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Post-traumatic stress disorder

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Summary

Post-traumatic stress disorder develops as a delayed and prolonged response to strong short-term or longer-term stressors which act destructively on every person regardless of their resilience

Three different factors seem to be relevant: the severity and duration of the stressing event, the personal and emotional characteristics of the victim, and the degree of psychological support received after the trauma.

Post-traumatic stress disorder must be differentiated from other mental disorders such as brief psychotic disorder, conversion disorder, major depressive disorder, acute stress disorder, obsessive compulsive disorder, schizophrenia, other psychotic disorders, mood disorder with psychotic features, a delirium, substance-induced disorders, psychotic disorders due to a general medical condition, and malingering.

Streszczenie

Zaburzenia stresowe pourazowe rozwijają się jako opóźniona i przedłużona w czasie reakcja na silne stresory, o krótkim lub dłuższym okresie trwania, które oddziaływają destrukcyjnie na wszystkich ludzi, bez względu na poziom odporności psychicznej.

Trzy różne czynniki wydają się być istotne: nasilenie i czas trwania sytuacji stresującej, osobowościowe i emocjonalne cechy ofiary, stopień psychologicznego wsparcia otrzymanego po urazie.

Zaburzenie stresowe pourazowe należy różnicować z innymi zaburzeniami psychicznymi, takimi jak: krótki epizod psychotyczny, zaburzenia konwersyjne, zaburzenia depresyjne, ostra reakcja na stres, zaburzenie obsesyjno-kompulsyjne, schizofrenia, inne zaburzenia psychotyczne, zaburzenia nastroju z cechami psychotycznymi, majaczenie, zaburzenia wywołane nadużywaniem substancji psychoaktywnych, zaburzenia psychotyczne wywołane ogólnym stanem zdrowia, symulacja.

Keywords: Post-traumatic stress disorder, anxiety
Słowa klucze: Zaburzenie stresowe pourazowe, lęk

The major symptom of post-traumatic stress disorder is anxiety, and its cause is stress acting on a person. The stress may be triggered by various factors, e.g., combat; some authors have even referred to this condition as "the irritable heart of the soldier." Other names, such as combat neurosis, battle fatigue, or traumatic war neurosis were coined in relation to the stress experienced during combat in the trenches of World War I. Placing the cause of mental disorders in numerous genetic and environmental factors, psychiatrists assume that Post-traumatic Stress Disorder (PTSD) is one of the most extreme examples of "environmentally-conditioned" disorders. Persons diagnosed with PTSD would not have become sick if they had not been exposed to strong stress. Currently, it is believed that this disorder occurs not only in soldiers during war but also in any person experiencing difficult events, e.g., after a car accident, a catastrophe, a fire, or a flood.

Post-traumatic stress disorder develops as a delayed and prolonged response to strong short-term or longer-term stressors which act destructively on all people regardless of their resilience, e.g., a natural disaster, war destruction, acts of terrorism, rape, violence, a house fire, or an accident at work. Post-traumatic stress disorder is characterized by persistent re-experiencing of the traumatic event, often with symptoms of increased arousal, avoidance, and diminished emotionality. The post-traumatic stress syndrome is a category with an increasing incidence due to the brutalization of social relations and the increase in crime and acts of terror recently observed in many countries including Poland.

The definition of PTSD comprises three groups of symptoms:

(1) re-experiencing of the traumatic event in different forms, e.g., intrusive recollections, distressing dreams, or sudden flashbacks.
(2) avoidance of situations which might arouse memories of the trauma or emotional numbing, i.e., an inability to recall the event or limited capacity to experience emotions,
(3) persistent symptoms of increased arousal (caused by autonomic hyperactivity such as

exaggerated vigilance, orienting reflex, or difficulty falling asleep or insomnia).

Three different factors seem to be relevant: the severity and duration of the stressing event, the personal and emotional characteristics of the victim, and the degree of psychological support received after the trauma. PTSD is solid evidence of the fact that psychological experiences have neurobiological consequences and that separation of the body from the mind is a fallacious oversimplification.

According to the American classification of diseases DSM-IV, typical symptoms of PTSD include: A/ Re-experiencing of the traumatic event (at least one of the following criteria): 1/ recurrent and intrusive distressing recollections of the stress situation, 2/ recurrent distressing dreams, 3/ feeling as if the event were to recur, 4/ psychological distress at recalling the event, 5/ vegetative symptoms in response to reminding cues. B/ Persistent avoidance or numbing of general responsiveness to external stimuli (at least three of the following criteria): 1/ avoidance of thoughts, feelings, or conversations associated with the event, 2/ efforts to avoid reminding cues, 3/ psychogenic amnesia, 4/ limited interest and participation in activities associated with the trauma, 5/ feeling of estrangement, 6/ sense of a foreshortened future.

Initially, it was believed that "shell shock" was a certain type of emotional manifestation of organic brain damage. Only later did it turn out that it was associated with dramatic stressful experiences. The person who contributed to this change of outlook was Freud, who, when observing the behavior of former soldiers with mental disorders, came to the conclusion that extreme situations may cause pathology. In his last work, *Moses and Monotheism*, published in 1939, Freud distinguished two types of psychological trauma: positive effects (e.g., fixations and compulsions) and negative effects (e.g., the defensive mechanism of avoidance, inhibition, and phobias).

World War II, the Holocaust, and the use of atomic bombs in Hiroshima and Nagasaki, affected further development of research on psychiatric consequences of stressful experiences. Prisoners of war and prisoners of concentration camps were observed to show acute symptoms of post-traumatic stress, which tended to deteriorate over time despite treatment. In later years, similar studies were conducted on children. Lacey [1] reported studies of disorders in children who were victims of traumatic experiences caused, among others, by an avalanche. The change in the approach of psychiatrists to the diagnosis of this disorder was strongly impacted by the appearance in the USA of thousands of Vietnam War veterans who were observed to show symptoms typical of PTSD.

Until the publication of DSM-III, the syndrome of PTSD practically did not exist in the literature of the subject. The paradox in this case was that in reality those disorders had been part of human life since prehistoric times, when our ancestors were attacked by wild animals and decimated by natural disasters or tribal wars. More serious research on the psychological consequences of traumatic experiences appeared only after World War I, during which soldiers were constantly threatened with death and grievous injuries. Military doctors coined the term "shell shock" to refer to those soldiers who reacted to combat with mental disorders. Initially, PTSD was diagnosed based on the occurrence of a traumatic stressor and three types of disorders: 1. re-experiencing of the trauma (among others, intrusive recollections and distressing dreams), 2. numbed response to stimuli and detachment from others, and 3. increased arousal.

Traumatic experiences of childhood leave permanent marks on a child's psyche and make normal functioning in adult life difficult. Without doubt, such children are at risk of suffering from various disorders which are an aftermath of their traumatic experiences. It is assumed that persons who have been victims of more serious forms of violence or neglect in their childhood, 2 to 5 times more often suffer from mental disorders in later periods of life. Such persons often have low self-esteem and experience learning, occupational, and social problems. One of the most interesting issues associated with early childhood traumatic experiences is the problem of their recollection after many years. The natural process of forgetting leads to the effacement of the multiple, previously memorized pieces of information from memory. It is, therefore, debatable whether adults reliably recall the details of the traumatic situations form their childhood. Data testifying to the forgetting of this class of experiences mainly come from clinical studies conducted for over 100 years now. Of particular interest are the results of studies conducted over the recent 15 years which have taken into consideration the effect of therapy on late consequences of sexual abuse. For instance, Herman and Schatzow [2] found that 28% of women who had been victims of incest in their childhood and participated in group therapy confirmed having serious difficulties recollecting the details associated with the trauma. To compare, in another study, conducted on 450 women and men who had been victims of sexual abuse in their childhood, as many as 59% of the participants failed to remember the trauma they had expe-

rienced [3]. In both studies, the acts of violence had been recorded in court or police records. It is highly probable that current situations bearing resemblance to the previously experienced traumatic events may facilitate recollection. Another problem is the precision with which the details of the traumatic event are recollected. Williams and Banyard [4], who compared present-day reports of women who had been victims of sexual abuse in their childhood with their depositions recorded 17 years earlier for medical and legal purposes, found that, despite previous periods of forgetting, it was possible to obtain from the women details of the traumatic situation.

Accounts given after many years may contain a lot of imprecise information or even confabulation, which is the result of suggestibility and distortions in recall as well as the tendency to fill memory gaps with invented content. After some time, when they have repeated the same account many times, some of the victims begin to believe deeply that they have seen, heard and participated in events, which in reality did not take place. The false information gets incorporated into the system of memories of the traumatic event. This shows how greatly recollection of distant events is influenced by the present attitudes, expectations, and wishes of victims.

To diagnose this disorder, at least 3 out of the 5 symptoms have to be present: 1/ sleep disturbances, 2/ irritability or outbursts of anger, 3/ difficulty concentrating, 4/ hypervigilance, and 5/ exaggerated startle response. If PTSD persists for three months, it becomes chronic. Sometimes pathological anxiety reactions supervene.

Dąbkowska [5] has presented a review of research on PTSD, which indicates that both genetic and environmental factors during development are conducive to the occurrence of this disorder. PTSD can occur in three forms, 1/acute: if duration of symptoms is less than 3 months, 2/ chronic: when duration of symptoms is three months or more, and 3/ with delayed onset: if onset of symptoms is at least 6 months after the stressor.

The core symptoms include, among others, intrusive recurrent recollections of the distressing events (in reality and in dreams), a sense of torpor and emotional numbing, insomnia, suicidal thoughts, detachment from the social surroundings, and avoidance of situations resembling the stressor. Additionally, patients complain of difficulty concentrating and remembering new information, irritability, and impulsiveness. As a rule, the patients are apathetic, reluctant to act, and depressed; they neglect their basic duties and have a sense of guilt. This is accompanied by hyperarousal of the autonomic nervous system and somatic complaints such as headaches, disrupted sleep, sweating, and stomach pain. Some patients may use psychoactive agents or alcohol.

When diagnosing this syndrome, one should make certain that it has occurred within six months of an extreme traumatic event. When this period is longer than 6 months, the diagnosis is probable. Of key importance here is the occurrence of disruptive memories and thoughts which make the patient "re-live" the traumatic event. Symptoms such as emotional indifference, avoidance of stressful situations, and autonomic disturbances are not necessary for the diagnosis of PTSD, although they support it.

Post-traumatic stress disorder must be differentiated from other mental disorders such as brief psychotic disorder, conversion disorder, major depressive disorder, acute stress disorder, obsessive compulsive disorder, schizophrenia, other psychotic disorders, mood disorder with psychotic features, a delirium, substance-induced disorders, psychotic disorders due to a general medical condition, and malingering.

Methods of relieving the tension include self alienation, when a person tries to ignore problems; external attribution, i.e. externalization of internal sensations, when a person assigns the cause of the problems to his surroundings and not to himself, and mental fragmentation, when one perceives one's self in fragments, as if it were comprised of separate factors. Those mechanisms serve the purpose of keeping up the appearance of internal calm. Another mechanism is automatic control, which consists in suppressing emotions and believing in the superiority of reason, trusting that knowledge will lead to internal healing. Internal tension can also be alleviated by a sense of wrong. This happens when a person believes to be an object of constant criticism and suspicions, and so feels humiliated and insulted, but through this feeling of being a wronged martyr relieves his tension. Such suffering justifies his inadequacy or failure to do his duties; the blame is not his, but other people's.

Recently, attempts to treat PTSD have been made which consisted in eliminating distressing memories or remembered content using cognitive-behavioral therapy and propranolol. The latter alleviates anxiety and blocks the action of adrenaline, also having a blocking effect on the synthesis of proteins in amygdalae, which play a role in retrieving unpleasant memories.

One variety of the post-traumatic disorder is adjustment disorder, which involves symptoms of emotional disturbance and subjectively experienced suffering caused by the necessity to adjust to important life changes or to the consequences

of stressful events, e.g., a change of workplace or place of residence, change of school, divorce, retirement, or emigration. The clinical picture may be diversified, but the most frequently occurring symptoms include markedly depressed mood, anxiety, chronic tension, lack of belief that one will be able to cope, difficulties planning ahead, and unskillfulness in the performance of job or home responsibilities. In children, there may be symptoms of regression, i.e., a return to earlier psychopathological symptoms, e.g., thumb sucking, bedwetting, or stuttering. The symptoms usually begin some time after the cause, most often within 1 month, and persist on average for no more than 6 months.

When diagnosing this disorder, one must make certain that there is a cause-effect relationship between the form and acuteness of symptoms on the one hand and the stressful event on the other.

Piśmiennictwo

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