Trauma outcomes: predisposing factors

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Almost 3-years study of posttraumatic stress disorder (PTSD) showed that trauma not always leads to the development of PTSD. In the majority of cases depressive and anxiety disorders are manifested.

The study of clinical dynamics of posttraumatic disorders on Karabakh veterans carried out in the “Stress center” during the last 20 years indicated that in 15% of cases the clinical description was corresponded to depressive disorders while in 20% of cases anxiety disorders were diagnosed. Traumatic events increased susceptibility both to depressive and emotional and psychophysiological disorders having shared diagnostic criteria with PTSD. In particular, significantly increased frequency of traumatic events as well as increased mean values of Dissociative Experiences Scale (DES) and more diagnostic criteria of PTSD was detected in several depressive patients. According to studies on the relationship between cerebral trauma and psychological response in victims, the presence of brain trauma is related to more severe depression or, in other words, trauma is rather predictor of depression than PTSD. A question is whether the traumatic events appeared during posttraumatic period must be considered as a separate manifestations despite being corresponding to their diagnostic criteria. It must be noted that trauma and its psychological consequences are the main symptoms of PTSD which is characterized as a wide spectrum of clinical manifestations including depressive and anxiety ones. Differentiation between those can be done based upon the experimental studies of cognitive abnormalities in posttraumatic disorders. Trauma changes basic cognitive statements included deep individual notions on self attitude and attitude towards the environment.

People who undergo traumatic stress are characterized by certain features. They selectively take their attitude towards the trauma; high mnemonic features related to the trauma are found during the testing; also difficulties to remember words related to the trauma are detected together with the extraction of particular autobiographical events in response to keywords, in contrast referring to “general” memories. Several studies were focused on the role of previous traumatic events in adults with PTSD. Each previous trauma “prepare” the organism to the next one, in other words, the previous trauma sensibilizes the organism

and individual, increases its reactivity to the upcoming stressors. Not only in the context of posttraumatic events but also in the concept of psychogenies, depressive and anxiety disorders are also related to the impact of stressors. Moreover, anxiety disorders have features of PTSD in the structure of manifestation of panic attacks, other vegetative paroxysms the features of avoidant behavior are represented, therefore, an individual tries to avoid situations leading to repetition of panic attacks or exacerbation of anxiety. The role of periodic stresses and the risk of psychological alterations after the upcoming stress have been studied first in terms of PTSD. It is known that PTSD is the feature of psychiatric disorder in people who underwent extreme stressors or, in other words, the etiological relationship with stressors is the important feature in PTSD diagnostics. In definitions of depression and anxiety, the role of the psychogenic factor isn't defined as etiological, however, the main focus here is on the phenomenology of these disorders; bad mood, decreased psychiatric activity and motor inhibition. However, the role of stress in the initiation and development of depression is well defined. Significant stressful events taken place during childhood are important factors of the development of depression in all age groups; both stressful life events and stress intensity might lead to the development of depression. Also, stress increased severity of depression and is an important predictor of depression relapse.

Thus, PTSD is not the only posttraumatic disorder and not even the main one. Here we face with controversial results obtained which are related to the importance of such kind of studies in or stressful times. On the one hand, from methodological and conceptual points of view it seems not plausible to define a separate nosology based on the only (actually, the main) etiological factor, not ordinary stress. The main etiological factor in the genesis of psychogenic psychiatric and psychosomatic disorders, affective disorders, individuality alterations are currently described under different criteria of international classification of diseases (ICD)-10. On the other hand, the frames of "not ordinary disorder" become unclear. The reason of this eclecticism is the absence of unique conceptual approach in understanding of psychiatric pathology, in blurring notion of "syndrome" and its unification with symptocomplex that is clearly reflected in the absence of syndromological classification of affective disorders in ICD-10, while anxiety wasn't considered as a component of depressive syndrome, it was rather defined as a comorbid disorder. "The concept of depression now becomes as wide that present in almost all patients besides manic and paraphrenic ones". The polymorphism of PTSD clinical manifestations is due to the diverse combination and relationship of pre- and posttraumatic factors, individual

differences, the general somatic state of the organism, age and other factors. The appearance of depressive, anxiety, dissociative, somatoform and other disorders after the trauma is related to the factors representing the same list as for PTSD; the question of specificity of these factors remains unclear. Both ICD-10 and Diagnostic and Statistical Manual of Diseases (DSM) are the result of our limited knowledge on etiology, pathogenesis and many other aspects of psychiatric disorders, the absence of theoretical bases of the meaning and science in psychiatry in general and in terms of PTSD, in particular.