

26.5.9 Acute stress disorder, adjustment disorders

26.5.9 Acute stress disorder, adjustment disorders, and post- traumatic stress disorder 6506 Jonathan I. Bisson

SECTION 26 Psychiatric and drug-related disorders 6506 and panic (e.g. sertraline 200 mg daily). CBT for OCD is a specific modality—gradual exposure to the feared stimulus such as dirt paired with relaxation, reframing, and eventual response prevention (i.e. not permitting hand-washing). This form of psychotherapy is not generally within the scope of physicians' expertise. Specific phobias such as snake or bridge phobias rarely present in medical settings, but needle or pill-swallowing phobias may interfere with medical care. CBT is the preferred modality, and includes talking about the fears and systematic desensitization, in which the patient is gradually exposed to the feared stimulus. As with OCD, a trained therapist usually delivers this. Outcome Without treatment, anxiety disorders tend to become chronic. Overall, approximately half of patients with anxiety disorders respond fully to either drug or psychological treatment and the remainder respond to varying degrees, but the relapse rate is high. Drug treatment should then be continued for a further 12 months and there should be follow up with maintenance therapy after treatment with CBT. FURTHER READING Craske MG, Stein MB (2016). Anxiety. *Lancet*, 388, 3048–59. Kroenke K, et al. (2010). The patient health questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. *Gen Hosp Psychiatry*, 32, 345–59. National Institute of Health and Care Excellence (NICE) (2014). Anxiety disorders. Quality standard [QS53]. <https://www.nice.org.uk/guidance/qs53> Roy-Byrne PD, et al. (2008). Anxiety disorders and comorbid medical illness. *Gen*

Hosp Psychiatry, 30, 208–25. 26.5.9 Acute stress disorder, adjustment disorders, and

post-traumatic stress disorder Jonathan I. Bisson ESSENTIALS Acute stress disorder, adjustment disorders, and post-traumatic stress disorder are all psychiatric consequences of traumatic experiences. Because trauma is so common in medical practice, in the form of accidents, severe illness, and sometimes medical and surgical treatments, these disorders are commonly seen by physicians. An initial severe reaction to a traumatic event such as severe accident is an acute stress disorder and is commonly characterized by dissociation. A more long-lasting emotional reaction to ongoing stress such as a new diagnosis of life-threatening illness is termed an adjustment disorder. An often longer-lasting and more severe psychological reaction associated with repeated mental re-experiencing of the traumatic event is called post-traumatic stress disorder. These trauma-related disorders are not only an important cause of suffering but may also complicate medical care, hence they require recognition and appropriate treatment. Introduction There is a group of psychiatric disorders specifically defined as being a response to severe psychological stress or trauma. These trauma- and stressor-related disorders include acute stress disorder, adjustment disorders, and post-traumatic stress disorder (PTSD). Acute stress disorder is the immediate emotional and behaviour reaction to an acute stress, for example, being told that a family member has died unexpectedly. Adjustment disorders are longer-lasting emotional and behavioural reactions to ongoing stressors, such as a new diagnosis of cancer. Post-traumatic stress disorder (PTSD) is usually a longer-lasting and severer effect of trauma, and is associated with the traumatic event being involuntarily relived in the imagination. These disorders are common in medical practice. Accidents and acute illness may be traumatic, as on occasion may treatment itself. These disorders are not only an important cause of suffering but may also significantly complicate medical care, for example, by leading to the avoidance of essential medical treatment. Aetiology Trauma generally refers to an event that is, or is perceived to be, severe enough to pose a threat to one's own or another person's physical or psychological integrity. Consequently many hospitalized patients may be considered to have suffered trauma, but most people exposed to traumatic events do not go on to develop a mental disorder; they are surprisingly resilient in the face of adversity. However, many people who have suffered traumatic events become severely distressed and some go on to develop a mental disorder. The criteria for trauma associated with acute stress disorder and PTSD are shown in Box 26.5.9.1. Epidemiology The point prevalence of acute stress disorder following exposure to traumatic events is between 5 and 20%, depending on the type Box 26.5.9.1 DSM-5 acute stress disorder/PTSD qualifying traumatic event criteria Exposure to actual or threatened death, serious injury, or sexual violence through: • Direct experience • Witnessing, in person • Learning of event happening to a close family member or friend (actual or threatened death must be violent or accidental) • Repeated or extreme exposure to aversive stimuli (e.g. human remains collection, police, and details of child abuse)

26.5.9 Acute stress disorder, adjustment disorders, and post-traumatic stress disorder 6507 of trauma and its severity. The point prevalence of adjustment disorders in the general population is between 3 and 12%, with a much higher prevalence in medical populations. The 12-month prevalence of PTSD is around 3%. Some traumatic events are more likely to precipitate PTSD than others; for example, the rate is over 50% after rape, 15% in conflict-affected populations, and 7.5% following accidents. Clinical features The key clinical feature of these disorders is a significant psychological reaction to a traumatic event. Acute stress disorder This is an immediate response

to a severe stressor. A person with acute stress disorder typically reports experiencing the world as unreal or dreamlike, feeling detached from their body, or that they are having increasing difficulty recalling specific details of the traumatic event (dissociative amnesia). The traumatic event may be persistently re-experienced as recurrent images, thoughts, or dreams. There may also be avoidance of stimuli that arouse recollections of the trauma (e.g. avoiding thoughts, feelings, conversations, activities, places, and people). They may also suffer from anxiety or symptoms associated with increased arousal such as difficulty sleeping, irritability, and poor concentration. The symptoms of acute stress disorder must last for a minimum of three days and a maximum of four weeks, and must occur within four weeks of the traumatic event. The person may cope with their emotional reaction by misuse of drugs or alcohol, which complicates the clinical picture.

Adjustment disorders These disorders are a longer-term response to ongoing stressors of a range of severities. The symptoms of adjustment disorders are varied and often include low mood, anger, anxiety, and sleep disturbance. These symptoms must be out of proportion to the severity or intensity of the stressor and be associated with significant impairment in social, occupational, or other important areas of functioning. They occur within three months of the onset of the stressor(s) and do not last for longer than six months after the stressor and its consequences have ended. The person does not meet the criteria for another form of mental disorder. Prolonged adjustment disorders can occur, for example, in individuals experiencing enduring stressors such as chronic physical illness or pain.

Post-traumatic stress disorder This is a more severe disorder following exposure to severe trauma. The symptoms of post-traumatic stress disorder (PTSD) are summarized in Table 26.5.9.1. In addition to the qualifying traumatic event, additional symptoms (one or more intrusion symptoms, one, or both avoidance symptoms, two or more negative alterations in cognitions and mood, and two or more alterations in arousal and reactivity) with a duration of at least one month and clinically significant distress or functional impairment are required to make the diagnosis. Symptoms usually commence shortly after the traumatic event, but there may be delayed onset if the full diagnostic criteria are not met within the first six months.

Assessment and differential diagnosis In assessing individuals, the main differential diagnosis to consider is a normal reaction to a traumatic event. Distress can be a normal, healthy reaction following a stressful event and it is factors such as the intensity and duration of symptoms along with impact on functioning that are important to consider in determining whether a reaction is pathological or not. These conditions must also be differentiated from other psychiatric diagnoses including depressive disorders and anxiety disorders. Acute stress reactions are defined as occurring within one month of a trauma. Adjustment disorder is defined as symptoms that do not last longer than six months after the stressor and its consequences have ended. Prolonged adjustment disorders can occur, for example, in individuals experiencing enduring stressors such as chronic physical illness or pain. Comorbid psychiatric diagnoses are common, especially with PTSD; the commonest being major depressive disorder, panic disorder, other anxiety disorders, and substance abuse or dependence disorder. These may require treatment in their own right.

Table 26.5.9.1 DSM-5 post-traumatic stress disorder (PTSD) symptom criteria

Criteria group	Individual criteria
Intrusion	Recurrent, involuntary, and intrusive distressing memories Recurrent distressing dreams (content and/or affect related) Dissociative reaction (acting or feeling as if event recurring)
Intense or prolonged psychological distress to cues	Marked physiological reactions to cues
Avoidance	Avoidance or efforts to avoid distressing thoughts or feelings about or closely associated with the trauma Avoidance or efforts to avoid external reminders (people, places, conversations, activities, objects, situations)
Negative alterations in cognitions and mood	Inability to remember an important aspect (typically due to dissociative amnesia)
Persistent and	

exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. 'I am bad', 'No one can be trusted', 'The world is completely dangerous') Persistent, distorted cognitions about the cause or consequences that lead to self-blame or the blame of others Persistent negative emotional state (e.g. fear, horror, anger, guilt, shame) Markedly diminished interest or participation in significant activities Feelings of detachment or estrangement from others Persistent inability to experience positive emotions (e.g. happiness, satisfaction, love) Marked alterations in arousal and reactivity Irritable behaviour and angry outbursts (with little or no provocation) Reckless or self-destructive behaviour Hypervigilance Exaggerated startle response Problems with concentration Sleep disturbance

SECTION 26 Psychiatric and drug-related disorders 6508 Treatment of trauma-related disorders Prevention Primary prevention through reducing exposure to traumatic events is the optimal approach to prevent these disorders, but is clearly difficult to deliver. There has been considerable interest in providing specific early interventions to prevent PTSD. One-off interventions provided to everyone involved in a traumatic event such as psychological debriefing (a structured process of working through the event in detail, normalizing reactions, and advising individuals of ways to deal with them) have not been shown to prevent PTSD despite being widely advocated. In fact, there is some evidence that one-off interventions may be harmful to some people, particularly those who are most distressed after traumatic events. As a result, most contemporary guidelines advise against this approach and recommend instead the provision of practical, pragmatic support delivered in an empathic manner using the principles of psychological first aid (Box 26.5.9.2). This form of support can be taught to individuals with no previous training in mental health and is appropriately provided by physicians and other non-mental health professionals in general healthcare settings, and it has become increasingly popular and adopted despite the fact it still has a very limited evidence base to support it. Early treatment The lack of evidence for early psychological interventions following traumatic events has led to approaches that aim to identify those who remain distressed and at risk of developing an acute stress disorder or PTSD between two weeks and three months after the traumatic event. Trauma-focused cognitive behavioural therapy prevents the development of more chronic forms of PTSD in such individuals. There is no evidence to support the routine use of pharmacological intervention such as antidepressant drugs to prevent or to treat PTSD within three months of a traumatic event. However, there is some evidence that giving hydrocortisone shortly after a traumatic event can reduce the incidence of PTSD in individuals with severe medical conditions such as septic shock. It is unclear if this finding generalizes to traumatized individuals who are not severely physically ill. Drug treatment can have a place in treating severe symptoms such as insomnia that have not responded to psychological approaches. Guidelines recommend the use of sedative antidepressants as opposed to benzodiazepines in such cases, because the latter may exacerbate symptoms of PTSD. If an individual is suffering from clinically significant symptoms of acute stress disorder or PTSD following a traumatic event that do not respond to practical, pragmatic support delivered in an empathic manner using the principles of psychological first aid, it would be appropriate to consider referral to a service that can provide the evidence-based interventions described. Psychological treatment There is some evidence that psychological treatment is effective in the treatment of adjustment disorders. It is also important to help the patient to address any ongoing stressors, if possible. Psychological treatments are also effective in the treatment of PTSD. These are specific therapies which are trauma focused (such as trauma-focused cognitive behavioural therapy or eye movement desensitization and reprocessing; Table 26.5.9.2). Nontrauma-focused psychological treatments (e.g. stress management, psychodynamic

therapy) appear to be less effective but are probably better than nothing. For more complex presentations of PTSD, it is often argued that individuals may benefit from a process termed 'emotional stabilization' before beginning trauma- focused work. This 'emotional stabilization' may include help with basic needs such as physical difficulties and social problems (e.g. accommodation, food, clothes, money) along with stress management, skills training in interpersonal relationship and emotional regulation, and symptom-relieving drug treatment.

Pharmacological treatment Selective serotonin reuptake inhibitors are effective in reducing symptoms of PTSD; the best evidence is for fluoxetine, paroxetine, and sertraline. The serotonin and noradrenaline inhibitor venlafaxine is similarly effective. Other drugs, including mirtazapine, amitriptyline, and phenelzine have been found effective in single randomized controlled trials that have not been replicated.

Outcome Acute stress reaction and adjustment disorders tend to resolve over time, although a severe acute stress disorder may predict the later

Table 26.5.9.2 Evidence-based trauma-focused psychological treatments for PTSD

Trauma-focused cognitive behavioural therapy (TFCBT)

- **Exposure** – The therapist helps the PTSD sufferer to confront their traumatic memories (written or verbal narrative, detailed recounting of the traumatic experience, repetition).
- **In vivo repeated exposure** to avoided and fear- evoking situations that are now safe but which are associated with the trauma.
- **Cognitive therapy** – Focus on the identification and modification of misinterpretations that lead the PTSD sufferer to overestimate current threat (fear).
- Also focus on modification of beliefs related to other aspects of the experience and how the individual interprets their behaviour during the trauma (eg issues concerning guilt and shame).

Eye movement desensitization and reprocessing (EMDR) Standardized, trauma-focused procedure with several elements. These involve the use of bilateral physical stimulation (eye movements, taps, or tones), hypothesized to stimulate the individual's own information processing in order to help integrate the targeted event as an adaptive contextualized memory.

Box 26.5.9.2 Components of psychological aid as described by the Inter-Agency Standing Committee in 2007

- Protection from further harm
- Opportunity to talk without pressure
- Nonjudgemental listening
- Identifying and meeting basic practical needs and concerns
- Discouraging negative ways of coping
- Encouraging normal daily routines and positive coping
- Encouraging, but not forcing, company from family or friends
- Offering the possibility to return for further support
- Referring to local support or clinicians

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