Trauma- and Stressor-related Disorders

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DSM-5
Trauma- and Stressor-related Disorders

• Reactive Attachment Disorder
• Disinhibited Social Engagement Disorder
• **Posttraumatic Stress Disorder**
• Acute Stress Disorder
• Adjustment Disorders
• Other Specified Trauma- and Stressor-related Disorder
• Unspecified Trauma- and Stressor-related Disorder
Posttraumatic Stress Disorder and Acute Stress Disorder
Posttraumatic 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 event.

• 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

• The lifetime incidence of PTSD is estimated to be 9 to 15 percent and the lifetime prevalence of PTSD is estimated to be about 8 percent of the general population.

• 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 the 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 event.
Predisposing Vulnerability Factors in PTSD

- Presence of childhood trauma.
- Borderline, paranoid, dependent, or antisocial personality disorder traits.
- Inadequate family or peer support system.
- Being female.
- Genetic vulnerability to psychiatric illness.
- Recent stressful life changes.
- Recent excessive alcohol intake.
DSM-5 Diagnostic Criteria for PTSD

Note: 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 event(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 event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
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 traumatic 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 the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(S).
C. Persistent **avoidance** of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced 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 the traumatic event(s).
DSM-5 Diagnostic Criteria for PTSD

D. **Negative alterations in cognitions and mood** associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced 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.
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 evidenced 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. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes 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.
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. Note: 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 event(s) (e.g., first responders collecting human remains, police officer repeatedly exposed to details of child abuse).
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). Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content.
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 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 or oneself (e.g., seeing oneself 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 feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
12. Hyper-vigilance.
13. Problems with concentration.
C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

   Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to one 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 is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition and is not better explained by brief psychotic disorder.
• 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 percent of patients recover completely, 40 percent continue to have mild symptoms, 20 percent continue to have moderate symptoms, and 10 percent remain unchanged or become worse.
• After 1 year, about 50 percent of patients will recover.
• A good prognosis is predicted by:
  - Rapid onset of the symptoms
  - Short duration of the symptoms (less than 6 months)
  - Good premorbid functioning
  - Strong social supports
  - The absence of other psychiatric, medical, or substance-related disorders or other risk factors.

In general, the very young and the 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 two other disorders.
- Common comorbid conditions include:
  - Depressive disorders.
  - Substance-related disorders.
  - Anxiety disorders.
  - Bipolar disorders.
DIFFERENTIAL DIAGNOSIS

• Head injury during the trauma.
• Epilepsy
• Alcohol-use disorders, and other substance-related disorders.
• Panic disorder
• Generalized anxiety disorder.
TREATMENT

• When a clinician is faced with 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).

• Pharmacotherapy:
  Selective serotonin reuptake inhibitors (SSRIs):
    Are considered first-line treatments for PTSD.
    They reduce symptoms from all PTSD symptom clusters.
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• Psychotherapy
Adjustment Disorders
• Adjustment disorders are characterized by an emotional response to a stressful event.
• 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.
EPIDEMIOLOGY

- The prevalence of the disorder is estimated to be from 2 to 8 percent of the general population.
- Women are diagnosed with the disorder twice as often as men.
- and single women are generally overly represented as most at risk.
- In children and adolescents, boys and girls are equally diagnosed with adjustment disorders.
- The disorders can occur at any age but are most frequently diagnosed in adolescents.
- Among adolescents of either sex, common precipitating stresses are school problems, parental rejection and divorce, and substance abuse.
- Among adults, common precipitating stresses 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 behavior are clinically significant, as evidenced by one or both of the following:

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 symptom severity and presentation.

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 than an additional 6 months.
DIFFERENTIAL DIAGNOSIS

• Uncomplicated bereavement.
• Major depressive disorder.
• Brief psychotic disorder.
• Generalized anxiety disorder.
• Somatic symptom disorder.
• Substance-related disorder.
• Conduct disorder.
• PTSD.
COURSE AND PROGNOSIS

• 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.
TREATMENT

- Psychotherapy
  - Remains the treatment of choice.

- Pharmacotherapy
  - No studies have assessed the efficacy of pharmacological interventions, but it may be reasonable to use medications to treat specific symptoms for a brief time.
• The presence of a stressor is a requirement in the diagnosis of adjustment disorder, PTSD, and acute stress disorder.
• 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 posttraumatic disorder threshold, the adjustment disorder diagnosis would be appropriate.
THE END