Posttraumatic Stress Disorder Posttraumatic stress disorder (PTSD) is recurring, intrusive recollections of an overwhelming traumatic event. The pathophysiology of the disorder is incompletely understood. Symptoms also include avoidance of stimuli associated with the traumatic event, nightmares, and flashbacks. Diagnosis is based on history. Treatment consists of exposure therapy and drug therapy. When terrible things happen, many people are lastingly affected; in some, the effects are so persistent and severe that they are debilitating and constitute a disorder. Generally, events likely to evoke PTSD are those that invoke feelings of fear, helplessness, or horror. These events might include experiencing serious injury or the threat of death or witnessing others being seriously injured, threatened with death, or actually dying. Combat, sexual assault, and natural or man-made disasters are common causes of PTSD. Lifetime prevalence approaches 8%, with a 12-mo prevalence of about 5%. Symptoms and Signs Most commonly, patients have frequent, unwanted memories replaying the triggering event. Nightmares of the event are common. Much rarer are transient waking dissociative states in which events are relived as if happening (flashback), sometimes causing patients to react as if in the original situation (eg, loud noises such as fireworks might trigger a flashback of being in combat, which in turn might cause patients The Merck Manual of Diagnosis & Therapy, 19th Edition Chapter 158. Anxiety Disorders 1663 to seek shelter or prostrate themselves on the ground for protection). Patients avoid stimuli associated with the trauma and often feel emotionally numb and disinterested in daily activities. Sometimes the onset of symptoms is delayed, occurring many months or even years after the traumatic event. PTSD is considered chronic if present $>$ 3 mo. Depression, other anxiety disorders, and substance abuse are common among patients with chronic PTSD. In addition to trauma-specific anxiety, patients may experience guilt because of their actions during the event or because they survived when others did not. Diagnosis Diagnosis is clinical based on criteria in the Diagnostic and Statistical Manual of Mental Disorders ,

Treatment of posttraumatic stress disorder Exposure therapy or other psychotherapy, including supportive psychotherapy SSRI or other drug therapy If untreated, chronic PTSD often diminishes in severity without disappearing, but some people remain severely impaired. The primary form of psychotherapy used, exposure therapy, involves exposure to situations that the person avoids because they may trigger recollections of the trauma. Repeated exposure in fantasy to the traumatic experience itself usually lessens distress after some initial increase in discomfort. Stopping certain ritual behaviors, such as excessive washing to feel clean after a sexual assault, also helps. Drug therapy, particularly with SSRIs (see p. 1543), is effective. Drugs with mood-stabilizing effects, such as valproate, carbamazepine, and topiramate, can help reduce arousal, nightmares, and flashbacks. Because the anxiety is often intense, supportive psychotherapy plays an important role. Therapists must be openly empathic and sympathetic, recognizing and acknowledging patients' mental pain and the reality of the traumatic events. Therapists must also encourage patients to face the memories through desensitizing exposure and learning techniques to control

anxiety. For survivor guilt, psychotherapy aimed at helping patients understand and modify their self-critical and punitive attitudes may be helpful. The Merck Manual of Diagnosis & Therapy, 19th Edition Chapter 158. Anxiety Disorders 1664 Chapter 159. Dissociative Disorders Introduction Everyone occasionally experiences a failure in the normal automatic integration of memories, perceptions, identity, and consciousness. For example, people may drive somewhere and then realize that they do not remember many aspects of the drive because they are preoccupied with personal concerns, a program on the radio, or conversation with a passenger. Typically, such a failure, referred to as nonpathologic dissociation, does not disrupt everyday activities. People with a dissociative disorder may totally forget a series of normal behaviors occupying minutes or hours and may sense missing a period of time in their experience. Dissociation thus disrupts the continuity of self and the recollection of life events. People may experience the following: Poorly integrated memory (dissociative amnesia) Fragmentation of identity and memory (dissociative fugue or dissociative identity disorder) Disruption of experience and self-perception (depersonalization disorder) Dissociative disorders are usually attributed to overwhelming stress. Such stress may be generated by traumatic events or by intolerable inner conflict. Depersonalization Disorder Depersonalization disorder consists of persistent or recurrent feelings of being detached from one's body or mental processes, usually with a feeling of being an outside observer of one's life. The disorder is often triggered by severe stress. Diagnosis is based on symptoms after other possible causes are ruled out. Treatment consists of psychotherapy. About 20 to 40% of the general population have had a transient experience of depersonalization, frequently occurring in connection with life-threatening danger, acute drug intoxication (marijuana, hallucinogens, ketamine, Ecstasy), sensory deprivation, or sleep deprivation. Depersonalization can also occur as a symptom in many other mental disorders as well as in physical disorders such as seizure disorders (ictal or postictal). When depersonalization occurs independently of other mental or physical disorders and is persistent or recurrent, depersonalization disorder is present. It is estimated to occur in about 2% of the general population. Symptoms and Signs Patients feel detached from their body, mind, feelings, or sensations. Most patients also say they feel unreal (derealization), like an automaton, or as if they were in a dream or in some other way detached from the world. Some patients cannot recognize or describe their emotions (alexithymia). Patients may describe themselves as the "walking dead." Symptoms are almost always distressing and, when severe, profoundly intolerable. Anxiety and depression are common. Symptoms are often chronic; about one third of patients have recurrent episodes, and two thirds have continuous symptoms. Episodic symptoms sometimes become continuous. Patients often have great difficulty describing their symptoms and may fear or believe they are going crazy. They always retain the knowledge that their unreal experiences are not real but rather are just the way that they feel. This awareness differentiates depersonalization disorder from a psychotic disorder, in which such insight is always lacking. Diagnosis Medical and psychiatric evaluation

Diagnosis is based on symptoms after ruling out physical disorders, ongoing substance abuse, and other mental disorders (especially anxiety, depression, and other dissociative disorders). Initial evaluation should include MRI and EEG to rule out physical causes, particularly if symptoms or progression are atypical. Urine toxicology tests may also be indicated. Psychologic tests and special structured interviews and questionnaires are helpful. Prognosis Patients often improve without intervention. Complete recovery is possible for many patients, especially if symptoms result from treatable or transient stresses or have not been protracted. In others, depersonalization becomes more chronic and refractory. Even persistent or recurrent depersonalization symptoms may cause only minimal impairment if patients can distract themselves from their subjective sense of self by keeping their mind busy and focusing on other thoughts or activities. Some patients become disabled by the chronic sense of estrangement, by the accompanying anxiety or depression, or both. Treatment Psychotherapy Treatment must address all stresses associated with onset of the disorder as well as earlier stresses (eg, childhood emotional abuse or neglect), which may have predisposed patients to late onset of depersonalization. Various psychotherapies (eg, psychodynamic psychotherapy, cognitive-behavioral therapy) are successful for some patients: Cognitive techniques can help block obsessive thinking about the unreal state of being. Behavioral techniques can help patients engage in tasks that distract them from the depersonalization. Grounding techniques use the 5 senses (eg, by playing loud music or placing a piece of ice in the hand) to help patients feel more connected to themselves and the world and more real in the moment. Psychodynamic therapy focuses on underlying conflicts that make certain affects intolerable to the self and thus dissociated. Moment-to-moment tracking and labeling of affect and dissociation in therapy sessions works well for some patients. Various drugs have been used, but none have clearly demonstrable efficacy. However, some patients are apparently helped by serotonin reuptake inhibitors, lamotrigine, opioid antagonists, anxiolytics, and stimulants. However, these drugs may largely be targeting other mental disorders (eg, anxiety, depression) that are often associated with or precipitated by depersonalization. Dissociative Amnesia Dissociative amnesia is inability to recall important personal information that is too extensive to be explained by normal forgetfulness. Diagnosis is based on history after ruling out other causes of amnesia. Treatment is psychotherapy, sometimes combined with hypnosis or drugfacilitated interviews. The information lost would normally be part of conscious awareness and would be described as autobiographic memory eg, the story of one's life: who one is, where one went, to whom one spoke, and what one did, said, thought, experienced, and felt. Although the forgotten information may be inaccessible to consciousness, it sometimes continues to influence behavior. The Merck Manual of Diagnosis & Therapy, 19th Edition Chapter 159. Dissociative Disorders 1666 Dissociative amnesia is likely underdetected. Prevalence, although not well-established, has been estimated at 2 to 6% in the general population. Dissociative amnesia is most commonly diagnosed in young adults. The amnesia appears to be caused by traumatic or stressful experiences endured or witnessed (eg, physical or sexual abuse, rape, combat,

abandonment during natural disasters, death of a loved one, financial troubles) or by tremendous internal conflict (eg, turmoil over guilt-ridden impulses, apparently unresolvable interpersonal difficulties, criminal behaviors). Symptoms and Signs The main symptom is memory loss, usually of information regarding traumatic or stressful events or entire periods of the patient's life. Characteristically, patients experience one or more episodes in which they forget some or all of the events that occurred during a period of time. These periods, or gaps in memory, may represent only a few hours or can encompass years. Usually, the forgotten period of time is clearly demarcated. Patients seen shortly after they become amnestic may appear confused. Some are very distressed; others are indifferent. Some, especially if the amnesia is for the remote past, may not even be aware of it, and if they present for psychiatric help, the presenting complaint is often different. Diagnosis Medical and psychiatric examination Diagnosis requires a medical and psychiatric examination. Initial evaluation should include MRI to rule out structural causes, EEG to rule out a seizure disorder, and blood and urine tests to rule out toxic causes, such as illicit drug use. Psychologic testing can help better characterize the nature of the dissociative experiences. Prognosis Most patients recover their missing memories, and amnesia resolves. However, some are never able to reconstruct their missing past. The prognosis is determined mainly by the patient's life circumstances, particularly stresses and conflicts associated with the amnesia, and by the patient's overall mental adjustment. Treatment To recover memory, a supportive environment and sometimes hypnosis or a drug-induced hypnotic state Psychotherapy to deal with issues associated with recovered memories If memory of only a very short time period is lost, supportive treatment is usually adequate, especially if patients have no apparent need to recover the memory of some painful event. Treatment for more severe memory loss begins with creation of a safe and supportive environment. This measure alone frequently leads to gradual recovery of missing memories. When it does not or when the need to recover memories is urgent, questioning patients while they are under hypnosis or, rarely, in a drug-induced (barbiturate or benzodiazepine) semihypnotic state can be successful. These strategies must be done gently because the traumatic circumstances that stimulated memory loss are likely to be recalled and to be very upsetting. The questioner also must carefully phrase questions so as not to suggest the existence of an event and risk creating a false memory. The accuracy of memories recovered with such strategies can be determined only by external corroboration. However, regardless of the degree of historical accuracy, filling in the gap as much as possible is often therapeutically useful in restoring continuity to the patient's identity and sense of self and in creating a cohesive narrative. Once the amnesia is lifted, treatment helps with the following: Giving meaning to the underlying trauma or conflict Resolving problems associated with the amnestic episode Enabling patients to move on with their life