Anxiety Disorders

Prof. Anatoly Kreinin

anxiety- definition

- A condition with physical, cognitive and emotional manifestations that cause them to experience an unpleasant feeling of fear and threat.
  Physical:Excessive sweating, palpitations, suffocation, dizziness, blurring, increased exits, increased urinal administration
  Psychic: appearance of negatively colored emotion, cranky dyspuri; Discomfort, with elements of despondence.
  Cognitive: concern about a negative result

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.. .)

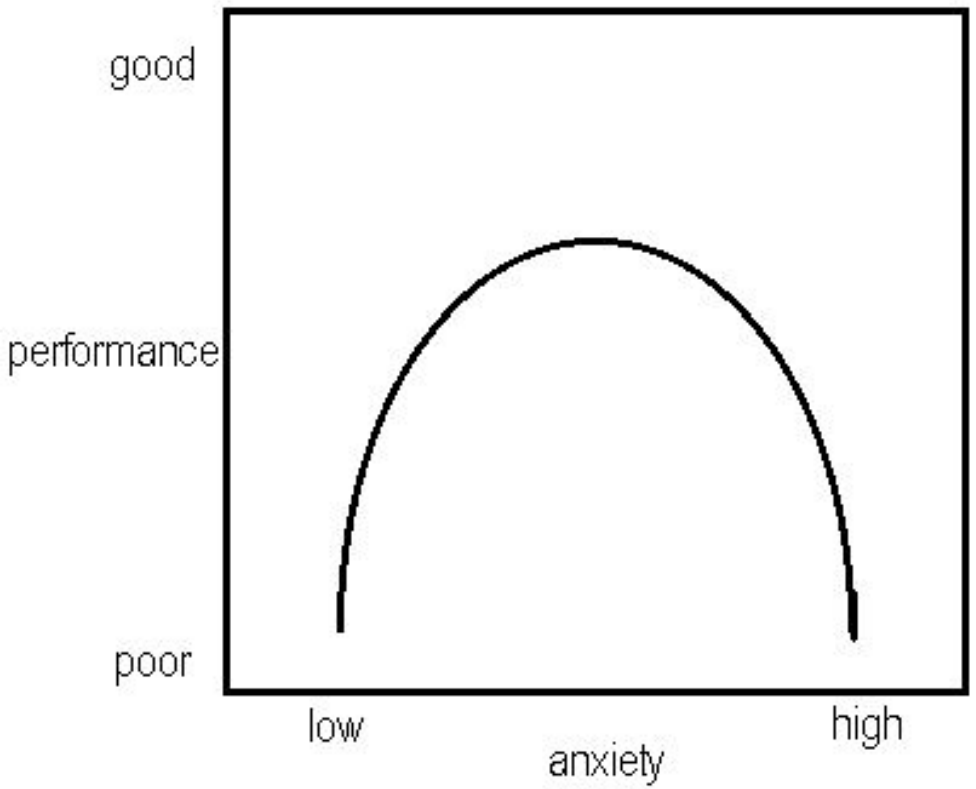
Что хорошего в Тревоге?

- 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

Общие сведения о тревожных расстройствах

- Часто имеют раннее начало - в подростковом возрасте или в начале двадцатых годов
- Преобладание у женщин 2: 1
- Имеет периоды обострения и ослабления симптоматики в течение всей жизни
- Подобно большой депрессии и хроническим заболеваниям, таким как диабет, вызывает функциональные нарушениях и снижает качество жизни

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

Primary versus Secondary Anxiety

- Тревога может быть вызвано одним из основных тревожных расстройств ИЛИ вторичным, в связи с употреблением психоактивных веществ (Substance-Induced Anxiety Disorder), медицинским заболеванием (Anxiety Disorder Due to a General Medical Condition), другим психическим заболеванием или психосоциальными стрессорами (Adjustment Disorder with Anxiety)

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

Comorbid diagnoses

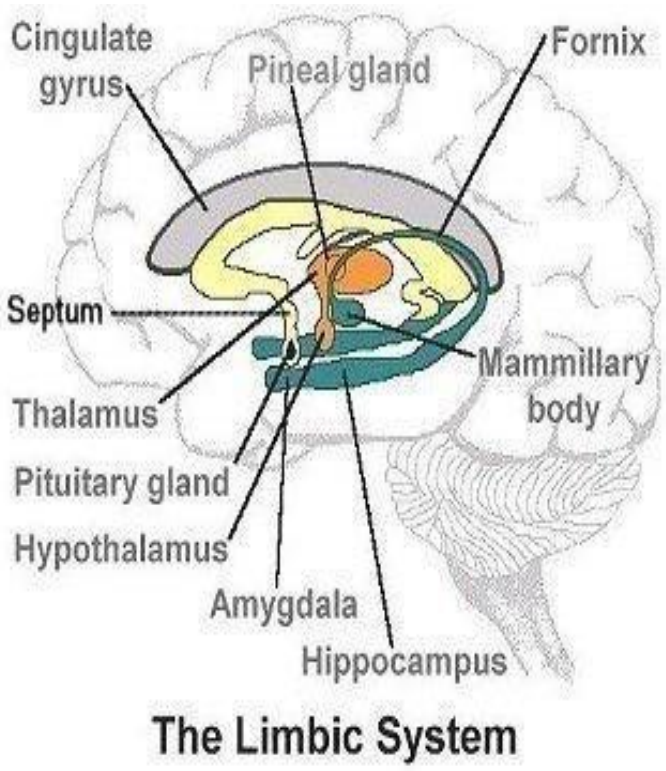
После постановки диагноза тревожного расстройства критически важно провести скрининг на наличие других психиатрических диагнозов, так как Тревога часто встречается при других расстройствах, и это может повлиять как на лечение, так и на прогноз.

Anxiety disorders

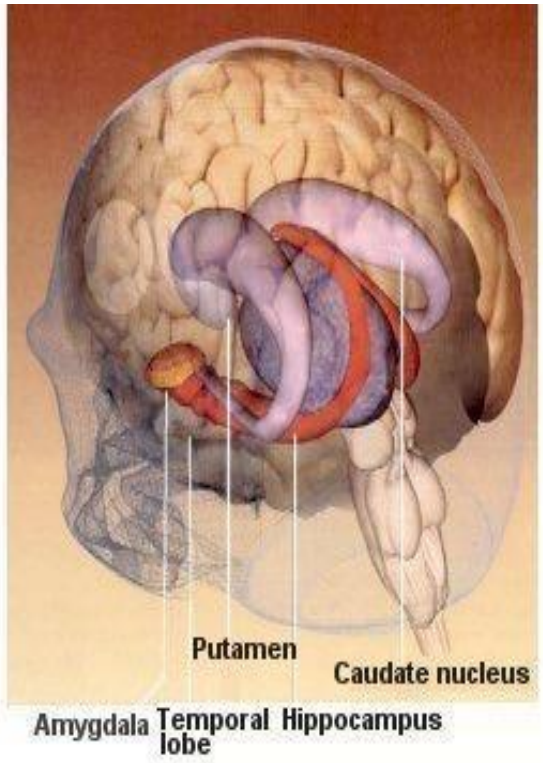
- Specific phobia
- Social anxiety disorder (SAD)
- Panic disorder (PD)
- Agoraphobia
- Generalized anxiety disorder (GAD)

- Anxiety Disorder due to a General Medical Condition
- Substance-Induced Anxiety Disorder
- Anxiety Disorder NOS

הבסיס הביולוגי של חרדה

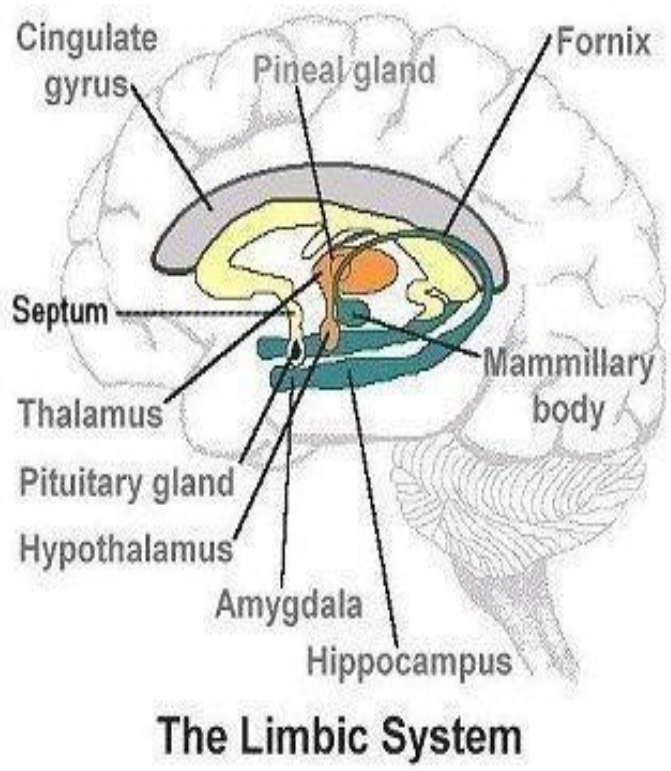


The Limbic System

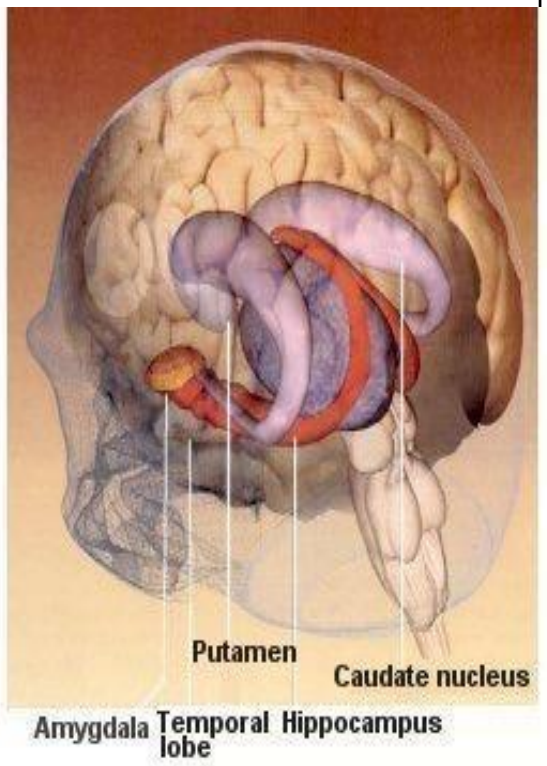


- מבנים מעורבים:
  - קורטקס פרונטלי
  - מערכת לימבית
    - היפוטלמוס, היפוקמפוס אמיגדלה
  - גזע המוח
  - ההיפופיזה
  - Adrenal Axis
  - המערכת הסימפטטית

Биологическая база Тревоги



The Limbic System



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

חרדה- מודלים ביולוגיים

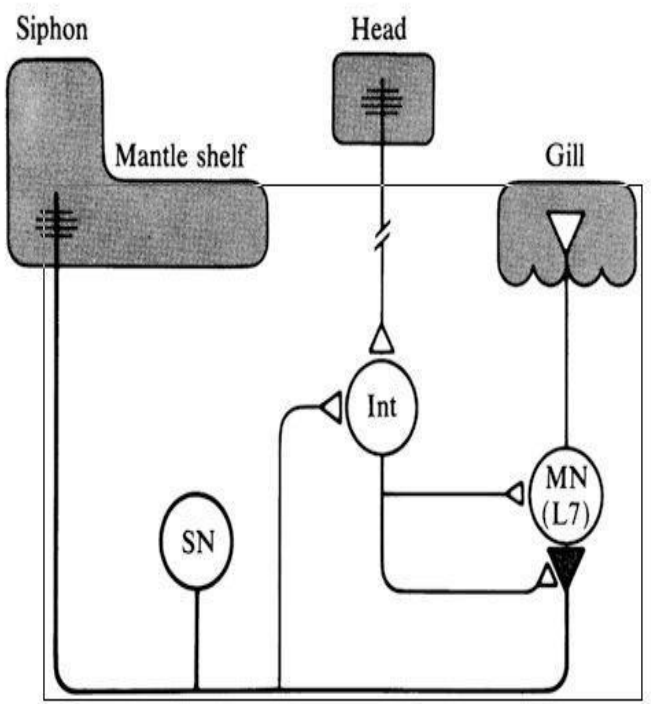
- אמנם המחקר העכשווי מתמקד במבנים אנטומיים כגון האמיגדלה, ההיפוקמפוס ומסלולים נוירואנדוקרינים אבל...
- תגובות התניית פחד ורתיעה קיימות ביצורים נחותים בהרבה וללא מבנים אלו.

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

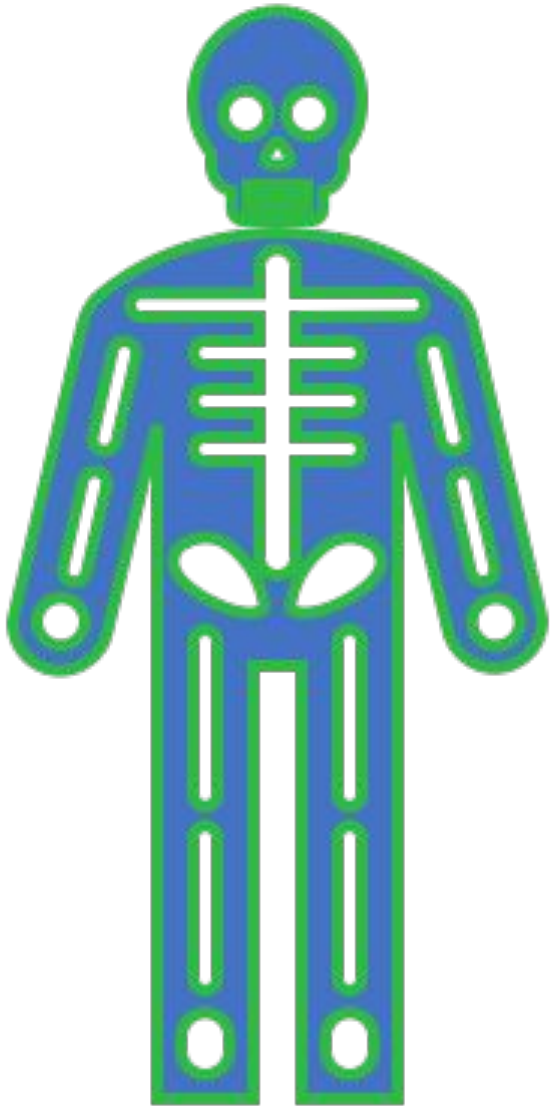
- Физиологическая реакция на стресс
- Адаптируется с помощью гипоталамуса и других мозговоых структур
- Позволяет адекватно реагировать на угрозу
- Существует у всех живых организмов, в этом отношении мы - животные
- « Симатическая реакция»

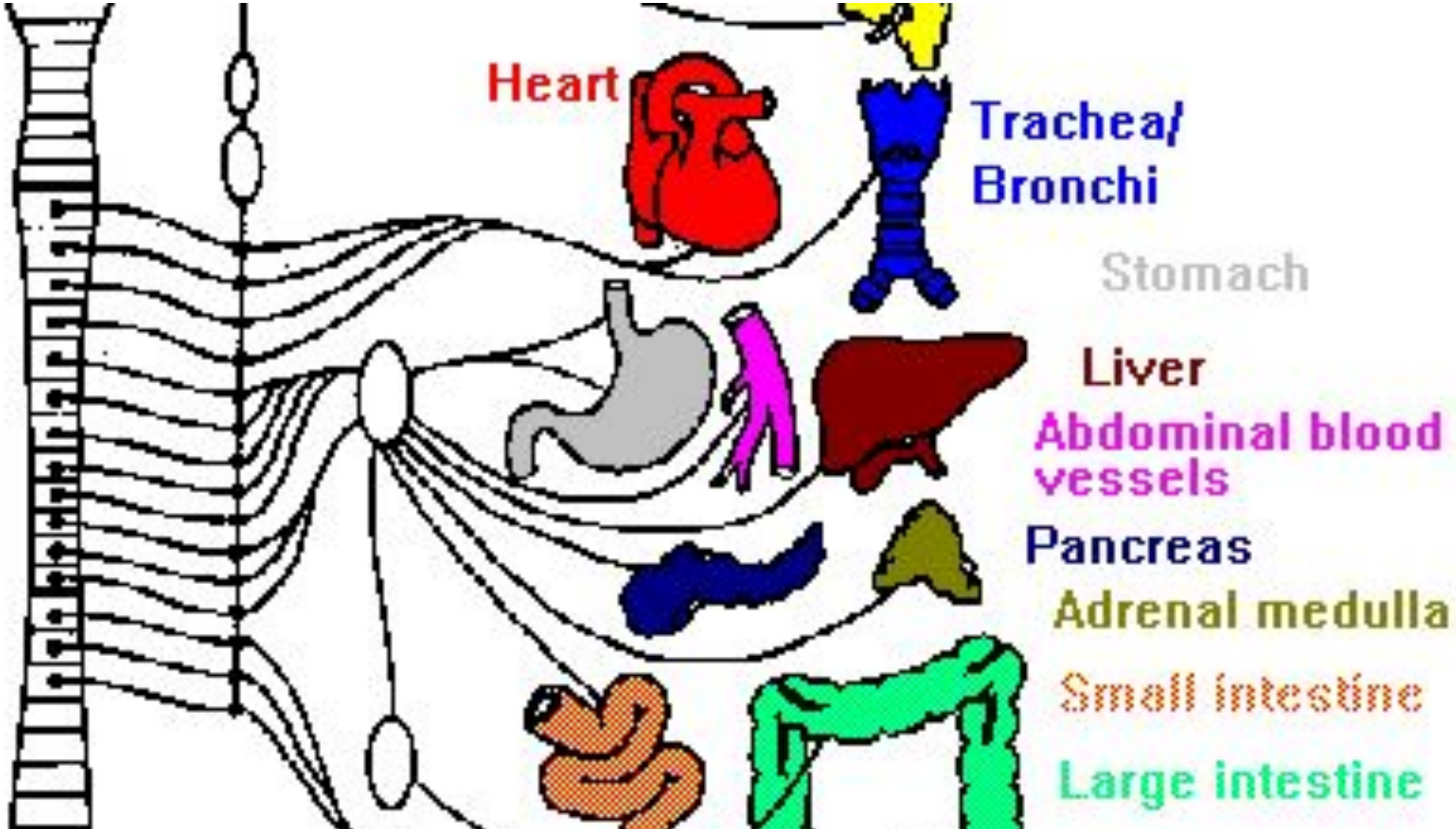
מה קורה בתגובה הסימפתטית?

- 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




Heart
Trachea/
Bronchi
Stomach
Liver
Abdominal blood
vessels
Pancreas
Adrenal medulla
Small intestine
Large intestine

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)

- To Be or NOT to Be

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»

- Сниженое настроение ⟶ Депрессия
- Радость ⟶ Мания, эйфория
- Подозрение ⟶ Паранойя
- Тревога ⟶ Паника

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

Нефобические тревожные реакции:

- GENERAILIZED ANXIETY DISORDER

• Фобические тревожные реакции:

- 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

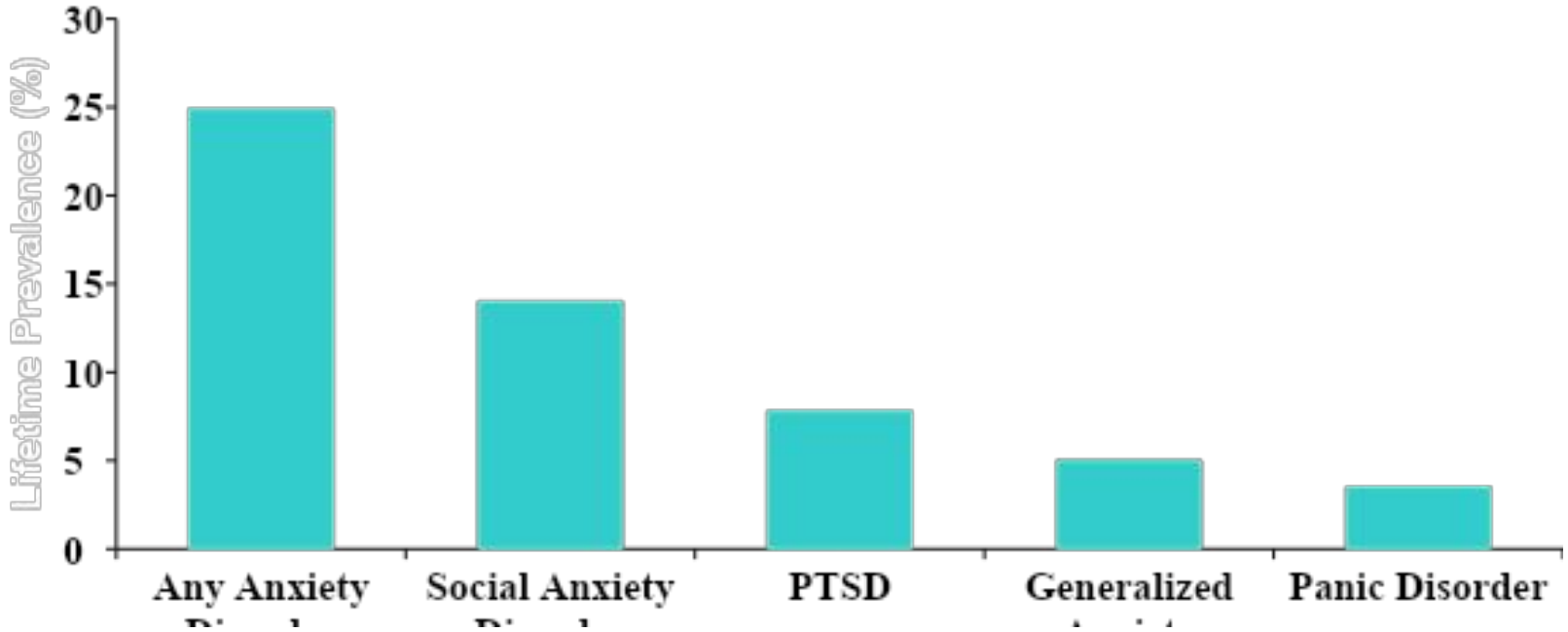
- В большинстве своем женщины страдают чаще мужчин, в основном в возрасте 16-40 лет
- Социофобия в 2 раза чаще у женщин, но мужчины ищут помощь чаще

Genetic Epidemiology of Anxiety Disorders

- Существует значительная семейная наследсвенность PD, GAD, OCD and phobias.
- Исследования близнецов показали, что наследуемость панического расстройства составляет 0,43, а для GAD - 0,32..

Prevalence of Anxiety Disorders

(life time prevalence %)



Anxiety Disorders

Агорафобия, Специфическая фобия и Социальное Тревожное Расстройство

Изменения в критериях:

Пациенты старше 18 лет нет необходимости, что должны осознавать, что их беспокойство чрезмерно или необоснованно.

Продолжительность 6 месяцев и более требуется для всех возрастов.

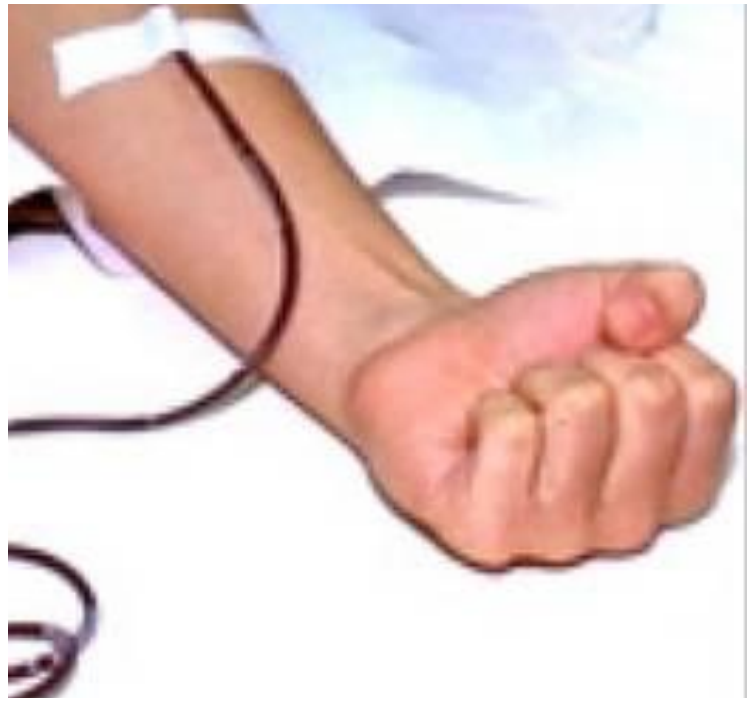
Anxiety Disorders

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

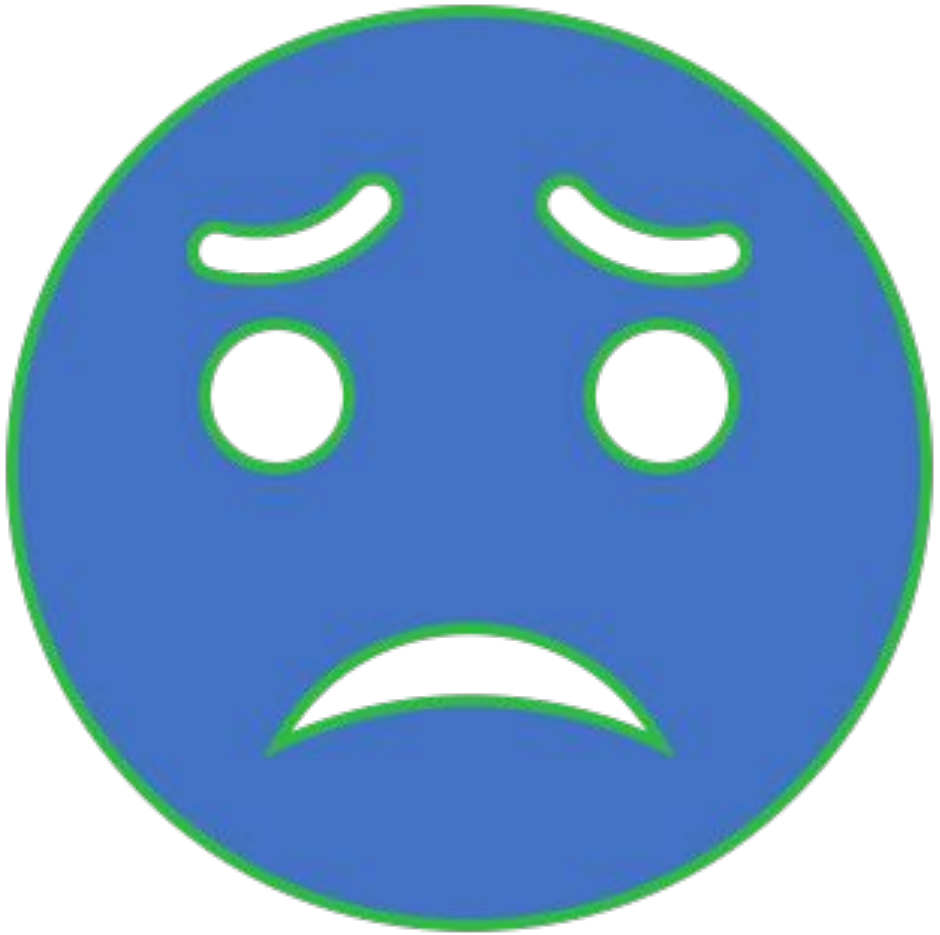


SPECIFIC PHOBIA

- 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

- Выраженный или постоянный страх (> 6 месяцев), чрезмерный или необоснованный, вызванный присутствием или ожиданием определенного объекта или ситуации
- Беспокойство должно быть несоразмерно реальной опасности или ситуации.
- Это значительно нарушает рутиный распорядок дня или функции человека.



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

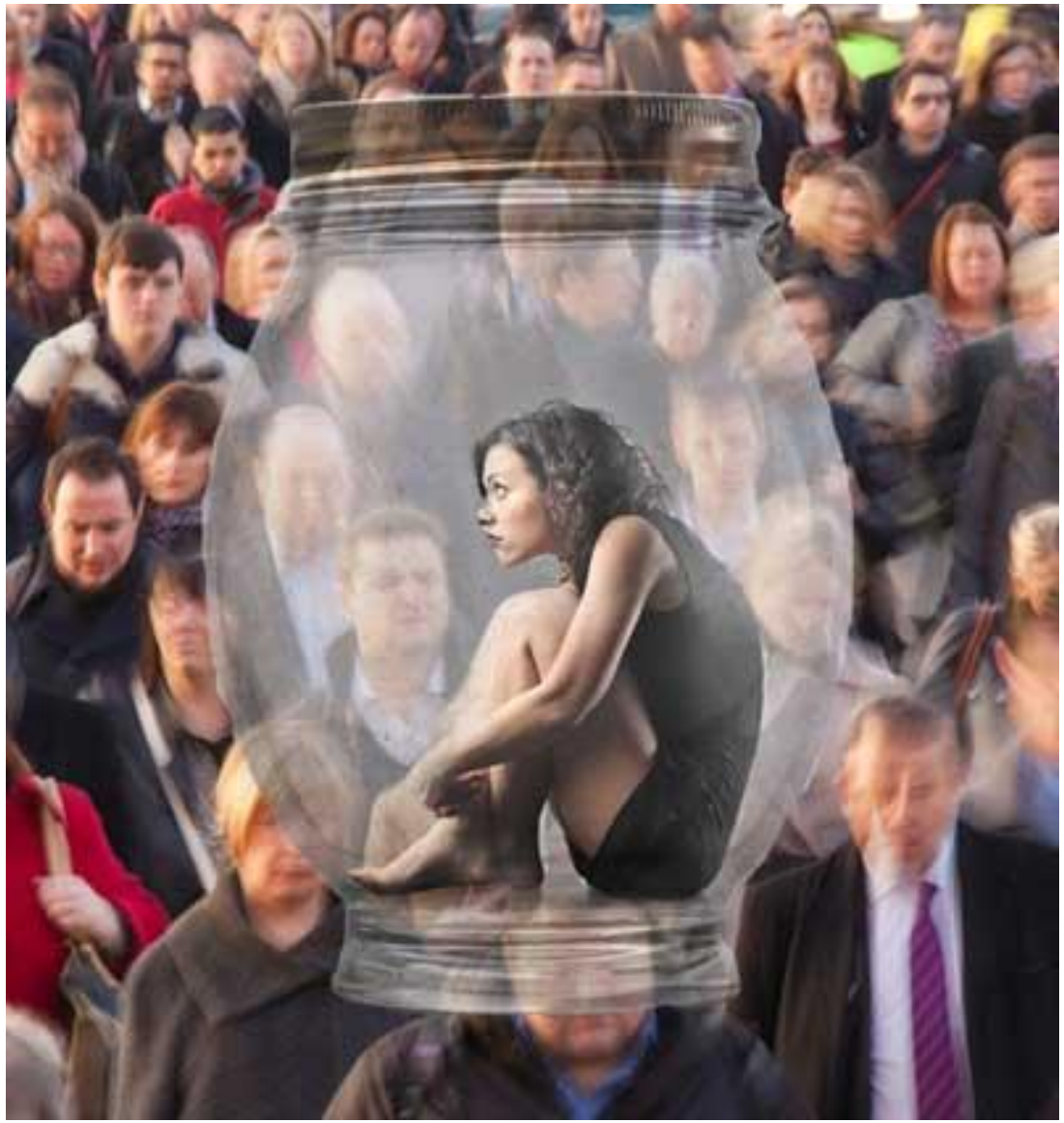
- Вне ситуации нормальное функционирование
- Избегание обеспечивает нормальное функционирование
- Высокая частота расстройства – до 20% в населении
- В основном не обращаются за лечением
- В основном нет осложнений
- Очень эффективно лечение КПТ (когнитивно-поведенческая терапия)

SPECIFIC PHOBIA

- The rest of the time normal functioning
  Avoidance allows for a normal life
  High incidence –up to 20% of the population
  You don't usually seek treatment.
  Usually without complications
  Treatment with CBT is very effective and do not need medications.

SOCIAL PHOBIA

- Подобно простой фобии, но здесь бессмысленный страх социального взаимодействия, отсюда:
- Более выраженные функциональные нарушения
- Больше провоцирующих ситуаций
- Стратегия **Избегания** не позволяет вести нормальную жизнь
- Содержание тревоги - страх унижения, презрения, неудачи и т. Д.



SOCIAL PHOBIA

- Similar to simple phobia but here the senseless fear of social interaction, hence:
  More functional impairment
  More exposure events
  Avoidance does not allow for a normal life
  The content of anxiety – the fear of humiliation, contempt, failure, etc.

SAD epidemiology

- 7% населения в целом
  Возраст наступления подростковый; чаще встречается у женщин.
- У половины пациентов SAD начало сиптомов в возрасте 13 лет и 90% в возрасте 23 лет.
  Вызывает значительную инвалидность
  Частые депрессивные расстройства

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

SAD

A more problematic diagnosis (personality disorder)

Two types:

- 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??

- Изучение 16 пациентов SAD и 16 контроля, во время fMRI при чтении текстов с нейтральными социальными событиями , либо с непреднамеренные социальные действия (подавится продуктами питания, и выплевывание их в общественных местах) или преднамеренное социально неприемлемое действие (неприязнь пищи и выплевывая его)

What is going on in their brains??

Both groups ↑ medial prefrontal cortex activity in response to intentional relative to unintentional transgression.

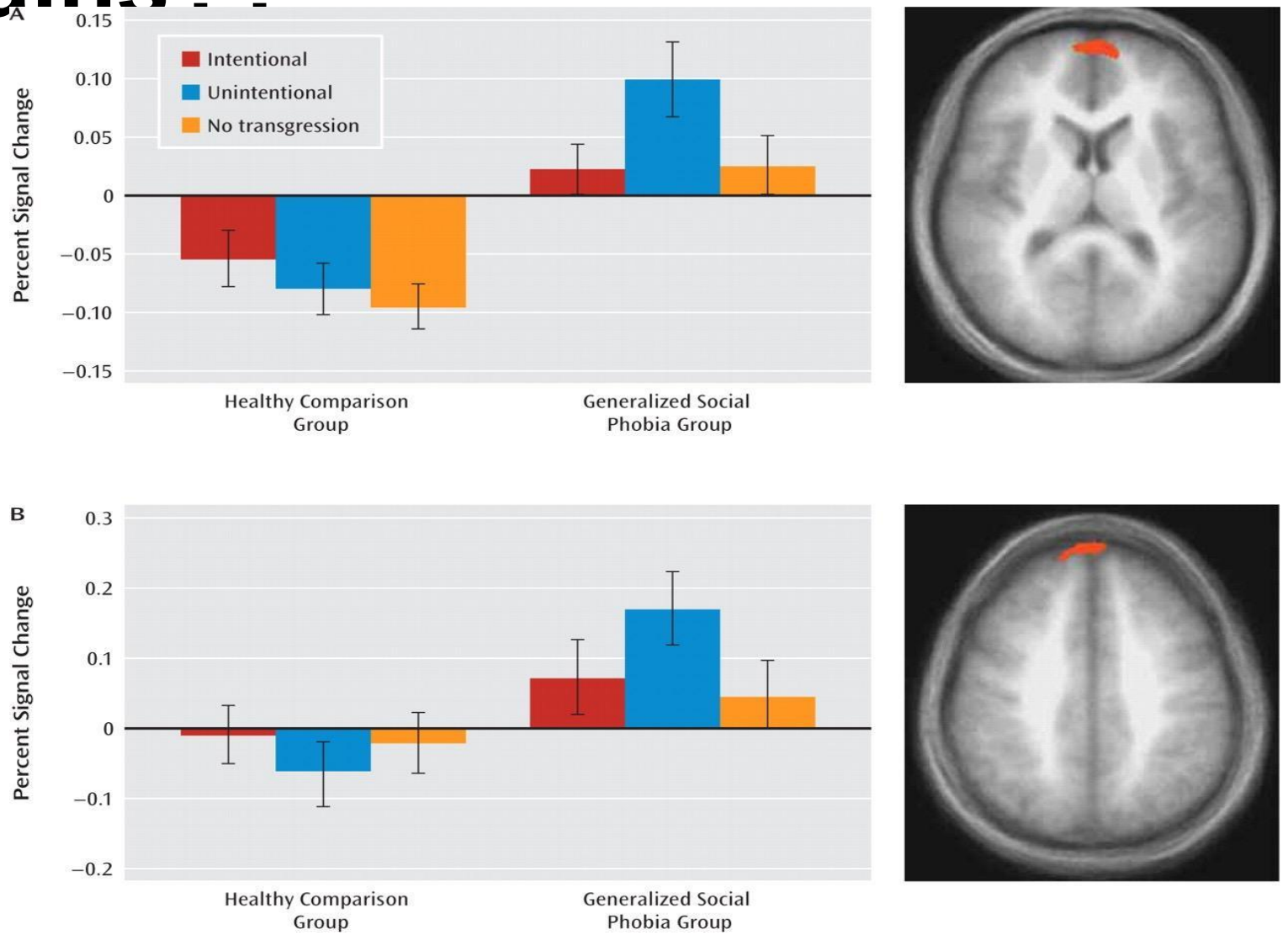
- SAD patients however showed a significant response to the unintentional transgression.
- SAD subjects also had significant increase activity in the amygdala and insula bilaterally.

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??

- Обе группы – обнаружена медиальная и префронтальная активность коры головного мозга в ответ на умышленное по отношению к непреднамеренному социально неприемлемому поведению.
  Пациенты SAD однако, показали более выраженную реакцию на непреднамеренное неприемлемое поведение.
  Пациенты САД также имели значительный рост активности в Amygdala and Insula bilaterally.

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

Functional imaging studies in SAD

- Несколько исследований обнаружили гиперактивность Amygdala даже при слабой форме провокации (представление человеческих лиц).
  Успешное лечение CBT or Citalopram показало снижение активации в Amygdala и Hippocampus

Social Anxiety Disorder treatment

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

Complications:

- Depression
  Use of addictive substances

PANIC DISORDER

- Horror attack, extreme anxiety
  Spontaneous appears (at least at the beginning of the disease)
  Including events
  Anxiety from **ANTICIPATION ANXIETY** -
  The development of avoidance – agoraphobia

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:

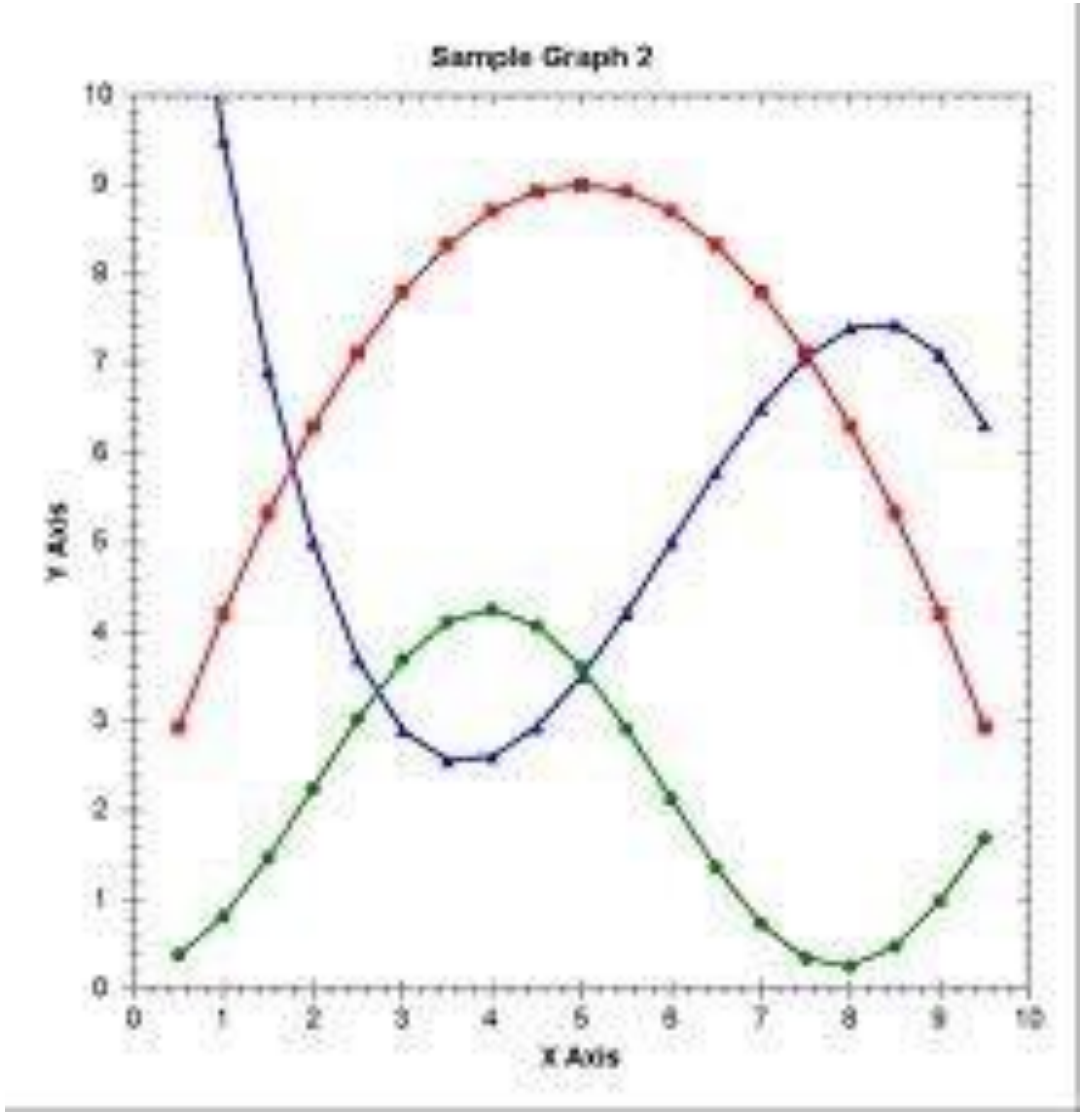
- Palpitations or rapid heart rate
- Sweating
- Trembling or shaking
- Shortness of breath
- Feeling of choking
- Chest pain or discomfort
- Nausea
- Chills or heat sensations
- Paresthesias
- Feeling dizzy or faint
- Derealization or depersonalization
- **Fear of losing control or going crazy**
- Fear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



Panic Attacks with Agoraphobia

•Fear or avoidance of being in places or situations where there is difficulty in escaping or getting help.

Panic Attacks with Agoraphobia

Complications:

- Depression up to 50%
  Dependence on addictive substances - alcohol, sedatives
  Severe functional impairment
  It is important to find out:
  Caffeine habits
  Physical ailments – thyrotoxic, pheochromocytoma, MVP

Treatment:

- Combination of CBT treatment and medications:
  1. Antidepressants
  2. Anxiolytics for the first stage

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, SNRI, 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

Excessive fear or anxiety, without any grasp of reality, is accompanied by expressions of motor tension, more activity of an autonomous system, a state of constant caution and alertness and anticipation that is going to read what has been.

- A more problematic diagnosis.
  Less specific, chronic
  Less defined complaints
  High incidence (5-12%)
  Long Duration

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

Generalized Anxiety Disorder

Чрезмерное беспокойство больше времени есть, чем нет, в течение, по крайней мере, **6 месяцев**, и оно трудно контролируется.

3 or more of the following symptoms:

Беспокойство или чувство что сейчас что-то плохое случится, быстрая утомляемость, трудности с концентрацией вниманием, раздражительность, мышечное напряжение, нарушение сна

Causes significant distress or impairment

GAD Comorbidity

- 90% have at least one other lifetime Major Psychiatric Disorder
- 66% have another current Major Psychiatric 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**

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

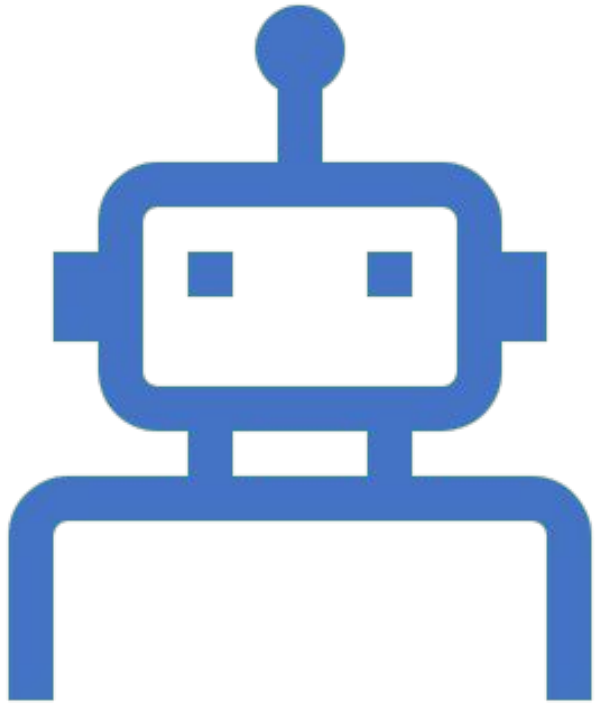
- Alternative antidepressant
  - Clomipramine
  - MAOI
- Other
  - Inositol
  - Atypical neuroleptics

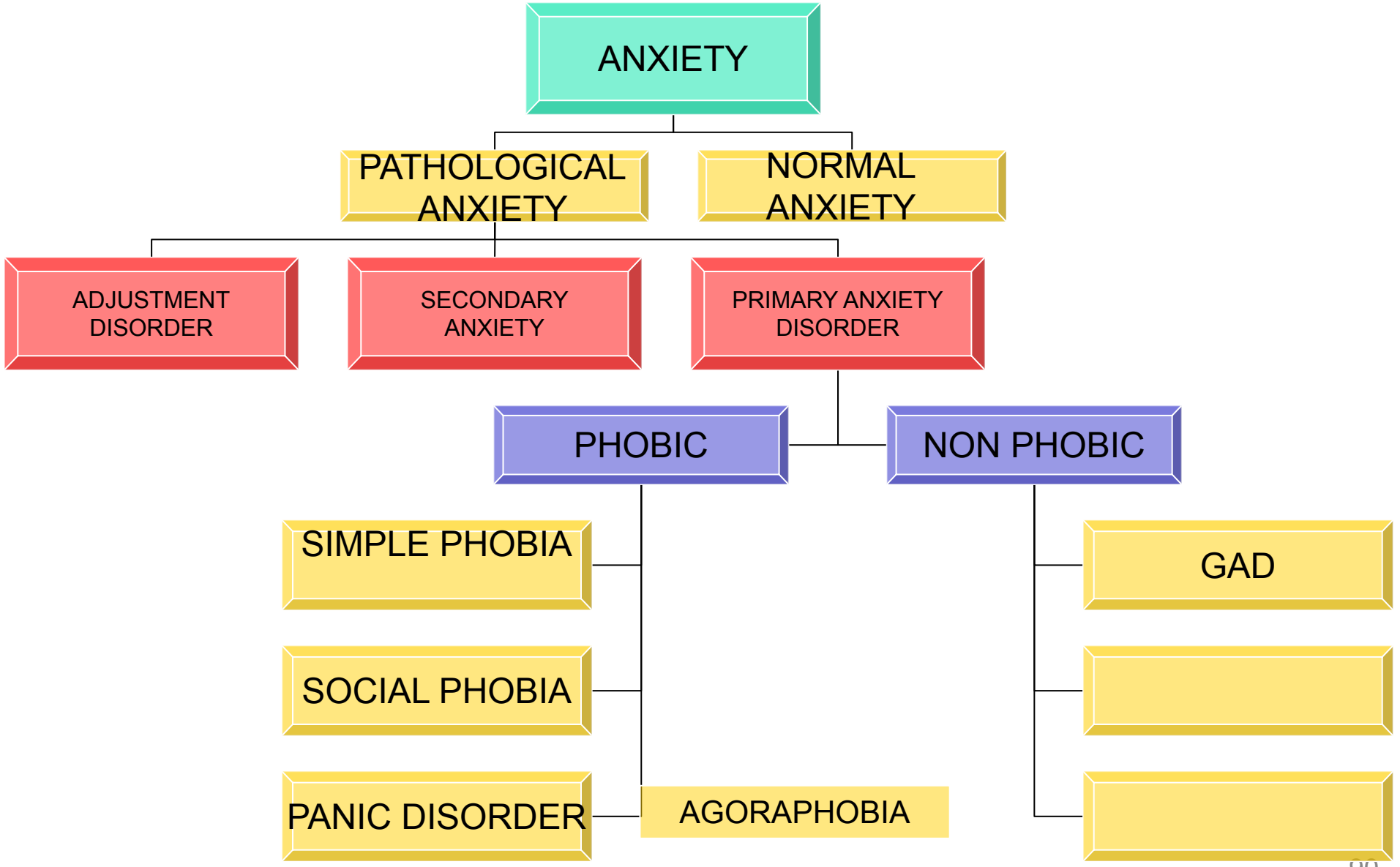
Screening questions

- 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)

Screening questions

- Как часто испытываете приступы паники?
- Опишите, что Вы называете Паникой
  Считаете ли Вы себя тревожным?
  У Вас когда-нибудь было какое-то происшествие. Или воспоминания, которое преследует Вас по сей день?
  Когда Вы находитесь в ситуации, когда люди могут наблюдать за Вами- нервничаете и беспокоитесь ли Вы, что они будут обсуждать или осуждать Вас?




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


THANK YOU FOR YOUR

Trauma- and Stressor-Related Disorders

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

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder (new)
- PTSD (includes PTSD for children 6 years and younger)
- Acute Stress Disorder
- Adjustment Disorders

Trauma- and Stressor-Related Disorders

•Новая глава в DSM-5 объединяет тревожные расстройства, которым предшествует тревожное или травматическое событие

Reactive Attachment Disorder

- Disinhibited Social Engagement Disorder (new)
- PTSD (includes PTSD for children 6 years and younger)
- Acute Stress Disorder
- Adjustment Disorders

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):

- Intrusion
- Negative Mood
- Dissociative
- Avoidance
- Arousal

ACUTE STRESS DISORDER

•A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

•1. Directly experiencing the traumatic event(s).

•2. Witnessing, in person, the event(s) as it occurred to others.

•3. Learning that the event(s) occurred to a close family member or close friend. **Note**: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

•4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).

•**Note**: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

ACUTE STRESS DISORDER

•A. Воздействие фактической или вероятной смерти, серьезных травм или сексуальных действий одним (или более) из следующих способов:
1. Directly experiencing the traumatic event(s).

•2. Свидетель (лично) события, которое произошло с другими.
3. Learning that the event(s) occurred to a close family member or close friend. **Note**: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

•4. Испытывают повторное или экстремальное воздействие на тяжелые (психологически) детали травматического события (e.g., собирающих человеческие останки, police officers repeatedly exposed to details of child abuse).

•**Note**: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

ACUTE STRESS DISORDER

•B. Presence of nine (or more) of the following symptoms from any of the five categories of:

1. intrusion,
2. negative mood,
3. dissociation,
4. avoidance,
5. arousal,

beginning or worsening after the traumatic event(s) occurred:

ACUTE STRESS DISORDER

Intrusion symptoms:

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

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). Note: In children, there may be frightening dreams without recognizable content.

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). Note: ın children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

ACUTE STRESS DISORDER

Intrusion symptoms:

1. Повторяющиеся, непроизвольные и навязчивые тревожные воспоминания о травматическом событии (ы). Примечание: У детей могут возникать повторяющиеся игры, в которых выражены темы или аспекты травматического события.
2. Повторяющиеся тревожные сны, в которых содержание и/ или влияние воспоминания связаны с событием (ы). Примечание: У детей могут быть пугающие сны без узнаваемого содержания.
3. Диссоциативные реакции (например, воспоминания), в которых человек чувствует или действует так, как будто травматическое событие повторяется. (Такие реакции могут происходить на континууме, при этом самым крайним выражением является полная потеря осознания окружающей действительности). Примечание: у детей, травма конкретных реконструкции может произойти в игре.
4. Интенсивный или длительный психологический стресс или отмеченные физиологические реакции в ответ на внутренние или внешние сигналы, которые символизируют или напоминают аспект травматического события (ы).

ACUTE STRESS DISORDER

•Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

•Dissociative Symptoms

6. An altered sense of reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).

7. Inability to remember an important aspect of traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

ACUTE STRESS DISORDER

•Negative Mood

5. Постоянная неспособность испытывать положительные эмоции (например, неспособность испытывать счастье, удовлетворение или чувство любви).

Dissociative Symptoms

6. Измененное чувство реальности своего окружения или себя (например, видеть себя со стороны, находясь в оцепенении, замедляется время).
7. Неспособность запомнить важный аспект травматического события (как правило, из-за диссоциативной амнезии, а не других факторов, таких как травма головы, алкоголь или наркотики).

ACUTE STRESS DISORDER

•Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

ACUTE STRESS DISORDER

Avoidance Symptoms

8. Усилия, чтобы избежать тревожных воспоминаний, мыслей или чувств тесно связанных с травмирующим событием (ы).
9. Усилия, чтобы избежать внешних напоминаний (люди, места, разговоры, мероприятия, объекты, ситуации), которые вызывают тревожные воспоминания, мысли или чувства о или тесно связаны с травмирующим событием (ы).

ACUTE STRESS DISORDER

- **Arousal Symptoms**

- 10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).

- 11. Irritable behavior and angry outburst (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.

- 12. Hypervigilance.

- 13. Problems with concentration.

- 14. Exaggerated startle response.

ACUTE STRESS DISORDER

C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

•**Note**: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

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

E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

ACUTE STRESS DISORDER

C. Продолжительность нарушения (симптомы критериев B) составляет от **3 дней до 1 месяца после Травматического события.**

Note: Симптомы обычно начинаются сразу после травмы, **но их постоянство, по крайней мере, в течение 3 дней и до месяца** необходимо для удовлетворения критериев расстройства.

D. Нарушение вызывает клинически значимые расстройства или нарушения в социальных, профессиональных или других важных областях функционирования.

E. Нарушение не связано с физиологическим воздействием веществ (например, лекарства или алкоголь) или другого заболевания (например, легкая черепно-мозговая травма) и не лучше объясняется кратким психотическим расстройством.

ADJUSTMENT DISORDERS

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) **occurring within 3 months of the onset of the stressor**(s).

B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

1. Marked distress that is out of proportion to the severity or intensity of the stressor, **taking into account the external context and the cultural factors that might influence symptom severity and presentation.**

2. Significant impairment in social, occupational, or other important areas of functioning.

ADJUSTMENT DISORDERS

C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisiting mental disorder.

D. The symptoms do not represent **Normal Bereavement**.

E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

ADJUSTMENT DISORDERS

- *Specify* whether:
- **With depressed mood**: Low mood, tearfulness, or feeling of hopelessness are predominant.
- **With anxiety**: Nervousness, worry, jitteriness, or separation anxiety is predominant.
- **With mixed anxiety and depressed mood**: A combination of depression and anxiety is predominant.
- **With disturbance of conduct**: Disturbance of conduct is predominated.
- **With mixed disturbance of emotions and conduct**: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.
- **Unspecified**: For maladaptive reactions that are nor classifiable as one of the specific subtypes of adjustment disorder.

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

- 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

- 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.
- Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree:
- Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including separation-reunion behavior with caregivers.
- Intense sorrow and emotional pain because of the death.
- Preoccupation with the deceased person.

Persistent Complex Bereavement Disorder (PCBD)

- **Диагностические критерии-МКБ**

Человек пережил смерть близкого родственника или друга по крайней мере 12 месяцев назад. В случае детей смерть могла быть за 6 месяцев до постановки диагноза.

После смерти, по крайней мере один из следующих симптомов наблюдается на более дней, чем нет, и в клинически значимой степени:

Стойкая тоска/тоска по умершему. У маленьких детей, тоска может быть выражена в игре и поведении, в том числе разделение воссоединения поведение с воспитателями.

Интенсивная скорбь и эмоциональная боль из-за смерти.

Забота об умершем человеке.

Persistent Complex Bereavement Disorder (PCBD)

- 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.
- 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:

Persistent Complex Bereavement Disorder (PCBD)

- Озабоченность обстоятельствами смерти. У детей эта забота об умерших может быть выражена через темы игры и поведения и может распространяться на заботу о возможной смерти других близких им людей.
  После смерти, по крайней мере шесть из следующих симптомов (от реактивного бедствия или социальной / идентичности нарушения) испытываются больше дней, чем нет, и в клинически значимой степени:

Reactive Distress to the Death

- Marked difficulty accepting the death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.
- Feeling shocked, stunned, or emotionally numb over the loss.
- Difficulty with positive reminiscing about the deceased.
- Bitterness or anger related to the loss.
- Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame).
- 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).

Reactive Distress to the Death

- **Значительные трудности принятия факта смерти. У детей это зависит от способности ребенка понять значение и постоянство смерти.**
  Чувство шока, ошеломления, или эмоционально онемение по поводу потери.
  Трудность с положительными воспоминаниями об умершем.
  Горь или гнев, связанные с потерей.
  Маладаптивные оценки себя по отношению к умершему или смерти (например, самообвинение, самобичевание).
  Чрезмерное избегание напоминаний о потере (например, избегание людей, мест или ситуаций, связанных с умершим; у детей это может включать избегание мыслей и чувств в отношении умершего).

Social/Identity Disruption

- A desire to die in order to be with the deceased.
- Difficulty trusting other people since the death.
- Feeling alone or detached from other people since the death.
- Feeling that life is meaningless or empty without the deceased or the belief that one cannot function without the deceased.
- 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).
- Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The bereavement reaction must be out of proportion or inconsistent with cultural, religious, or age-appropriate norms.

Social/Identity Disruption

- Стремление умереть, чтобы быть с покойным.
  Трудность доверять другим людям после смерти.
  Чувство одиночества или отчуждения от других людей после смерти.
  Ощущение, что жизнь бессмысленна или пуста без умершего или веры в то, что человек не может функционировать без умершего.
  Путаница в отношении своей роли в жизни или ослабленное чувство своей идентичности (например, ощущение, что часть себя умерла вместе с умершим).
  Трудности или нежелание преследовать интересы после потери или планировать на будущее (например, дружба, деятельность).
  Состояние вызывает клинически значимые расстройства или нарушения в социальных, профессиональных или других важных областях функционирования.
  Реакция утраты должна быть несоразмерной или несовместимой с культурными, религиозными или возрастными нормами.

•Specify if:

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

Specify if:

С травматической утратой:

- После смерти, которая произошла при травматических обстоятельствах (убийство, самоубийство, катастрофа, или несчастный случай), есть стойкие, частые тревожные мысли, образы, или чувства, связанные с травматическими особенностями смерти (степень страдания умершего, ужасные травмы, вина себя или других за смерть), в том числе в ответ на напоминания о потере.

Take home points

- Anxiety, 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!


PTSD

Trauma- and Stressor-Related Disorders

Changes in PTSD Criteria

Четыре кластера симптомов, а не три

- 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

Trauma- and Stressor-Related Disorders

Changes in PTSD Criteria

DSM-5 более четко определяет, что представляет собой травматическое событие

- Включено сексуальное насилие
  Повторяющаяся травма,

Trauma- and Stressor-Related Disorders

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. Directly experiencing the traumatic event(s).

2. Свидетель (лично) события, которое произошло с другими.

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 (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 A (continued):

3. Косвенно, узнать, что близкий родственник или близкий друг травмированы. Если событие связано с фактической или угрожаемой смертью, оно должно быть насильственным или случайным.
4. Повторное или крайнее косвенное воздействие на психологически тяжелые детали события (ы), как правило, в ходе выполнения профессиональных обязанностей (сбор частей тела; специалисты неоднократно подвергаюшиеся деталям жестокого обращения с детьми). **Это не включает в себя косвенное непрофессиональное воздействие через электронные средства массовой информации, телевидение, фильмы или фотографии.**

CRITERION B - Intrusion (5 Sx – Need 1)

1. Recurrent, involuntary and intrusive recollections *

* children may express this symptom in repetitive play

2. Traumatic nightmares

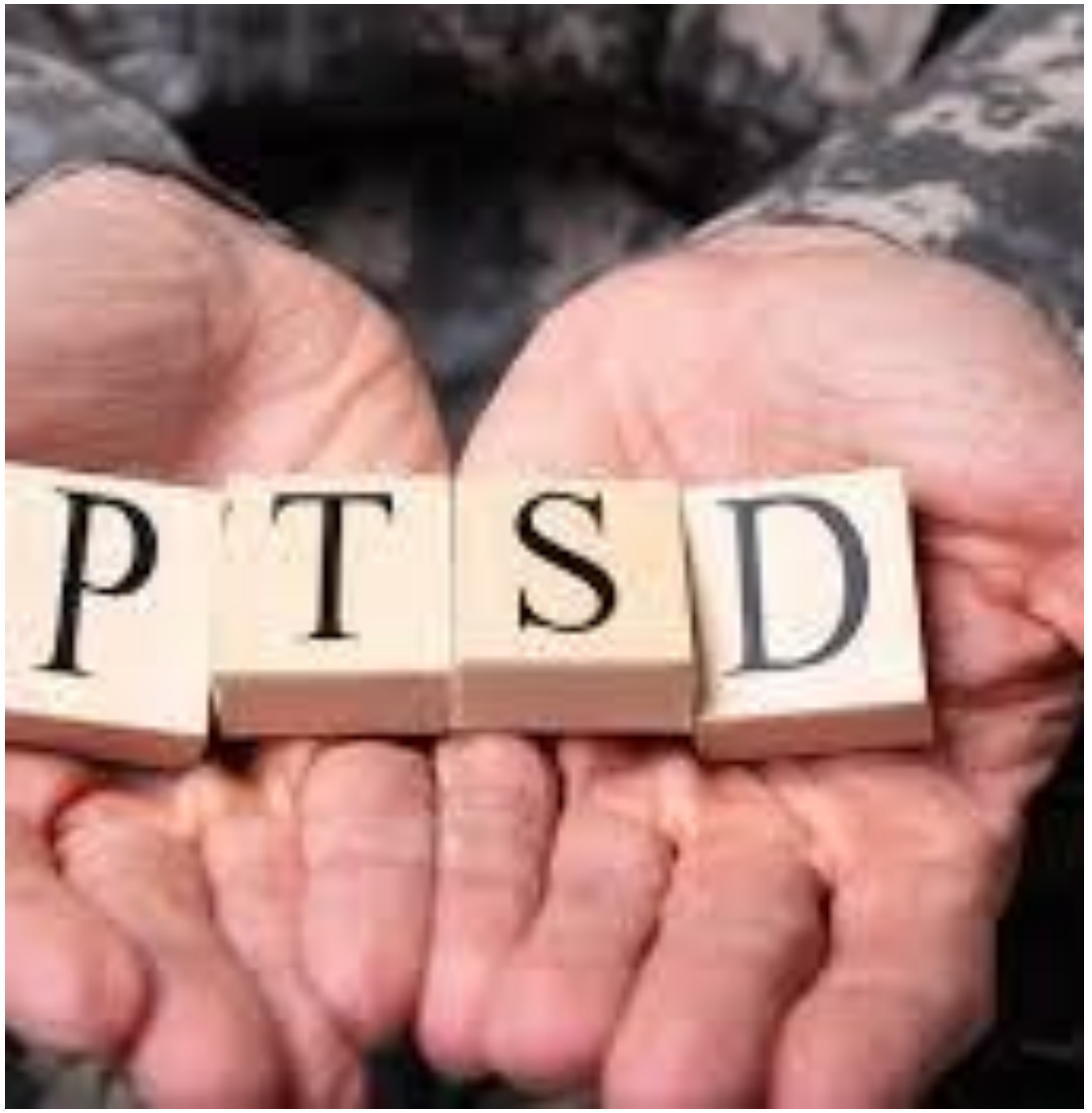
* children may have disturbing dreams without content related to trauma

3. Dissociative reactions (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

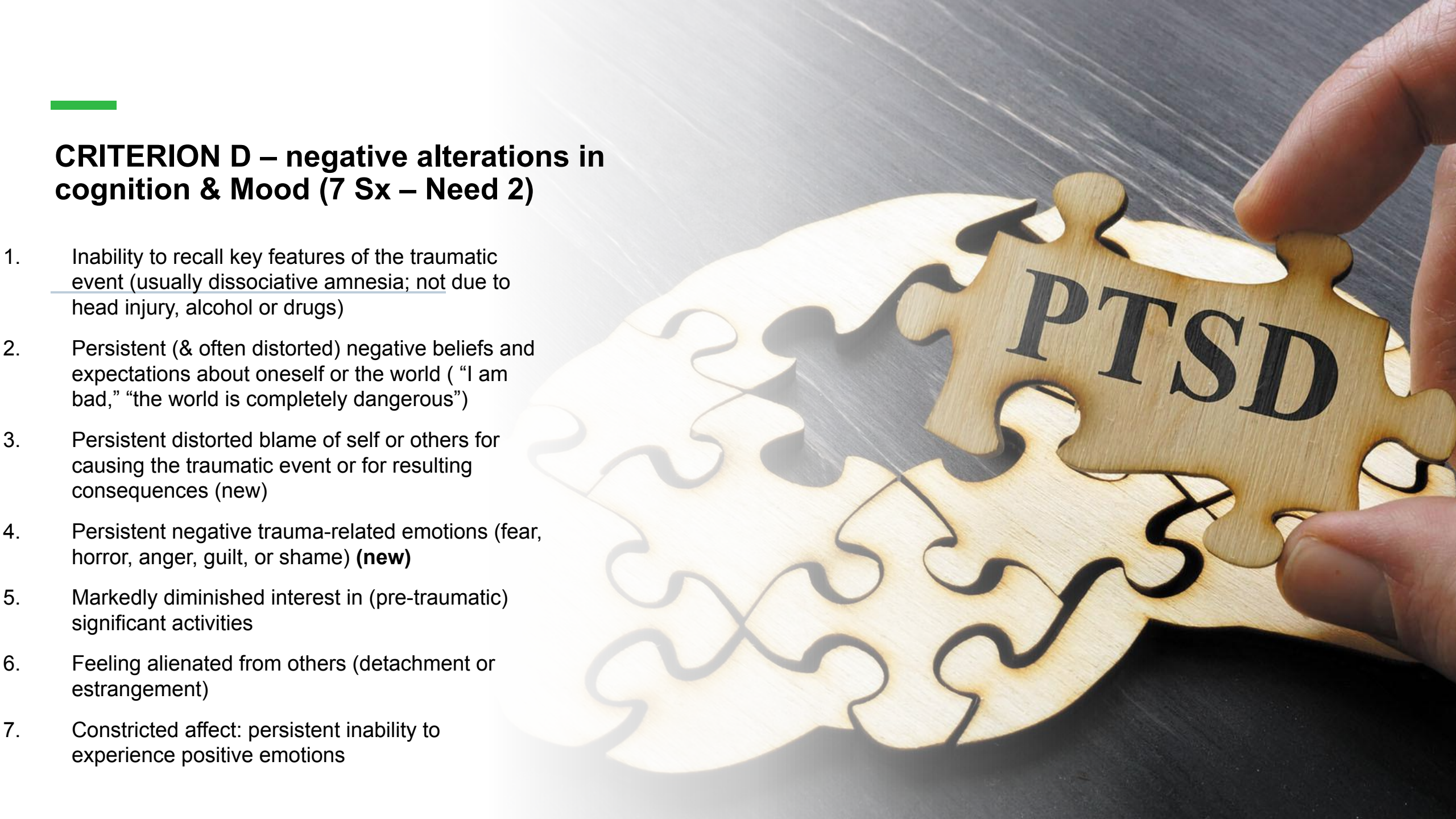


C. Persistent effortful avoidance of distressing trauma-related stimuli after the event (1/2 symptoms needed):

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

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

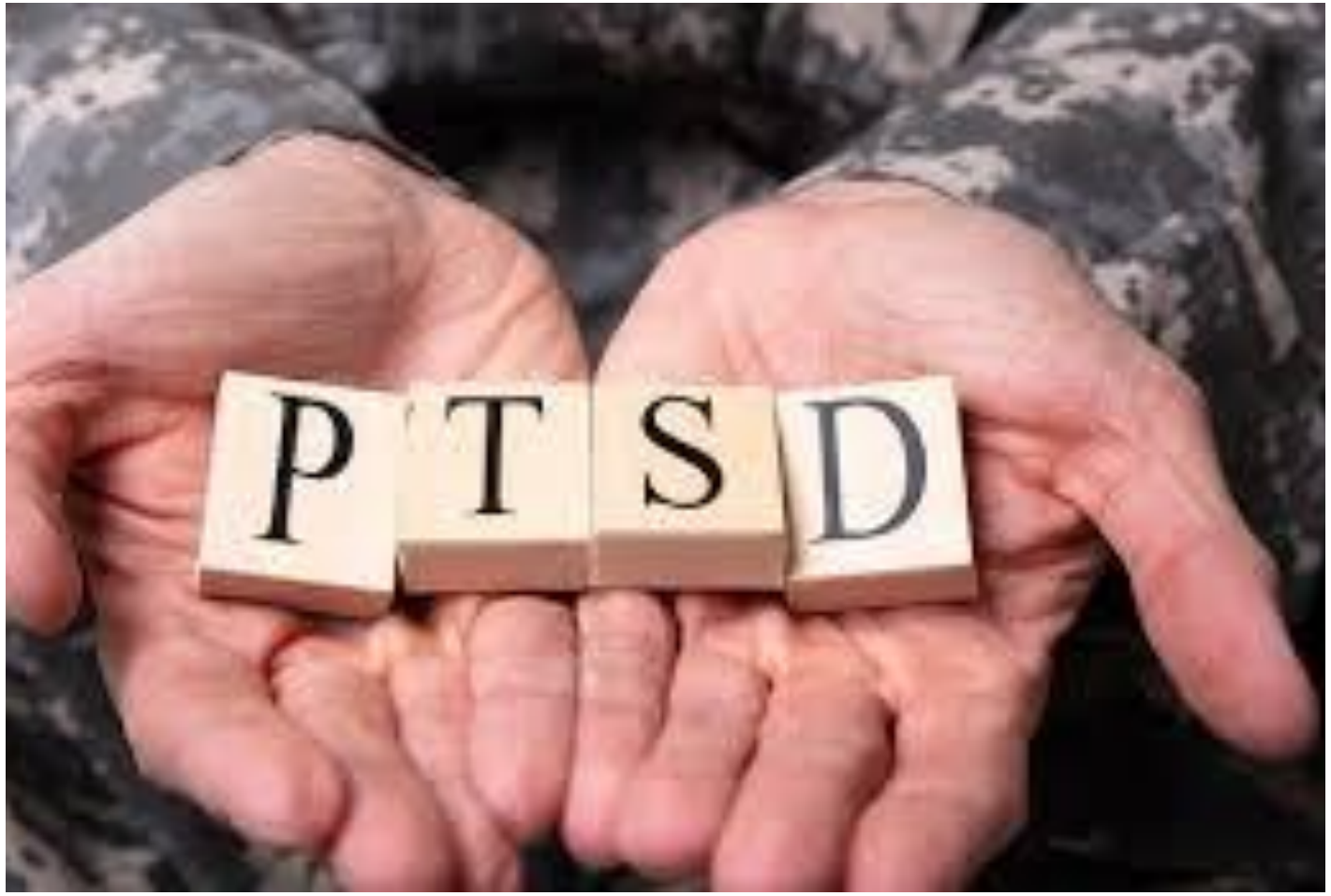
1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs)
2. Persistent (& often distorted) negative beliefs and expectations about oneself or the world (“I am bad,” “the world is completely dangerous”)
3. Persistent distorted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



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

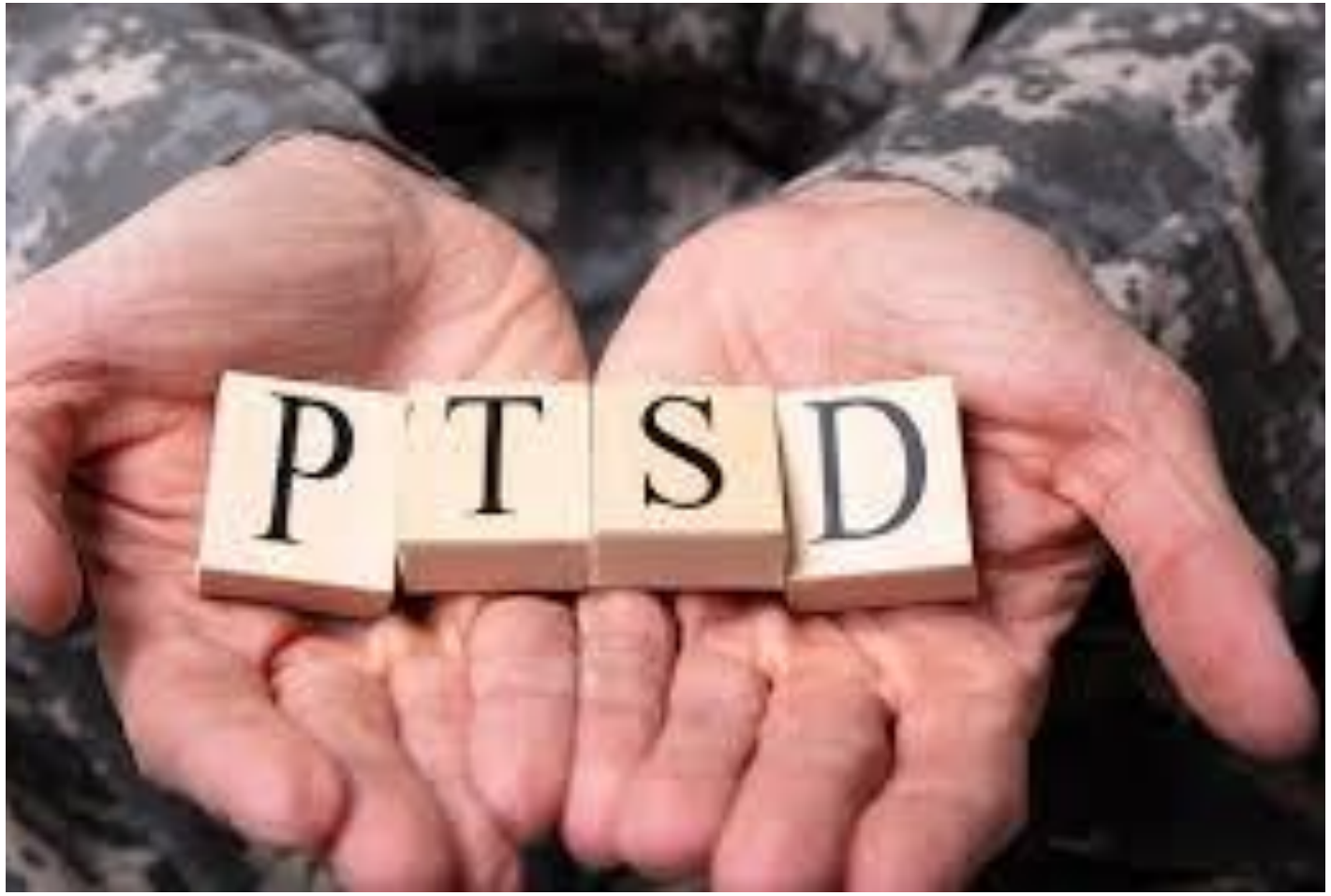
1. Неспособность вспомнить ключевые характеристики травматического события (обычно диссоциативная амнезия; не из-за травмы головы, алкоголя или наркотиков)
   Стойкие (часто искаженные) негативные убеждения о себе или мире ("Я плохой", "мир совершенно опасен")
   Постоянное искаженное обвинение себя или других в причинение травматического события или в результате последствий (новый)
   Постоянные негативные эмоции, связанные с травмой (страх, ужас, гнев, чувство вины или стыд) **(новые)**
   Заметно снижение интереса к (предтравматическому) тому, что вызывало
   Чувство отчуждения от других (отрешенность или отчуждение)
   Суженное эмоций: постоянная неспособность испытывать положительные эмоции

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



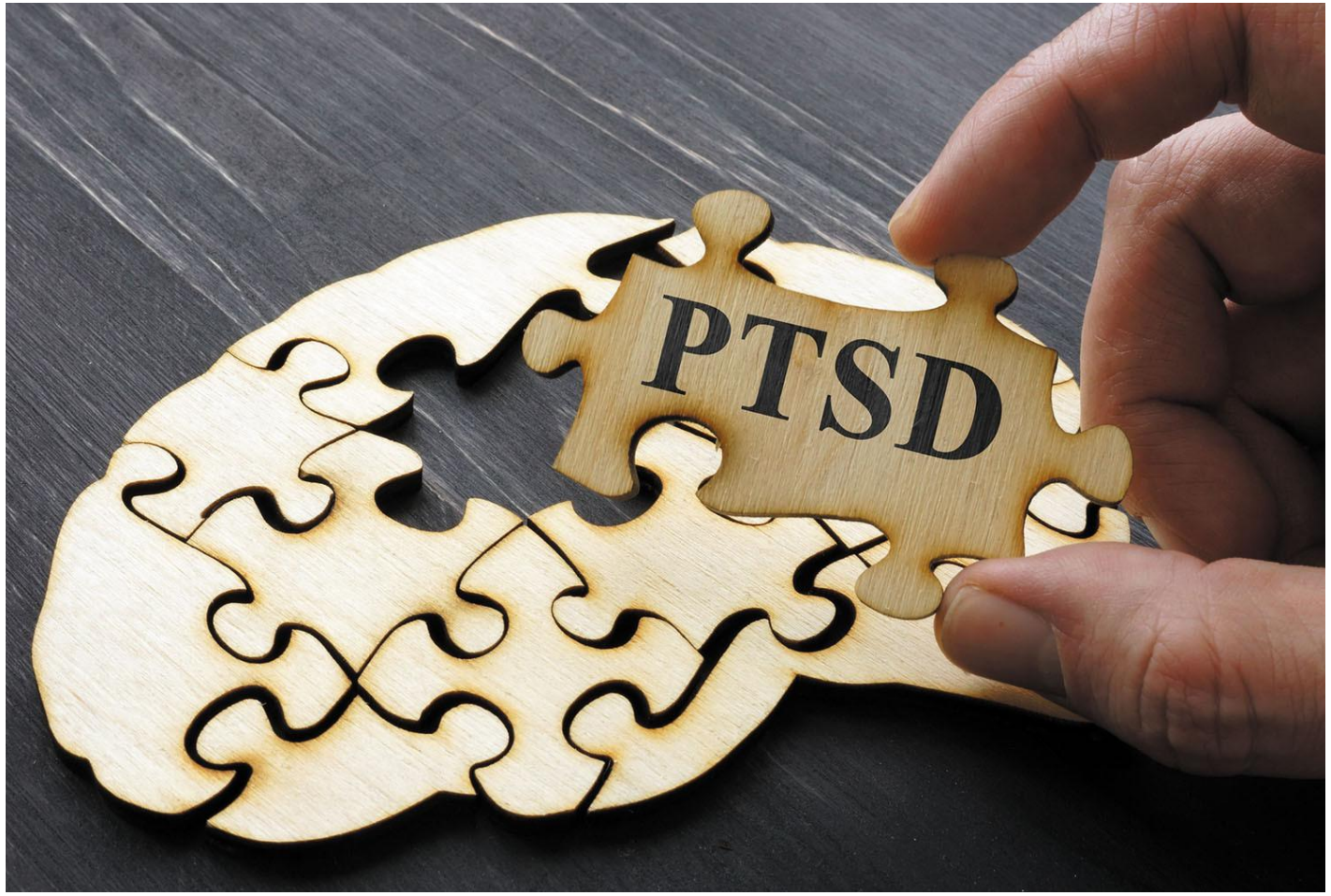
1. Irritable or aggressive behavior
2. Self-destructive or reckless behavior **(new)**
3. Hypervigilance
4. Exaggerated startle response
5. Problems in concentration
6. Sleep disturbance

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



1. Раздраженное или агрессивное поведение
   Саморазрушительное или безрассудное поведение (новое)
   Сверхбдительность
   Преувеличенный ответ startle response
   Проблемы в концентрации
   Нарушение сна

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.

Summary: PTSD in DSM-5

Возможно, ПТСР следует **ре-концептуализировать как расстройство спектра**, при котором несколько различных патологических посттравматических фенотипов отличаются симптоматично и психобиологически.
Если это так, оптимальное лечение для одного фенотипа не обязательно может быть лучшим лечением для другого.

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.

specifiers

Укажите, есть ли:
С диссоциативными симптомами: Симптомы человека отвечают критериям ПТСР, и, кроме того, в ответ на стрессор, человек испытывает стойкие или повторяющиеся симптомы любого из следующих:
Деперсонализация: *Постоянный или периодический опыт чувства оторванности от , и как если бы один был внешним наблюдателем, свои психические процессы или тело (например, чувство, как будто один был во сне; чувство нереальности себя или тела или времени- замедленно).*
Дереализация: *Постоянные или повторяющиеся переживания нереальности окружения (например, мир вокруг индивидуума испытывается как нереальный, сказочный, далекий или искаженный).*
Примечание: Для использования этого подтипа диссоциативные симптомы не должны быть связаны с физиологическим воздействием вещества или другим заболеванием.

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

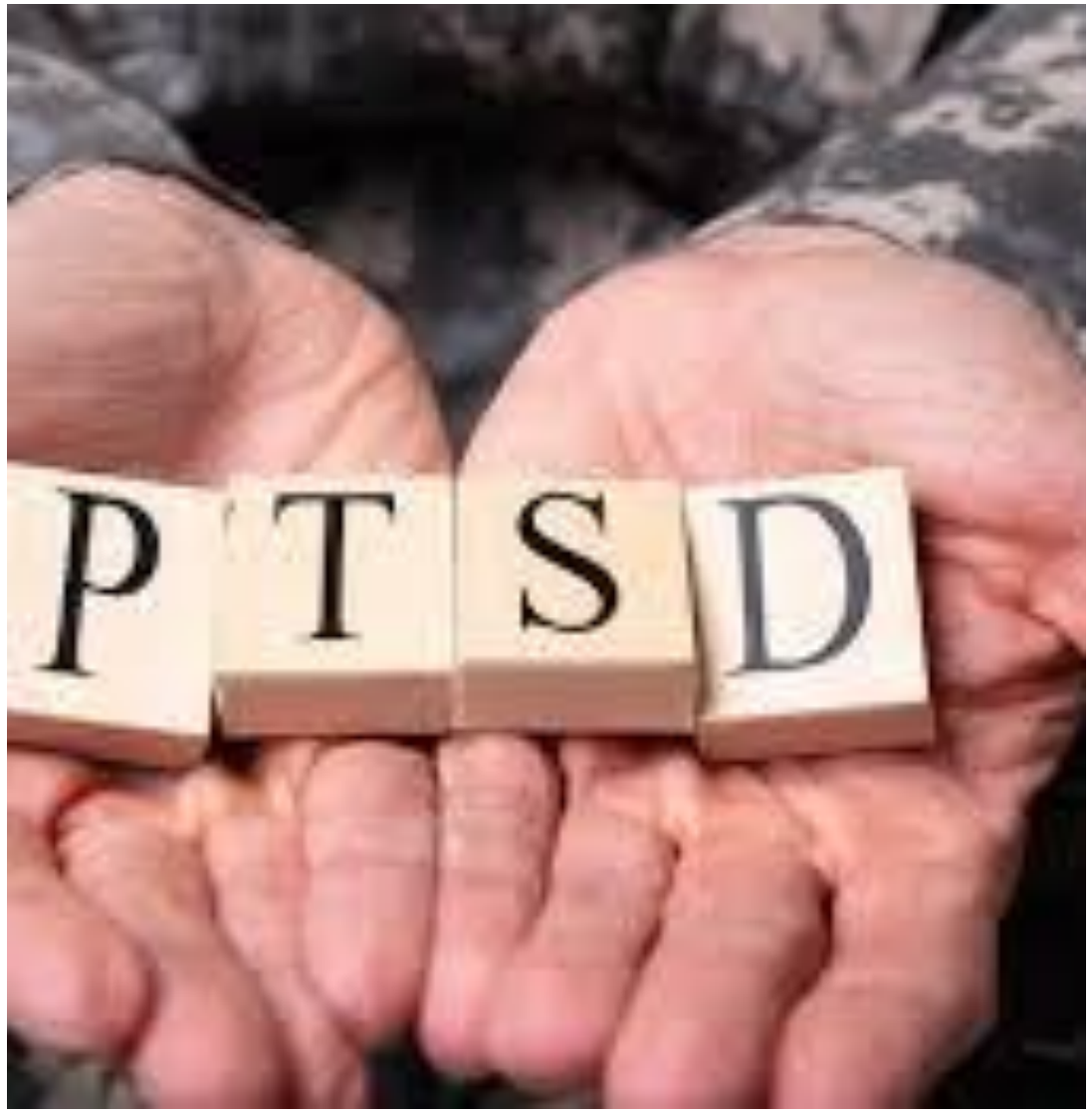
- National Center for PTSD (www.ptsd.va.gov)
- Simple, easy to administer
- Self-report or clinician administered
- 20 item – all 20 symptoms
- CRITERION B: Items 1-5
- CRITERION C: Items 6-7
- CRITERION D: Items 8 – 14
- CRITERION E: Items 15 – 20
- Score of $\geq$ 2 = endorsement of that symptom

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

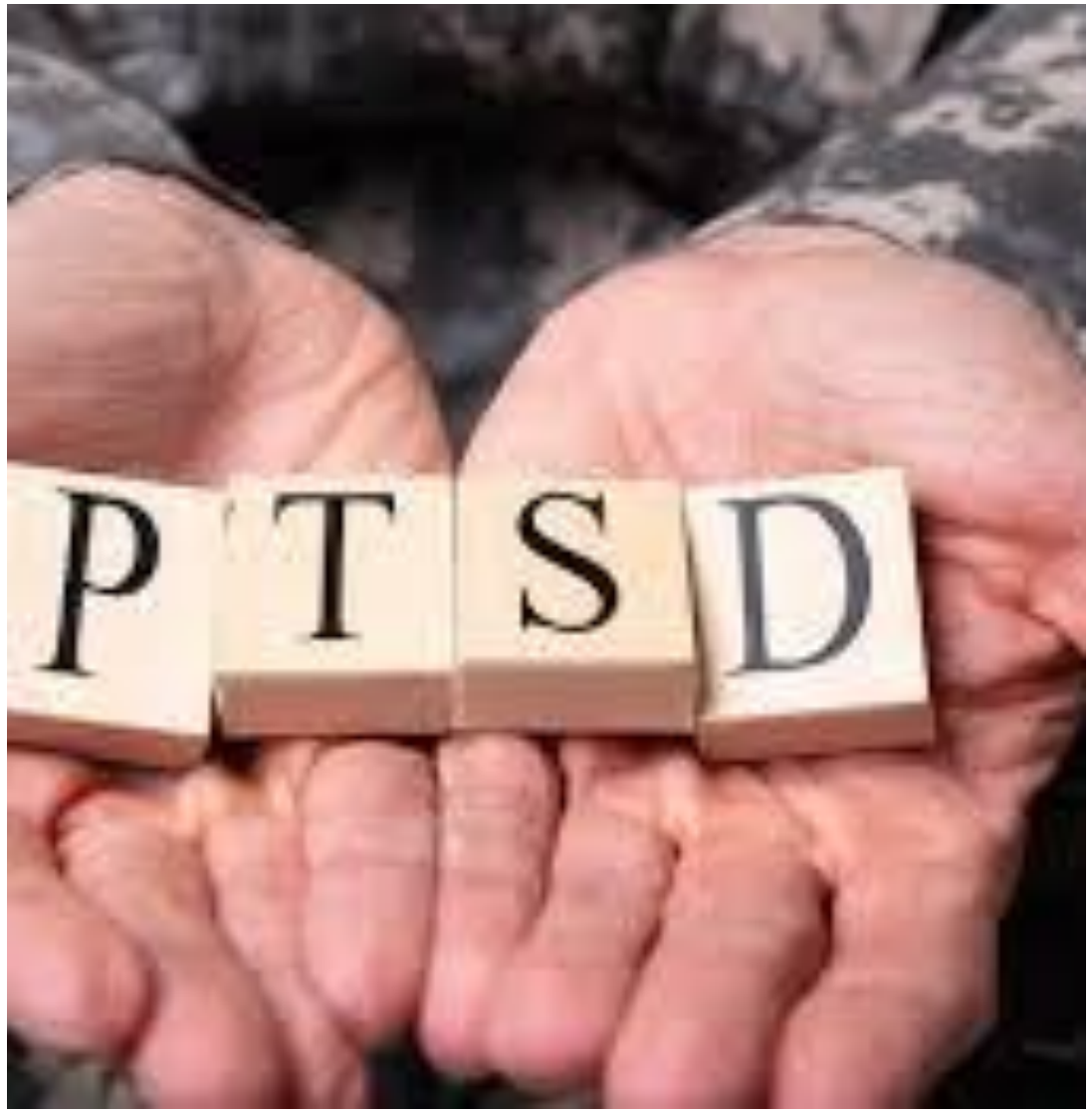
Early Sessions

- 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

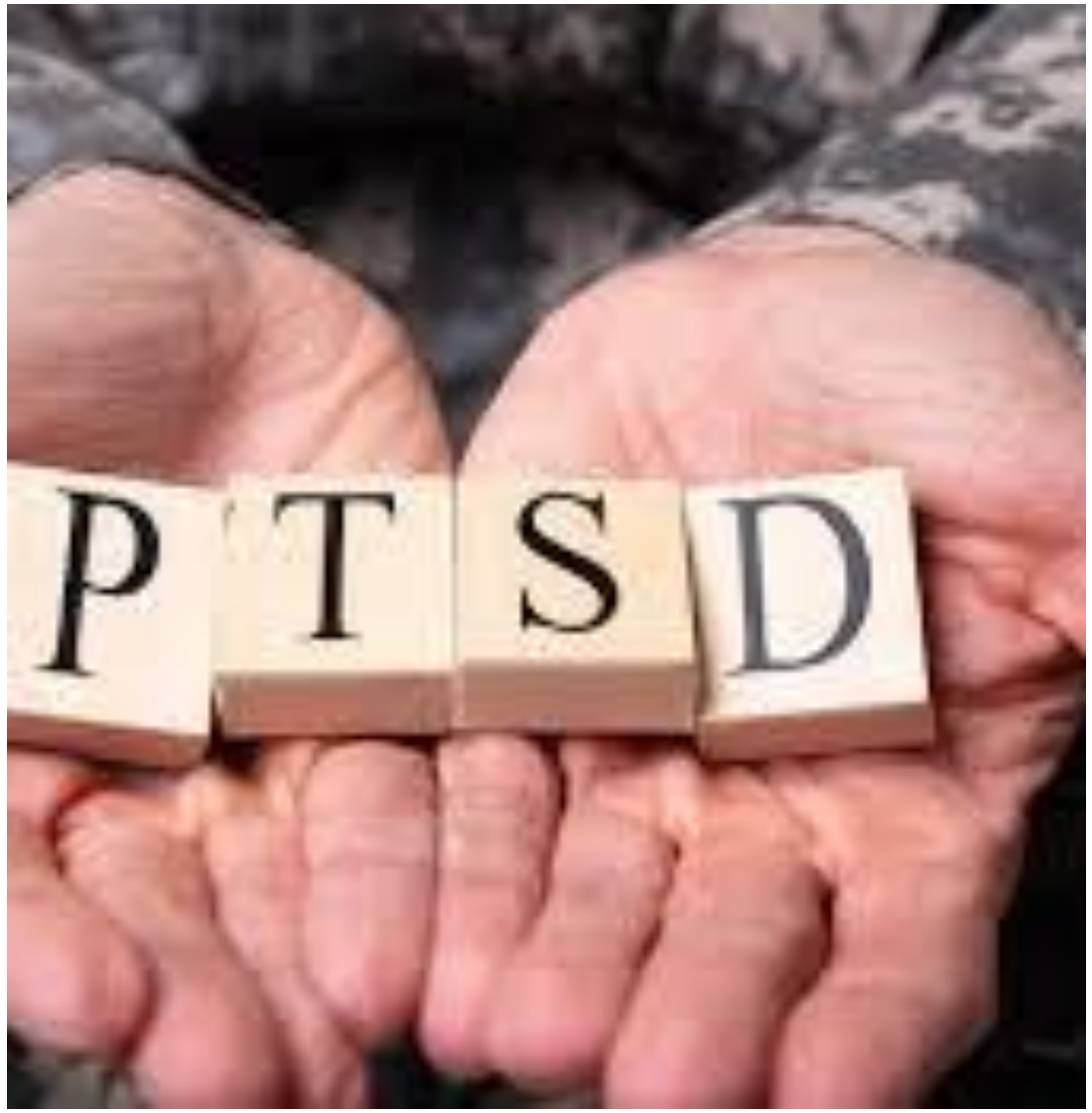
- 7-9% of general population
- 60-80% of trauma victims
- 30% of combat veterans
- 50-80% of sexual assault victims
- Increased risk in women, younger people
- Risk increases with “dose” of trauma, lack of social support, pre-existing psychiatric disorder



PTSD Epidemiology

Among the few diagnoses in DSM that speaks of etiology

- It is a severe mental response caused in response to a traumatic event, unusual in intensity such as: combat, rape, robbery, serious accident, attack, etc.
  About 20% of those exposed to a traumatic event will develop PTSD
  Lifetime prevalence - women, 10% - men. 5% -
  In 2005, nearly 8% of Americans had PTSD.
  8% men and 20% of women will develop PTSD after trauma and 30% of them will develop PTSD CHRONIC



PTSD Epidemiology

Среди немногих диагнозов в DSM, где известна этиология говорит об этиологии

- Это тяжелая умственная реакция, вызванная в ответ на травматическое событие, необычное по интенсивности, такие как: борьба, изнасилование, ограбление, серьезные несчастные случая, нападения и т.д.
- Около 20% из тех, кто подвергается травматического события будет развиваться PTSD
- Пожизненная распространенность - женщины, 10% - мужчины. 5% -
- В 2005 году почти 8% американцев имели PTSD.
- 8% мужчин и 20% женщин будут развиваться ПТСР после травмы и 30% из них будут развиваться 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]*

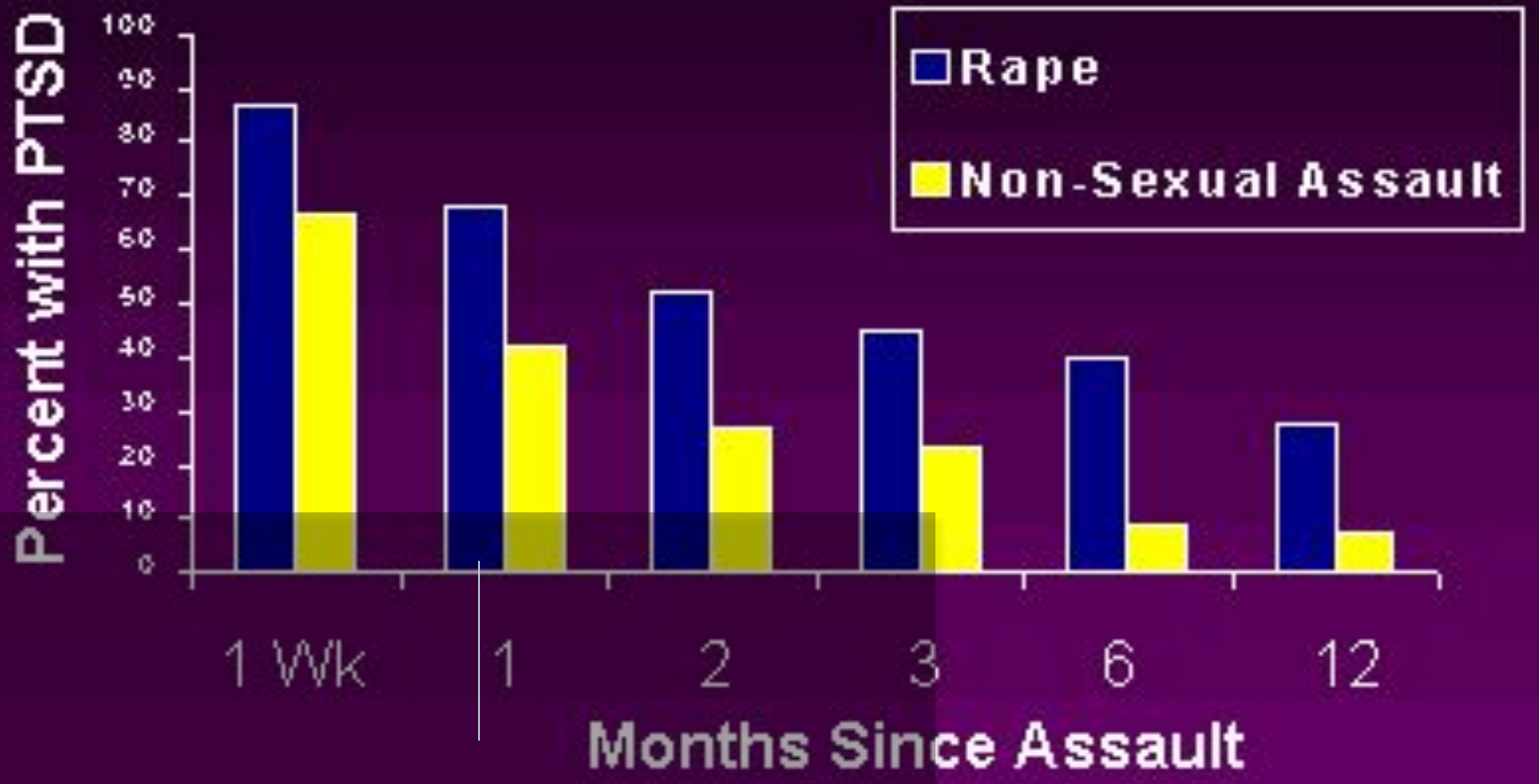
Age of Onset and Cultural Features

- 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.

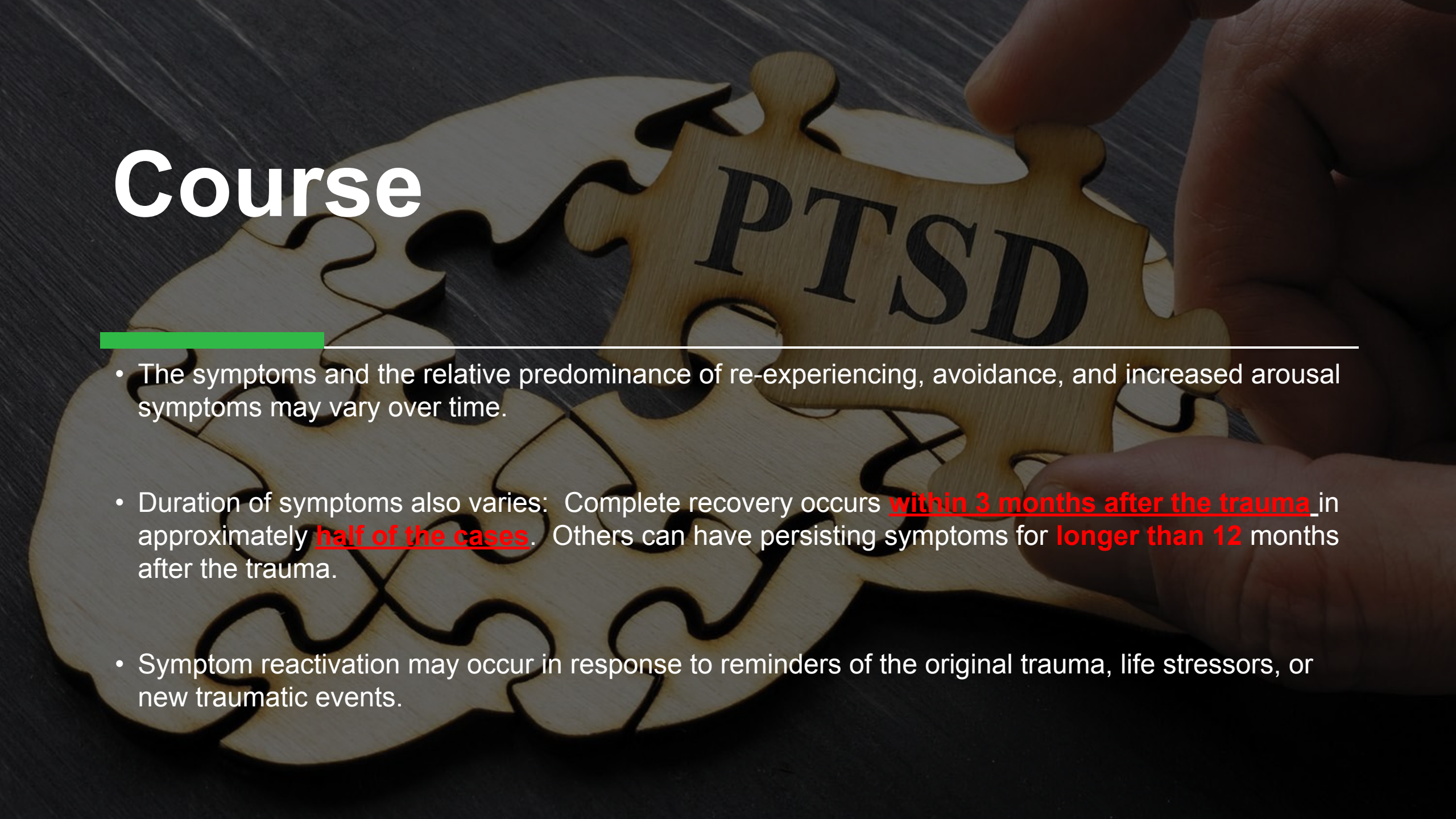
Onset

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).

Course Continued

- Тяжесть, продолжительность и близость воздействия травматического события являются наиболее важными факторами, влияющими на вероятность развития ПТСР.
Социальная поддержка, семейная история, детский опыт, не сформированные личности и уже существующие психические расстройства могут влиять на развитие ПТСР.
ПТСР может также развиваться у людей без каких-либо предрасполагающие условия, особенно если стрессор является экстремальным.
Расстройство может быть особенно тяжелым или длительным, когда стрессор человеческого дизайна (пытки, изнасилования).

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 (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%)

Differential Diagnosis

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

PTSD Compared to Other Disorders

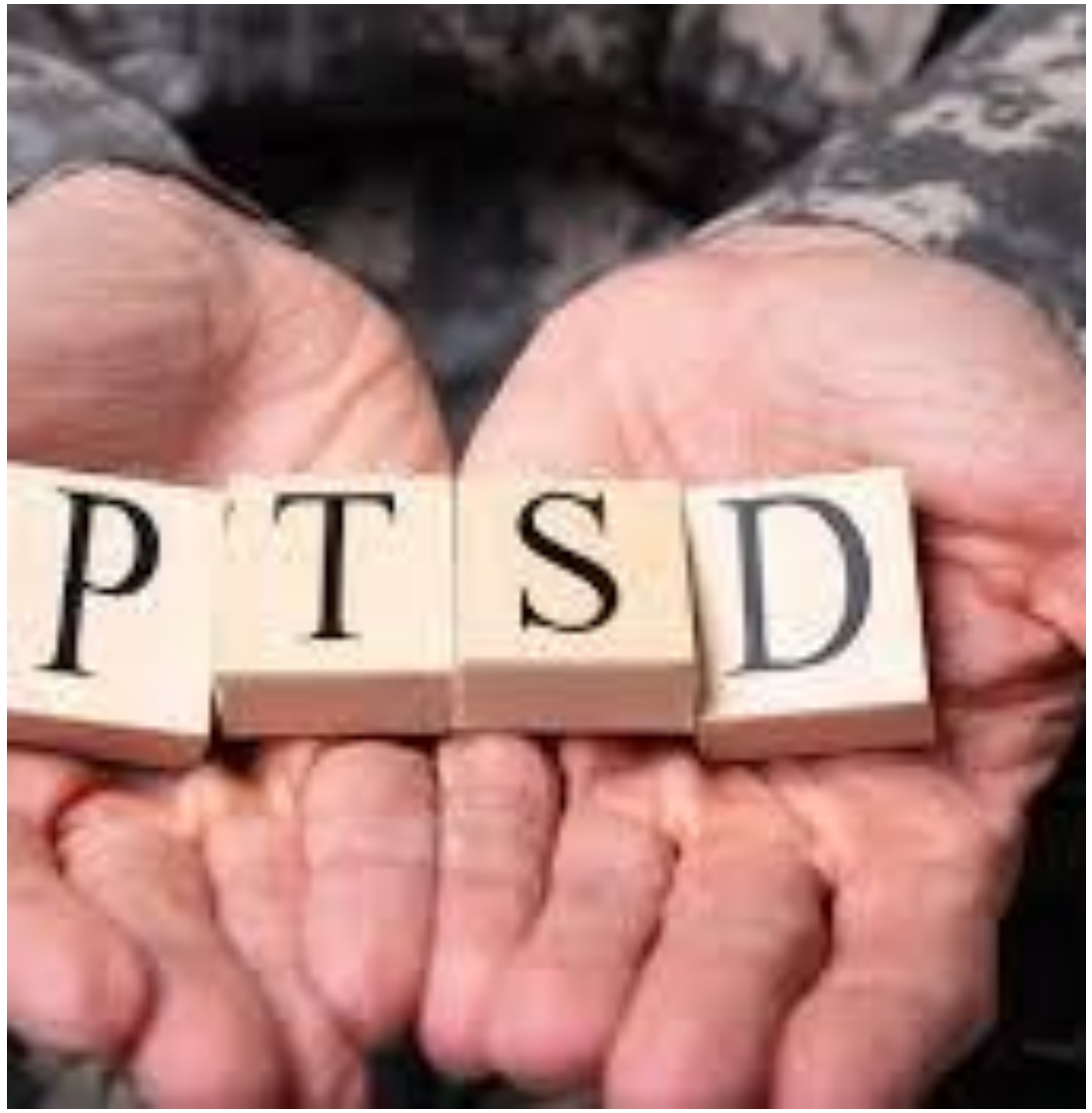
While the symptoms of posttraumatic stress disorder (PTSD) may seem similar to those of other disorders, there are differences.

- Acute stress disorder
- Obsessive-compulsive disorder
- Adjustment disorder

Differences between Acute Stress Disorder

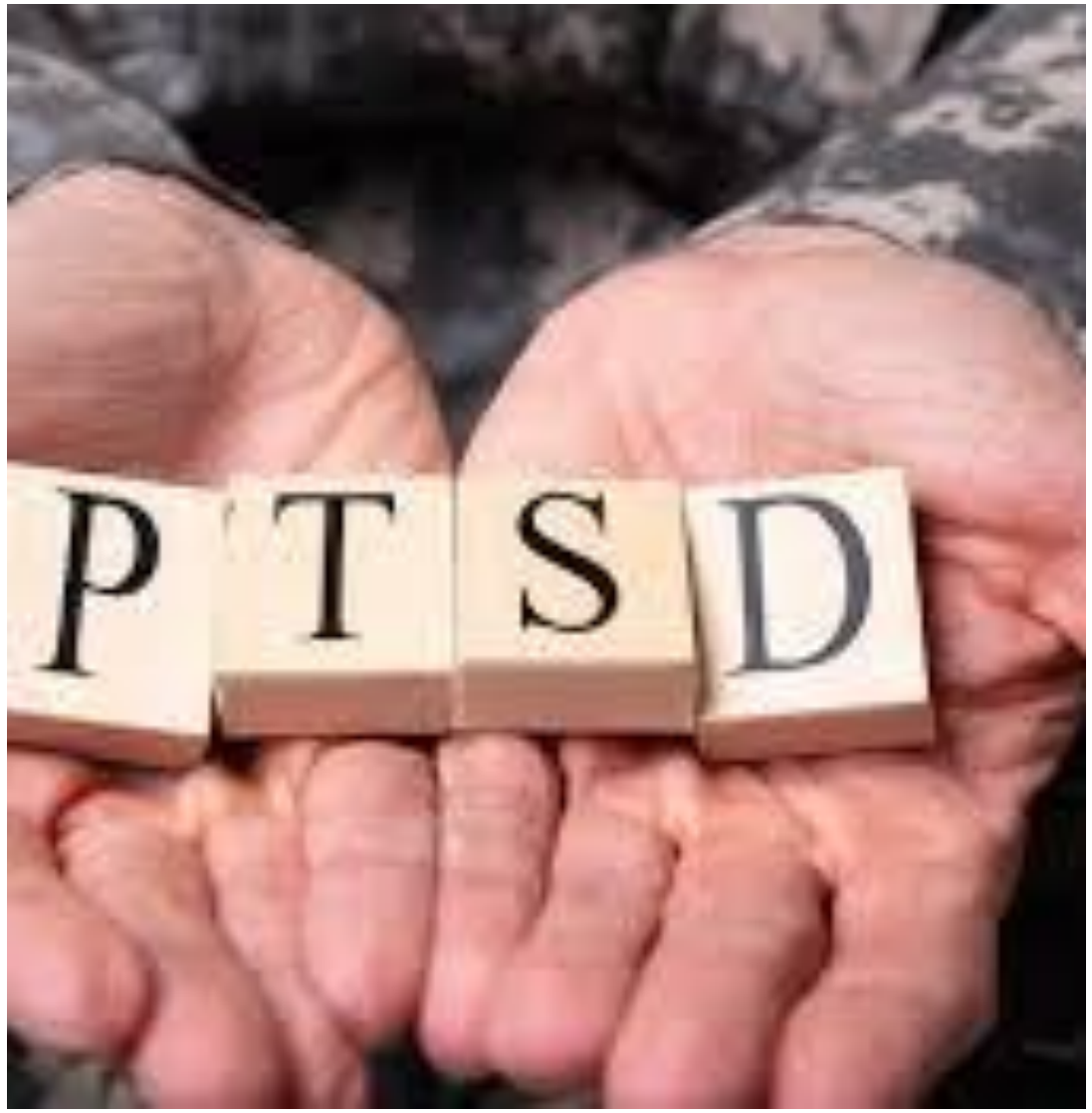
- In general, the symptoms of acute stress disorder must occur within four weeks of a traumatic event and come to an end within that four-week time period.

- 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

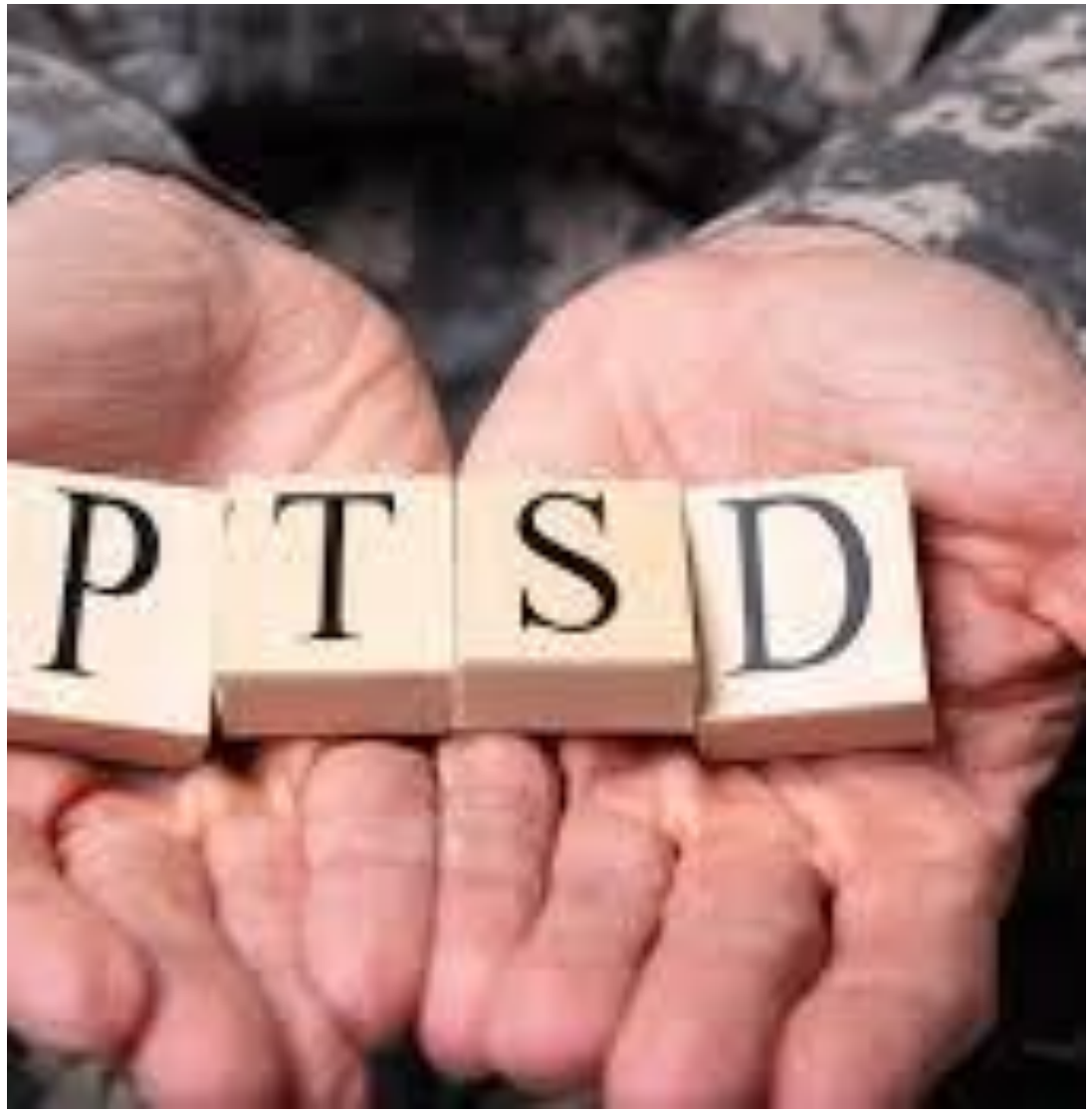
PTSD symptoms can also seem similar to adjustment disorder because both are linked with anxiety that develops after exposure to a stressor. **With PTSD, this stressor is a traumatic event. With adjustment disorder, the stressor does not have to be severe or outside the "normal" human experience.**

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**

Who's more for it?

- Stressor Volume
  Sudden (Unexpected)
  Inability to control what is happening
  Sexual as opposed to nonsexual-victimization
  In their young man
  Lack of support system



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

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

- 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 or substance abuse

Why PTSD Victims Might Be Resistant to Getting Help

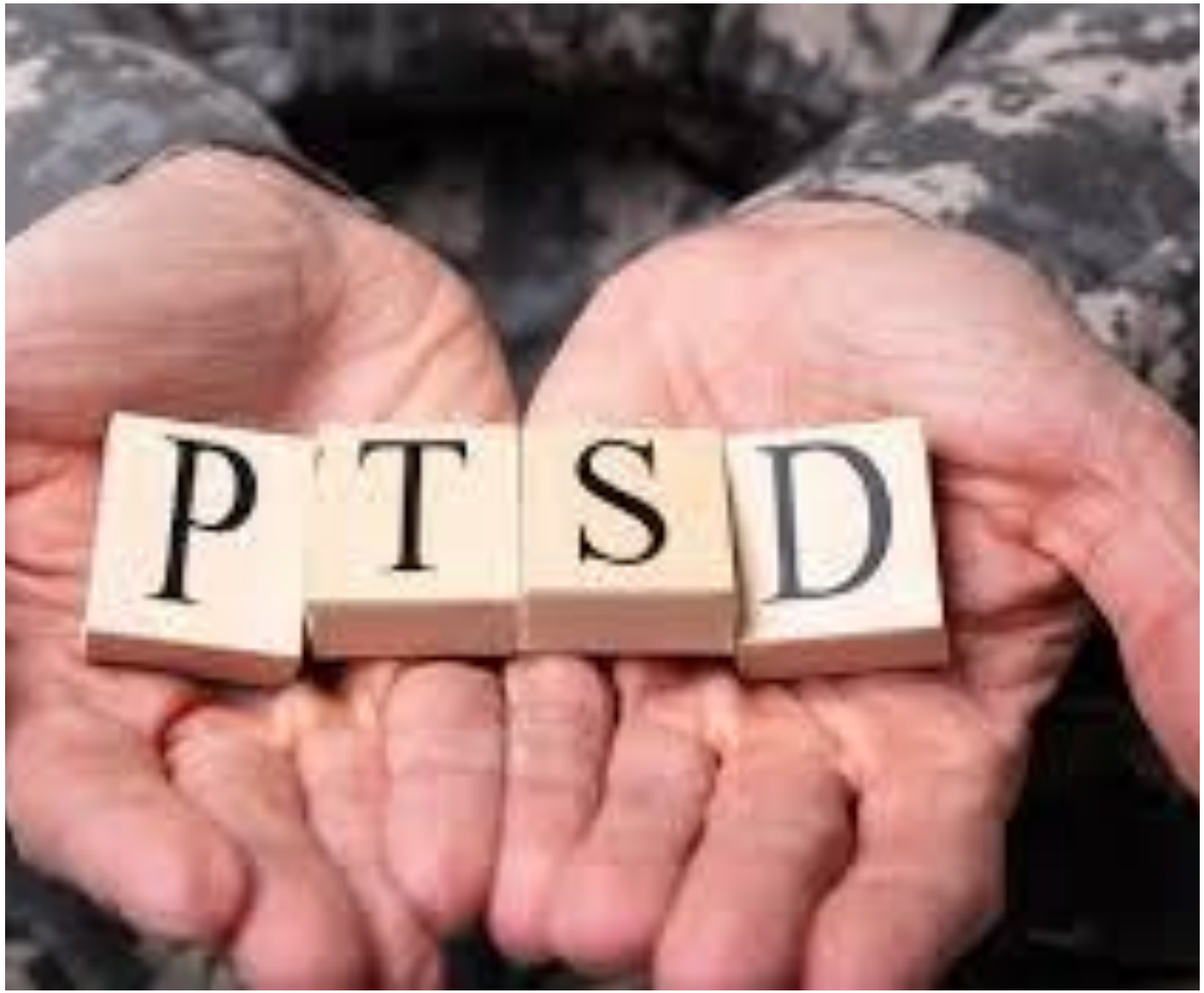
- Потому что люди ожидают, что смогут справиться сами по себе
  Люди могут винить себя
  Травматический опыт может быть слишком болезненным для обсуждения
  Некоторые люди избегают обсуждать события все вместе
  PTSD может заставить некоторых людей чувствовать себя изолированными, что затрудняет для них получение помощи
  Люди не всегда делают связь между травмирующим событием и симптомами; тревога, гнев, и возможные физические симптомы часто имеют более одного тревожного расстройства или могут страдать от депрессии или злоупотребления психоактивными веществами

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

Treatment

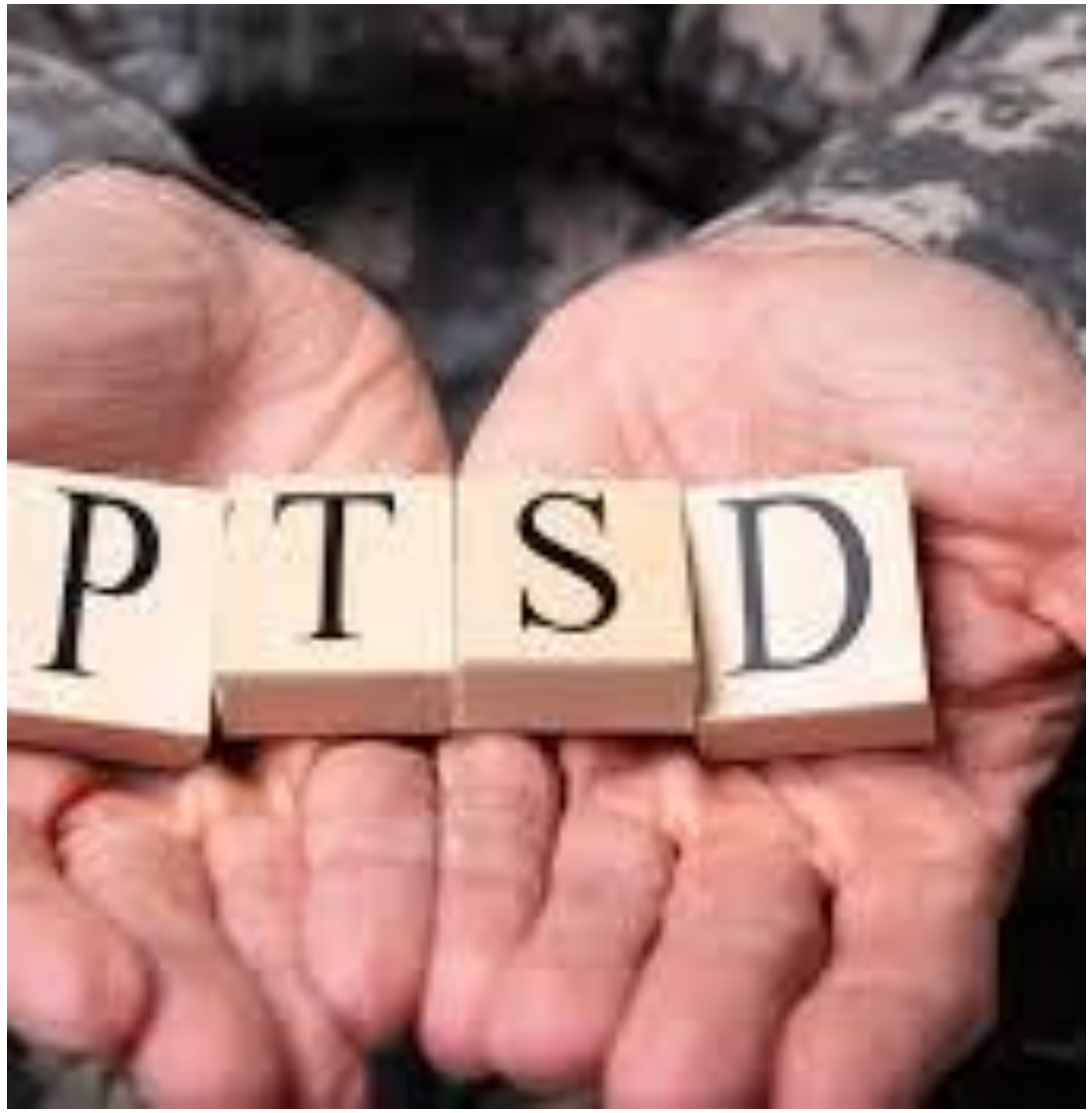
- Individual Therapy
- Group Support (especially for Chronic PTSD)
- Medication



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

- For PTSD in children, adolescents, and geriatrics the preferred treatment is psychotherapy

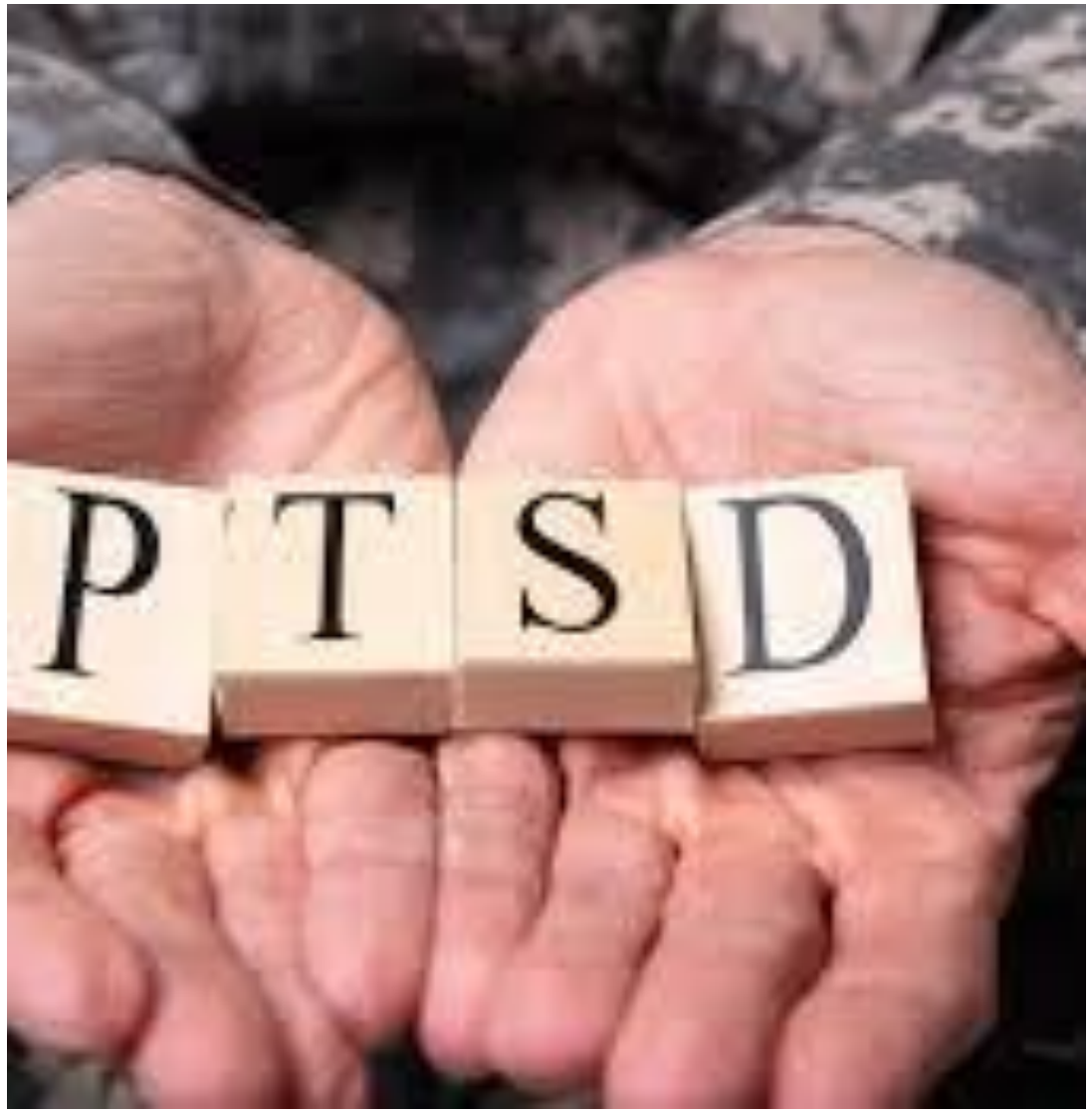


Treatment Continued

- **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 inoculation training**- variant of exposure training teaches client to relax. Helps the client relax when thinking about traumatic event exposure by providing client a script.



Treatment Continued

- **Exposure Therapy**- Объяснение об общих реакциях на травмы, обучение дыханию, и неоднократные обсуждения прошлых травм в **градуированных дозах**. Цель состоит в том, чтобы травматическое событие, вспоминалось без беспокойства или паники.
- **Cognitive Therapy**- Отделение навязчивых мыслей от связанного с этим беспокойства, которое они производят.
- **Stress inoculation training**- вариант обучения экспозиции, который учит пациента расслабляться. Помогает пациенту расслабиться, думая о травматической экспозиции событий, предоставляя пациенту сценарий.

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.”

in Adult Female Survivors of Childhood Sexual Abuse. *Journal of Consulting and Clinical Psychology*, 73, 515-524.)

Medications

- SSRIs – Sertraline, Paroxetine, Escitalopram, Fluvoxamine, Fluoxetine
- Affects the concentration and activity of the neurotransmitter Serotonin
- May reduce depression, intrusive and avoidant symptoms, anger, explosive outbursts, hyperarousal symptoms, and numbing

Medications Continued

- Tricyclic Antidepressants- Clomipramine , Doxepin, Nortriptyline, Amitriptyline, Maprotiline, Desipramine
- 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

Treatment

- Combination of antidepressant and anxiety medication
  In practice, you get to the whole spectrum of drugs.
  Psychological therapy – CBT is currently accepted pe method with very good results.

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:

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

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.

PTSD Myths

MYTH:

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

FACT:

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

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

FACT:

Многие люди, которые испытывают чрезвычайно травматическое событие проходят через период адаптации после этого опыта. Большинство из этих людей могут вернуться к нормальной жизни. Однако стресс, вызванный травмой, может повлиять на все аспекты жизни человека, включая психическое, эмоциональное и физическое благополучие. Исследования показывают, что длительная травма может нарушить и изменить химию мозга. Для некоторых людей травматическое событие меняет их взгляды на себя и окружающий мир. Это может привести к развитию ПТСР.

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?

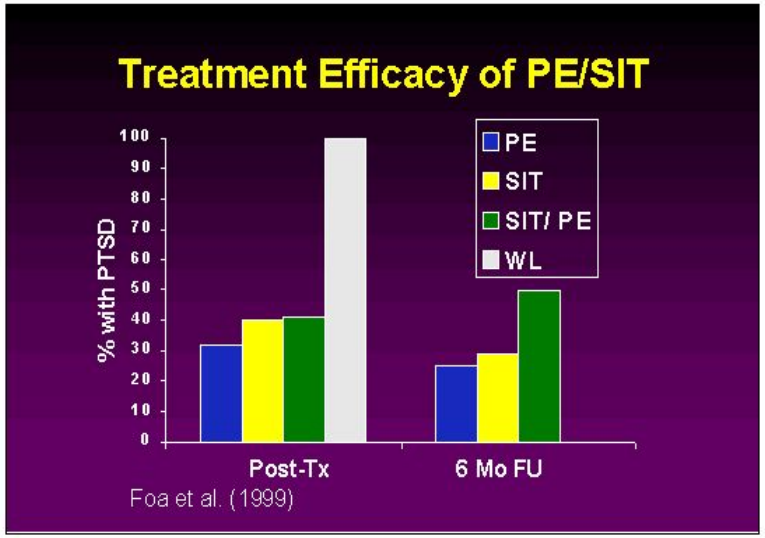
- PE is a type of CBT, which is designed to specifically target a number of trauma-related difficulties.
- Results of several controlled studies have shown it significantly reduce PTSD and other symptoms such as anxiety and depression, particularly in women following sexual and non-sexual assault (Foa 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

- 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.

The Background of Combat Reaction

- 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.

The Background of Combat Reaction

•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

- 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

Risk Factors

- 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

United States medical officer Thomas W. Salmon

- **P**roximity - treat the casualties close to the front and within sound of the fighting
- **I**mmediacy - treat them without delay and not wait till the wounded were all dealt with
- **E**xpectancy - ensure that everyone had the expectation of their return to the front after a rest and replenishment

The US services recently use BICEPS principles:

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

The US services recently use BICEPS principles:

- Краткости (Brevity)
  Непосредственности (Immediacy)
  Центральность или контакт (Centrality or Contact)
  Продолжительность (Expectancy)
  Близости (Proximity)
  Простота (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

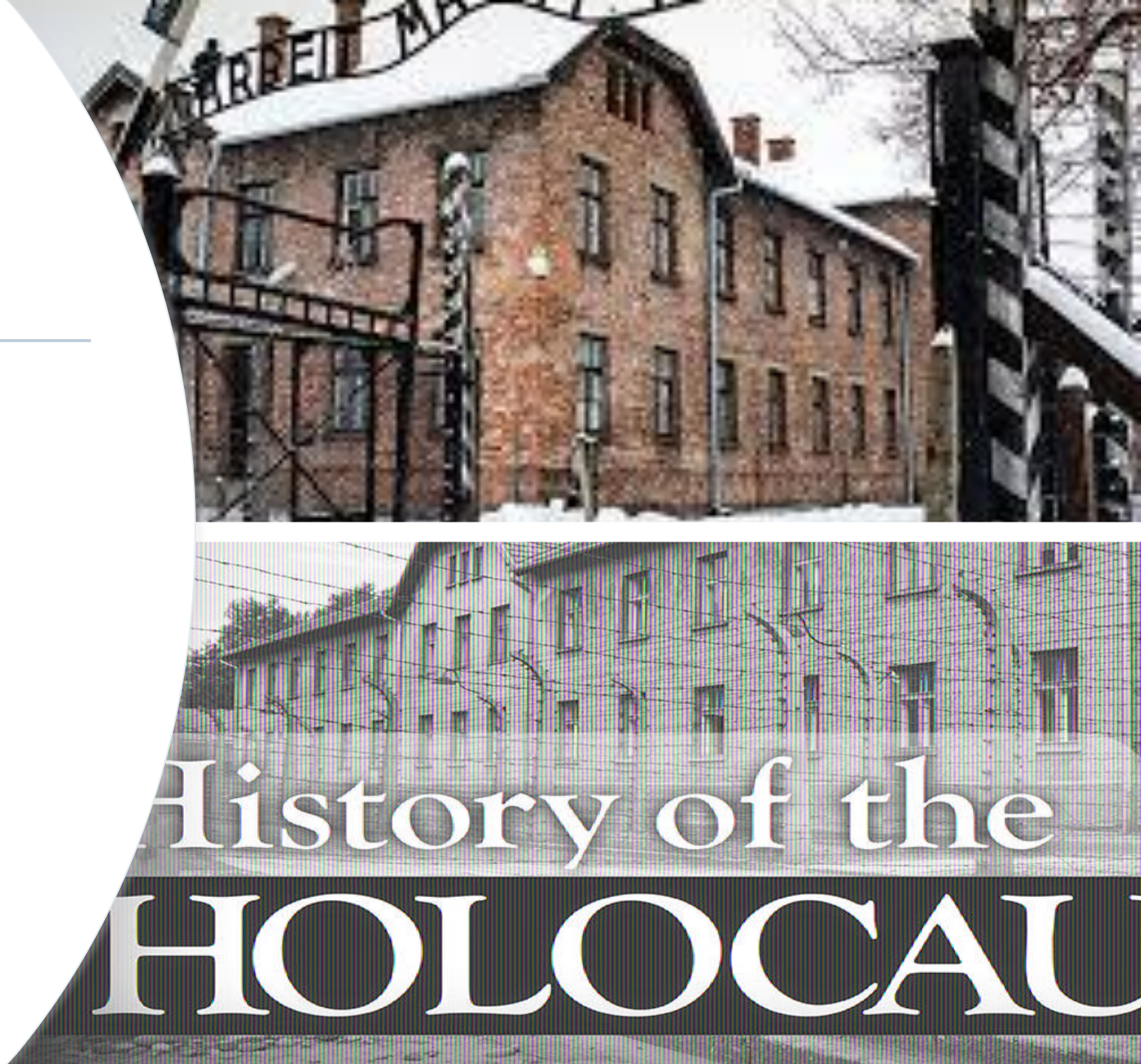
- Throughout wars but notably during the Vietnam War there has been a conflict amongst doctors about sending distressed soldiers back to combat.
- During the Vietnam War this reached a peak with much discussion about the ethics of this process.
- Proponents of the PIES principles argue that it leads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

Controversy

- На протяжении войн, но особенно во время войны во Вьетнаме, был конфликт между врачами об отправке проблемных солдат обратно в бой.
  Во время войны во Вьетнаме это достигло пика с большим обсуждением этики этого процесса.
  Сторонники принципов PIES утверждают, что это приводит к сокращению длительной инвалидности
  Противники утверждают, что боевые стрессовые реакции приводят к долгосрочным проблемам, таким как ПостТравматическое Стрессовое Расстройство.

Holocaust syndrome

- First generation
  Second generation



TAKE HOME

Avoidance

Reminders
Hyperarousal

Hyperarousal

•Re-experiencing

Intrusive thoughts
Nightmares
flashbacks

Angry outbursts
Startle response
Lacks concentration
Disomnia

Persistent negative alterations in mood and cognition

THREE PRONGS OF PTSD


hank you for your attenti
Any questions