Posttraumatic and Acute Stress Disorders

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Sixth Edition

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To Gayle and Dick

Preface

Although the basic format hasn't changed, this sixth edition of *Posttraumatic and Acute Stress Disorders* has been revised extensively. First of all, the new DSM-5 diagnostic criteria for PTSD and acute stress disorder (ASD) are discussed, in depth, in Chaps. 2 and 6, respectively. In addition, updated tables listing instruments for assessing diagnosis and symptom severity are cited and annotated in seven Appendices, as in previous editions. Separate lists are shown for adults and children and adolescents.

Second, thanks to remarkable progress in clinical trials research, Chaps. 3–5 have also been revised to keep pace with this expanding literature. This is especially true in Chap. 4 where, in addition to a focus on cognitive-behavioral therapy and other individual psychosocial treatments (e.g., eye movement desensitization and reprocessing, EMDR), the growing literature is presented on couples, family, group, and school-based treatments for adults, children, and adolescents. There are also sections on applications of technology to facilitate treatment by utilizing telehealth, the Internet, and mobile apps. In addition, Chap. 5 updates our psychobiological understanding of PTSD and presents the latest information on evidence-based pharmacotherapy for the disorder.

Finally, Chap. 6 addresses both normal acute stress reactions and clinically significant ASD. Besides a review of diagnostic and treatment issues, it addresses our emerging understanding of resilience and how such knowledge may guide preventive public health approaches in order to ameliorate the extreme distress caused by exposure to traumatic events.

Don't let the size of this book fool you. Although it is concise, it leaves few trauma-related stones unturned with regard to assessment and treatment. And for those inspired to learn more about any specific topic, the extensive bibliography is a good place to start. In short, this little book is a comprehensive, sophisticated, updated, and practical resource for clinicians, designed to assist your efforts to provide the best clinical attention to individuals suffering from posttraumatic and acute stress disorders.

White River Junction, VT — Matthew J. Friedman, M.D., Ph.D.

Contents

Chapter 1
Overview of Posttraumatic Stress Disorder (PTSD)

This Chapter Answers the Following Questions

- **What is trauma**?—This section defines trauma, the necessary precursor to PTSD.
- **What is the history and prevalence of PTSD**?—This section reviews how PTSD has been viewed since ancient times and presents information on how common PTSD is worldwide.
- **Can PTSD be prevented**?—This section offers recommendations for promoting resilience among those at risk for PTSD.
- **How severe and chronic is PTSD**?—This section identifies three general categories of PTSD sufferers: those with lifetime PTSD, those in remission but experiencing occasional relapses, and those with delayed onset.

During the course of a lifetime, everyone is exposed to stressful events such as failure, disappointment, rejection, and loss. Most of the time, most of us have the psychological capacity to cope successfully with such events and to continue our lives pretty much as before. Sometimes we are confronted by terrifying, catastrophic, or severely stressful (e.g., "traumatic") events in which there is a real possibility that we and/or a loved one might be killed, seriously injured, or sexually violated. As with less stressful events, most of us are resilient and will bounce back from the emotional distress or functional impairment that we experienced during the traumatic event. A significant minority of us, however, will be unable to cope psychologically with such traumatic stress. We will not bounce back but, instead, will develop the serious and potentially incapacitating symptoms that characterize posttraumatic stress disorder (PTSD).

In the USA, approximately half of all Americans will be exposed to at least one traumatic event, such as assault, military combat, an industrial or vehicular accident, rape, domestic violence, or a natural disaster (e.g., an earthquake). Traumatic exposure is higher for individuals who engage in professions where their work places them in traumatic situations on a regular basis; this includes military personnel, police, firefighters, emergency medical technicians, and others. Exposure to extreme

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stress is also much higher for people who live in nations subjected to war, state terrorism, or forced migration, such as Syria, Algeria, Cambodia, Palestine, or Iraq. In other words, there is a dose-response relationship between the amount of exposure to traumatic events and the likelihood of developing PTSD. For example, whereas approximately 8 % of Americans develop PTSD, in areas of conflict, PTSD prevalence is 20–30 % [1, 2].

We should emphasize that this represents a minority of all individuals exposed to traumatic events. Most people are resilient and can absorb the psychological impact of such experiences and resume their normal lives; however, a sizeable number cannot. This book is about the latter group, the minority of trauma-exposed individuals who develop PTSD. We will also discuss the resilient majority in Chap. 6.

PTSD is a disorder in which a person experiences trauma-related symptoms or impairments in everyday functioning that last for at least a month and sometimes for life. It has been recognized by many other names since antiquity and by modern psychiatry since the late 1800s. Although the specific symptoms included in the original PTSD diagnostic criteria [3] have been partially modified, the fundamental PTSD construct that exposure to catastrophic psychological stress can produce severe, debilitating and long-lasting distress and impairment, has clearly withstood the test of time. As a result, clinicians have had almost 35 years in which to utilize PTSD as a diagnostic tool and to develop effective treatments.

Although PTSD can only be diagnosed 1 month after an individual has been exposed to trauma, many people experience great distress during the immediate aftermath of a traumatic event, including having nightmares and avoiding people and places that may remind them of the trauma. Such acute, posttraumatic reactions will be considered in Chap. 6.

What Is Trauma?

When "trauma" was first introduced as a construct in the DSM-III (1980), it was defined as a catastrophic stressor that "would evoke significant symptoms of distress in most people" [3]. At that time, trauma was thought to be a "rare" and overwhelming event—"generally outside the range of usual human experience"—that differed qualitatively from "common experiences, such as bereavement, chronic illness, business losses, or marital conflict." Traumatic events cited in the DSM-III included rape, assault, torture, incarceration in a death camp, military combat, natural disasters, industrial/vehicular accidents, or exposure to war/civil/domestic violence.

Trauma is currently defined as a catastrophic event (or series of events) in which individuals have been exposed to situations in which they were personally threatened or witnessed death, physical harm, or sexual violence. Trauma also includes indirect exposure in which a loved one is exposed to trauma or in which individuals repeatedly confront the consequences of trauma (e.g., body parts in a war zone after a battle) in the line of professional duties. We will discuss this in much more detail in Chap. 2.

From the Patient's Perspective
That lawyer called again. He thinks I've got a great case against the trucking company and could win a huge settlement. It's tempting. I certainly need the money. But every time I even think about the accident (*like now*), *I go to pieces. And—if I start to talk about it—I get terrified. Then the nightmares. No sleep. That horrible jumpy feeling. And I turn into a nervous wreck. It isn't worth it, even if I could win a million bucks*! *I'll just have to call him back tomorrow and tell him I'm not interested. He'll have to find someone else to sue.*

Catastrophic events are not rare. Today, our understanding about trauma has changed significantly from that first described in the DSM-III since exposure to traumatic events is not unusual. Indeed, research has shown that over half of all American men (60.7 %) and women (51.2 %) are likely to be exposed to at least one catastrophic event during their lives [1]. Exposure is much higher in countries torn by war, civil strife, genocide, state-sponsored terrorism, or other forms of violence. For example, exposure to trauma was reportedly as high as 92 % in Algeria, where deadly conflict and violence have persisted for years [2]. As a result of these findings, the original DSM-III concept of trauma as "an event beyond the range of normal human experience" has been changed in subsequent editions of the Diagnostic and Statistical Manual (e.g., *DSM-IV*, *1994*; *DSM-IV-TR*, *2000*; *and DSM-5*; *2013*) [4–6] *which no longer characterize trauma exposure as a "rare" event. Indeed, from a global perspective, exposure to catastrophic stress is a common fact of life.*

What Is the History and Prevalence of PTSD?

Historically, poets and writers have recognized that exposure to trauma may produce enduring psychological consequences. Various literary works—Homer's *Iliad*, Shakespeare's *Henry IV*, and Dickens's *Tale of Two Cities*—present characters' psychological transformations and symptoms related to trauma. Even Harry Potter was perhaps traumatized when, as an infant, he witnessed his parents' murder by the evil wizard Lord Voldemort (Mueser, K. Personal communication. 2003).

Historical Overview

In the late nineteenth century, clinicians also began to focus on the psychological impact of military combat among veterans of the US Civil War and the Franco-Prussian War. Clinical formulations on both sides of the Atlantic focused either on

cardiovascular (e.g., soldier's heart, Da Costa's syndrome, neurocirculatory asthenia) or psychiatric (e.g., nostalgia, shell shock, combat fatigue, war neurosis) symptoms [7, 8]. Similar clinical presentations among nineteenth-century civilian survivors of train accidents were called "railway spine" [9]. Throughout this period, clinicians asked to provide treatment for survivors of military or civilian trauma were struck by the physiological as well as the psychological symptoms exhibited. Indeed, by the 1940s, Abram Kardiner, an American psychiatrist who worked extensively with World War I veterans suffering from "war neurosis," was so impressed by their excessive startle reactions that he called it a "physioneurosis" [10]· to characterize the significant physiological as well as psychological symptoms that he considered key components of the "war neurosis" syndrome. Chapter 5 reviews some of the major biological abnormalities that are central to this disorder.

Prevalence

With the growing recognition that catastrophic stress and traumatic events are much more common than originally suspected, it is clear that PTSD is a significant public health problem. Although over half of all American adults will have been exposed to a catastrophic stress event (60 % men and 51 % women), only 6.8 % (3.6 % men and 9.6 % women) will have developed PTSD at some point in their lives [1]. This means that millions of Americans will suffer from this disorder, and PTSD is a major public health problem in the USA and elsewhere. If untreated, many of these individuals will never recover. Research with veterans of World War II and survivors of the Nazi Holocaust has shown, for example, that PTSD can persist for more than 50 years or for a lifetime [11].

Worldwide, the psychological and physical consequences of traumatic exposure constitute a major public health challenge [12, 13]. The long-term impacts of major natural disasters such as the earthquakes in Haiti and Chile; the tsunamis in Indonesia, Sri Lanka, and Thailand; and hurricanes in the south coastal USA can be overwhelming, both for survivors and for aid workers. Countless individuals will be exposed to trauma from war in nations such as Iraq, Afghanistan, Syria, and Rwanda as well as Algeria, Palestine, and Bosnia [14]. We must also consider the millions of children and adults exposed to sexual, physical, domestic, criminal, urban, terrorist, and genocidal violence. From this perspective, it is very important to search for effective psychological preventive measures and to consider providing them to children and adults as part of a global public health strategy.

Can PTSD Be Prevented?

Theoretically, most PTSD can be prevented. All we have to do is prevent war, rape, interpersonal violence, child abuse, torture, and the like. Although we may all dream of such a utopian state of affairs, it is unlikely to materialize within the