ACUTE STRESS REACTION **MEDICAL APPENDIX**

(including acute stress disorder, shell shock, combat fatigue)

1. Various attempts have been made to formally classify psychiatric disorders, the two major systems being:

    1.1. The **ICD-10 Classification of Mental and Behavioural Disorders** (World Health Organisation, Geneva) is part of the 10th edition of the International Classification of Disease. This appendix follows the common abbreviation of **ICD-10.** It is the international system used by the majority of clinical psychiatrists in Great Britain.

    1.2. **The Diagnostic and Statistical Manual of Mental Disorders (fourth edition)** (American Psychiatric Association Washington DC). References to it in this appendix follow the common abbreviation of **DSM-IV.** It is a system devised mainly by and for workers in the USA. However UK psychiatrists were consulted in its formulation.

2. The two systems above have been in existence for many years but only in their current editions have they been closely comparable.

3. This appendix discusses the clinical features and aetiology of acute stress reaction. It is generally based on the ICD-10 system with any major comparisons and distinctions with DSM-IV being discussed where relevant. The ICD-10 codes (numbers usually prefixed with F or Z) are also provided.

REACTIONS TO STRESSFUL EXPERIENCES: THE NORMAL RESPONSE

4. Most people react to stress with an emotional or somatic (physical) response. These are normal reactions and do not constitute mental disorders in themselves, although some people seek help from their doctor. What is interpreted as being stressful will vary from one individual to another and the ways in which they respond vary similarly. The response depends on personality variables, childhood experiences, family history and the coping mechanisms developed as a result of these factors.

5. There are three components to the normal response:

    5.1. The emotional response to danger or threat is fear and anxiety. The response to loss is sadness or feeling "depressed".

    5.2. The somatic reactions to threat are those of autonomic arousal and include rapid pulse, dry mouth, increased muscle tension and gastro-intestinal sensations. The physical response to loss is reduced energy and physical activity.

    5.3. The third part of the response comprises those psychological mechanisms which reduce the impact of the emotions engendered. Everyone unconsciously develops a variety of these "defence mechanisms" to differing degrees in order to help them deal with mental conflict. Some of the most commonly employed psychological processes are

5.3.1. **regression** which is adopting behaviour from an earlier stage of development, e.g. passively being taken care of like a child.

5.3.2. **denial** which is refusing to accept what someone would normally be expected to believe, for example someone is told they have terminal cancer but carries on as if unaware of the diagnosis.

5.3.3. **displacement** where the emotion is shifted onto to another less sensitive object, e.g. being angry with other people instead of the spouse.

5.3.4. **repression** where uncomfortable memories or emotions are kept out of awareness.

5.3.5. **identification** where the characteristics of another are incorporated in a person's own behaviour to reduce the sense of loss, e.g. carrying on a spouse's activities or hobbies following their death.

5.4. Other coping strategies include actual avoidance (so that the stressful situation is no longer encountered) and coming to terms with the situation. This latter involves working through the unpleasant idea and emotion by repeatedly recalling the event and finding a way of accepting it has happened. It is then possible to progress. Maladaptive strategies may be employed including the excessive use of alcohol or drugs, aggressive behaviour and deliberate self-harm.

6. The **adjustment reactions** are differentiated from normal reactions to problems related to life experiences, these being observable normal behaviours or occurrences which may lead the individual into contact with health and related services. However **they are not considered to be illnesses, mental disorders or personality disorders.** These adjustment reactions and behaviours are recorded in the ICD-10 under "Z" and "X" codes and the DSM-IV as "V codes". Only a small selection of these is listed below:

7. Accentuation of personality traits ICD-10 Z 73.1

This refers to the more florid appearance of personality traits under certain circumstances. For example when a shy, restrained and timid person is required to speak in public for the first time, anxiety builds as the day approaches and the performance may be hampered by blushing and difficulty in speaking, their demeanour being even more timid than usual. This person is obviously not mentally ill, nor do they have a personality disorder. Other examples include the histrionic personality's increase in ostentatious weeping when their demands are thwarted, or the low mood of a depressive personality when faced with disappointments.

8. **Phase of life problem** ICD-10Z60

Most people find difficulties in adjusting to various changes during life including problems associated with starting school, changing jobs, starting a new career, marriage, divorce and retirement. Individuals with certain personality traits may have more difficulty than others; for example those with high dependency may find returning to work after a long break threatening. Similarly those with a strong need for structure may find difficulties in adjusting to retirement or change of career.

9. **Employment difficulties** ICD-10 Z 56

Some may encounter problems more specifically relating to employment this including job satisfaction or dissatisfaction, "burn-out" and unemployment. Personality traits such as a lack of initiative may hamper efficient resolution of employment difficulties.

10. **Problems relating to lifestyle** ICD-10Z72

This includes the effect of inappropriate diet and eating habits, lack of exercise; tobacco, alcohol and drug use, high-risk sexual behaviour.

11. **Bereavement** ICD-10 Z 63

The normal grief reaction can include disbelief, shock, numbness, waves of grief, pining, anger, guilt, hearing the dead person's voice, feelings of exhaustion, despair and powerlessness. The normal response to bereavement may cause severe disruption to the person's functioning but only if it is exceptionally severe or prolonged is it considered to be a mental disorder.

12. **Intentional self harm** ICD-1 OX 60-84

Of those people who harm themselves for example by cutting or taking overdoses of various medications, few have a major psychiatric disorder. The motive behind some of these impulsive acts is obscure although quarrels or threats of rejection by partners are common antecedents of many acts of deliberate self-harm. The reaction may represent a way of communicating in those people who have restricted internal resources, the behaviour being used to try and influence others. An isolated incident of this sort in the absence of other symptoms is a maladaptive response and does not constitute a mental disorder.

13. However if these acts are repeated or are accompanied by other symptoms, a mental disorder or personality disorder should be considered, the latter being diagnosed in one third of people who deliberately harm themselves.

THE ABNORMAL RESPONSE TO STRESSORS

14. A wide variety of behaviour falls within the normal range and most neurotic disorders are on a continuum with the normal. If a stressor is sufficiently severe and/or the person is vulnerable (see below) various mental disorders may develop. The stage at which symptoms constitute a disorder or disease depends on several factors including their severity and duration, whether or not treatment is required and various other social and cultural factors. The disorders most commonly associated with exposure to a stressful event include acute stress reaction, post-traumatic stress disorder, the adjustment disorders and depressive reactions, phobic and other anxiety disorders, acute and transient psychotic disorders.

ACUTE STRESS REACTION ICD-10 F43.0

DEFINITION AND CLINICAL MANIFESTATIONS

15. This is the transient response which sometimes occurs immediately following exposure to or during an exceptionally severe event which subsides within a short period of time, usually hours or days. This category may include conditions formerly given such labels as "combat fatigue" and "shell shock". If the condition lasted longer than a month then the more appropriate current diagnoses may be post-traumatic stress disorder or an adjustment disorder.

16. The type of event which may precipitate the disorder includes natural disasters war, assault, rape, fire etc. The types of stressor can be considered as similar to those which precipitate post-traumatic stress disorder.

17. The symptoms vary greatly but generally include

    17.1. a feeling of detachment, disorientation, inability to concentrate or respond sensibly and being in a "daze".

    17.2. autonomic arousal i.e. palpitations, pounding heart, or accelerated heart rate, sweating, trembling, shaking, dry mouth.

    17.3. difficulty breathing, choking, chest pain/discomfort, nausea, churning in stomach.

    17.4. feeling "dizzy" unsteady or faint, depersonalisation, derealisation, fear of losing control or passing out, fear of dying.

    17.5. muscle tension, inability to relax, feeling on edge or tense, a lump in the throat or difficulty swallowing.

    17.6. exaggerated response to minor surprises or being startled, the mind "going blank".

    17.7. There may be a fugue state (dissociative stupor) in which the person appears to be out of contact with others but is not unconscious or asleep.

    17.8. Following the trauma the event may constantly intrude into awareness with extreme clarity. Amnesia of varying degree for the event may occur.

18. The diagnosis of acute stress reaction is only made in those cases where no pre-existing mental disorder is in evidence immediately prior to the episode, except personality disorders. It therefore does not cover exacerbations of established mental disorders. The person must be exposed to an exceptional mental or physical stressor and the reaction usually occurs within an hour of exposure to that stressful event. If the stressor is transient the condition should begin to subside within 8 hours. If the stressor is ongoing the symptoms should begin to subside within 48 hours.

19. The condition may precede post-traumatic stress disorder. However the main differences between this condition and post-traumatic stress disorder are as follows:

    19.1. Post-traumatic stress disorder (PTSD) arises as a delayed response to a stressful event. It often manifests only after a few weeks, and can only be diagnosed after symptoms have been present for a month. An acute stress reaction passes within a few days.

    19.2. The symptoms of PTSD are very specific and are described in the appropriate appendix.

20. If acute stress reaction lasts for more than a month, the diagnosis should be changed to the most appropriate disorder including reaction to severe stress unspecified, the adjustment disorders, post-traumatic stress disorder or the transient psychotic disorders, depending on the psychopathology present.

Reaction to severe stress unspecified F43.9

21. This diagnosis is used when only some of the features of the full acute stress reaction are present. Those that are present should be specified in individual cases.

Differences between ICD-10 and DSM-IV

22. This condition also appears for the first time in the DSM system under the label of **acute stress disorder.** There are some differences in emphasis in the diagnostic criteria, the main ones being:

    22.1. that the event must be characterised by actual or threatened death, or serious injury was involved AND they respond with intense fear, helplessness or horror.

    22.2. The other main difference is that the disturbance occurs within 4 weeks of an event, lasts for a minimum of 2 days and a maximum of 4 weeks after the event.

    22.3. It is therefore apparent that these two conditions may be slightly different.

AETIOLOGY

23. The acute stress reaction, whether it occurs in the context of a vulnerable personality or not, results from **a reaction to an external stressor.** The nature of the reaction is determined by the individual personality type.

24. The stressor must be **an exceptionally distressing event,** either mental or physical.

25. The trauma may be experienced alone - e.g. rape or assault - or in the company of groups of people - e.g. military combat. Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (serious road traffic accidents with multiple or critical physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps).

26. The most important factors in determining whether the person will develop an acute stress reaction are proximity to the event, the severity of the event, the duration of exposure. Several factors also influence whether an acute stress reaction will develop, these being childhood experiences, family history, personality variables and pre-existing mental disorders.

CONCLUSION

27. **Acute stress** is a severe reaction to exposure to an exceptionally distressing event. It disappears over a relatively short period of time, its duration depending to some extent on the duration of the exposure to the stressor.

28. The differentiation between this disorder and the normal response is mainly one of degree, an acute stress reaction being more severe in its symptoms. A normal response to being in a stressful situation would include the sensation of the heart racing, the mouth being dry, trembling, emotional sweating (i.e. mainly axillary, palmar and plantar), rapid breathing, and a sense of fear.

REFERENCES

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