

POSTTRAUMATIC STRESS DISORDER: PARADIGM FOR NEW PSYCHIATRY

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SUMMARY

Although the description of the PTSD clinical picture dates from history, our professional community has known for about two decades. PTSD is clearly defined in the 10th International Classification of Diseases, World Health Organization and IV Diagnostic Statistical Manual of Mental Disorders. Together with panic disorder, agoraphobia, specific and social phobias, obsessive-compulsive disorder and generalized anxiety disorder is one of the large groups of anxiety disorders. A superficial approach, we could conclude that in the relation with PTSD is all clear. It was also found that PTSD is often associated with depression, anxiety disorders, and excessive drinking, substance abuse, and personality disorder, dissociative and other disorders.

It is true that our knowledge of PTSD from year to year is larger and larger. However, regarding PTSD, there are many uncertainties, doubts and controversies. Is PTSD a disorder, illness, rent or a passing phase in the development of various diseases? In recent years, there are many studies that are trying to illuminate different aspects of PTSD. Numerous clinical, neurobiological, psycho physiological and MR volumetric studies indicate many uncertainties related to PTSD. About psychotic PTSD is more frequently discussed and written. Whether PTSD is or its symptoms or complications during periods of decompensation may have the character of the psychosis and the psychosis within PTSD or a co-morbid diagnosis? It is certain that about PTSD there are many uncertainties and doubts, that the investigation should continue and that PTSD is a paradigm for new psychiatry.

Key words: *posttraumatic stress disorder - paradigm*

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INTRODUCTION

Although the description of the PTSD clinical picture dates from history, our professional community has known for it about two decades. In professional literature, but also in the literary work (Xenophon, Herodotus, Homer, Shakespeare, Krleža, Marinkovic, our folk songs and stories...) can be found a number of descriptions of mental state that is a consequence of war stress, which correspond to today's description of the clinical picture of PTSD (Jukić 1998). PTSD is a frequent companion of wars, revolutions and collective violence and natural disasters but can occur in many other situations as a result of catastrophic, traumatic stress experience.

The war that has passed in Bosnia and Herzegovina (BH), unfortunately, gave us the opportunity to better understand the developments and events related to war stress and stress caused by mental disorders that have emerged in the postwar period with many civilians, soldiers and traumatized, especially in difficult war veterans, refugees, the wounded and former prisoners of war (Babić et al. 2002, 2003, Pavlović 2004). In the 20th century, in two world wars and several local wars about 50 million people have lost their lives. However, military technology is so advanced, and modern war has become so harsh that in war conditions to go crazy is two times larger than to die. It has been scientifically proven that there is no complete training on catastrophic, psycho-traumatic experience and disproved the earlier hypothesis that in the war break down can only weak and cowards. War technology has become so

destructive that the question is whether any soldiers, except those who are already "crazy" can long endure on the future battlefield (Gabriel 1991). In modern wars, no one is spared the severe trauma, including the civilian population, local leaders, priests, health workers and teachers (Pedersen 2002).

The issue of psychological consequences of the war until the last few decades is accessed to systematic and methodologically rigorous way, which led to many scientific findings on the impact of war on man's psychic life, but also opening up many new questions to be answered only beginning to perceive (Keresteš 2002). The war, which passed in Bosnia and Herzegovina (BH) has caused heavy suffering of the population and left behind destruction and misery. Hundreds of thousands of people were killed, tens of thousands of seriously wounded, and almost the entire population suffered severe psychological trauma whose effects are still a number of war-related mental disorders, especially PTSD (Cerić et al. 1999). Considering the actuality post war and a number of difficult psycho-traumatized persons in BH in the last two decades, increased interest and need for this issue and psychiatrists have gradually increased their interest and knowledge about PTSD. After numerous individual and team research on the catastrophic consequences of war trauma and provided scientific confirmation of its surprisingly large representation. However, after the initial elation and opinion that about PTSD we know much, in recent years more frequently we have witnessed many doubts and we are facing with numerous difficulties and ambiguities.

PTSD TODAY

PTSD is clearly defined in the 10th International Classification of Diseases, World Health Organization and IV Diagnostic Statistical Manual of Mental Disorders. Together with panic disorder, agoraphobia, specific and social phobias, obsessive-compulsive disorder and generalized anxiety disorder is one of the large groups of anxiety disorders (Anonymous 1994). It was also found that PTSD is often associated with depression, anxiety disorders, and excessive drinking, substance abuse, and personality disorder, dissociative and other disorders. By superficial approach we could conclude that in the relation with PTSD is all clear.

In recent years, mental disorders as a result of war trauma were the subject of numerous investigations. Although the consequences of extreme stress are numerous, they are the official classifications of PTSD whose description cannot satisfy the needs of clinicians. Therefore is appropriate to speak of mental disorders caused by trauma, which would allow the application of other diagnostic groups other than PTSD, which is still subject to scientific research, while still not sufficiently defined, and are thinking about their inclusion in the official classification (Kocijan-Hercigonja et al. 1999). The fact that PTSD has included in the DSM-IV and ICD-10 with clearly defined diagnostic criteria, it could easily take us to the wrong conclusion that everything with PTSD is clear as a specific and unique diagnostic and psychopathological entity. PTSD can be unique and psychopathological diagnostic entity but also seems that it could be a developmental stage in pathogenesis of various mental disorders (Jakovljević 1998, 2000). Numerous studies show that people suffering from chronic, war-conditioned, PTSD tend to emotional difficulties in the form of impulsive, aggressive and violent behavior which has very negative consequences for families and for society (Roca & Freeman 2001, Begić & Begić-Jokić 2002, Zoričić et al. 2003, Pavić et al. 2003, Oquendo et al. 2003, Najavits et al. 2004), etc.

Today in the professional literature, various authors use different names for PTSD. So we find: acute, chronic, delayed, intermittent, residual, reactivated, partial, malignant, "de novo" complex and psychotic PTSD permanent personality changes after catastrophic experience. Some of these names overlap and this creates additional confusion. In last few decades, often is written and read about secondary traumatization (victimization) and sometimes we are not sure whether it is in our patients as part of PTSD symptomatology or provoked and caused by secondary traumatization or symptomatology interlaced in different ways. German psychiatrist Michael Linden in recent years on several occasions (2003, 2007 and 2010) has developed a new diagnostic entity posttraumatic embitterment disorder (PTED) or post-traumatic syndrome bitterness that has not been included in the official classification of ICD 10 and DSM IV, but procedures has been started for its inclusion in the DSM V. PTED represents a threat to the

fundamental belief system and the reaction is to: social injustice, loosing job and life events that lead to psychological shock and collapse of basic beliefs and values of a person. It is a prolonged emotional state of resentment, anger and hatred.

For decades about PTSD has been spoken and written in a negative context, and pointed to the negative health consequences for patients and a negative impact on the environment in which they live - especially family. Today it is increasingly discussed and written about posttraumatic growth in terms of positive consequences of post-traumatic stress after a catastrophic event. Literature data indicate at least some positive changes in 30-90% of traumatized, and often it manifests itself through: the creation of new ways of living, developing closer relationships with some people, an increased sense of confidence, deepen their spiritual life and even change the whole system of values. The traumatic event does not lead to positive change, but represents attempt at a personal and individual struggle to confront with such experiences. Posttraumatic growth can occur in parallel with PTSD or occur after the withdrawal symptoms of PTSD.

In recent years more and more frequently is written and spoken about the psychotic PTSD (Kilcommons and Morrison 2005; Sareen et al. 2005; Kastelan et al. 2007). although, today, psychotic PTSD does not exist in the current classification systems. In practice it is much more of those psychiatrists who classify PTSD in neurotic disorders, and eventual experience psychosis as a co-morbid diagnosis in (acute psychotic disorder, schizophrenia, schizoaffective psychosis, delusional disorder or psychosis in severe depressive episodes). Those psychiatrists who describe psychotic PTSD do this in three main ways: through review of individual cases, the description of psychotic symptoms in the PTSD and the description of psychotic PTSD. Psychotic PTSD include hallucinations and delusions that are associated with trauma (see pictures of dead, hear a groan of dying soldiers, has been followed, tapped him, felt a burning smell, etc.). Matthew et al. (2009) at Columbia University, in a sample of 5877 patients suffering from chronic PTSD have found in 52% of patients positive psychotic symptoms at some point in their lives (spy him: 27.5%, visual hallucinations: 19.8%, cenesthetic hallucinations: 16.8%, sound mind: 12.4%, olfactory hallucinations: 10.3%, control his thoughts and behavior: 10%). Following the publication of the 1980. and 2009. Braakman et al. (2009) in 24 comparative studies have found that psychotic PTSD syndrome consisting of PTSD with some psychotic features and psychotic symptoms occur continuously. Some researchers have attempted to compare the biological differences PTSD, schizophrenia and psychotic PTSD following spontaneous muscle movements of eyeballs, the concentrations of corticotrophin relising factor (CRF) and dopamine beta-hydroxylase activity. However, there is still no sufficient evidence for the existence of psychotic PTSD as nosological entities.

In recent years, researches on PTSD go further and further. Uzun, et al. (2010) searching the literature on contemporary knowledge of neurobiological basically found that PTSD genetic variability, sex differences and developmental exposures to stress influence neurobiological systems and mediate the risk for development of PTSD. Genetic polymorphisms that influence serotonin neurotransmission could contribute to susceptibility to PTSD. Previous studies have emphasized the role of the medial prefrontal cortex, amygdala and hippocampus in mediating the development of symptoms in PTSD. Important changes in neurotransmission have been observed in patients with PTSD. Also, investigations have resulted in observation reflecting the hypothalamic-pituitary-adrenal (HPA) axis dysfunction, which, in the aggregate, reflect a distinct neuroendocrine profile that differentiates PTSD from other psychiatric disorders. Furthermore, the results obtained in the investigations provide evidence on the involvement of the inflammatory component in pathogenesis of PTSD.

Varda R et al 2010. noted changes in the reactivity are observed in the glutamatergic, gabaergic, noradrenergic, neuropeptide Y and serotonergic systems in patients with PTSP, as well as changes in the release of corticotrophin releasing factor (CRF). The changes are even present in the release of dopamine, opioids and thyrotrophic hormones and in the function of immunological systems.

Exploring psycho-physiological diagnosis of disorders caused by stress in the intention of better understanding and distinguishing features of simulation and dissimulation Kozarić Kovačić (2010) found that getting used to the frightened and heart rate in rest are most realistic indicators of PTSD. Pavliša et al. (2010) have exploring high-resolution three-dimensional MR volume meter amygdale and hippocampus formation in patients with PTSD and diagnosed possible reduction in the volume of the amygdale and hippocampus to the right than the left. It may indicate plasticity induced by stress, however is not possible to completely exclude that it is ideally positioned state.

PTSD: PARADIGM FOR NEW PSYCHIATRY

Around the world, many psychiatrists, psychologists and other experts in the field of mental health research different aspects of PTSD. The truth is, every day of our knowledge about PTSD is a larger and larger. Also our uncertainties and doubts are higher. Although today's generally accepted classification systems provide very clear guidance about all aspects of PTSD, we still in practice (and in theory) find many differences. Different view at PTSD have winners from losers, richer than the poorer, western than eastern, and different views have psychiatrists who diagnosed it by psychiatrists who sit in various committees and disability pension assessed PTSD.

The largest number of psychiatrists, according to present knowledge, are looking right at it and experiencing PTSD as a mental disorder of neurotic level, as is now fixed with current classification systems (or neurotic anxiety disorder, anxiety, and stress caused by somatoform disorders). A number of psychiatrists thought that PTSD is a disease. Truly, sometimes the clinical picture of PTSD patients is so heavy, patients are dysfunctional and disintegrated long period of time, therapy is very complicated and demanding that in many ways it deserves to be ranked with the disease. Some psychiatrists almost completely underestimate the existence of PTSD. They say that it was invented diagnose in order to solve some social and financial difficulties. They argue that PTSD do not exist, and say: "This is rent," and sometimes in the everyday work we find it so-called "rented PTSD." In everyday work we all probably witnessed that once PTSD has like this, once some other clinical picture, and that it has moved from one form into such depression, alcoholism, psychosis, etc. And we are sure that it is PTSD or that it may be, a transitional or developmental stage in the development of various mental disorders or diseases.

And either way, we have huge steps forward and we are constantly increasing our knowledge related to PTSD we are deeply aware that in connection with PTSD, there are still many doubts, ambiguities and controversies. And though the past about 30 years, our knowledge about PTSD is greater than the whole of history it is necessary to continue intensive research, harmonize opinions and recognize that PTSD is a paradigm for new psychiatry.

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