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Psychiatric Diseases Caused by a Traumatic Event

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Introduction

Post-traumatic psychiatric disorders have been there since antiquity and are still classified today. Psychotraumatology has grown into a full-fledged specialty with neurobiological, psychological, and socio-anthropological ramifications. Although "post-traumatic stress disorder" (PTSD) is the most well-known of the chronic post-traumatic psychiatric diseases, there are a wide range of them. Expert assessments of psychological injury require a comprehensive description of posttraumatic symptoms, and psychotherapeutic and pharmaceutical choices must be tailored to each clinical entity [1].

Based on our own clinical expertise and the international literature, we propose clinical descriptions for existing post-traumatic symptoms and syndromes through a brief nosography. We explain post-traumatic psychotic, mood, and anxiety disorders after presenting clinical descriptions of psychological trauma, the immediate clinical response, and the cardinal persistent symptoms [2]. The impact of trauma on instinctive functions, conduct disorders, personality changes, and adjustment difficulties in professional and personal life is then described, followed by an overview of somatoform expressions, psychosomatic and somatic sequelae (including brain injury consequences if associated), and finally, the impact of trauma on instinctive functions, conduct disorders, personality changes, and adjustment difficulties in professional and personal life.

Description

Traumatic occurrence

Although a person may be exposed to multiple traumas throughout the course of his or her life, we will concentrate on the clinical repercussions of a single psychological trauma in adulthood. A sudden and direct contact with death or its equivalents is regarded as a potentially traumatic occurrence. An instantaneous subjective sensation of traumatic and peritraumatic distress, characterised by negative emotions of anxiety, helplessness, revulsion, and/or terror, is defined as a traumatic occurrence. Traumatic and peritraumatic dissociation is characterised by a loss of consciousness, changes in temporospatial perception, derealization, depersonalization, automated motor behaviour, and partial or complete dissociative amnesia as a result of the traumatic incident [3].

Post-traumatic symptoms

We give definitions and instances of post-traumatic clinical manifestations without attempting to reinterpret every illness reported in the literature. Negative thoughts or feelings about oneself or the world, decreased interest in activities, feelings of isolation, and trouble experiencing positive affect are all newly addressed depressive symptoms in the DSM-5 as a PTSD criterion. The reasons and repercussions of the trauma are the subject of morbid ruminations, which are generally fatalistic and dominated by feelings of humiliation, abandonment, and remorse [4]. Culpability is especially strong for survivors who had to flee from danger or who blame themselves for their role in the tragedy. Pessimistic reflections taint connections to the world and others: the impossibility of managing one's own destiny, the lack of meaning in life, and so forth. A lack of faith in human nature endures, as does the belief that others are incapable of comprehending severe pain. It's common to withdraw within oneself and limit one's social activities [5,6].

During and immediately after a traumatic occurrence, intense anxiety is common. Later, anxiety is associated with re-experiencing events, hyper-arousal heightens anxious response, and avoidance techniques heighten anticipatory worry. Agoraphobia is more common when a traumatic occurrence occurs in a public setting, such as a market or on public transportation, when an individual may also have specific phobias.

This clinical entity is characterised by a sense of invulnerability, with the person blaming himself or herself for the traumatic experience and its repercussions. Several features of psychological trauma might trigger latent schizophrenia: fragmentation anxiety after witnessing amputation, fear of being devoured after witnessing anthropophagy, and annihilation anxiety after watching total destruction.

Conclusion

Patients frequently conceal or minimise traumatic events and their repercussions for reasons related to the condition. Rather than only recognising the most well-known symptoms, the practitioner must look for various posttraumatic psychic diseases. We used a rational and didactic taxonomy to describe the landscape of post-traumatic disorders in this study. Although a nomenclature is useful for semeiological descriptions and professional assessments, a comprehensive examination of the patient's overall psychological functioning is also required.

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Conflict of Interest

There are no conflicts of interest by author.

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