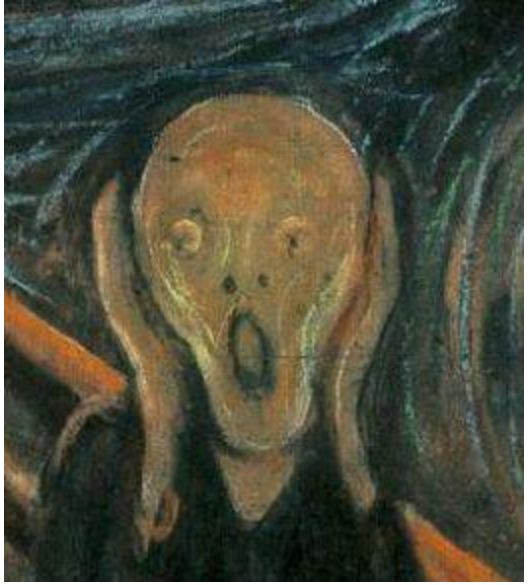


Anxiety Disorders

Prof. Anatoly Kreinin

חרדה- הגדרה

- מצב בעל ביטויים פיזיים, קוגניטיביים ורגשיים הגורמים לחווה אותם לתחושה לא נעימה של פחד ואיום.
- פיזיים:הזעת יתר, פלפיטציות, חנק, סחרחורת, טשטוש, יציאות מוגברות, מתן שתן מוגבר
- נפשיים: הופעה של רגש בעל גוון שלילי, דיספורי רגזוני; אי נוחות), עם אלמנטים של דכדוך(
- קוגניטיביים: דאגה מפני תוצאה שלילית

Определение понятия Тревога

- Это душевное состояние , характеризующееся психологическими, физиологическими и когнитивными изменениями, вызывающие у того, кто это состояние переживает, ощущение угрозы.
- Физиологический компонент – пальпитации, пот, удушье, головокружение, расплывчатое зрение, учащенные мочеиспускание и дефекация,
- Психологический компонент – неприятное чувство дисфории, ощущение дискомфорта, сниженное настроение
- Когниция – мысли о том, что должно случиться что-то неприятьное, страшное

Не всякая Тревога патологична

Патологическая Тревога

- Существует и при отсутствии стрессора
- Выраженность реакции не соответствует триггеру
- Продолжается и после исчезновения триггера
- Нарушается функционирование

Нормальная Тревога

- Есть стрессор
- Выраженность реакция соответствует триггеру
- Проходит при отсутствии триггера
- Нет нарушения функционирования

תפקידה החיובי של חרדה

- מוכנות- אנו נוטים להגיב יותר לאיומים המוכרים לנו מאלפי שנות אבולוציה (נחש, דם, סערה, זרים)
- לא מפתחים חרדה בתגובה לעלים, פרחים, מים רדודים
- לא כתגובה ראשונית לאיומים מודרנים (רובים.. .)

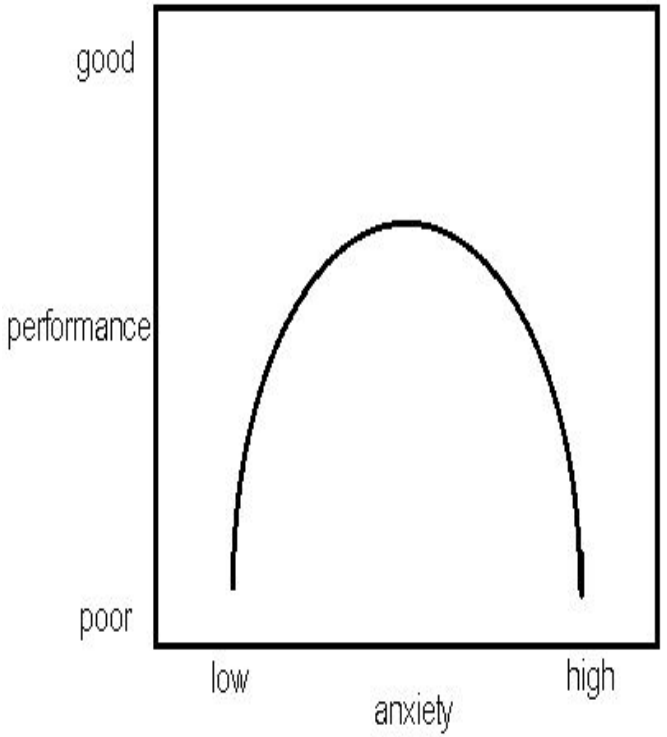
Что хорошего в Тревоге?

- Готовность – мы легко реагируем на угрозы, знакомые нам в процессе тысячелетней эволюции (кровь, змея, буря, наводнение, землятресение…)
- Нет тревоги на цветы, листья, лужу..
- Нет первичной тревоги на современные угрозы – ружье, машина, кирпич…

Benefits of anxiety

Закон Давидсона:

Функционирование улучшается с усилением тревоги до определенного уровня, после которого начинает снижаться



General considerations for anxiety disorders

- Often have an early onset- teens or early twenties
- Show 2:1 female predominance
- Have a waxing and waning course over lifetime
- Similar to major depression and chronic diseases such as diabetes in functional impairment and decreased quality of life

Primary versus Secondary Anxiety

Anxiety may be due to one of the primary anxiety disorders OR secondary to substance abuse (Substance-Induced Anxiety Disorder), a medical condition (Anxiety Disorder Due to a General Medical Condition), another psychiatric condition, or psychosocial stressors (Adjustment Disorder with Anxiety)

The differential diagnosis of anxiety. Psychiatric and Medical disorders. Psychiatr Clin North Am 1985 Mar;8(1):3-23

Comorbid diagnoses

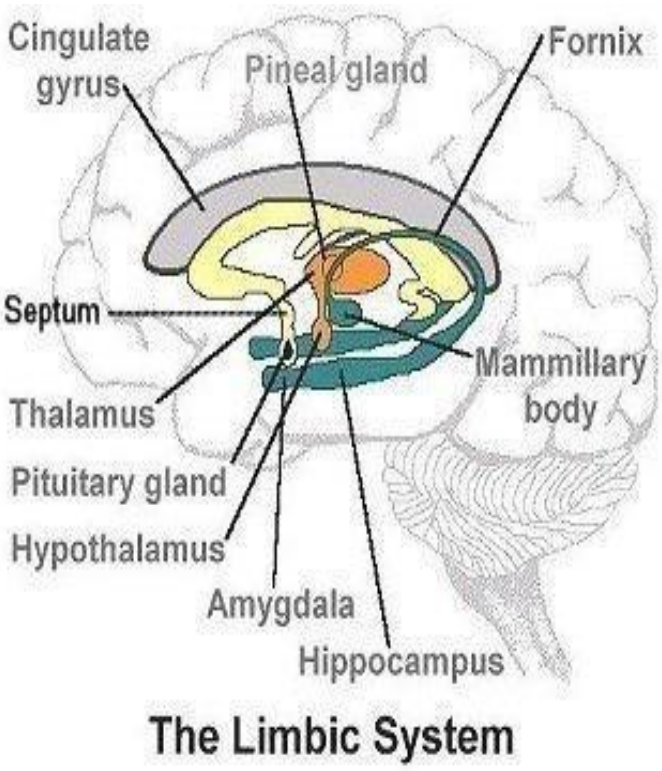
- Once an anxiety disorder is diagnoses it is critical to screen for other psychiatric diagnoses since it is very common for other diagnoses to be present and this can impact both treatment and prognosis.

What characteristics of primary anxiety disorders predict subsequent major depressive disorder. J Clin Psychiatry 2004 May;65(5):618-25

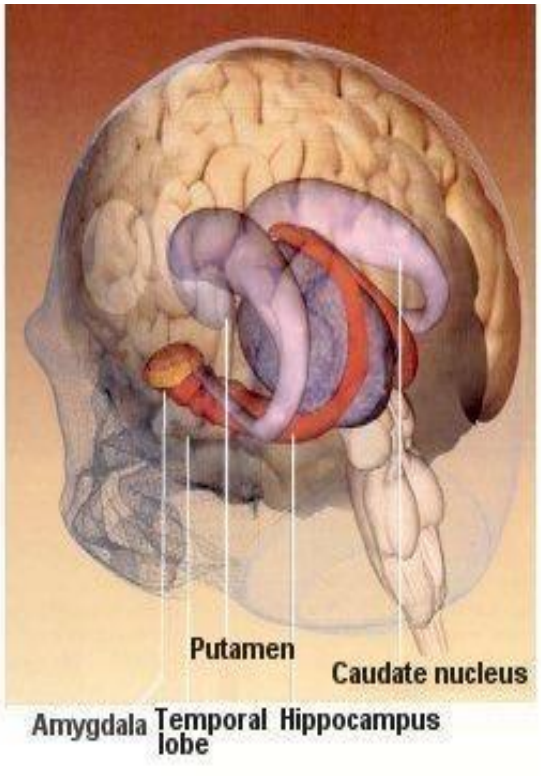
Anxiety disorders

- Specific phobia
- Social anxiety disorder (SAD)
- Panic disorder (PD)
- Agoraphobia
- Generalized anxiety disorder (GAD)
- Anxiety Disorder due to a General Medical Condition
- Substance-Induced Anxiety Disorder
- Anxiety Disorder NOS

הבסיס הביולוגי של חרדה

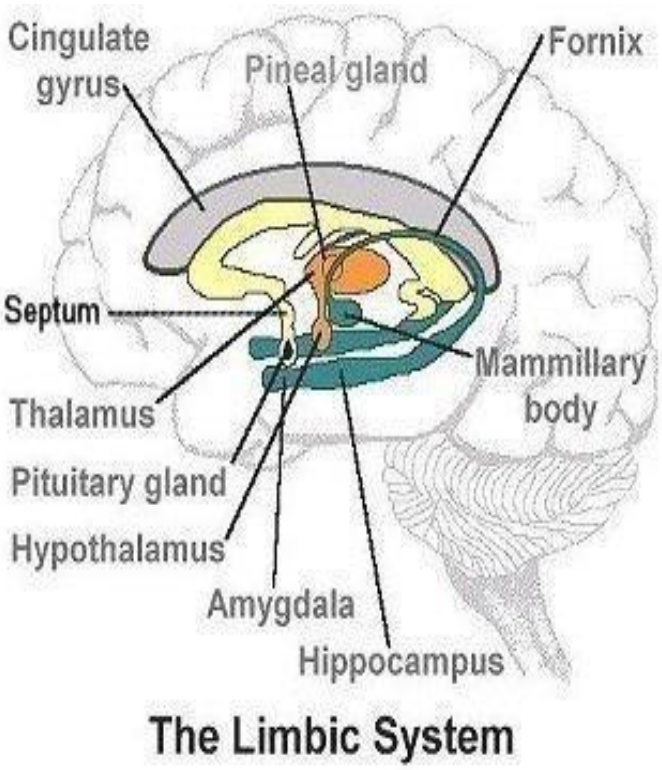


The Limbic System

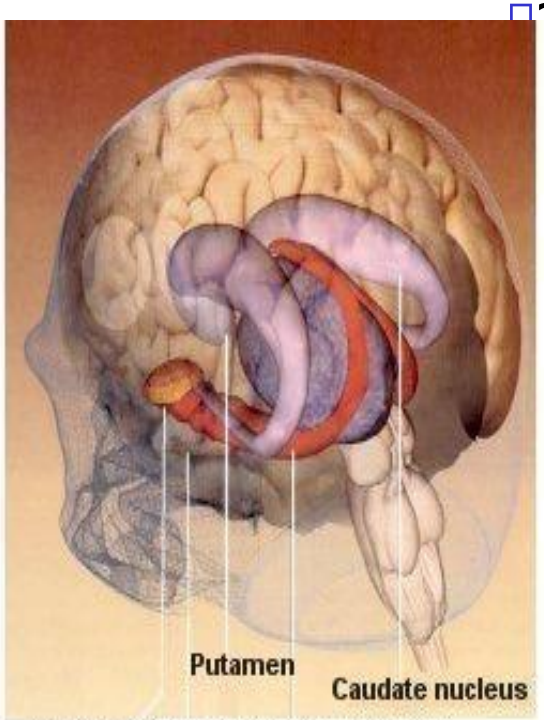


- מבנים מעורבים:
  - קורטקס פרונטלי
  - מערכת לימבית
    - היפוטלמוס, היפוקמפוס אמיגדלה
  - גזע המוח
  - ההיפופיזה
  - Adrenal Axis
  - המערכת הסימפטטית

Биологическая база Тревоги



The Limbic System



- Замешанные структуры:
  - Логбные доли
  - Лимьическая система
    - Гипоталамус, Гипокампус Амигдала
  - Ствол мога
  - Гипофиз
  - Adrenal Axis
  - Симпатическая система

חרדה- מודלים ביולוגיים

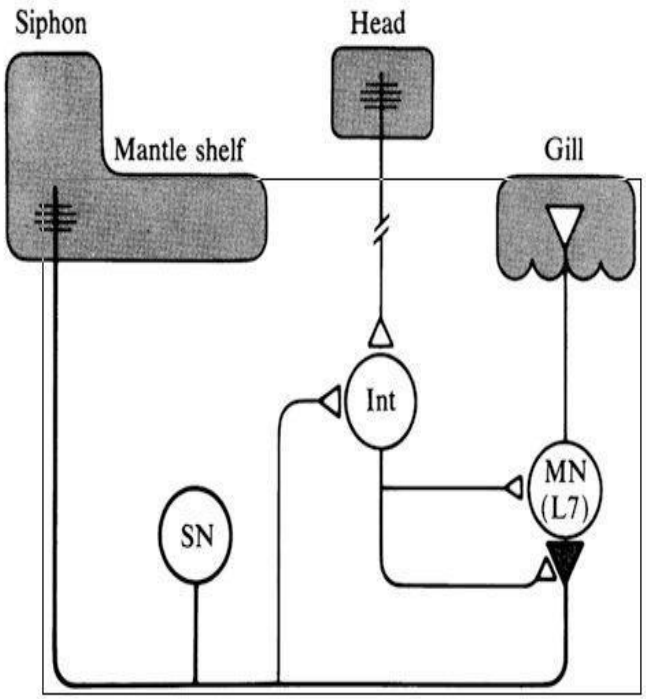
- אמנם המחקר העכשווי מתמקד במבנים אנטומיים כגון האמיגדלה, ההיפוקמפוס ומסלולים נוירואנדוקרינים אבל...
- תגובות התניית פחד ורתיעה קיימות ביצורים נחותים בהרבה וללא מבנים אלו.

אריק קנדל, חתן פרס נובל לרפואה/פיזיולוגיה לשנת 2000

- האפליזיה קליפורניקה, רכיכת ים בעלת מערכת עצבים פרימיטיבית המורכבת מ- 20,000 נוירונים בלבד, חלקם הגדול עבים מאוד, אפשרה מחקרים פורצי דרך בתחום הלימוד והזיכרון- ברמה העצבית

- נגיעה בסיפון של האפליזיה גורמת לרתיעה
- נגיעה חוזרת בסיפון של האפליזיה מפחיתה את הרתיעה = הביטואציה
- מתן גירוי חזק (חשמל) בשלב זה יוצר סנסיטיזציה וגורם לרתיעה בתגובה לגירוי שהיה תת-ספי קודם לכן
- בנוסף, ניתן ליצור תגובה של האפליזיה לגירוי מותנה, בדומה לבע"ח מפותחים יותר

- נגיעה בחישני מגע נקלטת ב SN
- ה SN מעורר תגובה מוטורית ב MN
- הביטואציה= ירידה בכמות Ca שמשתחררת בסינפסה ופחות תגובה מוטורית
- סנסיטיזציה גורמת ל INTלשחרר סרוטונין הנצמד לרצפטורים סרוטונרגיים ב SN המעוררים, דרך cAMP שיפעיל רצפטור Ca נוסף, S-shaped)) המגביר כניסת קלציום ומוטוריקה.



תגובת דחק
Fight or Flight

- תגובה פיזיולוגית לדחק
- מווסתת דרך ההיפותלמוס ומבנים נוספים
- מאפשרת להתגונן בפני איום פיזי
- קיימת בכל בעלי החיים (מהבחינה הזו אנחנו עדיין בעל חיים)...
- "תגובה סימפתטית"

Fight or Flight

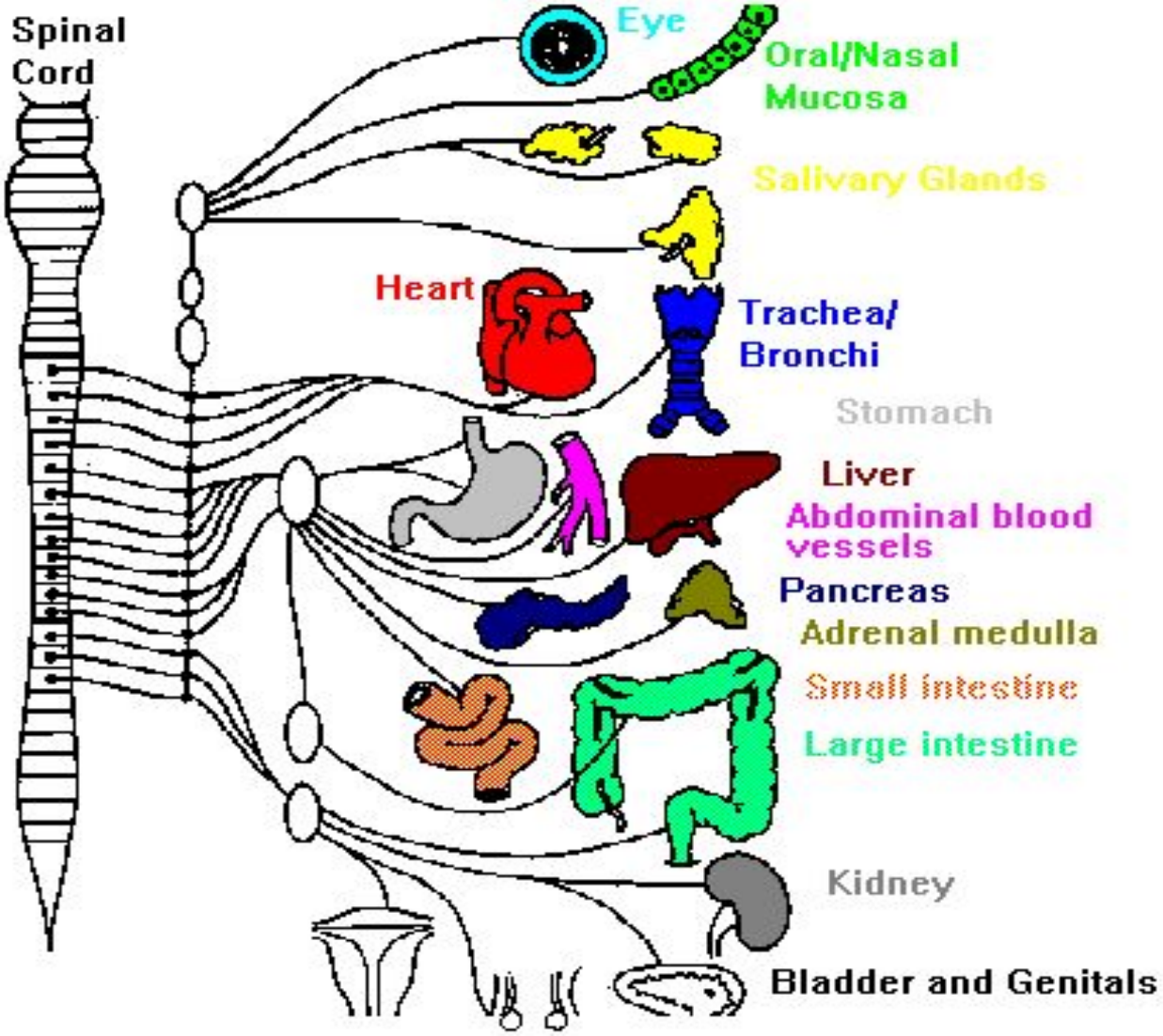
- Физиологическая реакция на стресс
- Адаптируется с помощью гипоталамуса и других мозговоых структур
- Позволяет адекватно реагировать на угрозу
- Существует у всех живых организмов, в этом отношении мы - животные
- « Симатическая реакция»

מה קורה בתגובה הסימפתטית?

- מתרחשת על ידי אדרנלין ונוראדרנלין
- מעלה קצב לב והתכווצות הלב
- קצב נשימה מוגבר
- הזעה
- עליה בניצול גלוקוזה
- הפניית דם לשרירים
- עליה במתח השרירים
- קרישת דם משתפרת

Что происходи при реакции ?симпатической системы

- Происходит с помошью адреналина и норадреналина
- Усиливает частоту и силу сердечных сокращений
- Ускоряется частота дыхания
- Усиливается потоотделение
- Усиливается утилизация глюкозы
- Перераспределение крови к мышцам
- Увеличение напряжения в мышцах
- Улучшение свёртываемости крови


Spinal Cord
Eye
Oral/Nasal Mucosa
Salivary Glands
Heart
Trachea/ Bronchi
Stomach
Liver
Abdominal blood vessels
Pancreas
Adrenal medulla
Small intestine
Large intestine
Kidney
Bladder and Genitals

Pierre Janet

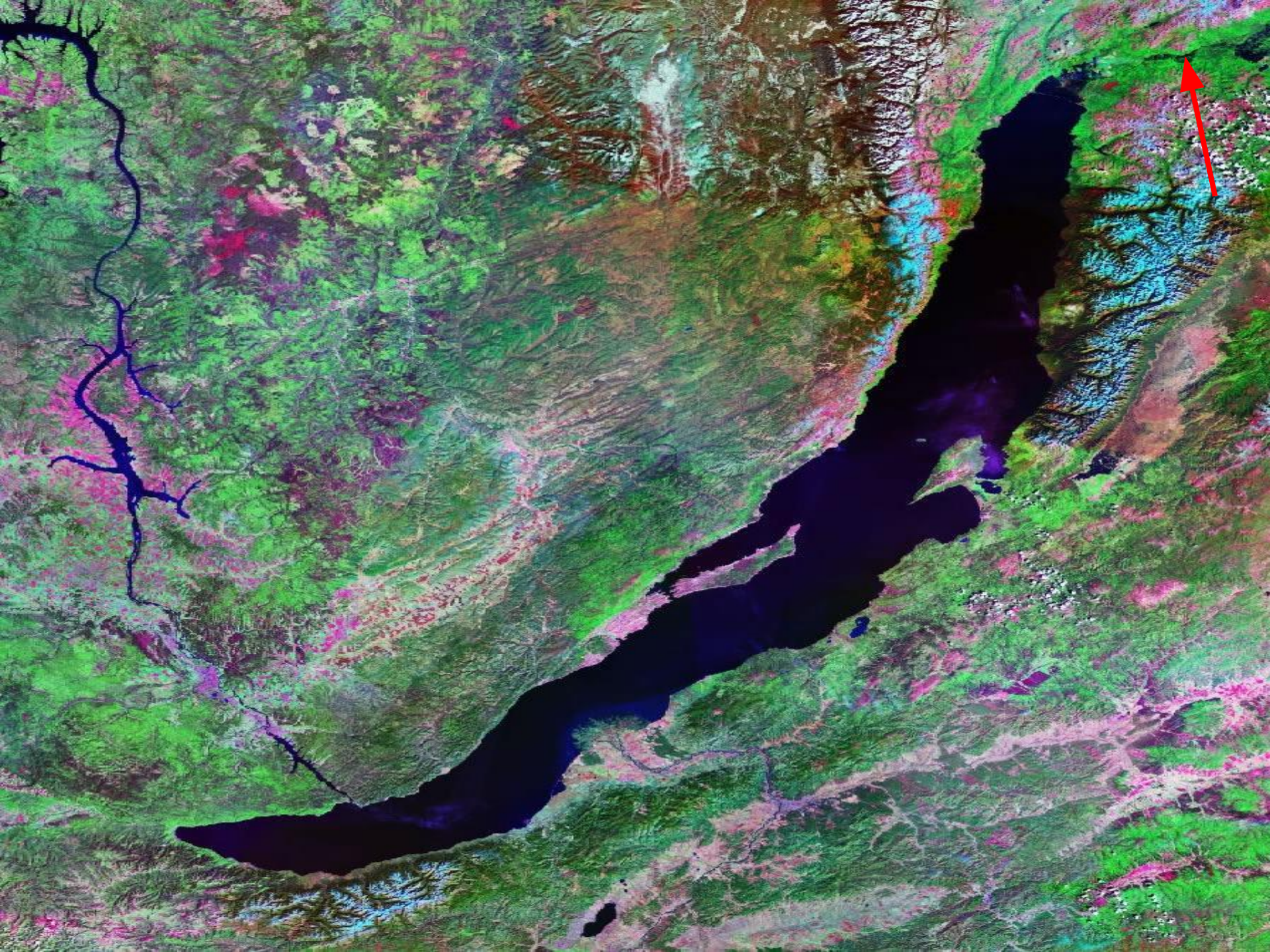
- לכל אדם יש כבאנטום מובנה של אנרגיה נפשית ובמצב תקין אין פעילות מנטאלית תת הכרתית
- אירועים טראומטיים שוחקים את האגו והוא עובר דגנרציה, מאבד את יכולתו לנווט את האדם בעולם ומביא אותו למצב של חוסר אונים פסיבי

Sigmund Freud

- דחפים מיניים ואגרסיביים מסולקים מעל פני השטח בגלל מוסכמות ואיסורים (סופר אגו) והקונפליקט יוצר חרדה
- הפריד בין פסיכונוירוזות לבין anxiety בה ראה תופעה כמעט פיזיולוגית לחלוטין
- בניגוד ל Janet האגו אצל פרויד מהווה מרכיב חשוב בהתפתחות הפרעות חרדה (פסיכונוירוזות).

A Developmental Hierarchy of Anxiety

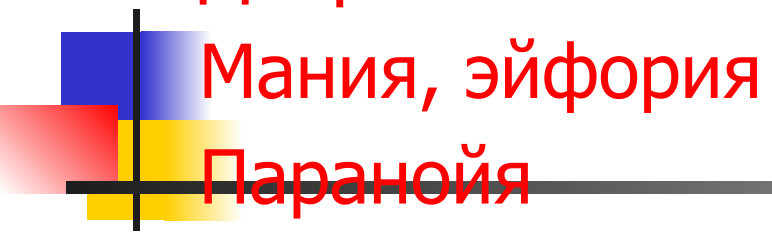
- Superego anxiety
- Castration anxiety
- Fear of loss of love
- Separation anxiety (fear of the loss of the object—Kleinian depressive anxiety)
- Persecutory anxiety (Klein)
- Disintegration anxiety (Kohut)



אהרון בק:
""בבסיס כל פסיכופתולוגיה עומדת הכללת יתר

עצבות	דיכאון
שמחה	אופוריה, מאניה
חשד	פאראנויה
חרדה	הפרעת חרדה

А. Барак:
"В основе любой патологии лежит чрезмерное и необоснованное обобщение»



Депрессия	Сниженое настроение
Мания, эйфория	Радость
Паранойя	Подозрение
Паника	Тревога

Pathological Anxiety

- כחלק מהפרעת הסתגלות
- כחלק ממחלה / הפרעה נפשית אחרת
- **הפרעת חרדה ראשונית**

Pathological Anxiety

- Как часть патологической адаптивной реакции
- Часть другого патологического расстройства
- **Первичная патологическая реакция**

Primary Anxiety Disorders

הפרעות חרדה לא פוביות:

- GENERAILIZED ANXIETY DISORDER
- OCD

הפרעות חרדה פוביות:

- SIMPLE PHOBIA
- SOCIAL PHOBIA
- PANIC DISORDER

Primary Anxiety Disorders

Нефобические тревожные реакции:

- GENERAILIZED ANXIETY DISORDER

Фобические тревожные реакии:

- SIMPLE PHOBIA
- SOCIAL PHOBIA
- PANIC DISORDER

אפידמיולוגיה

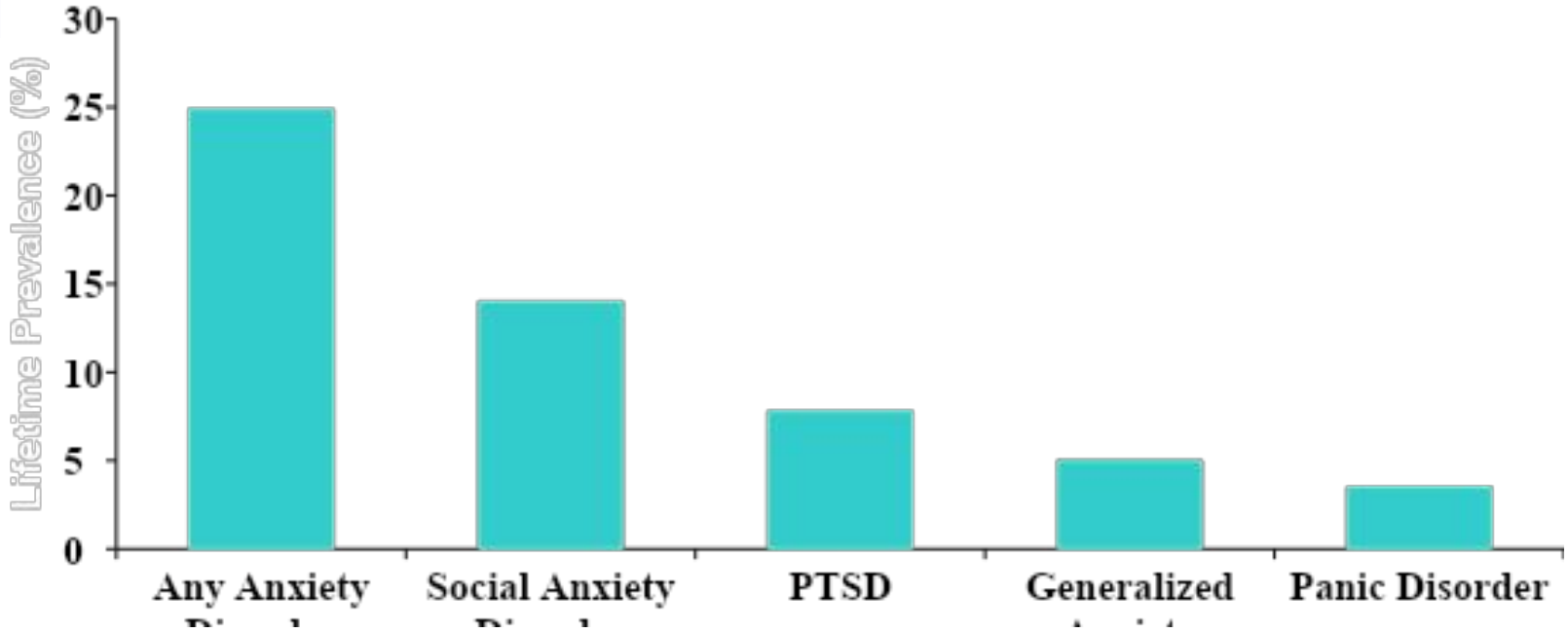
- ברוב המקרים נשים סובלות יותר, במיוחד בגילים בין 16 ל – 40.
- פחד קהל פי 2 יותר אצל נשים, גברים מחפשים עזרה יותר מנשים.

Эпидемиология

- В большинстве своем женщины страдают чаще мужчин, в основном в возрасте 16-40 лет
- Социофобия в 2 раза чаще у женщин, но мужчины ищут помощь чаще.

Prevalence of Anxiety Disorders

(life time prevalence %)



Kessler et al. *Arch Gen Psychiatry*. 1995;52:1048.
Kessler et al. *Arch Gen Psychiatry*. 1994;51:8.

Genetic Epidemiology of Anxiety Disorders

- There is significant familial aggregation for PD, GAD, OCD and phobias
- Twin studies found heritability of 0.43 for panic disorder and 0.32 for GAD.

Hetteman J. et al. A Review and Meta-Analysis of the Genetic Epidemiology of Anxiety disorders. Am J Psychiatry 2001;158:1568-1575

Anxiety Disorders

"The anxiety must be out of proportion to the actual danger or threat in the situation"

This chapter no longer includes OCD and PTSD

DSM 5 creates new chapters for OCD and PTSD

Chapter is arranged developmentally.

- Sequenced by age of onset
- Now includes Separation Anxiety and Selective Mutism

Anxiety Disorders

Agoraphobia ,

Specific Phobia, and

Social Anxiety Disorder

Changes in criteria :

Clients over 18 do not have to recognize that their anxiety is excessive or unreasonable

Duration of 6 months or longer is required for all ages

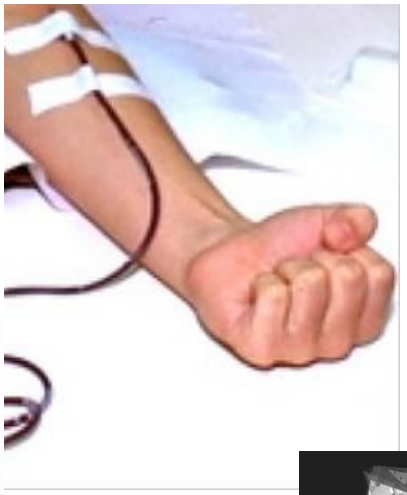
Anxiety Disorders

Panic Attacks and Agoraphobia are "unlinked" in DSM- 5

DSM- IV terminology describing different types of
Panic Attacks replaced in DSM-5 with the terms
"expected" or "unexpected" panic attack

Social Anxiety Disorder :
"Generalized" specifier in DSM-IV has been deleted
Replaced with "performance only" specifier

Specific Phobia



SPECIFIC PHOBIA

- Animal Type
- Natural Environment Type (e.g., heights, storms, water)
- Blood-Injection-Injury Type
- Situational Type (e.g., airplanes, elevators, enclosed places)
- Other Type

Specific Phobia

- Marked or persistent fear (>6 months) that is excessive or unreasonable cued by the presence or anticipation of a specific object or situation
  - Anxiety must be out of proportion to the actual danger or situation
  - It interferes significantly with the persons routine or function

SPECIFIC PHOBIA

- בשאר הזמן תפקוד נורמאלי
- המנעות מאפשרת חיים נורמאליים
- שכיחות גבוהה –עד 20% מהאוכלוסייה
- בד"כ לא פונים לטיפול
- בד"כ ללא סיבוכים
- טיפול ב CBT יעיל מאוד, לא זקוקים לתרופות.

SOCIAL PHOBIA

- בדומה לפוביה פשוטה אך כאן הפחד חסר הגיון מאינטראקציה חברתית, ומכאן:
  - יותר פגיעה תפקודית
  - יותר אירועי חשיפה
  - ההימנעות לא מאפשרת חיים נורמליים
- התוכן של החרדה- החשש מהשפלה, ביזוי, כישלון וכו'

SAD epidemiology

- 7% of general population
- Age of onset teens; more common in women. Stein found half of SAD patients had onset of sx by age 13 and 90% by age 23.
- Causes significant disability
- Increased depressive disorders

Incidence of social anxiety disorders and the consistent risk for secondary depression in the first three decades of life. Arch Gen Psychiatry 2007 Mar(4):221-232

- אבחנה יותר בעייתית (הפרעת אישיות??)
- שני סוגים:
  - LIMITED
  - PERVASIVE

What is going on in their brains??

- Study of 16 SAD patients and 16 matched controls undergoing fMRI scans while reading stories that involved neutral social events , unintentional social transgressions (choking on food then spitting it out in public) or intentional social transgressions (disliking food and spitting it out)

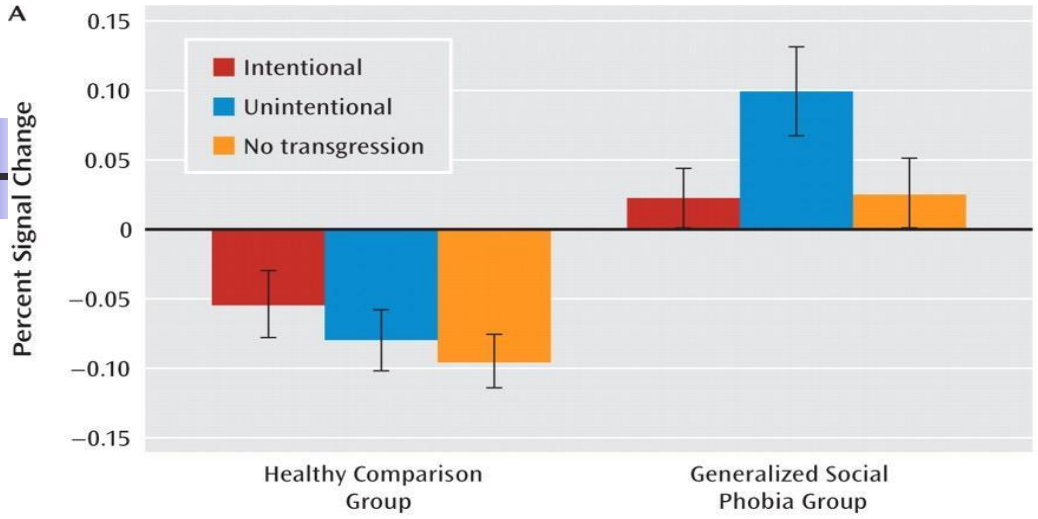
Blair K. Et al. Social Norm Processing in Adult Social Phobia: Atypical Increased Ventromedial Frontal cortex Responsiveness to Unintentional (Embarassing) Transgressions. Am J Psychiatry 2010;167:1526-1532

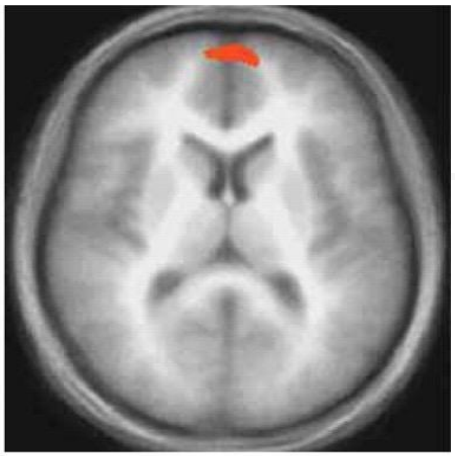
What is going on in their brains??

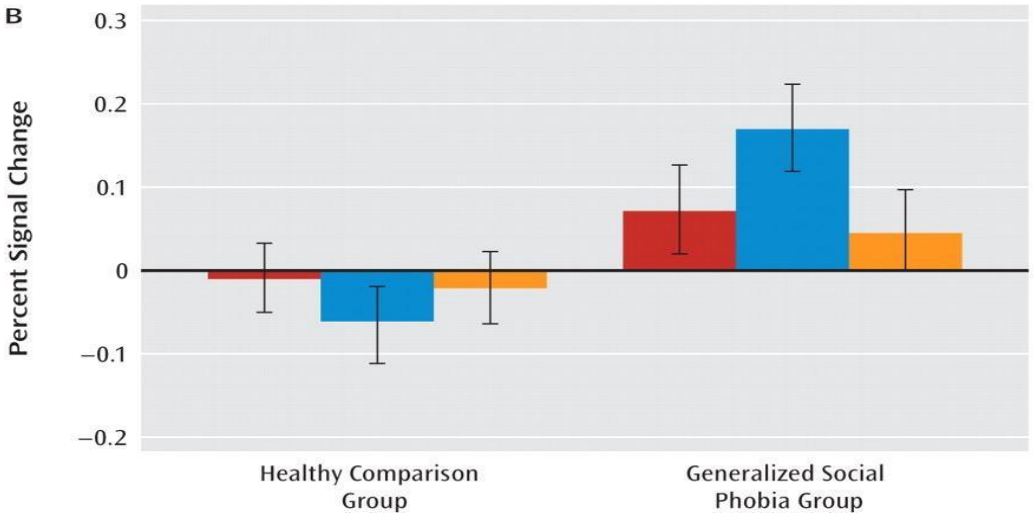
- Both groups ↑ medial prefrontal cortex activity in response to intentional relative to unintentional transgression.
- SAD patients however showed a significant response to the unintentional transgression.
- SAD subjects also had significant increase activity in the amygdala and insula bilaterally.

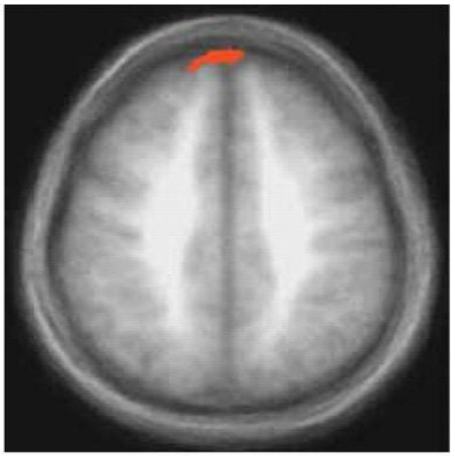
Blair K. Et al. Social Norm Processing in Adult Soical Phobia: Atypical Increased Ventromedial Frontal cortex Responsiveness to Unintentional (Embarrasing) Trasgressions. Am J Psychiatry 2010;167:1526-1532

What is going on in their brains??









Blair K. Et al. Social Norm Processing in Adult Soical Phobia: Atypical Increased Ventromedial Frontal cortex Responsiveness to Unintentional (Embarrasing) Trasgressions. Am J Psychiatry 2010;167:1526-1532

Functional imaging studies in SAD

- Several studies have found hyperactivity of the amygdala even with a weak form of symptom provocation namely presentation of human faces.
- Successful treatment with either CBT or citalopram showed reduction in activation of amygdala and hippocampus

Furmark T et al. Common changes in cerebral blood flow in patients with social phobia treated with citalpram or cognitive behavior therapy. Arch Gen Psychiatry 2002; 59:425-433

Social Anxiety Disorder treatment

- Social skills training, behavior therapy, cognitive therapy
- Medication – SSRIs, SNRIs, MAOIs, benzodiazepines, gabapentin

- סיבוכים:
  - דיכאון
  - שימוש בחומרים ממכרים

PANIC DISORDER

- התקף אימה, חרדה בעוצמה קיצונית
- מופיע ספונטאנית (לפחות בתחילת המחלה)
- הכללת אירועים
- חרדה מטרימהANTICIPATION ANXIETY -
- התפתחות המנעות – אגורפוביה

Panic Disorder

- Recurrent unexpected panic attacks and for a one month period or more of:
  - Persistent worry about having additional attacks
  - Worry about the implications of the attacks
  - Significant change in behavior because of the attacks

A Panic Attack is:

A discrete period of intense fear in which 4 of the following Symptoms abruptly develop and peak within 10 minutes:

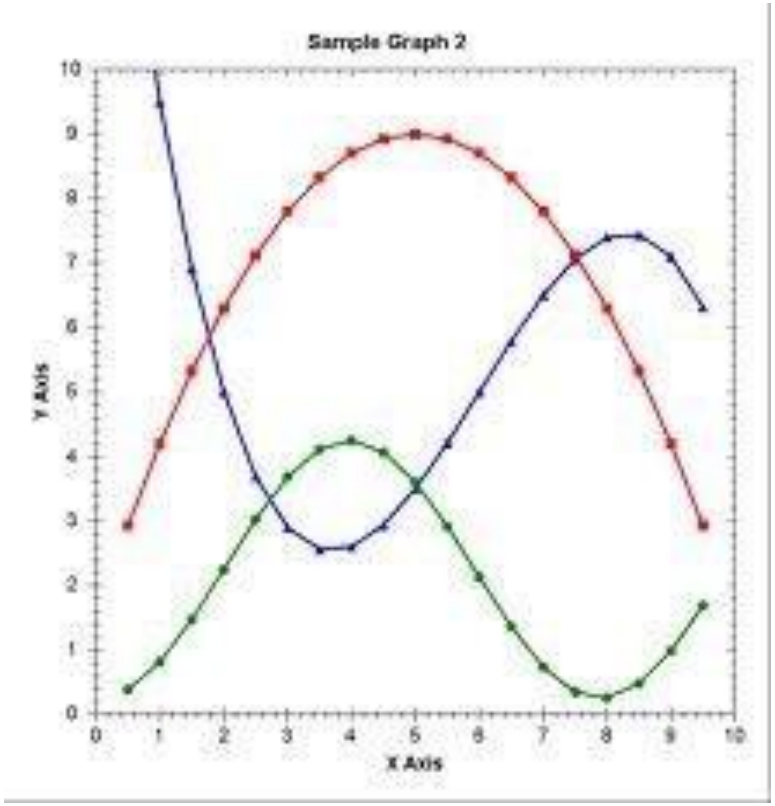
- Palpitations or rapid heart rate
- Sweating
- Trembling or shaking
- Shortness of breath
- Feeling of choking
- Chest pain or discomfort
- Nausea
- Chills or heat sensations
- Paresthesias
- Feeling dizzy or faint
- Derealization or depersonalization
- Fear of losing control or going crazy
- Fear of dying

Panic disorder epidemiology

- 2-3% of general population; 5-10% of primary care patients.Onset in teens or early 20's
- Female:male 2-3:1

Things to keep in mind

- A panic attack ≠ panic disorder
- Panic disorder often has a waxing and waning course



With Agoraphobia

- פחד או המנעות להיות במקומות או במצבים בהם יש קושי לברוח או לקבל עזרה.

סיבוכים :

- דיכאון עד 50%
- תלות בחומרים ממכרים- אלכוהול, תרופות הרגעה
- פגיעה תפקודית קשה
- חשוב לברר:
  - הרגלי קפאין
  - מחלות גופניות – תירוטוקסיות, פאוכרומוציטומה, MVP,

טיפול:

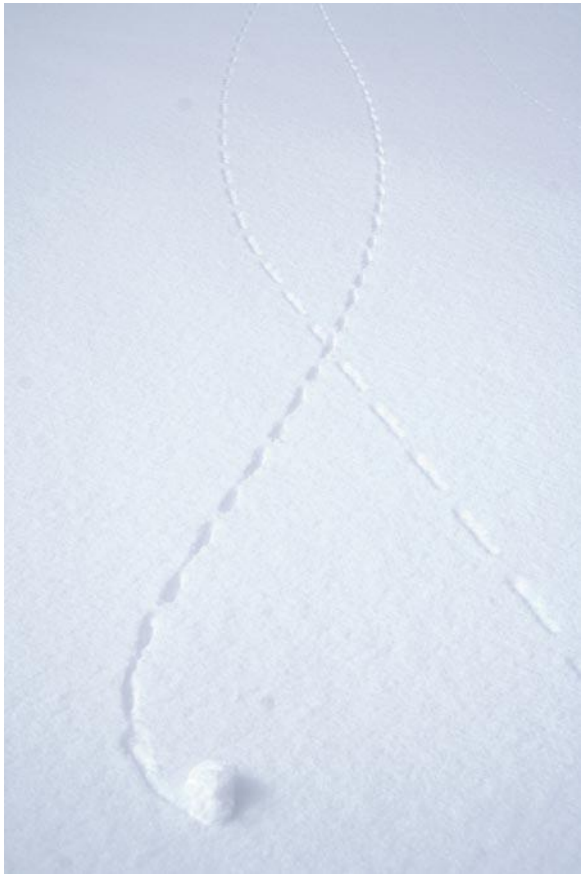
- שילוב של טיפול CBT ותרופות:
  - נוגדי דיכאון
  - נוגדי חרדה **לשלב הראשון**

Panic Disorder Comorbidity

- 50-60% have lifetime major depression
  - One third have current depression
- 20-25% have history substance dependence

Panic Disorder Etiology

- Drug/Alcohol
- Genetics
- Social learning
- Cognitive theories
- Neurobiology/conditioned fear
- Psychosocial stressors
  - Prior separation anxiety



Treatment

- See 70% or better treatment response
- Education, reassurance, elimination of caffeine, alcohol, drugs, OTC stimulants
- Cognitive-behavioral therapy
- Medications – SSRIs, venlafaxine, tricyclics, MAOIs, benzodiazepines, valproate, gabapentin

Agoraphobia

- Marked fear or anxiety for more than 6 months about two or more of the following 5 situations:
  - Using public transportation
  - Being in open spaces
  - Being in enclosed spaces
  - Standing in line or being in a crowd
  - Being outside of the home alone

Agoraphobia

- The individual fears or avoids these situations because escape might be difficult or help might not be available
- The agoraphobic situations almost always provoke anxiety
- Anxiety is out of proportion to the actual threat posed by the situation
- The agoraphobic situations are avoided or endured with intense anxiety
- The avoidance, fear or anxiety significantly interferes with their routine or function

Prevalence

- 2% of the population
- Females to males:2:1
- Mean onset is 17 years
- 30% of persons with agoraphobia have panic attacks or panic disorder
- Confers higher risk of other anxiety disorders, depressive and substance-use disorders

Generalized Anxiety

- פחד או חרדה מוגזמים, ללא כל אחיזה במציאות, מלווים בביטוים של מתח מוטורי, פעילות יותר של מערכת אוטונומית, מצב של זהירות וכוננות תמידים וצפייה שהולך לקרואת מה שהו.
- אבחנה יותר בעייתית.
- פחות ספציפית, כרונית
- תלונות פחות מוגדרות
- שכיחות גבוהה (5-12%)
- משך זמן ארוך

Generalized Anxiety Disorder

- Excessive worry more days than not for at least 6 months about a number of events and they find it difficult to control the worry.
- 3 or more of the following symptoms:
  - Restlessness or feeling keyed up or on edge, easily fatigued, difficulty concentrating, irritability, muscle tension, sleep disturbance
- Causes significant distress or impairment

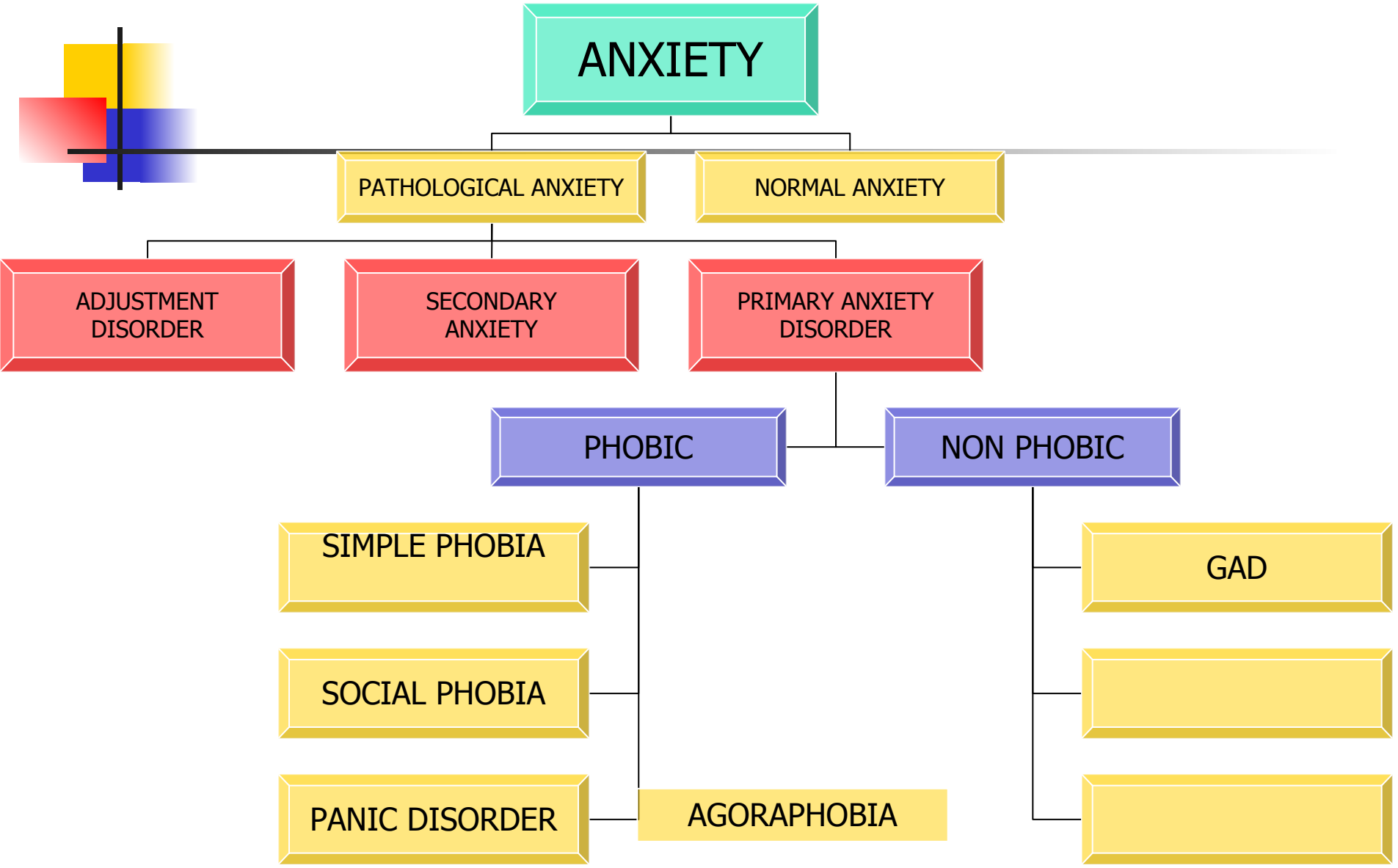
GAD Comorbidity

- 90% have at least one other lifetime Axis I Disorder
- 66% have another current Axis I disorder
- Worse prognosis over 5 years than panic disorder

Long-Term Treatment Of GAD

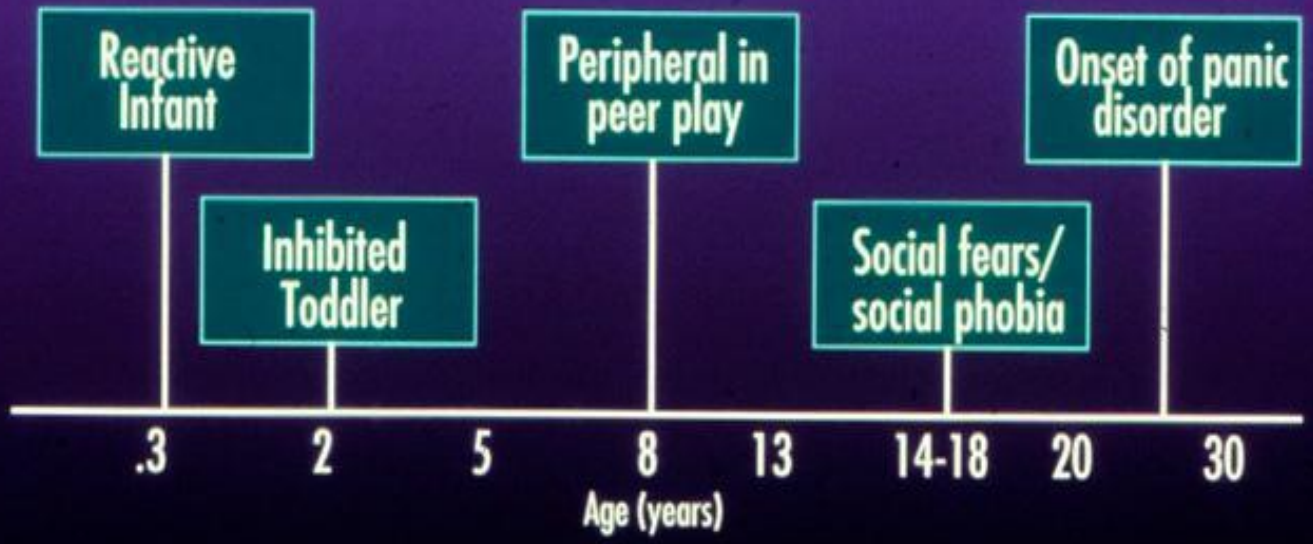
- Need to treat long-term
- Full relapse in approximately 25% of patients 1 month after stopping treatment
- 60%-80% relapse within 1st year after stopping treatment

Hales et al. *J Clin Psychiatry*. 1997;58(suppl 3):76.
Rickels et al. *J Clin Psychopharmacol*. 1990;10(3 suppl):101S.


ANXIETY
PATHOLOGICAL ANXIETY
NORMAL ANXIETY
ADJUSTMENT DISORDER
SECONDARY ANXIETY
PRIMARY ANXIETY DISORDER
PHOBIC
NON PHOBIC
SIMPLE PHOBIA
SOCIAL PHOBIA
PANIC DISORDER
AGORAPHOBIA
GAD

Anxiety Diathesis

Behavioral Inhibition → Childhood Anxiety → Social Phobia → Panic Disorder



Panic patients with comorbid social phobia are significantly more likely to have had childhood anxiety disorder than panic patients without social phobia (62/76, 82% vs 71/170, 42%; p<.001)

Pollack et al. 1993

Pharmacotherapy for Anxiety Disorders

Antidepressants

Serotonin Selective Reuptake Inhibitors (SSRIs)

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Atypical Antidepressants

Tricyclic Antidepressants (TCAs)

Monoamine Oxidase Inhibitors (MAOIs)

Benzodiazepines

Other Agents

Azaspirones

Beta blockers

Anticonvulsants

Other strategies

Discontinuation of Treatment for Anxiety Disorders

- Withdrawal/rebound more common with Bzd than other anxiolytic treatment
- Relapse: a significant problem across treatments. Many patients require maintenance therapy
- Bzd abuse is rare in non-predisposed individuals
- Clinical decision: balance comfort/compliance/ comorbidity during maintenance treatment with discontinuation-associated difficulties

Strategies for Anxiolytic Discontinuation

- Slow taper
- Switch to longer-acting agent for taper
- Cognitive-Behavioral therapy
- Adjunctive
  - Antidepressant
  - Anticonvulsant
  - clonidine, beta blockers, buspirone

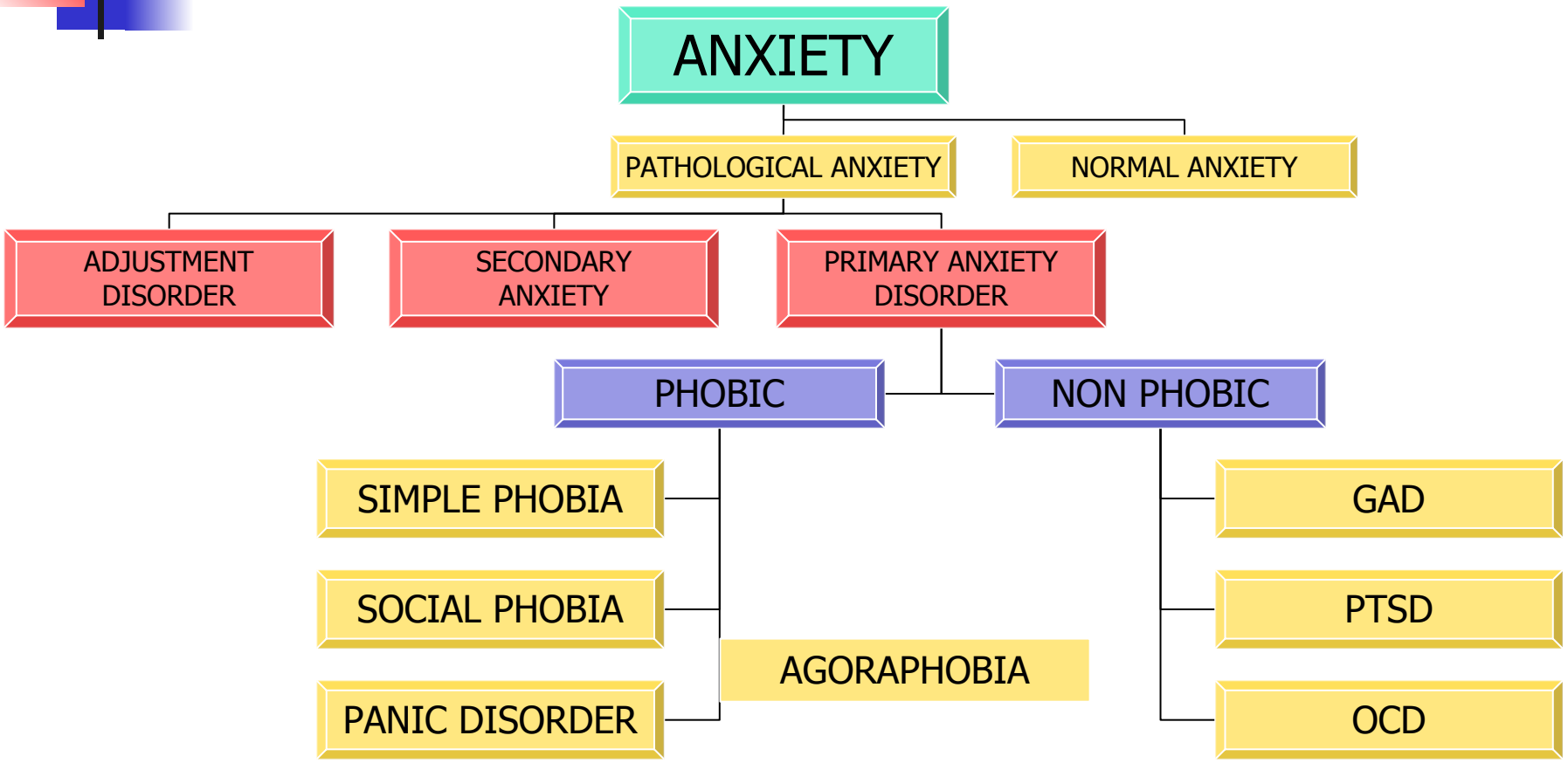
Strategies for Refractory Anxiety Disorder

- Maximize dose
- Combine antidepressant and benzodiazepine
- Administer cognitive-behavioral therapy
- Attend to psychosocial issues

Strategies for Refractory Anxiety Disorders

- Augmentation
  - Anticonvulsants
    - Gabapentin
    - Valproate
    - Topiramate
  - Beta blocker
  - Buspirone
  - Clonidine/Guanfacine
  - Pindolol -**nonselective** beta blocker
  - Dopaminergic agonists for social phobia (pergolide)
  - Cyproheptadine
- Combined SSRI/TCA
- Alternative antidepressant
  - Clomipramine
  - MAOI
- Other
  - Inositol
  - Atypical neuroleptics

סיכום: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SOCIAL PHOBIA
PANIC DISORDER
AGORAPHOBIA
GAD
PTSD
OCD

Screening questions

- How ever experienced a panic attack? (Panic)
- Do you consider yourself a worrier? (GAD)
- Have you ever had anything happen that still haunts you? (PTSD)
- Do you get thoughts stuck in your head that really bother you or need to do things over and over like washing your hands, checking things or count? (OCD)
- When you are in a situation where people can observe you do you feel nervous and worry that they will judge you? (SAD)

Take home points

- Anxiety, Obsessive-Compulsive and Related, and Trauma and Stressor-related disorders are common, common, common!
- There are significant comorbid psychiatric conditions associated with anxiety disorders!
- Screening questions can help identify or rule out diagnoses
- There are many effective treatments including psychotherapy and psychopharmacology
- There is a huge amount of suffering associated with these disorders!


Question


THANKS

Trauma- and Stressor-Related Disorders

New chapter in DSM-5 brings together anxiety disorders that are preceded by a distressing or traumatic event

1. Reactive Attachment Disorder
2. Disinhibited Social Engagement Disorder (new)
3. PTSD (includes PTSD for children 6 years and younger)
4. Acute Stress Disorder
5. Adjustment Disorders

Disinhibited Social Engagement Disorder

"The essential feature of disorder is a pattern of behavior that involves culturally inappropriate, overly familiar behavior with relative strangers. This behavior violates the social boundaries of the culture." DSM-5, p. 269

Trauma- and Stressor-Related Disorders

Acute Stress Disorder

A. PTSD A Criterion

B. No mandatory (e.g., dissociative, etc.) symptoms from any cluster

C. Nine (or more) of the following (with onset or exacerbation after the traumatic event):

1. Intrusion (4)
2. Negative Mood (1)
3. Dissociative (2)
4. Avoidance (2)
5. Arousal (5)

Trauma- and Stressor-Related Disorders

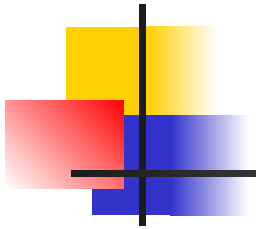
Adjustment Disorders -DSM-5

Adjustment Disorders are redefined as an array of stress-response syndromes occurring after exposure to a distressing event.

Adjustment Disorder subtypes are unchanged

- with depressed mood
- with anxiety
- with disturbance of conduct

Chronic Adjustment Disorder



- Omitted by mistake from DSM-5
- Acute AD – less than 6 months
- Chronic AD –cannot persist more than 6 months **after termination of stressor or its consequences**

Other Specified Trauma/Stressor-Related Disorder (309.89)

AD with duration more than 6 months without prolonged duration of stressor

- subthreshold PTSD
- persistent complex bereavement disorder
- ataques nervios and other cultural symptoms

Reactive Attachment Disorder

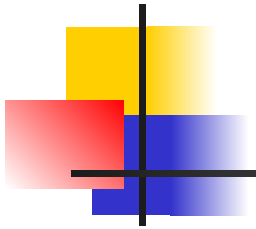
- Emotionally withdrawn behavior
- Social/emotional disturbance

- reduced responsiveness, limited affect &/or irritability, sadness or fearfulness

- Exposure to extremes of insufficient care

- social neglect/deprivation, repeated changes in caregivers, rearing in unusual settings

Persistent Complex Bereavement Disorder



- Onset > 12 months after death of loved one
- Yearning/Sorrow/Pre-occupation with deceased
- Reactive distress to the death
- Social/Identity disruption
- Significant distress or impairment
- Out of proportion to cultural norms
- Traumatic specifier

Persistent Complex Bereavement Disorder (PCBD)

Diagnostic Criteria-ICD

A. The person experienced the death of a close relative or friend at least 12 months ago. In the case of children, the death may have occurred 6 months prior to diagnosis.

B. Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree:

1. Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including separation-reunion behavior with caregivers.
2. Intense sorrow and emotional pain because of the death.
3. Preoccupation with the deceased person.

Persistent Complex Bereavement Disorder (PCBD)

4. Preoccupation with the circumstances of the death. In children, this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.

c) Since the death, at least six of the following symptoms (from either reactive distress or social/identity disruption) are experienced on more days than not and to a clinically significant degree:

Reactive Distress to the Death

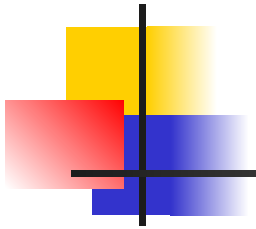
1. Marked difficulty accepting the death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.
2. Feeling shocked, stunned, or emotionally numb over the loss.
3. Difficulty with positive reminiscing about the deceased.
4. Bitterness or anger related to the loss.
5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame).
6. Excessive avoidance of reminders of the loss (e.g., avoidance of people, places, or situations associated with the deceased; in children, this may include avoidance of thoughts and feelings regarding the deceased).

Social/Identity Disruption

7. A desire to die in order to be with the deceased.
8. Difficulty trusting other people since the death.
9. Feeling alone or detached from other people since the death.
10. Feeling that life is meaningless or empty without the deceased or the belief that one cannot function without the deceased.
11. Confusion about one's role in life or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased).
12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).

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

E. The bereavement reaction must be out of proportion or inconsistent with cultural, religious, or age-appropriate norms.



- Specify if:
- With Traumatic Bereavement: Following a death that occurred under traumatic circumstances (e.g. homicide, suicide, disaster, or accident), there are persistent, frequent distressing thoughts, images, or feelings related to traumatic features of the death (e.g., the deceased's degree of suffering, gruesome injury, blame of self or others for the death), including in response to reminders of the loss.


PTSD

Changes in PTSD Criteria

Four symptom clusters, rather than three

- -Re-experiencing
- -Avoidance
- -Persistent negative alterations in mood and cognition
- -Arousal: describes behavioral symptoms

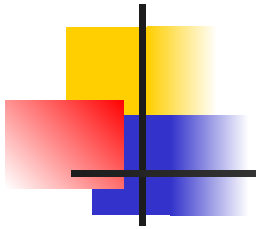
Trauma- and Stressor-Related Disorders

Changes in PTSD Criteria

DSM-5 more clearly defines what constitutes a traumatic event

Sexual assault is specifically included

Recurring exposure, that could apply to first responders



Changes in PTSD Criteria

Recognition of PTSD in Young children

Developmentally sensitive:

Criteria have been modified for children age 6 and younger

Thresholds – number of symptoms in each cluster - have been lowered

DSM-5: PTSD Criterion A

A. The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows:

1. Direct exposure

2.Witnessing, in person

Criterion A (continued):

- 3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
- 4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies or pictures.

CRITERION B - Intrusion (5 Sx – Need 1)

1. Recurrent, involuntary and intrusive recollections *

* children may express this symptom in repetitive play

2. Traumatic nightmares

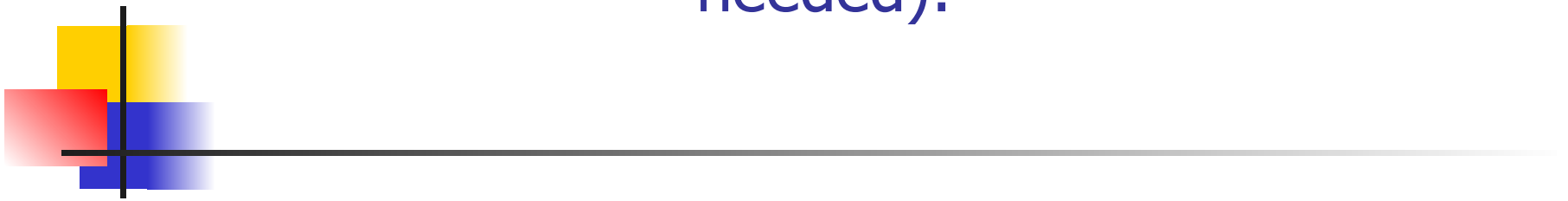
* children may have disturbing dreams without content related to trauma

3. Dissociative reactions (e.g. flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness *

* children may re-enact the event in play

4. Intense or prolonged distress after exposure to traumatic reminders
5. Marked physiological reactivity after exposure to trauma-related stimuli

C. Persistent effortful avoidance of distressing trauma-related stimuli after the event (1/2 symptoms needed):



1. Trauma-related thoughts or feelings
2. Trauma-related external reminders (e.g. people, places, conversations, activities, objects or situations)

CRITERION D – negative alterations in cognition & Mood (7 Sx – Need 2)

1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs)
2. Persistent (& often distorted) negative beliefs and expectations about oneself or the world (e.g. "I am bad," "the world is completely dangerous")
3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences (new)
4. Persistent negative trauma-related emotions (e.g. fear, horror, anger, guilt, or shame) **(new)**
5. Markedly diminished interest in (pre-traumatic) significant activities
6. Feeling alienated from others (e.g. detachment or estrangement)
7. Constricted affect: persistent inability to experience positive emotions

CRITERION E – Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event (2/6 symptoms)

1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior **(new)**
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

PTSD Criteria for DSM-5

F. Persistence of symptoms (in Criteria B, C, D and E) for more than one month

G. Significant symptom-related distress or functional impairment

H. Not due to medication, substance or illness

Preschool Subtype: 6 Years or Younger
Relative to broader diagnosis for adults (or those over 6 years):

- Criterion B – no change (1 Sx needed)
- 1 Sx from EITHER Criterion C or D
  - C cluster – no change (2 Avoidance Sx)
  - D cluster – 4/7 adult Sx
- ✔ Preschool does not include: amnesia; foreshortened future; persistent blame of self or others
- Criterion E – 5/6 adult Sx (2 Sx needed)
- ✔ Preschool does not include reckless behavior

A. In children (younger than 6 years), exposure to actual or threatened death, serious injury, or sexual violence, as follows:

1. Direct exposure
2. Witnessing, in person, (especially as the event occurred to primary caregivers) Note: Witnessing does not include viewing events in electronic media, television, movies, or pictures.
3. Indirect exposure, learning that a parent or caregiver was exposed

DSM-5: Preschool PTSD Criterion B

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

1. Recurrent, involuntary, and intrusive distressing recollections (which may be expressed as play)
2. Traumatic nightmares in which the content or affect is related to the traumatic event(s). Note: It's not always possible to determine that the frightening content is related to the traumatic event.
3. 3.Dissociative reactions (e.g., flashbacks); such trauma-specific re-enactment may occur in play
4. 4.Intense or prolonged distress after exposure to traumatic reminders
5. 5.Marked physiological reactions after exposure to trauma-related stimuli

Preschool PTSD Criterion C

One or more symptoms from either Criterion C or D below:

C. Persistent effortful avoidance of trauma-related stimuli:

1. Avoidance of activities, places, or physical reminders
2. Avoidance of people, conversations, or interpersonal situations

D. Persistent trauma-related negative alterations in cognitions and mood beginning or worsening after the traumatic event occurred, as evidenced by one or more of the following:

1. Negative emotional states (e.g., fear, guilt, sadness, shame, confusion)
2. Diminished interest in significant activities, including constriction of play
3. Socially withdrawn behavior
4. Reduced expression of positive emotions

Preschool PTSD Criterion E

E. Alterations in arousal and reactivity associated with the traumatic event,, as evidenced by two or more of the following:

1. Irritable behavior and angry outbursts (including extreme temper tantrums)
2. Hypervigilance
3. Exaggerated startle response
4. Problems with concentration
5. Sleep disturbance

Preschool PTSD for DSM-5

F. Duration (of Criteria B, C, D and E) is more than 1 month

G. The symptoms causes clinically significant distress or impairment in relationships

H. Symptoms are not attributable to a substance (e.g., medication or alcohol) or medical condition

Summary: PTSD in DSM-5

Perhaps PTSD should be re-conceptualized as a spectrum disorder in which several distinct pathological posttraumatic phenotypes are distinguished symptomatically & psycho-biologically.

If so, optimal treatment for one phenotype might not necessarily be the best treatment for another.

Dissociative Subtype of PTSD

New subtype for both age groupings of PTSD diagnosis:

1. Meets PTSD diagnostic criteria
2. Experiences additional high levels of depersonalization or derealization
3. Dissociative symptoms are not related to substance use or other medical condition

specifiers

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for PTSD, and in addition, in response to the stressor, the individual experiences persistent or recurring symptoms of either of the following:

- **Depersonalization:** Persistent or recurrent experiences of feeling detached from , and as if one was an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling sense of unreality of self or body or of time moving slowly).
- **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted).

Note: To use this subtype, the dissociate symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during intoxication) or other medical condition.

CAPS

Clinician Administered PTSD Scale

- National Center for PTSD (www.ptsd.va.gov)
- 20 item structured clinical interview
- Primarily for diagnosis
- Good psychometrics and inter-rater relaibilty
- "Gold Standard" for diagnosing PTSD (if diagnosis will be questioned or challanged)
- Clinician administered and clinician scored (not self-report)
- Each symptom has a qualitative section used to derive quantitative evaluation of symptom
- Intensity x Frequency/2 = Severity
- Severity score of $\geq$ 2 = endorsement of that symptom

1. (B1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

In the past month, have you had any unwanted memories of (EVENT) while you were awake, so not counting dreams? [Rate 0=Absent if only during dreams]

How does it happen that you start remembering (EVENT)?

[If not clear:] ***(Are these unwanted memories, or are you thinking about [EVENT] on purpose?)*** [Rate 0=Absent unless perceived as involuntary and intrusive]

How much do these memories bother you?

Are you able to put them out of your mind and think about something else?

Circle: Distress = *Minimal Clearly Present Pronounced Extreme*

How often have you had these memories in the past month? *# of times*

_____

Key rating dimensions = frequency / intensity of distress

Moderate = at least 2 X month / distress clearly present, some difficulty dismissing memories

Severe = at least 2 X week / pronounced distress, considerable difficulty dismissing memories

0 – absent

1 – mild

2 – moderate

3 – severe

4 – extreme

PCL
Posttraumatic Check List

- National Center for PTSD (www.ptsd.va.gov)
- Simple, easy to administer
- Self-report or clinician administered
- 20 item – all 20 symptoms
- CRITERION B: Items 1-5
- CRITERION C: Items 6-7
- CRITERION D: Items 8 – 14
- CRITERION E: Items 15 – 20
- Score of $\geq$ 2 = endorsement of that symptom

TRS
Trauma Recovery Scale

- Gentry, 1996
- Developed as an outcome instrument
- Good psychometrics (Chronbach's a = .86 & convergent validity with IES = -.71)
- Solution-focused
- Mean score = % recovery from trauma
- Scores > 75 = minimal impairment
- Scores < 75 begin impairment spectrum and need stabilization
- 5a & 5b opportunity to discuss "am safe vs. feels safe"
- Part I is trauma inventory and administered only at intake
- Part II is repeated measure for outcomes
- Scores < 50 = treatment plan issue

Early Sessions

- Graphic Time Line of life including ALL significant traumatic experiences
- Verbal Narrative using GTL as map
- Video-recording
- Asking client to view video (if they can tolerate) with attitude of ACCEPTANCE, COMPASSION & CURIOSITY

PTSD Epidemiology

- 7-9% of general population
- 60-80% of trauma victims
- 30% of combat veterans
- 50-80% of sexual assault victims
- Increased risk in women, younger people
- Risk increases with “dose” of trauma, lack of social support, pre-existing psychiatric disorder

PTSD Epidemiology

- בין אבחנות בודדות ב DSM שמדברת על אטיולוגיה
- זוהי תגובה נפשית קשה הנגרמת כתגובה לאירוע טראומטי, **חריג בעוצמתו** כגון: קרב, אונס, שוד, תאונה קשה, פיגוע וכו'
- כ 20% מהנחשפים לאירוע טראומתי יפתחו PTSD
- lifetime prevalence - נשים, 10% - גברים. 5% -
- בשנת 2005 כמעט 8% אמריקאים סבלו מ PTSD.
- 8% גברים ו- 20%נשים יפתחו PTSD אחרי טראומה ו-- 30% מתוכם יפתחו PTSD CHRONIC

Comorbidities

- Depression
- Other anxiety disorders
- Substance use disorders
- Somatization
- Dissociative disorders

Types of PTSD

- Acute PTSD - symptoms less than three months
- Chronic PTSD - symptoms more than three months
- Although symptoms usually begin within 3 months of exposure, a delayed onset is possible months or even years after the event has occurred.

[Can J Psychiatry, Vol 51, Suppl 2, July 2006]

Age of Onset and Cultural Features

- Can occur at any age, including childhood, and can affect anyone.
- Individuals who have recently immigrated from areas of considerable social unrest and civil conflict may have elevated rates of PTSD.
- No clear evidence that members of different ethnic or minority groups are more or less susceptible than others.

Onset

- Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear.
- **Immediate Onset**
- Better response to treatment
- Better prognosis (i.e., less severe symptoms)
- Fewer associated symptoms or complications
- Symptoms are resolved within 6 months
- **Delayed Onset**
- Characterized by an onset of symptoms at least 6 months after the stressor
- Associated symptoms and conditions develop
- Condition more likely to become chronic
- Possible repressed memories
- Worse prognosis

Natural Recovery: One Year Data

Riggs et al. (1995), Foa (1997)

Course

- The symptoms and the relative predominance of re-experiencing, avoidance, and increased arousal symptoms may vary over time.
- Duration of symptoms also varies: Complete recovery occurs within 3 months after the trauma in approximately half of the cases. Others can have persisting symptoms for longer than 12 months after the trauma.
- Symptom reactivation may occur in response to reminders of the original trauma, life stressors, or new traumatic events.

Course Continued

- The severity, duration, and proximity of an individual's exposure to a traumatic event are the most important factors affecting the likelihood of developing PTSD.
- Social supports, family history, childhood experiences, personality variables, and pre-existing mental disorders may influence the development of PTSD.
- PTSD can also develop in individuals without any predisposing conditions, particularly if the stressor is extreme.
- The disorder may be especially severe or long lasting when the stressor is of human design (torture, rape).

Estimated Risk for Developing PTSD Based on Event

- Rape (49%)
- Severe beating or physical assault (31.9%)
- Other sexual assault (23.7%)
- Serious accident or injury (i.e. car or train accident) (16.8%)
- Shooting or stabbing (15.4%)
- Sudden, unexpected death of family member or friend (14.3%)
- Child's life-threatening illness (10.4%)
- Witness to killing of serious injury (7.3%)
- Natural Disaster (3.8%)

www.ptsdalliance.org
www.nimh.nih.gov/pulicat/reliving.cfm

Differential Diagnosis

- Differential diagnosis of the disorder or problem; that is, what other disorders or problems may account for some or all of the symptoms or features. PTSD is frequently co-morbid with other psychiatric disorders including:

  - Anxiety disorders
  - Acute Stress Disorder
  - Obsessive compulsive disorder
  - Adjustment disorder
  - Depressive disorders
  - Substance Abuse disorders

PTSD Compared to Other Disorders

- While the symptoms of posttraumatic stress disorder (PTSD) may seem similar to those of other disorders, there are differences.
- Acute stress disorder
- Obsessive-compulsive disorder
- Adjustment disorder

Differences between Acute Stress Disorder

- In general, the symptoms of acute stress disorder must occur within four weeks of a traumatic event and come to an end within that four-week time period.

- If symptoms last longer than one month and follow other patterns common to PTSD, a person's diagnosis may change from acute stress disorder to PTSD.

Differences between PTSD and Obsessive-Compulsive Disorder

- Both have recurrent, intrusive thoughts as a symptom, but the types of thoughts are one way to distinguish these disorders. Thoughts present in obsessive-compulsive disorder do not usually relate to a past traumatic event. With PTSD, the thoughts are invariably connected to a past traumatic event.

Differences Between PTSD and Adjustment Disorder

- PTSD symptoms can also seem similar to adjustment disorder because both are linked with anxiety that develops after exposure to a stressor. With PTSD, this stressor is a traumatic event. With adjustment disorder, the stressor does not have to be severe or outside the “normal” human experience.

Differences Between PTSD and Depression

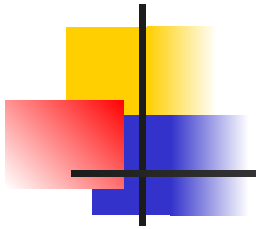
- Depression after trauma and PTSD both may present numbing and avoidance features, but depression would not induce hyperarousal or intrusive symptoms

מי מיועד יותר?

- עוצמה של סטרסור
- פתאומיות (לא צפוי)
- חוסר יכולת לשלוט על מתרחש
- sexual as opposed to nonsexual- victimization
- אצל צעירים
- העדר מערכת תמיכה

An adult's risk for psychological distress will increase as the number of the following factors increases:

- Female gender
- 40 to 60 years old
- Little previous experience or training relevant to coping with disaster
- Ethnic minority
- Low socioeconomic status
- Children present in the home



- For women, the presence of a spouse, especially if he is significantly distressed
- Psychiatric history
- Severe exposure to the disaster, especially injury, life threat, and extreme loss
- Living in a highly disrupted or traumatized community
- Secondary stress and resource loss

Why PTSD Victims Might Be Resistant to Getting Help

- Sometimes hard because people expect to be able to handle a traumatic even on their own
- People may blame themselves
- Traumatic experience might be too painful to discuss
- Some people avoid the event all together
- PTSD can make some people feel isolated making it hard for them to get help
- People don't always make the connection between the traumatic event and the symptoms; anxiety, anger, and possible physical symptoms often have more than one anxiety disorder or may suffer from depression

During a Traumatic Event

- Norepinephrine- Mobilizing fear, the flight response, sympathetic activation, consolidating memory
- Too much = hypervigalence, autonomic arousal, flashbacks, and intrusive memories
- Serotonin- self- defense, rage and attenuation of fear
- Too little = aggression, violence, impulsivity, depression, anxiety
- PTSD victims – switch is stuck on

Causal Attributions

- "PTSD is typified by both automatic, involuntary symptoms, (e.g. flashbacks, intrusive thoughts, autonomic hyperarousal) and consciously mediated attempts to make meaning of the trauma experience. The automatic and involuntary symptoms appear to represent conditioned responding to environmental triggers associated with the trauma."

- However, much less is known about the origins and consequences of victims' efforts to understand their traumas or about how best to treat the symptoms associated with personal beliefs about traumas. The most comprehensive and widely cited guidelines for treating PTSD include using variants of cognitive therapy (including attribution retraining and cognitive restructuring)."

Massas., Phillip M and Hulsey, Timothy L. (2006)Causal Attributions in Posttraumatic Stress Disorder: Implications for Clinical Research and Practice, *Psychotherapy: Theory, Research, Practice*

Treatment

- Individual Therapy
- Group Support (especially for Chronic PTSD)
- Medication

Treatment Continued

- Acute PTSD - Stress debriefing and psychotherapy

- Severe Acute PTSD - Stress debriefing, medication, group and individual psychotherapy

- Chronic PTSD - Stress debriefing, medication, group and individual psychotherapy

Treatment Continued

- Exposure Therapy- Education about common reactions to trauma, breathing retraining, and repeated exposure to the past trauma in graduated doses. The goal is for the traumatic event to be remembered without anxiety or panic resulting.
- Cognitive Therapy- Separating the intrusive thoughts from the associated anxiety that they produce.
- Stress

Treatment Continued

- "Cognitive Restructuring involved teaching and reinforcing self-monitoring or thoughts and emotions, identifying automatic thoughts that accompany distressing emotions, learning about different types of cognitive distortions, and working to dispute the distress-enhancing cognitions, with a particular focus on abuse-related cognitions, for which the therapist remained alert during the personal experience work."

- "In summary for women who did not drop out, CBT treatment was highly effective for achieving remission of PTSD diagnosis, ameliorating PTSD symptom severity, and reducing trauma-related cognitive distortions, compared with a WL control Group."

(McDonagh, A., McHugo, G., Sengupta, A, Demment C.C., et al., (2005) Randomized Trial of Cognitive-Behavioral Therapy for Chronic Posttraumatic Stress

Medications

- SSRIs – Sertraline (Zoloft), Paroxetine (Paxil), Escitalorpram (Lexapro), Fluvoxamine (Luvox), Fluxetine (Prozac)
- Affects the concentration and activity of the neurotransmitter serotonin
- May reduce depression, intrusive and avoidant symptoms, anger, explosive outbursts, hyperarousal symptoms, and numbing
- FDA approved for the treatment of Anxiety Disorders including PTSD

Medications Continued

- Tricyclic Antidepressants- Clomiprimine (Anafranil), Doxepin (Sinequan) Nortriptyline (Aventyl), Amitriptyline (Elavil), Maprotiline (Ludiomil) Desipramine (Norpramin)
- Affects concentration and activity of neurotransmitters serotonin and norepinephrine
- Have been shown to reduce insomnia, dream disturbance, anxiety, guild, flashbacks, and depression

Treatment

- With treatment, symptoms should improve after 3 months
- In Chronic PTSD cases, 1-2 years

Future Direction of Treatment

- Noradrenergic Agents
- Beta Blockers – Propranolol

PTSD - Treatment

- שילוב של טיפול תרופתי בנוגדי דיכאון וחרדה
- בפועל מגיעים לכל הספקטרום של התרופות
- טיפול פסיכולוגי – CBT כיום מקובלת שיטת ה- PE עם תוצאות טובות מאוד.

Future Direction of Treatment Continued

"Early Diagnosis and intervention- either psychotherapeutic or pharmacological- following trauma may some day reduce symptoms of posttraumatic stress disorder."

"Cognitive models- how the victim understands and appraises the stressful experience- are influential, and cognitive style also helps predict the occurrence of PTSD."

(Levin, Aaron, Experts Seek Best Way To Treat Trauma Reactions, *Psychiatric News*, 2006, 41)

PTSD Myths

PTSD is a complex disorder that often is misunderstood. Not everyone who experiences a traumatic event will develop PTSD, but many people do.

MYTH:

PTSD only affects war veterans.

FACT:

Although PTSD does affect war veterans, PTSD can affect anyone. Almost 70 percent of Americans will be exposed to a traumatic event in their lifetime. Of those people, up to 20 percent will go on to develop PTSD. An estimated one out of 10 women will develop PTSD at sometime in their lives.

Victims of trauma related to physical and sexual assault face the greatest risk of developing PTSD. Women are about twice as likely to develop PTSD as men, perhaps because women are more likely to experience trauma that involves these types of interpersonal violence, including rape and severe beatings. Victims of domestic violence and childhood abuse also are at tremendous risk for PTSD.

PTSD Myths Continued

- **MYTH:**
  - People should be able to move on with their lives after a traumatic event. Those who can't cope are weak.

- **FACT:**
  - Many people who experience an extremely traumatic event go through an adjustment period following the experience. Most of these people are able to return to leading a normal life. However, the stress caused by trauma can affect all aspects of a person's life, including mental, emotional and physical well-being. Research suggests that prolonged trauma may disrupt and alter brain chemistry. For some people, a traumatic event changes their views about themselves and the world around them. This may lead to the development of PTSD.

PTSD Myths Continued

- **MYTH:**
- People suffer from PTSD right after they experience a traumatic event.

- **FACT:**
- PTSD symptoms usually develop within the first three months after trauma but may not appear until months or years have passed. These symptoms may continue for years following the trauma or, in some cases, symptoms may subside and reoccur later in life, which often is the case with victims of childhood abuse.

- Some people don't recognize that they have PTSD because they may not associate their current symptoms with past trauma. In domestic violence situations, the victim may not realize that their prolonged, constant exposure to abuse puts them at risk.

What is Prolonged Exposure?

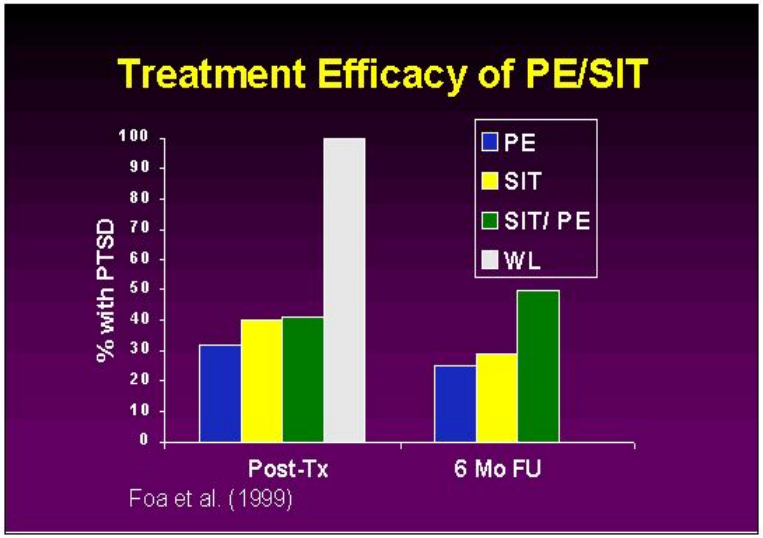
- PE is a type of CBT, which is designed to specifically target a number of trauma-related difficulties.
- Results of several controlled studies have shown it significantly reduce PTSD and other symptoms such as anxiety and depression, particularly in women following sexual and non-sexual assault (Foa et al., 1999).
- Clients meet once a week with a therapist for 60 to 90 minutes.

Treatment sessions include

1. education about common reactions to trauma
2. breathing retraining (or relaxation training)
3. prolonged (repeated) exposure to trauma memories
4. repeated in vivo (i.e., in real life) exposure to non-dangerous situations that are avoided due to trauma-related fear.

- Clients are encouraged to confront the memory of the trauma through repeatedly telling the story to the therapist and to confront things in life that are avoiding because they are frightening (e.g., driving in a car, walking on the street at night).

- Post-treatment data from a study conducted by Foa and colleagues (1999) comparing prolonged exposure (PE), stress inoculation training (SIT; another cognitive-behavioral therapy focusing on anxiety management techniques), and the combination of PE and SIT, to a waitlist control (WL). 96 sexual and non-sexual assault survivors with chronic PTSD

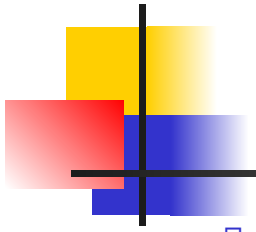


Combat Reaction

- Combat stress reaction, better known as "Shell Shock" is the post traumatic reaction of a soldier to an event which happened while in active combat.
- Between 10 and 15% (30%...or more) of all wounded soldiers during a war are combat reaction victims.
- In Israel there are 4000 such victims.

The Background of Combat Reaction

- The transition from civilian life to military life is acute.
- The soldier loses freedom of choice and mobility and he must submit to coercing commanding authorities.
- In order to adapt to the military surroundings and to the accompanying unpleasant conditions, the soldier must find within himself and use coping and adjusting mechanism.



- In wartime, a new and even more acute transition is added - the transition from conditions of peace and security to conditions of war.
- This transition entails further conflicts which add to the emotional burden of the soldier.
- The danger of being wounded or even killed is clear and tangible and becomes a constant burden on his emotional state.
- This pressure brings with it a drive to leave the danger zone.

- On the other hand the soldier feels solidarity with his unit, pride and honor and a bond to his friends and commanding officers and a feeling of responsibility for their fate, all of which contribute to his drive to continue and fight.

Risk Factors

- Risk factors for Combat Reaction are all the factors that influence the incidence of post-traumatic reactions in general, plus:
- Physical fatigue
- Lack of sleep
- Prolonged physical exertion
- Conditions of hunger
- Heat or cold

- Enforced passivity. When the soldier is deprived of activity and is in a state of waiting
- Decreased morale.
- The degree of support the soldier receives in his unit
- The degree of identification with the goal.
- How much the soldier feels a part of the mission he is involved in?

PIE principles

- **Proximity** - treat the casualties close to the front and within sound of the fighting
- **Immediacy** - treat them without delay and not wait till the wounded were all dealt with
- **Expectancy** - ensure that everyone had the expectation of their return to the front after a rest and replenishment

The US services now use the more recently developed **BICEPS** principles:

- Brevity
- Immediacy
- Centrality or Contact
- Expectancy
- Proximity
- Simplicity

Treatment results

- Data from the 1982 Lebanon war showed that with **proximal** treatment 90% of CSR casualties returned to their unit, usually within 72 hours.
- With **rearward** treatment only 40% returned to their unit.
- In Korea 85% of US battle fatigue casualties returned to duty within three days and 10% returned to limited duties after several weeks.

Controversy

- Throughout wars but notably during the Vietnam War there has been a conflict amongst doctors about sending distressed soldiers back to combat.
- During the Vietnam War this reached a peak with much discussion about the ethics of this process.
- Proponents of the PIES principles argue that it leads to a reduction of long-term disability
- Opponents argue that combat stress reactions lead to long-term problems such as posttraumatic stress disorder.

תסמונת שואה

- דור ראשון
- דור שני

TAKE HOME

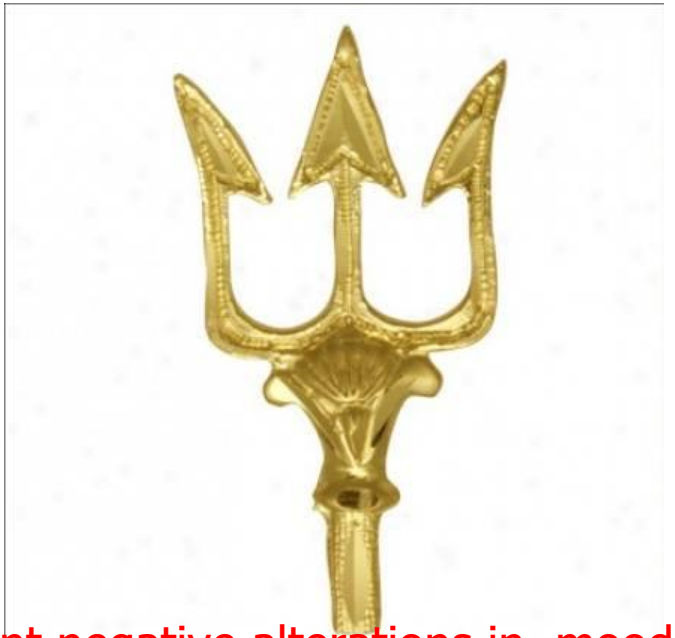
Re-experiencing

Avoidance

Hyperarousal

Reminders
Hyperarousal

Intrusive thoughts
Nightmares
flashbacks



Angry outbursts
Startle response
Lacks concentration
Disomnia

Persistent negative alterations in mood and cognition

THREE PRONGS OF PTSD