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The position statement of the working group on the diagnosis of post-traumatic stress disorders in adults

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Summary

Experiencing a situation of extreme danger can lead to serious stress disorders (such as PTSD) that can affect both the victims and the professional helpers. Military operations in Ukraine in the first half of 2022 started an ongoing migration crisis, resulting in the displacement of approximately 3.5 million people to Poland. It is indicated that post-traumatic stress disorders may affect up to one third of adult refugees. Exposure to traumatic stress related to assault, limitation of basic resources, fear, insecurity, death, and a sense of injustice affected the entire population of the country. As a result, refugees, healthcare professionals, uniformed services, volunteers, and NGO workers constitute a group at risk of developing stress-related disorders, including post-traumatic stress disorder (PTSD). The presented recommendations were developed by an interdisciplinary team of experts in the field of psychiatry, clinical psychology, psychotherapy, and family medicine to present systematic guidelines for diagnostic procedures in medical and psychological practice.

Key words: post-traumatic stress disorder, diagnostic recommendations, post-traumatic stress diagnosis

Introduction

Lots of research show that experience of extreme danger leads to serious stress disorders such as post-traumatic stress disorder, which affects up to one third of adult refugees [1, 2] and its prevalence in global scale increases [3]. In the United States the risk of PTSD is 8.7%, while in Europe, most of the Asian, African, and Latin American countries it is in the range from 0.5% up to 1.0%. The risk of occurrence and severity of PTSD is different depending of cultural background, which could be related to different kinds of trauma exposure. The PTSD prevalence is higher in women than in men, for example because of diverse types of violence, including sexual abuse. The group of substantial risk includes veterans, professionals exposing to trauma (police officers, firefighters, paramedics), rape victims, combatants, prisoners of war and politically or ethnically motivated intern, and genocide survivors. People with comorbid disorders and dysfunctions in the form of taking and abusing substances, depressive, anxiety, dissociative and personality disorders, psychosis, cognitive disorders, violence towards oneself and others, as well as self-harm and suicidal behaviour are also at particular risk. The psychosocial effects of PTSD may include homelessness, poverty and conflicts with the law resulting in imprisonment [4]. Although children, adolescents and senior adults [5] are considered slightly less prone to PTSD, children are at risk of developing other mental disorders caused by traumatic stress. Studies of Syrian and Iraqi refugees displaced to the United States revealed that around half of the children felt high anxiety and 70% experienced separation anxiety. The terror experienced by children is often so strong that they are unable to part with their parents, even when they are no longer in immediate danger [2].

As a result of the migration crisis caused by the Russian invasion of Ukraine, since February 24, 2022, the sense of security, health and life of millions of people have been threatened. Exposure to traumatic stress related to assault, limitation of basic resources, fear, insecurity, death, and a sense of injustice affected the entire population of the country. According to the data of the Polish border guard of May 19, 2022, over 3.46 million refugees have crossed the Polish-Ukrainian border since the beginning of the invasion [6]. Millions more have been resettled within the borders of Ukraine [7]. It is a situation that causes chronic stress which has a harmful influence on the mental health of not only refugees, but also health and uniformed workers, volunteers, NGO workers, and grassroots aid providers. Thus, the potential group of people exposed to stress-related disorders can be estimated in the millions.

Research on the consequences of the first stage of Russian aggression show that among 1.5 million of Ukrainians fighting and internally displaced as a result of the 2014 invasion of eastern Ukraine, 27% of them revealed PTSD [8]. Another nationwide study on people internally displaced within Ukraine in 2016 showed the prevalence of PTSD at the level of 32% of respondents, while depression was present in 22% and anxiety in 17% [9].

Methodology

The position statement of the working group was developed by a group of experts as part of a three-stage procedure including: literature review, discussion of the issue and development of a common expert position. The materials were discussed at the online working meeting. In the article the diagnostic and therapeutic process of post-traumatic stress disorders and other stress-related disorders in the face of the ongoing migration crisis caused by the Russian invasion of Ukraine was discussed. This Part I of the recommendation concerns diagnostic procedures.

Stress-related mental disorders

According to the psychological dictionary of the American Psychological Association (APA), stress is the physiological and psychological response of the body to an internal or external stressor. Majority of human body systems engage in the stress response, which affects state of being and behavior. The characteristic symptoms include rapid heart rate, sweating, dry mouth, shortness of breath, motor anxiety, accelerated speech, intensification of negative emotions, and exhaustion due to prolonged exposure to stress. The stress response model describes the general adaptation syndrome that occurs always when the body is exposed to stressors. As a result of the changes within the body and mind, stress directly contributes to physiological and psychological disorders and diseases and affects somatic and mental health, as well reduces life quality [10].

According to the International Classification of Diseases and Health Problems ICD-11, disorders especially related to stress are directly involved with stress or traumatic events or series of these events or negative experiences. For all these disorders group an identifiable stressor is a necessary, though insufficient, causative factor. Although not all individuals exposed to the identified stressor will develop the disorder, the disorder in this group would not have occurred without experiencing the stressor. The stressful events associated with some of the disorders in this group fall within the normal range of life experiences (e.g., divorce, socio-economic problems, bereavement). Others require the experience of an extremely dangerous or frightening stressor (e.g., exposure to traumatic stress). For all disorders in this group, it is the character, pattern and duration of symptoms that appear in response to stressful events – together with the accompanying functional impairment – that distinguish the disorders [11]. All the stress-related disorders listed in ICD-11 are presented in Table 1.

Table 1. **Disorders specifically associated with stress according to ICD-11**

6B40	Post-traumatic stress disorder
6B41	Complex post-traumatic stress disorder
6B42	Prolonged grief disorder

table continued on the next page

6B43	Adjustment disorder
6B44	Reactive attachment disorder
6B45	Disinhibited social engagement disorder
6B4Y	Other Specified Disorders Specifically Associated with Stress
6B4Z	Specified Disorders Specifically Associated with Stress

Source: compiled based on Gałecki, 2022 [11].

Post-traumatic stress disorder

APA Psychological Dictionary defines trauma as any harmful experience causing fear, a sense of helplessness, emotion dissociation, confusion, and other bothersome feelings that are intense enough to have long-term negative influence on attitudes, behaviors and other aspects of individual's function. Traumatic events include both circumstances caused by human, such as rapes, wars, work accidents, and by nature, e.g., earthquakes, fires, floods. The traumatic experiences often disturb previous sense of safety, order and justice [10].

Post-traumatic stress disorder (PTSD) can develop after exposure to an extremely threatening or frightening event or series of events. It is characterized by all the following features: (1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. Re-experiencing may occur through one or many sense modalities and it is usually accompanied by strong and overwhelming emotions such as fear or fright and strong physical sensations; (2) avoidance of thoughts and memories of the event or events, or avoidance of the activities, situations, or people reminding of the event or events; and (3) persistent perceptions of heightened current threat, for example, as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational, or other key areas of functioning. Diagnostic procedure compiled based on DSM-5 is illustrated by Table 2.

Table 2. **Diagnostic procedure compiled based on DSM-5**

Diagnosis according to DSM-5			
At least one symptom	At least one symptom	At least two symptoms	At least two symptoms
Recurrent, involuntary distressing memories of the traumatic event: retrospections, nightmares, scary thoughts, intense psychical distress, physiological reaction to stimulus that reminds of trauma.	Avoiding stimuli related with trauma: avoiding places/ events/items that remind of trauma, avoiding thoughts/ feelings related to the traumatic event.	Negative changes in cognitive abilities and moods: troubles with remembering of important aspects of traumatic event, negative thoughts about oneself/ the world, distorted perception of trauma leading to guilt, loss of interest in pleasant activities, alienation.	Symptoms of agitation and reactivity: increased response to surprising events, sense of tension, nervousness, difficulty sleeping, outbursts of anger.

Source: on the basis of Gałecki, 2018 [5].

Complex post-traumatic stress disorder (Complex PTSD)

Complex post-traumatic stress disorder (Complex PTSD) is a disorder that can develop after exposure to very severe or horror event or series of events, generally after prolonged or repeated events, from which the escape is difficult or impossible (e.g., tortures, slavery, genocide campaigns, prolonged domestic violence, multiple sexual or physical abuse in childhood). All the diagnostic criteria are being met. Besides complex PTSD is characterized by severe and perseverate (1) difficulties in affect regulation; (2) self-conceptions as diminished, defeated, valueless, accompanied by a feeling of shame, guilty, failure involved with the traumatic event; and (3) difficulty in keeping relationships and feeling close to others. These symptoms cause severe deterioration in personal, family, social, educational, professional, or other important areas of functioning.

According to DSM-5, the risk factors of PTSD are divided into pre-traumatic, peritraumatic and post-traumatic. The first ones include temperamental, environmental, genetic, and physiopathological attributes. Temperamental factors include emotional problems which appeared up to the age of six and past psychiatric disorders. To environmental risk factors belong lower socio-economic position, lower education level, lower intelligence, ethnic/racial minority origin, previous psychiatric history in generation family, previous experience of trauma and harm, especially those that occurred in childhood. The cultural dimension is also significant, e.g., in terms of coping strategies referring to fatalism and self-blame. Having social support before experiencing trauma is considered as a protective factor. The last group includes pre-traumatic genetic and physiopathological factors, to which belong some genotypes, female sex and younger age at the time of exposure to trauma.

Peri-traumatic factors are searched in the severity of the trauma, which consists of a sense of life threat, being injured, being a victim of violence by other people, dissociation during and after the trauma. In the case of people on military duty, being the perpetrator or witness of harmful actions should also be considered as a risk factor. The risk factors during post-traumatic stage are temperamental aspects in the form of negative evaluations, improper strategies of coping and the occurrence of an acute stress reaction, as well as environmental factors such as later exposure to factors activating traumatic memories, experiencing further harm and loss [5].

Table 3. **Differential diagnosis of post-traumatic stress disorders and other psychiatric disorders**

Differential diagnosis		
Post-traumatic stress disorder	/	Adaptive disorders The type and severity of the stressor are different from Criterion A (exposure to death or threat of death, severe injury or sexual violence). If criterion A is met but another criterion for PTSD or any other mental disorders criterions are not met.
	/	Other post-traumatic conditions and disorders A complex of psychopathological symptoms after exposure to extreme stress that does not correspond to PTSD, e.g., dissociative amnesia. It is possible to make this diagnosis together with PTSD.
	/	Acute stress disorders Different duration of the symptoms complex. In acute stress disorder, three days to one month after experiencing the trauma.
	/	Anxiety disorders and obsessive-compulsive disorders Recurring thoughts that do not fit the definition of obsession occur. Thoughts are not involved with trauma exposure and are usually accompanied by compulsions. Other criteria for PTSD and acute stress disorder are not met. Generalized anxiety disorders (avoidance, irritability, anxiety), panic disorders (agitation, dissociative symptoms), separation symptoms of anxiety disorder (related to separation from home or family) are not associated with the experience of trauma.
	/	Major depressive disorder When depression occurs after trauma and the PTSD criteria B, C, D, and E are not met.
	/	Personality disorders Interpersonal problems are absent regardless of the experience of the trauma.
	/	Dissociative disorders When PTSD coexists with dissociative amnesia, with dissociative identity disorders and depersonalization/derealization disorders, the subtype of PTSD with dissociative symptoms should be diagnosed.
	/	Conversion disorders (disorders with functional neurological symptoms) New somatic symptoms after experiencing trauma indicate a diagnosis of PTSD.

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Post-traumatic stress disorder	/	Psychotic disorders Flashbacks should be distinguished from delusions, hallucinations and other perceptual disturbances found in schizophrenia and other psychotic, depressive and bipolar disorders with psychotic symptoms, delirium, intoxication-induced disorders, psychosis in other medical conditions.
	/	Traumatic brain injury The experience of a psychological traumatic event accompanied by a traumatic brain injury (TBI) may result in PTSD symptoms and neurocognitive disorders, therefore the diagnoses are not mutually exclusive. The differentiation of TBI and PTSD is based on the identification of the characteristic symptoms: disorientation and confusion in traumatic brain injury and reliving and avoiding in post-traumatic stress disorder.

Source: based on DSM-5 [5].

The features confirming the diagnosis of post-traumatic stress disorder include developmental regression, delusional beliefs, auditory pseudo-hallucinations, disturbances in emotional regulation, difficulties in keeping constant relationships with other people, dissociative symptoms, coexistence of prolonged grief after the death of a close person [5].

The important stage of the diagnostic process, preceding recommendation of psychological or pharmacological treatment, is conducting a detailed assessment of mental state of the patient and identification of specific symptoms. This is necessary in order to tailor the treatment to the individual needs of the patient. A psychiatrist, general practitioner or clinical psychologist may perform this type of evaluation. The treatment should be implemented if symptoms persist for more than four weeks or are significantly severe [12]. Many individuals exposed to traumatic event experience symptoms specific to PTSD within few days after an accident. However, the diagnosis of PTSD is considered only if symptoms last more than one month and cause significant suffering or disturb daily functioning. Many trauma victims develop symptoms within three months after traumatic injury, but they may occur later and often they last for months or years [4].

Trauma includes experiences that constitute a serious physical, emotional or psychological threat to an individual or their loved ones, that are overwhelming and shocking in nature. Although common reaction in people exposed to traumatic stress is the occurrence of post-traumatic psycho-physiological reactions, most of them resolve spontaneously within the first month [13, 14]. The presence of the risk factors, individual mental resilience, personal situation, age, severity of symptoms, duration of disorders, and social support determines whether the symptoms occur. If symptoms of the stress reaction persist, they can meet the criteria of one or more post-traumatic diagnoses, such as acute stress disorder (ASD) or post-traumatic stress disorder (PTSD) [5].

When the PTSD symptoms are mild or last less than one month, it is recommended to use the so-called active monitoring. It bases on careful monitoring of symptoms by the patient, which serves to assess whether the mental state is improving or worsening. This kind of intervention helps to avoid initiation of unnecessary therapeutic procedures,

because two thirds of individuals who developed difficulties after traumatic stress exposure recover within weeks without pharmacological or psychological treatment. If active monitoring is recommended to the patient, a follow-up visit within one month should be arranged [12]. Therefore, it can be assumed that in the first stage of treatment the disorder may be considered as an adjustment disorder that may or may not develop into post-traumatic stress disorder or other stress-related disorders.

PTSD evaluation

The basic and at once required PTSD diagnostic criterion is exposure to a traumatic event [15]. Initial clinical evaluation should answer the following questions:

1. Does the patient have symptoms of PTSD?; and if so, what is the severity of individual symptoms? Do they change over time?
2. What are the other diagnoses in relation to current difficulties? (e.g., substance abuse or personality disorders. They can mask the actual PTSD and the presence of the primary trauma).
3. What contextual geographic, time, social, and political conditions influence the interpretation of traumatizing events from the past. The same person in a different historical period and place may be viewed in quite different ways – as a criminal in some circumstances and as a wounded victim in others [16].

Diagnostic scales

The best diagnostic tool is a structured medical interview. For this purpose, clinicians may use the tools presented in Table 4.

Table 4. **Characteristics of selected clinical structured diagnostic interviews for diagnosing PTSD**

	Items	Test duration	Advantages	Limitations	Age	Psychometric properties
SCID-I-PTSD: Module F, Structured Clinical Interview for DSM-IV-TR) [17–19]	17	20–30 minutes	Polish adaptation available. Allows to reduce the risk of making false positive diagnoses.	Allows to assess only the intensityity of symptoms, not the frequency. Based on DSM-IV. No Polish version for DSM-5 available. Intended for psychologists and psychiatrists.	Adults	Good psychometric properties (except C3 – the inability to reconstruct certain aspects of the traumatic event). Cronbach's alpha (0.90) for the total and 0.69–0.79 for individual scales.
PSS-I-5, PTSD Symptom Scale – Interview [20]	24	15–25 minutes	Allows to make diagnose and determine the intensity of PTSD symptoms. Allows to assess the severity and frequency of symptoms. It can be carried out by any trained person. Based on DSM-5	No Polish version available.	Adults	Very good psychometric properties. Satisfactory internal consistency.
CAPS-5, Clinician Administered PTSD Scale [21]	30	45–60 minutes	Allows to assess 17 PTSD symptoms in terms of frequency and intensity. Based on the DSM-5.	No Polish version available.	Adults, children (CAPS-CA-5),	Very good psychometric properties.

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DIS-IV, Diagnostic Interview Schedule [22, 23]	17	75–150 minutes; 75 minutes in computer testing	Can be used by a trained non-specialist. Computer version available (C-DIS).	Allows to determine the intensity of symptoms only, without assessing their frequency. There is no Polish language version available. Based on DSM-IV.	Adults, Children (PC-DISC v. 3.0)	Poor psychometric properties in PTSD diagnosis.
PTSD-I, Posttraumatic Stress Disorder Interview [24, 25]	20	No data	It has a Polish adaptation. Allows to determine the traumatic event and assess the frequency and intensity of PTSD symptoms in three dimensions: relapse to the traumatic event, avoidance of stimuli related to the event, and excessive arousal. In addition, the period of occurrence of symptoms is determined.	Based on DSM-III.	Adults	Good psychometric properties. Cronbach's alpha = 0.92.
Structured Interview for PTSD (SI-PTSD) [26]	17 + 2	20–30 minutes	Refers to DSM-IV Criteria B, C and D, and survivor guilt and guilt. It allows to assess the severity and frequency of PTSD symptoms.	No Polish adaptation available. Based on DSM-IV.	Adults	Satisfactory reliability. Cronbach's alpha = 0.80–0.94.

For the symptomatic assessment of PTSD, self-report methods are also used, the usefulness of which results from time saving, low cost and ease of use. Table 5 presents the selected self-report diagnostic methods.

Table 5. **Characteristics of selected self-report diagnostic tools**

	Items	Test duration	Capabilities	Limitations	Age	Psychometric properties
PTSD-Checklist (PCL-5) [27–29]	20	<10 minutes	It has a Polish adaptation. Allows to assess the severity of symptoms on four scales: intrusion, avoidance, negative changes in cognitive and emotional processes, and arousal and reactivity. It can be used in clinical practice in differential diagnosis. Has a cutoff point (≥33). Based on DSM-5.	Useful for screening or making an initial diagnosis of PTSD. A psychometric diagnosis requires confirmation by clinical examination.	Adults	Good psychometric properties. Very good reliability of the Polish version. The Cronbach's alpha for the whole scale = 0.96, and test-retest = 0.89.
Civilian Mississippi PTSD Scale (M-PTSD Civilian) [30]	35	10–15minutes	It has a Polish adaptation. Allows to assess the severity of PTSD symptoms: re-experiencing the traumatic event, avoidance, emotional numbness, and over-arousal. Additionally, accompanying symptoms are assessed: depression, suicidal tendencies, sense of guilt.	Based on DSM-III.	Adults	Satisfactory reliability and validity of the Polish version.
Questionnaire for the Measurement of Posttraumatic Stress Disorder (K-PTSD) [24]	17	No data	It has the Polish original version. Allows to diagnose and determine the severity of symptoms in large groups of people exposed to trauma with high probability in a short time and with little resources. Enables the assessment of PTSD in three groups of symptoms: recurrence, avoidance and arousal, and the overall score.	The questionnaire cannot replace a clinical diagnosis. Based on DSM-IV.	Adults	Satisfactory psychometric properties. Internal consistency coefficients for individual subscales are as follows: Recurrence = 0.78; Avoidance = 0.74; Agitation = 0.87. High internal consistency. Cronbach's alpha = 0.90.

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The factorial version of the PTSD Inventory (PTSD-F) [31, 32]	30	No data	It has a Polish language version. Allows to assess the severity of symptoms on the scale of intrusion/agitation, avoidance/numbness and the general scale of PTSD. The scale can be used in the diagnosis and therapy of post-traumatic disorders. It can be used at various stages after the traumatic event. The method was created based on national data relating to Polish reality.	Based on the DSM-IV.	Adults	Good psychometric properties. High validity of the scale. High Cronbach's alpha: general scale from 0.93 to 0.96, intrusion/arousal scale from 0.92 to 0.96, and avoidance/numbness scale from 0.88 to 0.92.
The clinical version of the PTSD Inventory (PTSD-C) [33]	40	No data	It has a Polish language version. Includes not only the 17 basic symptoms of PTSD, but also some of their consequences (category F): psychosomatic disorders, personality changes and specific ways of coping with stress after trauma. It assesses the severity and frequency of symptoms. It allows the assessment of the clinical severity of PTSD both in the period shorter than six months after the trauma and after a longer period. The flexibility of the procedure for using the questionnaire gives many possibilities to choose the diagnostic version and use it depending on the purpose of the study.	In groups with higher PTSD risk, there is lower diagnostic efficiency, i.e., the risk of false negative diagnoses. A questionnaire survey requires an individual psychiatric diagnosis. Based on DSM-IV.	Adults	Satisfactory reliability and validity.
Self-Rating Scale for PTSD (SRS-PTSD) [25, 34, 35]	22	No data	Assesses 17 PTSD symptoms on three dimensions: intrusion, hyperarousal and avoidance. Allows to assess the intensity and frequency of PTSD symptoms.	No Polish adaptation available. Based on DSM-IV.	Adults	Good reliability, high sensitivity (86%) and specificity (80%) compared to a structured clinical interview assessing PTSD.

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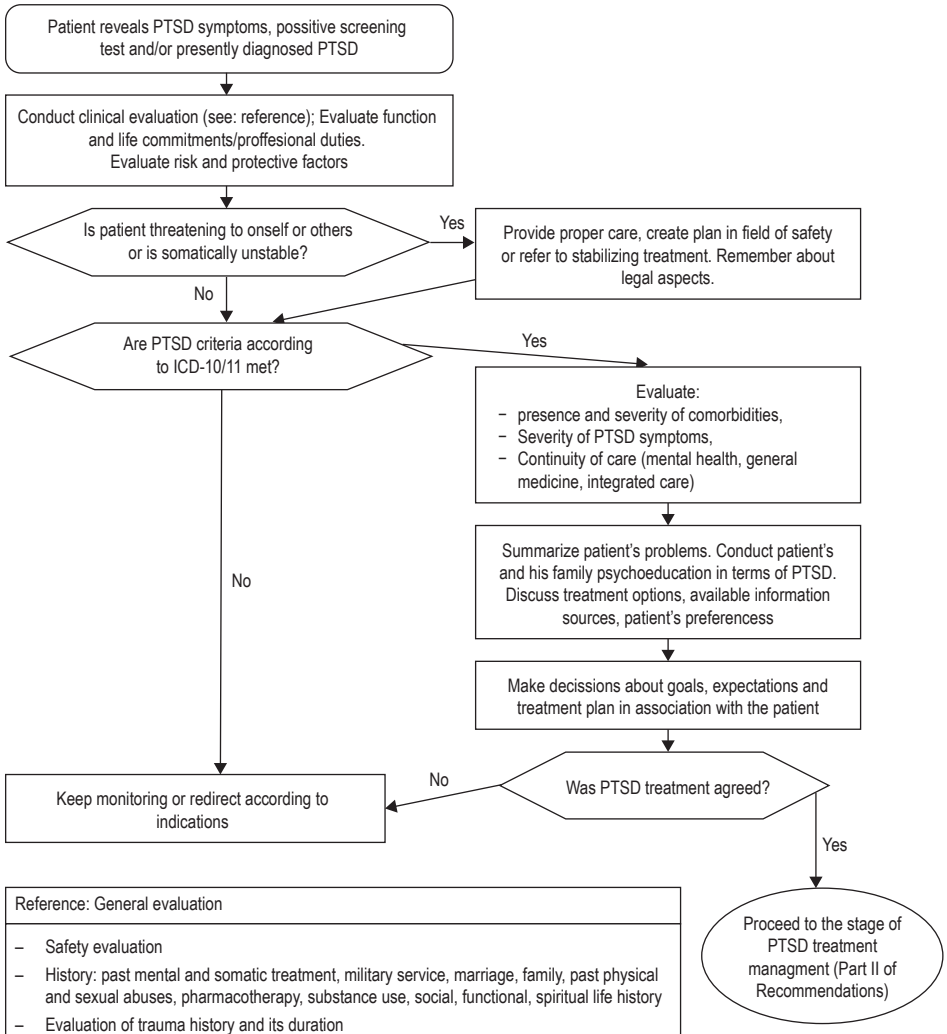
DTS, Davidson Trauma Scale [36–38]	17	10 minutes	Allows to assess the intensity and frequency of symptoms on four dimensions of PTSD: startle, physiological arousal, anxiety, and numbness.	No Polish adaptation available. Based on DSM-IV.	Adults	Very good psychometric properties. Cronbach's alpha = 0.97–0.99 for frequency, intensity and overall score. Test-retest reliability = 0.86.
IES, Impact of Event Scale and IES-R, Impact of Event Scale-Revised [39–41]	22	<10 minutes	It has a Polish adaptation. Assesses three dimensions of PTSD: intrusion, avoidance and arousal. It can be used by psychologists, psychiatrists and other specialists dealing with stress, health promotion, health education, prevention, and therapy.	Allows to determine the intensity of individual symptoms over the last seven days, without assessing their frequency. Limited clinical use. It can be used to monitor changes in the severity of symptoms. Clinical use requires great care. It does not allow to make a diagnosis. Based on DSM-IV.	Adults	Satisfactory reliability. Cronbach's alpha = 0.92 for the whole scale, 0.89 for the Intrusion scale, 0.85 for Arousal, and 0.78 for Avoidance.

The diagnostic process of PTSD may include neuropsychological examinations, in which patients exhibit reduced visual-spatial function and verbal memory scores. Mental disorders associated with PTSD may exacerbate cognitive dysfunctions. On the other hand, neuroimaging diagnostic indicates the dominance of the activity of the subcortical areas over the brain cortical activity [42].

In the diagnostic and therapeutic process of stress-related disorders, the basis of the doctor-patient relationship is the appropriate attitude of healthcare specialist. Therapeutic contact with a trauma victim dealing with negative emotions and emotional conflict states, requires the creation of a full acceptance atmosphere, which allows to return to traumatic experiences. Recalling dramatic memories is difficult, also because of fear of stigmatization and victimization on the part of a specialist. Therefore, it is extremely important to accept the patient's history without prejudice even when it is difficult and aggravating [16]. The diagnostic process is shown on graph on page 695.

Psychological differential diagnosis

The differential psychological diagnosis of post-traumatic stress disorder complements the medical diagnosis in the ICD-11 and DSM-5 diagnostic categories. Characteristics of psychological indicators (emotional, cognitive distortions and behavioral) in different stages of post-traumatic stress are not mutually exclusive and may significantly complement the medical diagnosis and be of great importance for the directions of therapeutic proceedings.



Graph. **Evaluation and diagnosis of post-traumatic stress disorders [43]**

Table 6. **The psychological differential diagnosis and directions of therapeutic procedures**

Stage of post-traumatic stress	Psychological indicators	Purpose and directions of therapeutic procedures
Acute post-traumatic stress The shock phase: stupor, flight or denial of the situation – or increased activity and a specific struggle: taking action to combat traumatic event – at the expense of other physiological and psychological functions, often leads to the exhaustion of the body.	Excessive emotional tension, horror, fear, strong anxiety for one's or relative's life, reactions with disproportionate anxiety and alert sleep, excessive sensitivity or excessive indifference to stimuli from the environment and the organism. Somatic symptoms: excessive psycho-physiological agitation of the autonomic nervous system, somatic symptoms, often pain and suffering present. Impulsive behavior and distrust, suspicion, helplessness, also verbal aggression in interpersonal contacts.	1. First assessment of the life threat and the current situation as well as the level of deprivation of the sense of security – mainly emotional and instrumental support, other in the indicated direction. 2. Medical consultation, pharmacotherapy 3. Next – psychological consultation Psychoeducation for families, individuals and professionals towards emphasizing the importance of the principle of normalizing a crisis situation (the presented emotions, thoughts and behaviors of a person are normal, similar to those in people in situations of strong stress and life-threatening conditions)
Chronic stress (PTSD)	Psychological diagnosis a. experienced emotions (from emotional numbness, horror to anxiety in the form of seizures, constant anxiety, depression, apathy, helplessness, etc.) b. cognitive distortions (especially perception and thinking mistakes: narrowing the perception to stimuli associated with a traumatic event, perceiving oneself as helpless and powerless, anxiety-generating and pessimistic thinking dominates in explaining events; so-called dichotomous thinking (black and white)/understanding reality and catastrophizing, memory disorders, attention disorders. c. diagnosis of the specificity of an individual's behavior (avoidance, aggressive behavior, isolating oneself from other people, or aggressive behavior, distrust, suspicion towards others).	1. Medical consultations – assessment of the psycho-physical condition and determination of pharmacotherapy continuation 2. Psychological crisis intervention depending on the needs and severity of one's disorders in terms of emotional and cognitive functioning and exposed behaviors. Cognitive behavioral therapy directed to reduction of the symptoms and post-traumatic stress mechanisms. 3. Support provided to the individual and his/her family depends on their needs. 4. Psychoeducation for the family and the individual. Still the principle of normalization, ensuring a sense of security.

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Complex post-traumatic stress disorders Underlying personal conditions, such as sexual trauma or physical abasements experience.	Clinical psychological diagnosis related to experienced specific disorders of the personality structure: specific psychological mechanisms, emotions, and cognitive distortions (especially thinking mistakes) and diagnosis of self-destructive behaviors, substance abuse, depression associated with self-mutilating behaviors (eating disorders, sleep disorders and other somatic disorders).	Specialist psychological treatment and psychotherapy focused on changes in personality structure and features.

Source: based on [44].

Patterns of maladjustment in PTSD

Individuals suffering from PTSD may expose specific patterns of maladjustment, which may provide additional diagnostic clues. Patterns of maladjustment include:

(1) faced with almost certain death;
(2) survivor guilt;
(3) desensitization;
(4) alienation;
(5) emotional confusion.

Ad. (1) Exposure to traumatic experience breaks down the sense of one's indestructibility, which is replaced by anger and rage at one's own mortality. The line between life and dying is blurred. The feeling of being dead appears, which is accompanied by the hunt for intense sensations, which may result in conflicts with the law, environment and with relatives.

Ad. (2) People after experiencing trauma experience many forms of guilt associated with, e.g., surviving, not supplying enough help to victims, being not brave enough or feeling of not deserving the possibility of signaling one's own suffering in the situation of staying alive.

Ad. (3) The consequence of trauma may be desensitization to unacceptable accidents, which may result in a clear calm, which is lined with a constant readiness to violence, and at the same time a strong fear. These oppositional emotional states cause enmity, defensive, anxious, and depressive reactions and an anxious mood

Ad. (4) Experience of trauma causes emotional isolation and loosing of trust to other people, who appear incomprehensible and false. Additional exposure to secondary victimization from social or healthcare workers causes increase of alienation and resignation from help and social support.

Ad. (5) The last pattern is the inability to rearrange one's life caused by incapability of finding life's sense [16].

Other stress-related disorders

Optional diagnoses, which should be considered in people after traumatic experience caused by exposure to war, displacement or various forms of violence are not limited to PTSD, although they may lead to it in the long term. These include those listed below.

Prolonged grief disorder

Prolonged grief disorder is a disorder in which, after the death of a partner, parent, child, or other close person, the bereaved person experiences a persistent and ubiquitous mourning reaction characterized by longing for the deceased or persistent preoccupation with the deceased, accompanied by intense emotional pain (e.g., sadness, guilt, anger, denial, difficulty in accepting death, feeling of losing the part of oneself, inability to experience a positive mood, emotional numbness, difficulty in engaging oneself in social or other activity). The grief response persists for an unusually long time after loss (at least over 6 months) and visibly exceeds the expected social, cultural or religious norms for the culture and context of the individual. Grief responses that persist over an extended period and fit within the normative bereavement period, considering the individual's cultural and religious context, are viewed as normal bereavement responses, and are not assigned as diagnosis. The disorder causes significant deterioration of personal, family, social, educational, professional, or other key areas of functioning.

Adjustment disorder

Adjustment disorder is a maladaptive reaction to an identifiable psycho-social stressor or multiple stressors (e.g., divorce, illness or disability, socioeconomic problems, home or work conflicts) that usually occur within one month of the stress onset. The disorder is characterized by preoccupation with the stressor or its consequences, including excessive sorrow, recurrent and distressing thoughts about the stressor or constant thinking about its consequences, also failure to adapt to the stressor, resulting in significant deterioration of personal, family, social, educational, professional, or other key areas of functioning. Symptoms are not better explained by another mental disorder (e.g., affective disorder, another disorder especially related to stress) and usually resolve within 6 months, unless the stressor persists for an extended period.

Reactive attachment disorder

Reactive attachment disorder is characterized by significantly inappropriate attachment behaviors in early childhood, in the context of grossly inadequate childcare (e.g., severe neglect, abuse, institutional deprivation). Even if the main caregiver is recently available the child does not turn to him/her for comfort, support and upbring-

ing, rarely exhibits safety-seeking behavior with any adult, and is unresponsive when offered comfort.

Disinhibited social engagement disorder

Disinhibited social engagement disorder is characterized by grossly abnormal social behaviors, occurring in the context of grossly inappropriate childcare (e.g., severe neglect, institutional deprivation). A child treats adults uncritically, lacks restraint in approach, walks away with unknown adults and shows excessively familiar behavior towards strangers. Similar to reactive attachment disorder, disinhibited social engagement disorder can be diagnosed only in children and features of this disorder are developed within the first five years of live. However, the disorder cannot be diagnosed before the age of one (or developmental age under nine months), when the ability for selective attachment may not be fully developed or in the context of autism spectrum disorders [5].

Recommendations for taking care of own mental health by specialists

Therapeutic help for people suffering from disorders caused by trauma experience is a difficult, demanding and mentally burdensome task. Even in experienced medics, psychologists and psychotherapists exposure to trauma may cause strong emotional states in the form of anxiety, anger, fear, and even horror or despair. To be able to work with patients with disorders caused by traumatic stress, it is necessary to develop and increase tolerance to patients' psychical suffering. To do this, the doctor must accept the legitimacy of the treatment, during which the patient comes back to the memories that cause suffering. And just like the patient, the specialist needs to understand that painful memories cannot hurt again as much as the original trauma, and that anxiety does not last forever.

The important form of specialist support is participation in supervisions, which may be performed by a person who has expert qualification to this role or have friendly form [45]. The purposes of supervision are creating a safe space in which the specialist receives emotional support, gives to consideration his/her own work with the patient and his/her reaction and emotions, conceptualizes the conducted cases, and plans further activities in treatment process. Supervision may reduce fear, shame and uncertainty of own competences. It supports professional and emotional development and increases specialist's competences [46].

The World Health Organization has recommended guidelines for health professionals to protect form chronic stress. They include:

- regular monitoring of mental state;
- taking care of effective communication;
- maintaining the right proportions between work and rest time;
- the possibility to freely express concerns and ask questions;
- mutual friendly support;

– access to mental health and psychological first aid, both at work and outside [47].

Recapitulation

The experience of trauma and its impact on mental state are often hidden or marginalized by patients due to the specificity of the disorder itself, which is accompanied by a sense of shame, anxiety and depression, memory and other cognitive disorders, and often co-occurring physical injuries. From a clinical perspective, prompt and correct diagnostic procedures for the presence of traumatic stress disorders are necessary due to the substantial risk of consequential mental disorders and even suicide [48]. During the examination, the clinician's task is to create safe conditions of contact. The diagnostic procedure itself does not pose a threat, does not trigger an alarm response and modulation of the hypothalamic-pituitary-adrenal (HPA) axis, or changes in psychological function, even in people with severe post-traumatic stress disorder, e.g., in survivors of torture [49].

Around the world, recommendations for the diagnosis and treatment of PTSD are periodically formulated by key opinion-forming institutions, such as the American Psychological Association (APA) [50], International Society for Traumatic Stress Study of (ISTSS) [51], National Institute for Health and Care Excellence (NICE) [52], Phoenix Australia Centre for Posttraumatic Mental Health [53], and the U.S. Department of Veterans Affairs [54]. Individual recommendations supply a rich resource of varying form and criteria for the selection of scientific studies forming the evidence base [55].

The recommendations presented in this publication, developed by the expert working group, are aimed at drawing the attention of clinicians to the importance of proper differentiation of disorders associated with traumatic stress, diagnostic procedures based on the use of reliable measurement methods, implementation of proper clinical assessment procedures, and building an empathic and safe environment.

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