST TRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER:

- Both Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder are marked by increased stress and anxiety following exposure to a traumatic or stressful events. (the response to the traumatic event must involve intense fear and horror)

- Traumatic or stressful events may include being a witness to or being involved in a violent accident or crime, military combat, or assault, being kidnapped, being involved in a natural disaster, or experiencing systematic physical or sexual abuse.

EPIDEMIOLOGY OF PTSD:

- The lifetime incidence of PTSD is estimated to **9 to 15%** and the lifetime prevalence of PTSD is estimated to be about 8% of general population.
- The lifetime prevalence rate is **10% in women** and **4% in men**.
- According to the National Vietnam Veterans Readjustment Study (NVVRS), 30 percent of men develop full-blown PTSD after having served in the war
- Although PTSD can appear at **any age**, it is most prevalent in young adults, because they tend to be more exposed to precipitating situations.
- The most important risk factors are **severity**, **duration**, and **proximity of a person's exposure to the actual trauma.**
- A familial pattern seems to exist as first-degree biological relatives of persons with a history of depression have an increased risk for developing PTSD following a traumatic events.

ETIOLOGY

Stressor

By definition, a stressor is the prime causative factor in the development of PTSD. Not everyone experiences the disorder after a traumatic event, however. The stressor alone does not suffice to cause the disorder. The response to the traumatic event must involve intense fear or horror. Clinicians must also consider individual's preexisting biological and psychosocial factors and events that happened before and after the trauma. For example, a member of a group who lived through a disas ter can sometimes better deal with trauma because others have also shared the experience. The stressor's subjective meaning to a person is also important. For example, survivors of a catas trophe may experience guilt feelings (survivor guilt) that can predispose to, or exacerbate, PTSD.

Biological Factors

Many neurotransmitter systems have been implicated by both sets of data. In clinical populations, data have supported hypotheses that the noradrenergic and endogenous opiate systems, as well as the HPA axis, are hyperactive in at least some patients with PTSD. Other major biological findings are increased activity and responsiveness of the autonomic nervous system, as evidenced by elevated heart rates and blood pressure readings and by abnormal sleep architecture (e.g., sleep fragmentation and increased sleep latency).

PREDISPOSING FACTORS IN PTSD:

1. Presence of childhood trauma.
2. Borderline, paranoid, dependent, or antisocial personality disorder traits.
3. Inadequate family or peer support system.
4. Female gender.
5. Genetic vulnerability to psychiatric illness.
6. Recent stressful life changes.
7. Recent excessive alcohol intake.

DSM-5 DIAGNOSTIC CRITERIA FOR PTSD:

(THE FOLLOWING CRITERIA APPLY TO ADULTS, ADOLESCENTS, AND CHILDREN OLDER THAN 6 YEARS.)

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic events(s).

2. Witnessing in person the event(s) as it occurred to others.

3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic events(s) (e.g. First responders collecting human remains; police officers repeatedly exposed to details of child abused).

DSM-5 DIAGNOSTIC CRITERIA FOR PTSD:

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

DSM-5 DIAGNOSTIC CRITERIA FOR PTSD:

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, evidence by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders(people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with traumatic event(s).

DSM-5 DIAGNOSTIC CRITERIA FOR PTSD:

D. Negative alterations in cognitions and mood associated with the beginning or worsening after the traumatic event(s) occurred, as evidence by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. "I am bad." "No one can be trusted" "The world is completely dangerous" "My whole nervous system is permanently ruined").

3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others. (Survivor's guilt)

4. Persistent negative emotional state (e.g. Fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estranged from others.

7. Persistent inability to experience positive emotions (e.g. inability to experience happiness, satisfaction, or loving feelings).

DSM-5 DIAGNOSTIC CRITERIA FOR PTSD:

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidence by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Problems with concentration.
5. Exaggerated startle response.
6. Sleep disturbance (e.g. difficulty falling or staying asleep or restless sleep)

DSM-5 DIAGNOSTIC CRITERIA FOR PTSD:

F. Duration of the disturbance (Criteria B, C, D, and E) is **more that 1 Month.**

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

H. The disturbance is not attributable to the physiological effects of a substance (e.g. medication, alcohol) or another medical condition.

CRITERIA FOR PTSD:

Trauma

Traumatic event

Re-experiencing the event

Avoidance of stimuli associated with trauma

Unable to function

More than a **M**onth

Arousal increased

+negative alterations in cognition and mood.

ACUTE STRESS DISORDER

DSM-5 DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER:

A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the event(s) occurred to a close family member or close friend. (the events must be violent or accidental)
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)(e.g. first responders collecting human remains, police officer repeatedly exposed to details of child abuse).

DSM-5 DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER:

B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the event(s).

3. Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.(Such reactions may occur on a continuum, with the most expression being a complete loss of awareness of present surroundings.)

4. intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

DSM-5 DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER:

Negative mood:

5. Persistent inability to experience positive emotions (e.g. inability to experience happiness, satisfaction or loving feelings.)

Dissociative Symptoms:

6. An altered sense of the reality of one's surroundings on oneself (e.g. seeing one self from another's perspective, being in a daze, time slowing.)

7. Inability to remember an important aspect of the traumatic event(s).(typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs.)

Avoidance Symptoms:

8. Efforts to avoid distressing memories, thoughts, or feeling about or closely associated with the traumatic event(s).

9. Efforts to avoid external reminders (people, places, conversation, activities, object, situations) that arouse distressing memories, thought, or feelings about closely associated with the traumatic event(s).

DSM-5 DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER:

<u>Arousal Symptoms:</u>

10. Sleep disturbance (e.g. difficulty falling or staying asleep, restless sleep).

11. Irritable behavior and angry outburst (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.

12. Hypervigilance.

13. Problems with concentration.

14. Exaggerated startle response.

DSM-5 DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER:

C. Duration of the disturbance (symptoms in Criterion B) is **3 days to 1 months** after trauma exposure.

(Symptoms typically begin immediately after the trauma, but persistence for at least 3 days up to 1 month is needed to meet disorder criteria).

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

E. The disturbance in not attributable to physiological effects of a substance (e.g. medication, alcohol) or another medical condition and is not better explained by brief psychotic disorder.

COURSE AND PROGNOSIS OF PTSD:

- PTSD usually develops some time after the trauma. The delay can be as short as 1 week or as long as 30 years.
- Symptoms can fluctuate over time and may be most intense during periods of stress.
- Untreated, about 30% of patients recover completely, 40% continue to have mild symptoms, 20% continue to have moderate symptoms, 10% remain unchanged or become worse.
- After 1 year, about 50% of patient will recover.

COURSE AND PROGNOSIS:

- A good prognosis is predicted by:

1. Rapid onset of the symptoms.
2. Short duration of the symptoms(less than 6 months)
3. Good premorbid functioning.
4. Strong social support.
5. The absence of other psychiatric, medical, or substance-related disorder or other risk factors.

- In general, the very young and very old have more difficulty with traumatic events than do those in midlife.

COMORBIDITY:

- Comorbidity rates are high among patients with PTSD, with about two thirds having at least 2 other disorders.

- Common comorbid condition include:

1. Depressive disorders.
2. Substance- related disorders.
3. Anxiety disorders.
4. Bipolar disorders.

- Comorbid disorders make persons more vulnerable to develop PTSD.

DIFFERENTIAL DIAGNOSIS:

1. Head injury during the trauma.
2. Epilepsy.
3. Alcohol-use disorders, and other substance-related disorders.
4. Panic disorder.
5. Generalized anxiety disorder.

TREATMENT:

- When a clinician is faced with the a patient who has experienced a significant trauma, the major approaches are support, encouragement to discuss the event, and education about a variety of coping mechanisms(e.g. relaxation).
- Additional support for the patient and family can be obtained through local and national support groups.
- Eye Movement desensitization and reprocessing (EMDR) (Gold standard)
- Pharmacotherapy:

1. SSRIs (Sertraline and Paroxetine).
2. TCAs (Imipramine and Amitriptyline).
3. Prazosin (for treating disturbing dreams and nightmares)
4. Benzodiazepines (for acute anxiety)

- Adjunctive atypical antipsychotics (risperidone, olanzapine)

  Benzodiazepines are not preferred because of high rates of dependence among patients.

- Psychotherapeutic interventions (behavior therapy, cognitive therapy and hypnosis).

- Eye movement desensitization and reprocessing(EMDR): an experimental method of reprocessing memories of distressing events by recounting them while using a form of dual attention stimulation such as eye movements, bilateral sound, or bilateral tactile stimulation.

ADJUSTMENT DISORDERS

ADJUSTMENT DISORDERS:

- Adjustment disorders are characterized by an emotional response to a stressful events.

- Typically, the stressor involves financial issues, a medical illness, or relationship problem.

- The symptom complex that develops may involve anxious or depressive affect or may present with a disturbance of conduct.

- By definition, the symptoms must begin within **3 months** of the stressor.

SUBTYPES OF ADJUSTMENT DISORDER:

1. Adjustment disorder with depressed mood.

2. Adjustment disorder with mixed anxiety and depressed mood.

3. Adjustment disorder with disturbance of conduct.

4. Adjustment disorder with mixed disturbance of emotion and conduct.

5. Adjustment disorder unspecified.

EPIDEMIOLOGY OF ADJUSTMENT DISORDERS:

- The prevalence of Adjustment Disorders is estimated to be from 2-8% of the general population.
- In adults, F:M = 2:1
- And single women are generally overly represented as most at risk.
- In children and adolescent, F:M = 1:1
- The disorders can occur at any age but most frequently diagnosed in adolescents.
- Among adolescent, common precipitating factors are school problems, parental rejection and divorce, and substance abuse.
- Among adults, common precipitating factors are marital problems, divorce, moving to a new environment, and financial problems.

DSM-5 DIAGNOSTIC CRITERIA FOR ADJUSTMENT DISORDERS:

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
C. 1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptoms severity and presentation.
D. 2. Significant impairment in social, occupational or other areas of functioning.
C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
D. The symptoms do not represent normal bereavement.
E. Once the stressor or its consequences have terminated, the symptoms do not persist for more that 6 months.

DIFFERENTIAL DIAGNOSIS OF ADJUSTMENT DISORDERS:

1. Uncomplicated bereavement.(normal psychological and emotional reaction to a significant loss, also called grief or mourning)
2. Major depressive disorder.
3. Brief psychotic disorder.
4. Generalized anxiety disorder.
5. Somatic symptom disorder.
6. Substance-related disorder.
7. Conduct disorder.
8. PTSD

COURSE AND PROGNOSIS OF ADJUSTMENT DISORDERS:

- With appropriate treatment, the overall prognosis is generally favorable.
- Most patients return to their previous level of function within 3 months.
- Some persons (particularly adolescents) will later have a diagnosis of mood disorders or substance-related disorders.
- Adolescents typically require a longer time to recover than adults.
- Risk for suicide, especially in adolescent patients with depressed mood subtype.(comorbid diagnosis of substance abuse and personality disorder increase the risk of suicide)

TREATMENT OF ADJUSTMENT DISORDERS:

1. Psychotherapy– treatment of choice.
2. Pharmacotherapy – no studies have assessed the efficacy of pharmacological interventions, but it may beneficial to use medications to treat specific symptoms for a brief time.(e.g. benzodiazepines for significant anxiety symptoms(short-term and low-dose))

NOTES:

- The presence of a stressor is a requirement for the diagnosis of PTSD, Acute Stress Disorder and Adjustment Disorders.

- PTSD and acute stress disorder have the nature of the stressor better characterized and are accompanied by a defined constellation of affective and autonomic symptoms.

- In contrast, the stressor in adjustment disorder can be of any severity, with a wide range of possible symptoms.

- When the response to an extreme stressor does not meet the acute stress or PTSD threshold, the adjustment disorder would be appropriate.

THE END