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Online publication ahead of print, AJMHS Vol 59, 2022

Post-Traumatic Stress Disorder and Trauma Related Notions

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Abstract

Post-traumatic stress disorder (PTSD) is a mental health condition after experiencing a traumatic event such as combat, crime, an accident or natural disaster. Anyone can develop PTSD at any age. The course of the illness is different and varies according to complex factors. Although some people recover within 6 months, others have symptoms that last for a year or longer. People with PTSD often have co-occurring conditions, such as depression, substance use, or anxiety disorders. They may feel stressed or frightened, even when they are no longer in danger. Early treatment is essential for preventing mental health complications and normal functioning. Other trauma related notions are stress, post-traumatic stress, complex PTSD, secondary traumatization and disorder of extreme stress not otherwise specified (DESNOS). Each of the concepts has its own specific characteristics.

Keywords: stress, trauma, PTSD, Complex PTSD, DESNOS

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INTRODUCTION

Notions as stress, trauma, traumatic stress and post traumatic stress disorder often are misused.

Stress is defined as a state of mental or emotional strain which results from unfavorable, i.e. very demanding circumstances. It is thought to be a normal part of life.

Trauma according to APA (American Psychological Association) is a response to the emotionally harmful experiences such as a horrific event as war, violence, rape, accident, loss or natural disaster. After experiencing the traumatic event, typical signs are the appearance of denial and shock. Trauma has no differences with regard to gender, age, race, ethnicity or socioeconomic status. Flashbacks, unpredictable emotions, nightmares, tense relationships and multiple physical symptoms such as body pains, headaches, nausea are long term consequences of experienced trauma. These feelings are normal, but some individuals have difficulties in normal daily life and functioning. In such cases, when individuals have difficulties moving on in their lives, professional help is needed in order to manage constructively such emotions (1).

According to Giller, psychological trauma is the unique experience of the event or steady state in which the individual's individual ability to integrate emotional experience is shaken or the individual subjectively experiences a threat to life, bodily integrity, or normal state. Therefore, the traumatic event or situation creates psychological trauma when it shakes the individual ability to cope, leaving the person to feel shaken not only emotionally but also shaken cognitively and physically. Usually the circumstances of the event include abuse of force, betrayal of trust, blockage, helplessness, pain confusion and loss.

Trauma involves responding to incidents that once occur such as accidents, natural disasters, crimes, surgical interventions, deaths and other violent events. It also includes responding to repetitive or chronic experiences such as child abuse, neglect, war, urban violence, concentration camps, relationships where there is violence and persistent deprivation (2).

There are a number of mental disorders associated with trauma. Although some mental illnesses are clearly related to trauma, empirical data show that among patients with various mental disorders, a large proportion of them and in some cases virtually all report trauma (3).

According to diagnostic criteria, there are two diagnoses which have as criteria the individual who has experienced or witnessed the traumatic event. These are acute traumatic stress and post-traumatic stress disorder.

POST TRAUMATIC STRESS

PTS - (**Post Traumatic Stress**) is used as a term for a normal reaction, and often an adaptive response to experiencing a non-stressful traumatic event. The most common occurrences, such as traffic accidents, losses, natural disasters or even kidnappings and wars. In the diagnostic criteria according to DSM V (308.3) and ICD 10 (F 43.0), it is categorized in the diagnostic entity

as Acute Stress Disorder and is characterized by symptomatic, physical and emotional distress. It was first incorporated into the DSM classification in 1980. Physical symptoms include tremors, rapid breathing, shortness of breath, stomach upsets, dizziness, general weakness, and cold sweats. Emotional symptoms include excessive shock, distrust, fear, sadness, guilt, helplessness, shame, and anxiety. Although the symptoms can be quite intense, they usually go away a few days after the event and do not cause significant prolonged interference in the life of the person who experienced the event. The duration of symptomatology is not more than one month after experiencing the traumatic event. It is therefore considered that PTS is a normal reaction and not a mental illness (4).

However, whether it remains as such a diagnosis or not, acute traumatic stress predicts subsequent PTSD (5).

In 1980, the American Psychiatric Association (APA) added PTSD to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III) nosologic classification scheme (2). Although controversial when first introduced, the PTSD diagnosis has filled an important gap in psychiatric theory and practice (6).

Experiencing or witnessing a traumatic terrifying event is a key issue for the development of PTSD, as a mental health condition. Symptoms of PTSD include flashbacks, nightmares, severe anxiety, as well as uncontrollable thoughts about the event. Although exposure to potentially traumatic events is common, the development of PTSD is relatively rare, usually between 5 and 10% in the general population (7,8). The longitudinal course of PTSD is variable. About 50% of people diagnosed with PTSD will improve and the remaining 50% will develop a chronic form of the disorder. 40% of these patients will remain with symptoms after 10 years, while 10% even after 30 years (9). It should be added that in addition to psychological distress, long-term consequences can be severe somatic disorders (10).

PTSD is categorized as an acute (current) and chronic (lifetime) disorder. PTSD is acute when the duration of symptoms is less than 3 months, while it is categorized into chronic when the symptoms last 3 months or more and has a delayed onset which means that at least 6 months have elapsed between the traumatic event and the onset of symptoms (3).

COMPLEX POST-TRAUMATIC STRESS DISORDER

The new term incorporated in the differently conceptualized ICD-11 is also the complex PTSD that has the specific characteristics of this diagnostic entity (C-PTSD). C-PTSD, which is often referred to as complex trauma, is the result of multiple traumatic events occurring over a period of time. The causes can be many such as prolonged domestic violence, concentration camp experiences, torture, genocide and multiple incidents of child abuse, especially physical and sexual abuse of children (11).

Unlike PTSD, C-PTSD as a disorder causes significant impairment in important areas of functioning, such as personal, family, social, educational and professional. In other words, C-PTSD in addition to the essential symptoms of PTSD which are: feeling of threat, avoidance and re-experiencing the traumatic event, is also characterized by:

- severe and widespread problems in affect regulation,
- persistent beliefs about oneself as degraded, possible or worthless, accompanied by deep and expressed feelings of shame, guilt or failure related to stress, and
- constant difficulties in stable relationships and closeness to others (11).

These characteristics of C-PTSD are described in the ICD 10 diagnostic entity called "Sustained personality change after a catastrophic experience," code F 62.0 (ICD 10), which is considered equivalent to C-PTSD. This personality change should be present for at least 2 years and should not be attributed to pre-existing personality disorder or other mental disorder other than PTSD (F 43.1) (11).

Secondary trauma

Another concept related to trauma and PTSD is secondary trauma. Although research has focused on the development of symptoms in direct victims of trauma, more recently many studies have focused on the interpersonal effect of individual trauma on family members. Empirical data show that living in a family with a member suffering from PTSD can have a major impact on other family members, family dynamics, and the family system as a whole. As a result, such families or individuals face secondary traumatic stress, burn-out phenomenon, delegated trauma, or compassion fatigue. It should also be noted that a family member's PTSD has the potential to be passed on to future generations (12). Secondary trauma can also occur in those who provide care to those suffering from PTSD such as health workers or careers.

Disorders of Extreme Stress Not Otherwise Specified (DESNOS)

Disorders of Extreme Stress Not Otherwise Specified (DESNOS), is another concept of complex sequel of psychological trauma.

DESNOS diagnostic criteria entail: alterations in regulation of affect and impulses, disturbances in attention and consciousness, disturbances in self-perception, disturbances in relationships, somatization and disturbances in meaning system (13).

Further considerations

Back to PTSD, what are the etiological factors that contribute to the development of this disorder.

PTSD has multifactorial etiology with interaction of traumatic environmental factors as well as genetic factors (14).

Previous studies have identified several variables before and after the traumatic event in addition to the traumatic event itself, such as genetic factors, perceived lack of parental care, history of previous traumas and psychological problems, unhealthy lifestyles, personality traits,

intelligence, as well as post-trauma support, beliefs, expectations and attributes (14).

Understanding the intrapsychic and neurobiological phenomenon that acts as vulnerable, the resilience, and the personal growth factors that accompany traumatic experiences can clarify the above questions (15).

It is estimated that the hereditary component for PTSD is about 30-40%: the severity of the trauma and the frequency most significantly affect the risk for PTSD.

Previous twin studies have been followed by studies of candidate genes, which have identified several genes and environmental interactions modifying the risk for PTSD (16,17).

Some studies showed that some adults may be predisposed to develop PTSD after a preliminary pathological reaction (18).

The results of a study showed that individuals who have a history of stressful life events are more likely to develop PTSD and / or MDD after a natural disaster than their counterparts who have not had such a history (19).

When it comes to mental health, the famous German philosopher Nietzsche's saying "What does not kill us makes us stronger" does not stand, according to researcher Stephen Buka, PhD, professor of epidemiology at Brown University. Researchers have found that people with PTSD are about 6 times more likely to develop depression than those without PTSD and about 5 times more likely to develop another anxiety disorder (20). PTSD as well as high rates of intentional self-harm have been found among those with PTSD (21).

Getting the effective treatment after PTSD symptoms is a critical moment in order to reduce symptoms and improve function. The main treatments are psychotherapy, medications, or both.

Acknowledgements: None declared.

Conflict of Interest Statement: The authors declare that they have no conflict of interest.

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