Stress related disorders

- Stressful events frequently provoke psychiatric disorders. Such events can also provoke emotional reactions that are distressing, but not of the nature or severity required for the diagnosis of an anxiety disorder or a mood disorder.
- These less severe reactions are discussed here, together with posttraumatic stress disorder (PTSD), which is an intense and prolonged reaction to a severe stressor.

The response to stressful events

- The response to stressful events has three components:
- **1.** An emotional response, with somatic accompaniments.
- **2.** A coping strategy.
- **3.** A defense mechanism.

Emotional and somatic responses

- These responses are of two kinds:
- **1.** *Anxiety* responses, with autonomic arousal leading to apprehension, irritability, tachycardia, increased muscle tension, and dry mouth.
- **2.** *Depressive* responses, with pessimistic thinking and reduced physical activity.

Coping strategies

- Coping strategies serve to reduce the impact of stressful events, thus attenuating the emotional and somatic responses and making it more possible to maintain normal performance at the time
- Coping strategies are of two kinds: *problem-solving strategies*, which can be used to make adverse circumstances less stressful; and *emotion-reducing strategies*, which alleviate the emotional response to the stressors.

- Problem-solving strategies include:
- ● *Obtaining information or advice* that would help to solve the problem.
- ● *Solving problems*—making and implementing plans to deal with the problem.
- ● *Confrontation*—defending one's rights, and persuading other people to change their behaviour.

- Emotion-reducing strategies include:
- ● *Ventilation of emotion*—talking to another person and expressing emotion.
- ● *Evaluation of the problem*—to assess what can be changed and try to change it (by problem-solving), and what cannot be changed and try to accept it.
- ● *Positive reappraisal of the problem*—recognizing that it has led to some good (e.g. that the loss of a job is an opportunity to find a more satisfying occupation).
- ● *Avoidance of the problem*—by refusing to think about it, avoiding people who are causing it, or avoiding reminders of it.

- Coping strategies are generally useful for reducing the problem or lessening the emotional reaction to it. However, they are not always adaptive.
- For example, avoidance may not be adaptive in the early stages of physical illness, because it can lead to delay in seeking appropriate treatment.

Maladaptive coping strategies

- These strategies reduce the emotional response to stressful circumstances in the short term, but lead to greater difficulties in the long term.They include the following:
- ● *Use of alcohol or unprescribed drugs* to reduce the emotional response or to reduce awareness of stressful circumstances.
- ● *Deliberate self-harm*, either by drug overdose or by self-injury. Some people gain relief from tension by cutting their skin with a sharp instrument to induce pain and draw blood.

- ● *Unrestrained display of feelings* can reduce tension, and in some societies such behaviour is sanctioned in particular circumstances (e.g. grieving). In other circumstances, such behaviour can damage relationships with people who would otherwise have been supportive.

- ● *Aggressive behaviour*—aggression provides immediate release of feelings of anger. In the longer term, it may increase the person's difficulties by damaging relationships.

- When particular coping mechanisms are used repeatedly by the same person in different situations, they are said to .constitute a **(coping style**)

Defence mechanisms

- Defence mechanisms are unconscious responses to external stressors as well as to anxiety arising from .internal conflict

Acute stress reaction and acute stress disorder

- Definition of *acute stress reaction* requires that the response should start within 1 hour of exposure to the stressor, and that it begins to diminish after not more than 48 hours, disappearing after a few days.
- The definition of *acute stress disorder* states that the onset should occur while or after experiencing the distressing event, and requires that the condition lasts for at least 2 days and for no more than 4 weeks.

Clinical picture

- The *core symptoms* of an acute psychological response to stress are anxiety or depression. Anxiety is the response to threatening experiences, and depression is the response to loss. Anxiety and depression often occur together, because stressful events often combine danger and loss. Other symptoms include feelings of being numb or dazed, difficulty in remembering the whole sequence of the traumatic event, insomnia, restlessness, poor concentration, and physical symptoms of autonomic arousal, especially sweating, palpitations, and tremor. Anger or histrionic behaviour may be part of the response.

- Avoidance is the most frequent coping strategy,
- where the person avoids talking or thinking about the stressful events, and avoids reminders of them. The most frequent defence mechanism is denial.

Epidemiology

- Rates in the general population are unclear. The rate of acute stress disorder has ranged from around 15% in motor accident survivors to over 50% in women victims of sexual assault. After the Wenchuan earthquake in China, about 30% of the survivors met criteria for acute stress disorder

Aetiology

- Not all people who are exposed to the same stressful situation develop the same degree of response. This variation suggests that differences in constitution, previous experience, and coping styles may play a part in aetiology. A history of psychiatric disorder and particularly of depression and dissociation prior to the trauma are predisposing factors.

Management

- After a traumatic event, many people talk informally to a sympathetic relative or friend, or to a member of the professional staff dealing with any physical injuries that originated during the incident. If anxiety is severe, an

anxiolytic drug may be prescribed for a day or two, and if sleep is severely •
.disrupted a hypnotic drug may be given for one or two nights

- Since in most cases stress reactions will resolve with time, a policy of *watchful waiting* is appropriate, although it is good practice to offer a follow-up appointment around two weeks after the trauma to identify people whose symptoms are not settling and who are therefore at increased risk of developing the more long-term and disabling *PTSD*.

Post-traumatic stress disorder

- This term denotes an intense, prolonged, and sometimes delayed reaction to an intensely stressful event. The essential features of a post-traumatic stress reaction are as follows:
- 1. Re-experiencing of aspects of the stressful event.
- 2. Hyperarousal.

.Avoidance of reminders .3 •

Examples of extreme stressors that may cause this disorder are natural disasters such as floods and earthquakes, man-made calamities such as major

fires and serious transport accidents, or the circumstances of war, and rape or serious physical assault on the person. The original concept of PTSD was of a reaction to such an extreme stressor that any person would be affected by

it. Epidemiological studies have shown that not everyone who is exposed to the same extreme stressor develops PTSD; thus personal predisposition plays .a part

Clinical picture

.The clinical features of PTSD can be divided into three groups

The most characteristic and diagnostically important symptoms are related to *re-experiencing* (also called *intrusion*) and include flashbacks, recurrent nightmares, and intrusive images or other sensory impressions .from the event

The second group of symptoms is concerned with *avoidance*, and includes difficulty in recalling stressful events at will, avoidance of reminders of the events, a feeling of detachment, and inability to feel emotion (numbing). The third group of symptoms is related to *hyperarousal*, and includes persistent .anxiety, irritability, insomnia, and poor concentration

Maladaptive coping responses may occur, including persistent aggressive behaviour, the excessive use of alcohol or drugs, and deliberate self-harm and suicide

Other features

Depressive symptoms are common, and guilt and shame are often experienced by the survivors of a disaster. There can be diminished interest in activities and an inability to experience positive emotions. After some traumatic events, survivors feel forced into a painful reconsideration of their beliefs about the meaning and purpose of life. Some develop exaggeratedly negative views of the world as well as of .themselves and others

Onset and course

Symptoms of PTSD may begin very soon after the stressful event, or after an interval, usually of days, but usually within 3 months. It is now accepted, however, that a minority of cases of PTSD can have a delayed onset or, more accurately, that subthreshold symptoms may not develop .to fulfil diagnostic criteria for PTSD for many months or even years

Aetiology

The stressor

The necessary cause of PTSD is an exceptionally stressful event. It is not necessary that the person should have been harmed physically or threatened personally; those involved in other ways may develop the disorder—for example, the driver of a train in whose path someone has .thrown himself for suicide, and the bystanders at a major accident

:Epidemiological research has revealed the following findings

The majority of people will experience at least one traumatic event in-
.their lifetime

Intentional acts of interpersonal violence, in particular combat and -
sexual assault, are more likely to lead to PTSD than accidents or
.disasters

Men tend to experience more traumatic events in general than women, - but women experience more events that are likely to lead to PTSD (e.g. .childhood sexual abuse, rape, and domestic violence)

Women are also more likely to develop PTSD in response to a traumatic-event than men. This enhanced risk is not explained fully by differences .in the type of traumatic event

Biological factors

Studies of twins suggest that differences in susceptibility to PTSD are in part-
.genetic

Research to date on the neurobiology of PTSD has focused on monoamine-
neurotransmitters and the hypothalamic–pituitary–adrenal (HPA) axis, both

.of which are involved in mediating defensive responses to stressful events

In addition, brain imaging studies have implicated changes in the *hippocampus*, a brain region that is important in memory formation, and .the *amygdala*, which plays a role in non-conscious emotional processing

These findings suggest that hippocampal dysfunction prevents adequate memory processing, while increased activity in noradrenergic innervation of the amygdala increases arousal and facilitates the automatic encoding .and partial recall of traumatic memories

Psychological factors

-Fear conditioning

Some patients with PTSD experience vivid memories of the traumatic events in response to sensory cues, such as smells and sounds related to the stressful situation. This finding suggests that classical conditioning .may be involved, as well as failure to *extinguish* conditioned responses

-Cognitive theories

These suggest that PTSD arises when the normal processing of emotionally charged information is overwhelmed, so that memories persist in an unprocessed form in which they can intrude into conscious awareness. In support of this idea, patients with PTSD tend to have .incomplete and disorganized recall of the traumatic events

Treatment

Psychological treatments are generally preferred in the treatment of PTSD, although pharmacotherapy has a role in patients presenting with significant comorbid depression or where psychological approaches are .not beneficial

Where alcohol or substance use disorders coexist with PTSD, it may be advisable to treat the substance misuse prior to offering psychological treatment for PTSD

Psychological treatments such as *trauma-focused cognitive behavior therapy* and *eye movement desensitization and reprocessing* are more effective than less specific treatments such as stress management, supportive therapy, and hypnotherapy

Cognitive behavioural treatment

Cognitive behaviour therapy is the most appropriate treatment. This treatment :has several components

- Information about the normal response to severe stress, and the importance .of confronting situations and memories related to the traumatic events
- .Self-monitoring of symptoms
- .Exposure in imagination and then *in vivo* to situations that are being avoided

- Recall of images of the traumatic events, to integrate these with the rest of the patient's experience. When first recalled these images are often fragmentary and are not clearly related in time to the other contents of memory.
- Cognitive restructuring through the discussion of evidence for and against the appraisals and assumptions.
- Anger management for people who still feel angry about the traumatic events and their causes.

Medication

Anxiolytic drugs such as benzodiazepines should be avoided in patients with established PTSD, because prolonged use may lead to dependence. A number of antidepressant drugs have shown efficacy in clinical trials, including selective serotonin reuptake inhibitors (SSRIs), serotonin and noradrenaline reuptake inhibitors (SNRIs), tricyclic .antidepressants (TCAs), and monoamine oxidase inhibitors (MAOIs)

Adjustment disorders

This term refers to the psychological reactions that arise in relation to adapting to new circumstances. Such circumstances include divorce and separation, a major change of work and abode (e.g. transition from school to university, or migration), and the birth of a handicapped child. Bereavement, the onset of a terminal illness, and sexual abuse are .associated with special kinds of adjustment

Clinical features

The symptoms of an adjustment disorder include anxiety, worry, poor concentration, depression, and irritability, together with physical symptoms caused by autonomic arousal, such as palpitations and tremor. There may be

outbursts of dramatic or aggressive behaviour, single or repeated episodes of deliberate self-harm, or the misuse of alcohol or drugs. The onset is more gradual than that of an acute reaction to stress, and the course is more

.prolonged. Social or occupational function is impaired

The *impairment in social or occupational function*, as well as the *intensity of distress*, is what distinguishes adjustment disorder from normal .adaptive reactions

Stressful life events may precipitate depression, anxiety, schizophrenia, and other psychiatric disorders. For this reason, the diagnosis of adjustment disorder is not made when diagnostic criteria for another .psychiatric disorder are met

It usually starts within 1 month. An essential point is that the reaction is understandably related to, and in proportion to, the stressful experience when account is taken of the patient’s previous experiences and personality. Once the stressor or its consequences are removed, the .symptoms resolve within 6 months

Treatment

Treatment is designed to help the patient to resolve the stressful problems if this is possible, and to aid the natural processes of adjustment. The latter is done by reducing denial and avoidance of the stressful events, encouraging

problem-solving, and discouraging maladaptive coping responses. Anxiety can usually be reduced by encouraging the patient to talk about the problems

and to express their feelings. Occasionally, an anxiolytic or hypnotic drug is needed for a few day

Illness behaviour

Mechanic (1978) suggested the term *illness behaviour* to describe behavior associated with adjustment to physical or mental disorder, whether adaptive or not. Illness behaviour includes consulting doctors, taking medicines, seeking help from relatives and friends, and giving up inappropriate activities. These behaviours are adaptive in the early stages of illness, but may become maladaptive if they persist into the stage of convalescence when the patient should be becoming .independent

Illness behaviour results from the person's conviction that he is ill rather than from the objective presence of disease, and it may develop when no disease is present. Illness behavior without disease is an important problem in general practice and, once firmly established, it is difficult to treat. The concept of illness behaviour overlaps with that of the sick role (described below), but the two are described separately because they .have different origins

The sick role

Society bestows a special role on people who are ill. The sociologist Talcott Parsons (1951) called this the *sick role*, which is made up of two :privileges and two duties

exemption from certain social responsibilities ●

the right to expect help and care from others ●

the obligation to seek and cooperate with treatment ●

.the expectation of a desire to recover ●

While the person is ill, the sick role is adaptive. If they continue in the sick role after the illness is over, recovery is delayed as they continue to avoid responsibilities and depend on others instead of becoming .independent

Grief and adjustment to bereavement

Terminology

Although the words , bereavement, mourning, and grief are sometimes used interchangeably, they have separate meanings which incorporate distinctions that are .useful in psychiatry

.*Bereavement* is the loss through death of a loved person ●

.*Grief* is the involuntary emotional and behavioural response to bereavement ●

Mourning is the voluntary expression of behaviours and rituals that are socially ● sanctioned responses to bereavement. These behaviours and rituals differ between .societies and between religious groups both in their form and in their duration

Grief is a continuous process, but for clarity can be described as having three stages

The *first stage* lasts from a few hours to several days. There is denial, which is manifested as a lack of emotional response (numbness), often with a feeling of unreality, and incomplete acceptance that the death has taken place. The bereaved person may be restless, as if searching for .the dead person

The *second stage* usually lasts from a few weeks to about 6 months, but may be much longer. There may be extreme sadness, weeping, loneliness, and often overwhelming waves of yearning for the dead person. Anxiety is common; the bereaved person is anxious and restless, sleeps poorly, lacks appetite, and may experience panic attacks. Many bereaved people feel guilt that they failed to do enough for .the deceased

Some feel anger and project their feelings of guilt, blaming doctors or others for failing to provide optimal care for the person who has died. Many bereaved individuals have a vivid experience of being in the presence of the dead person, and about one in ten experience brief .hallucinations

In the *third stage*, these symptoms subside and everyday activities are resumed. The bereaved person gradually comes to terms with the loss and recalls the good times shared with the deceased in the past. Often there is a temporary return of symptoms on the anniversary of the death. Although these stages are a useful guideline, individual responses vary, and no one feature is universal

Abnormal grief

Grief is considered to be abnormal if it is delayed or inhibited, or unusually intense and prolonged, when it is referred to as *complicated* or *pathological*. The usual criterion for delay is that the first stage of grief has not occurred by 2 weeks after the death. The criterion for abnormal .duration is that the response lasts for more than 6 months

Depression in the course of a grief reaction. Depressive symptoms are a frequent component of normal grief, and around 30% of bereaved people meet the criteria for a depressive disorder at some time during their .grieving

Causes of abnormal grief

:Abnormal grief is generally thought to be more likely to occur when

- .The death was sudden and unexpected
- The bereaved person had a very close, or dependent, or ambivalent .relationship with the deceased
- The survivor is insecure, or has difficulty in expressing their feelings, or has .suffered a previous psychiatric disorder
- The survivor has to care for dependent children and so cannot show their .grief easily

Management

help of family, friends, spiritual advisers, and the rituals of mourning, medication and psychotherapy