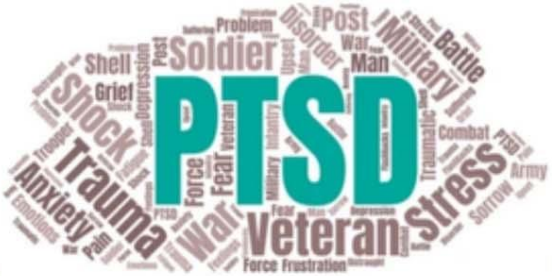


Speaker-

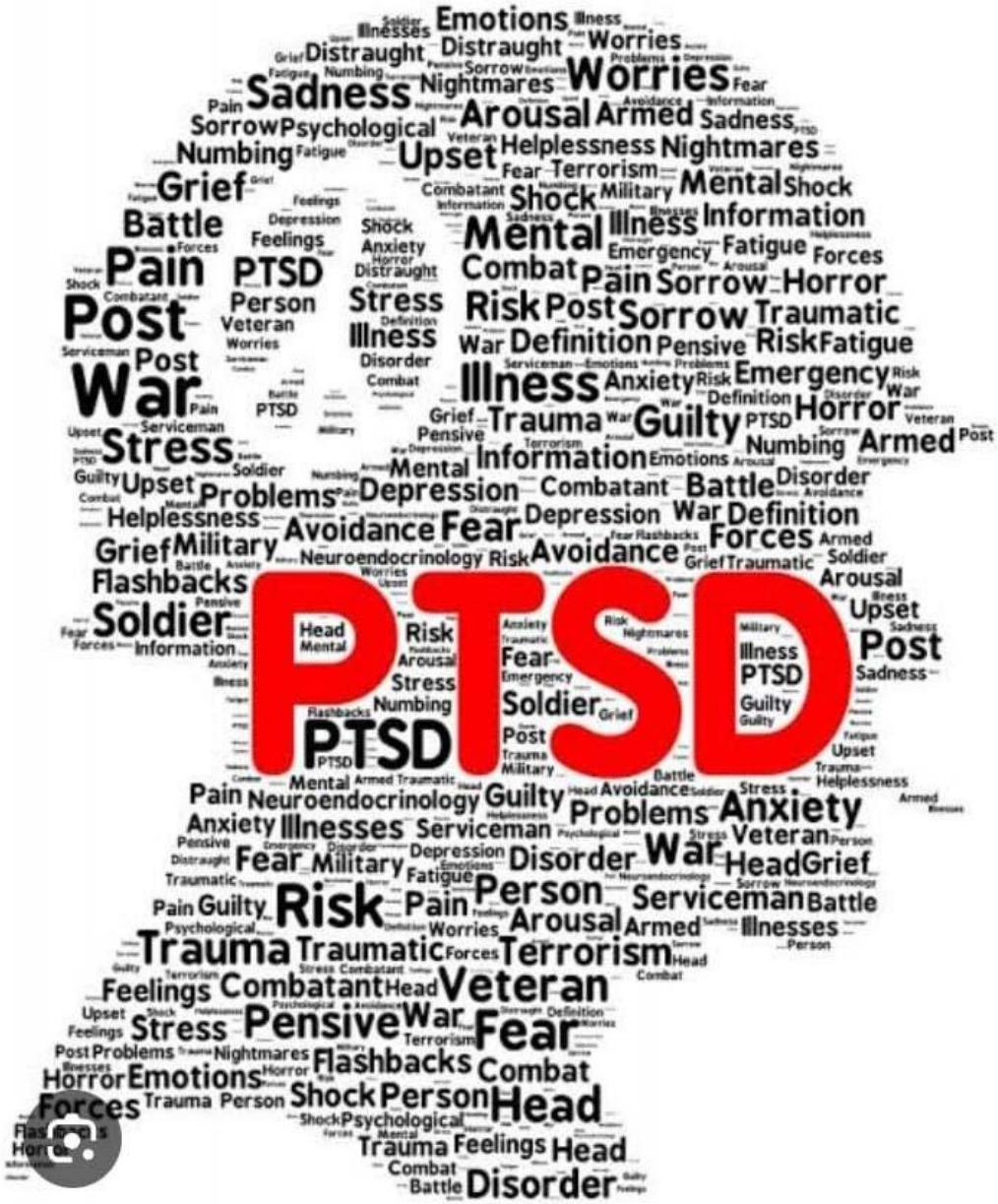
Dr. Mahjabeen Aftab Solaiman
Assistant Professor
Department of psychiatry
Ad-din women's medical college & hospital

24 September 2024

TUESDAY
Start At 8Am

BARRISTER RAFIQUL HUQ
AUDITORIUM, 6TH FLOOR

Organized by: Medical Education unit, AWMCH


PTSD
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Emotions
Worries
Distraught
Sadness
Nightmares
Arousal
Armed
Psychological
Upset
Helplessness
Terrorism
Numbing
Grief
Shock
Mental
Illness
Information
Battle
Pain
PTSD
Person
Veteran
Stress
Risk
Post
Sorrow
Traumatic
War
Definition
Pensive
Fatigue
Anxiety
Emergency
Horror
Trauma
Guilty
Armed
Problems
Depression
Combatant
Avoidance
Fear
Forces
Flashbacks
Soldier
Neuroendocrinology
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Serviceman
Disorder
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Feelings
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Terrorism
Emotions
Horror
Shock
Person
Head
Disorder

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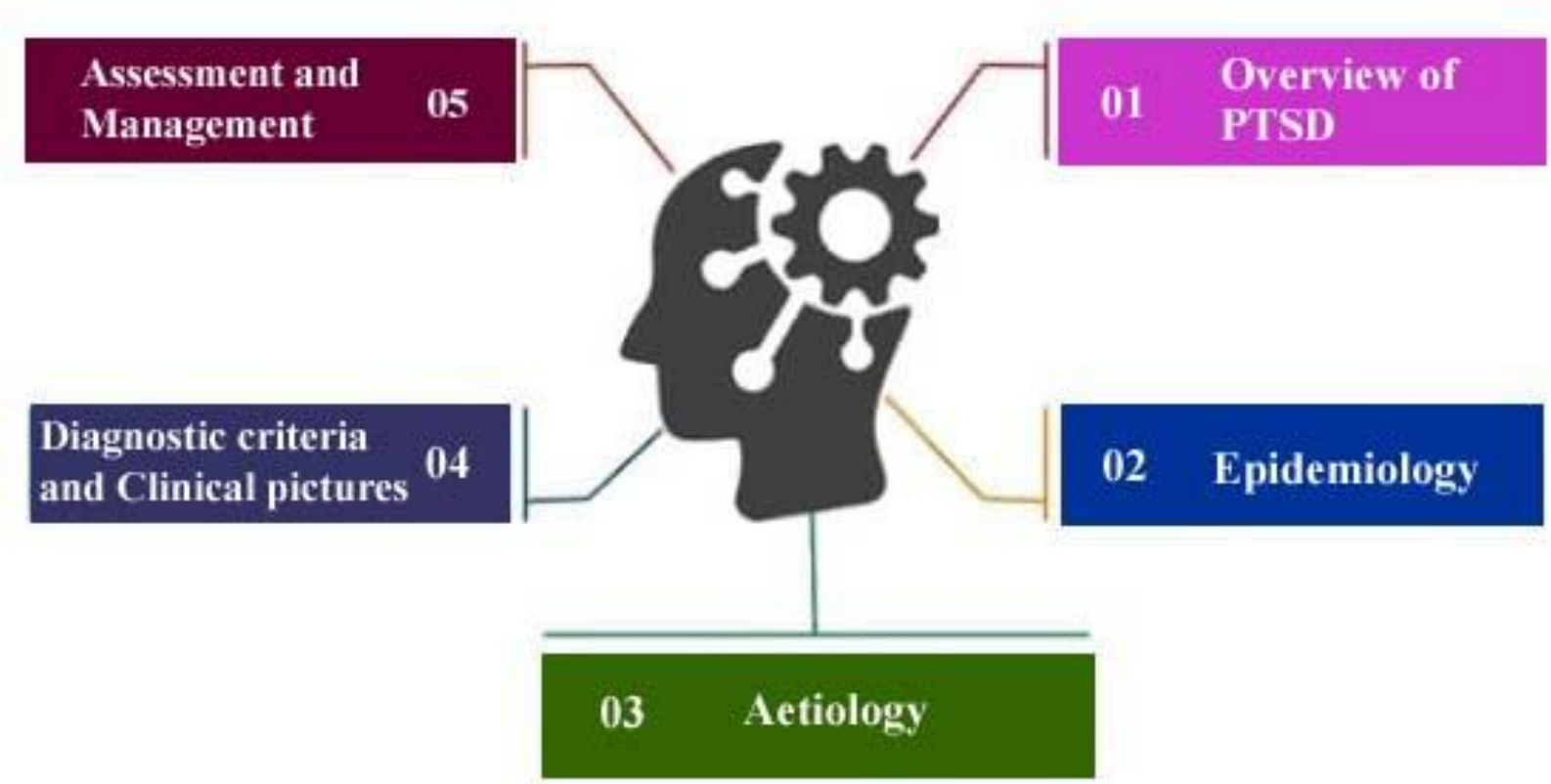
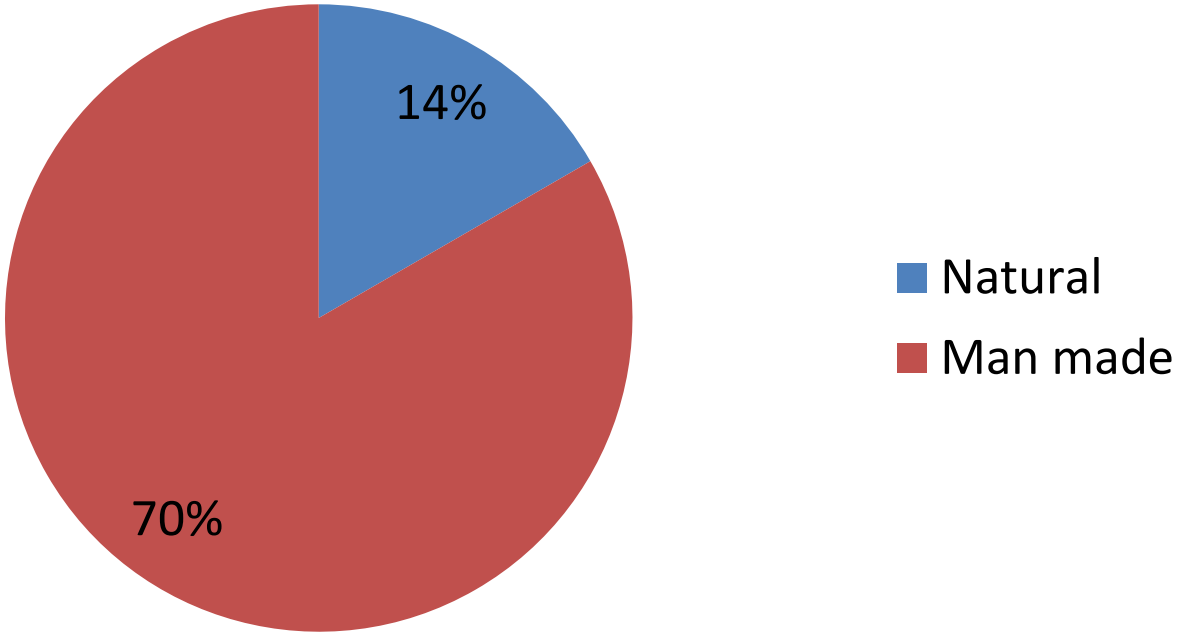


OVERVIEW OF PTSD

Definition

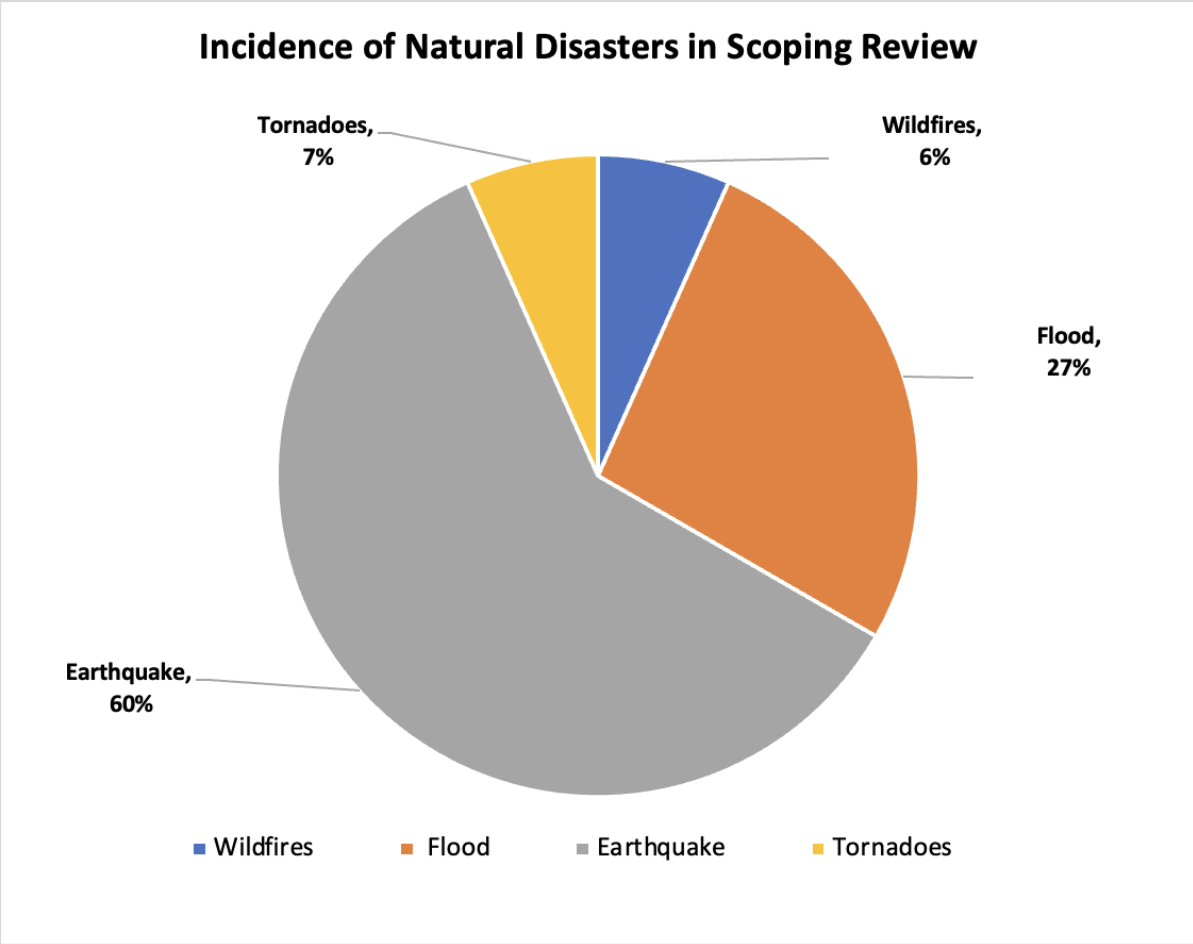
This term denotes a serious debilitating mental ailment that can affect people who have encountered or witnessed and intensely terrifying and stressful experience or life-threatening accident.

Traumatic Events



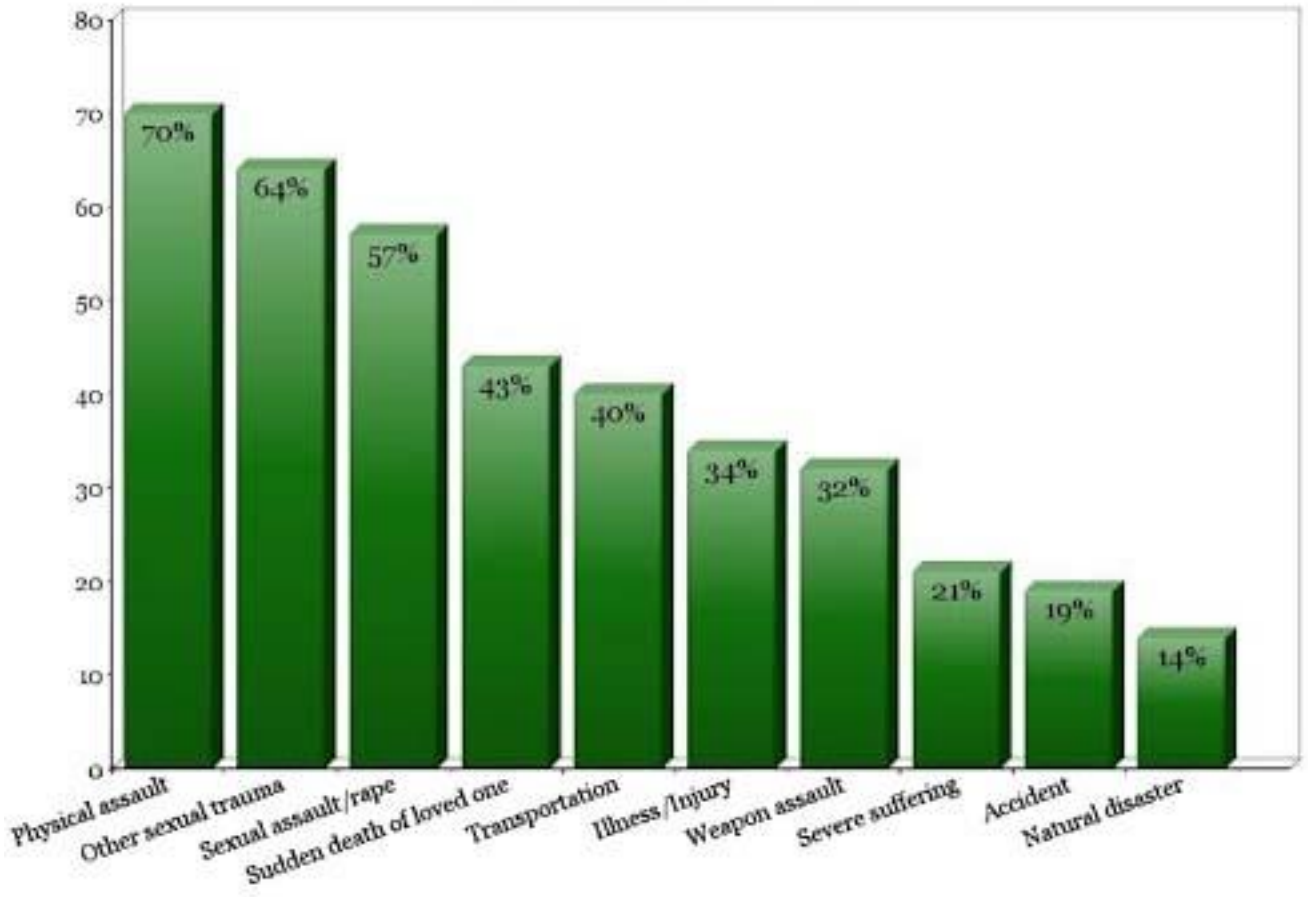
Well-being and post-traumatic stress disorder due to natural and man-made disasters on adults.
Riaz et al., Pakistan Journal of Medical Research, 54(1):25-28, March 2015

Natural Disaster



Scoping Review of PTSD Treatments for Natural Disaster Survivors.
Nanduri A et al., Health Psychology Research, Vol 11, December 2023.

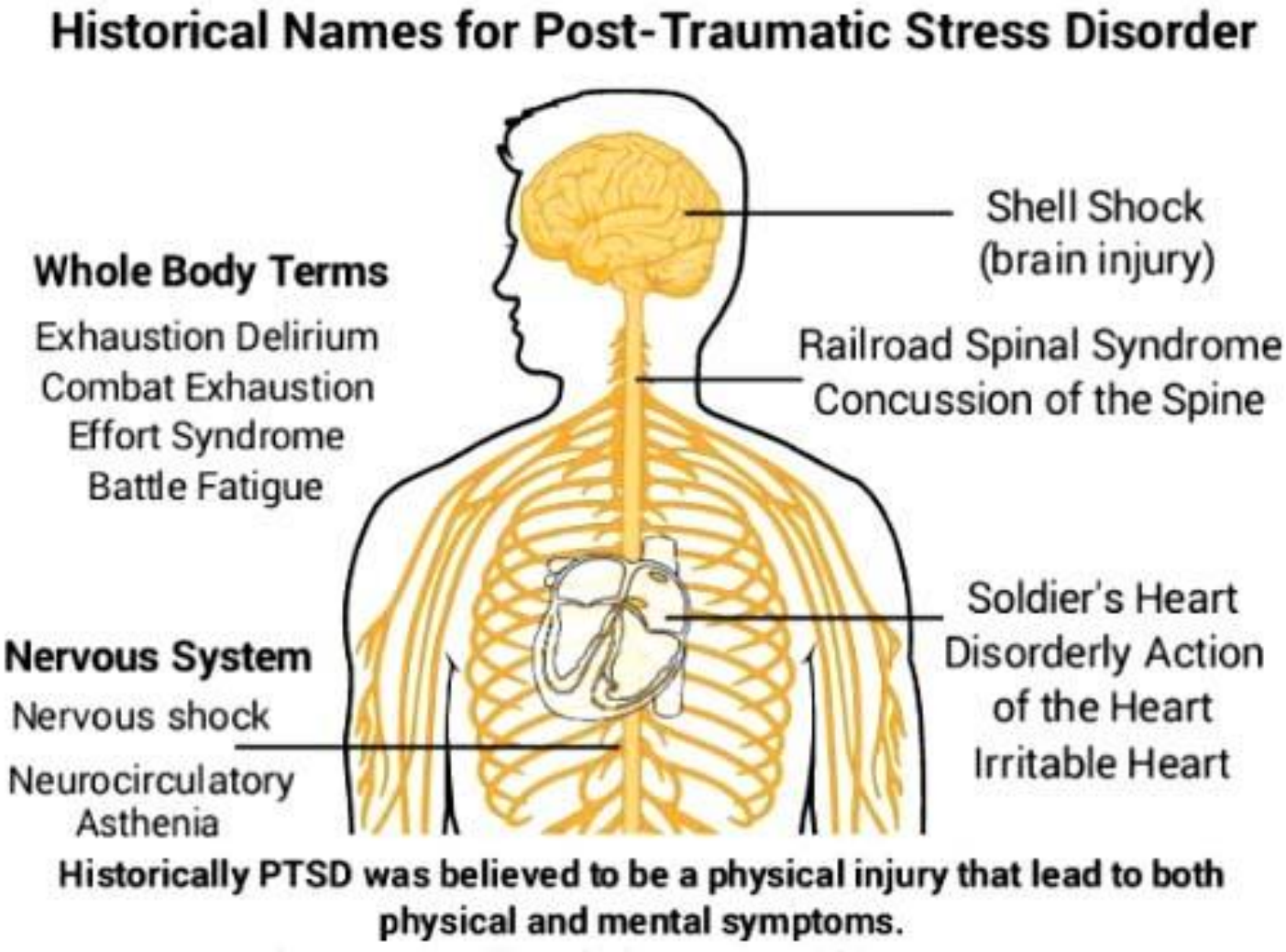
Man made Disaster



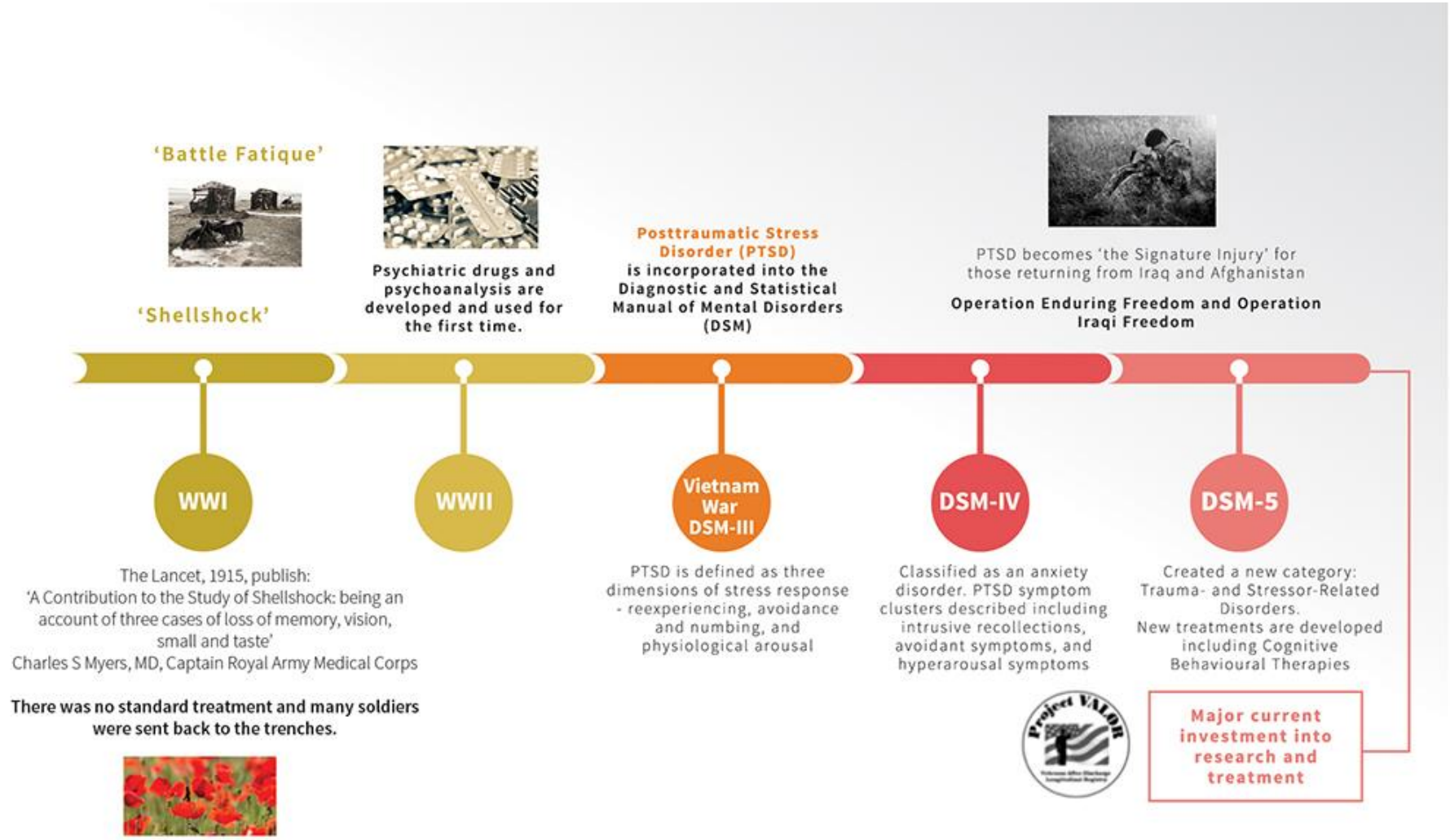
Nineteen types of trauma were surveyed in 244 adults. Military/war was least common, experienced by only 6%.

Spence, et al. (2011). PLoS ONE 6(7): e21864. doi:10.1371/journal.pone.0021864.

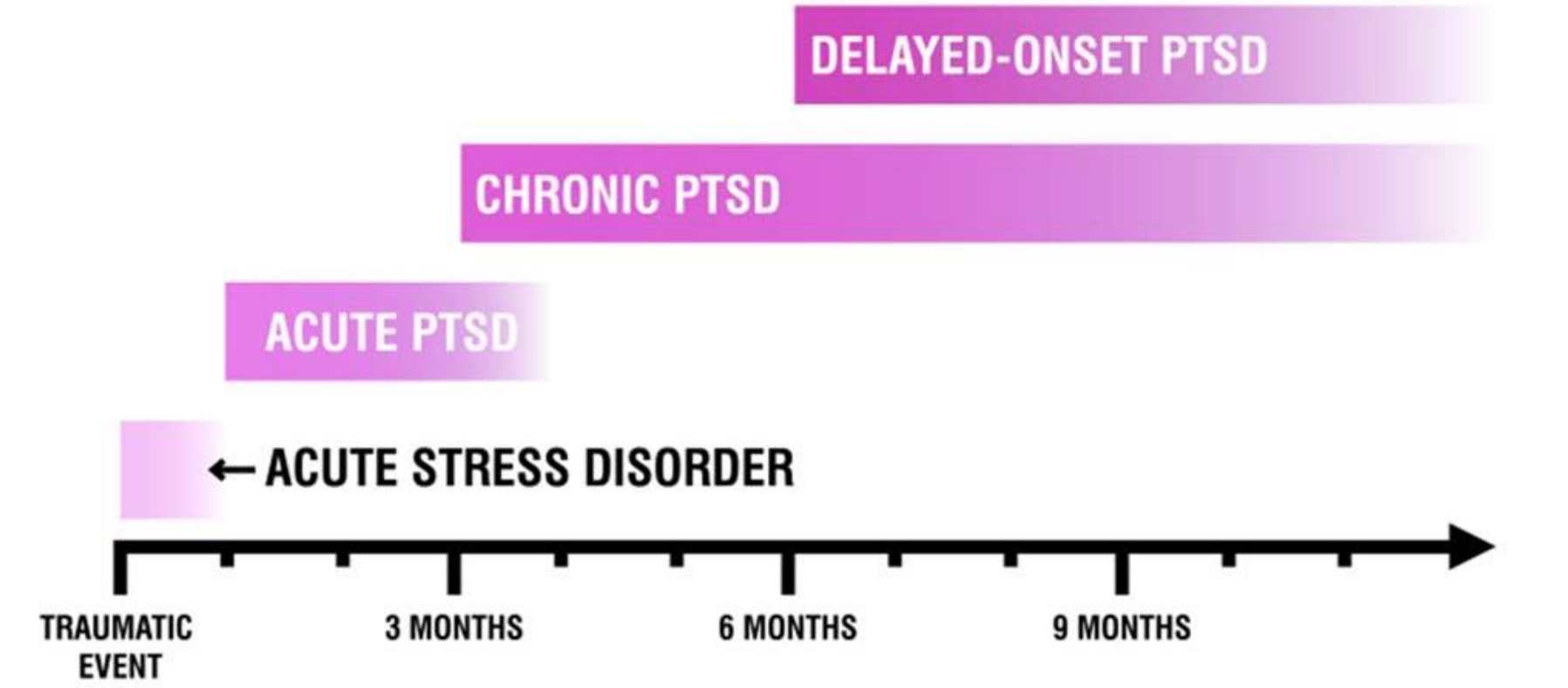
Historical Names for PTSD



Historical Names for PTSD



Onset and Course



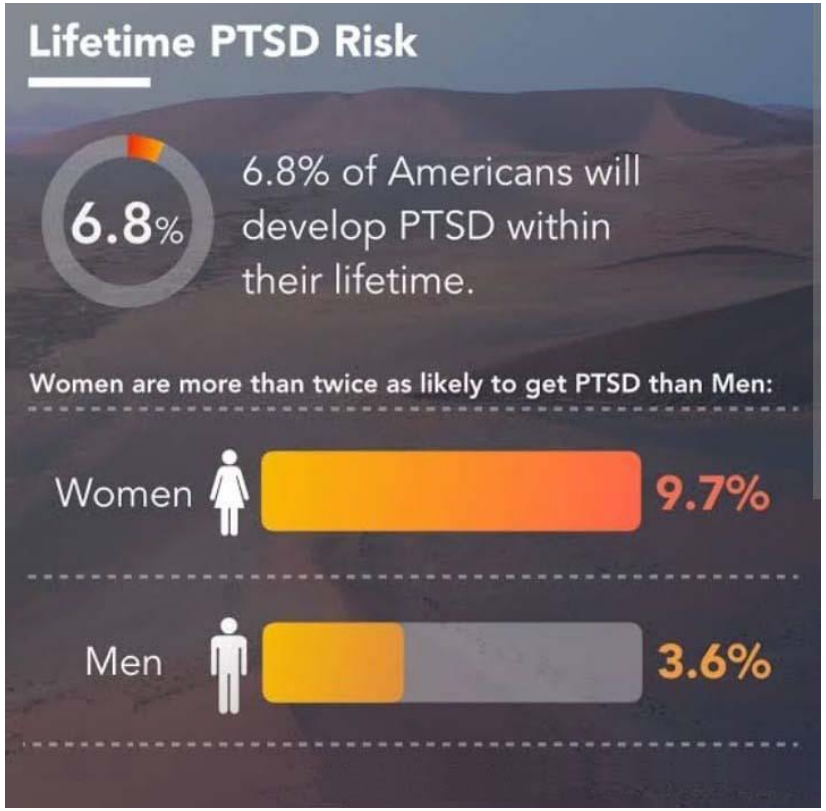
- Regarding the typical course of PTSD one third of the cases remit within three months but about 40% of patients have a chronic course marked by remission and relapses.

[Santingo et al., 2013]

EPIDEMIOLOGY

- Prevalence : An estimated 6% to 9% of world population has experienced PTSD at some points in their lives.

[Sareen, 2014]



- Gender Difference : 10% of women have PTSD sometime in their lives compare to 4% of men.

- Typical age of onset :

  Middle and young adulthood.

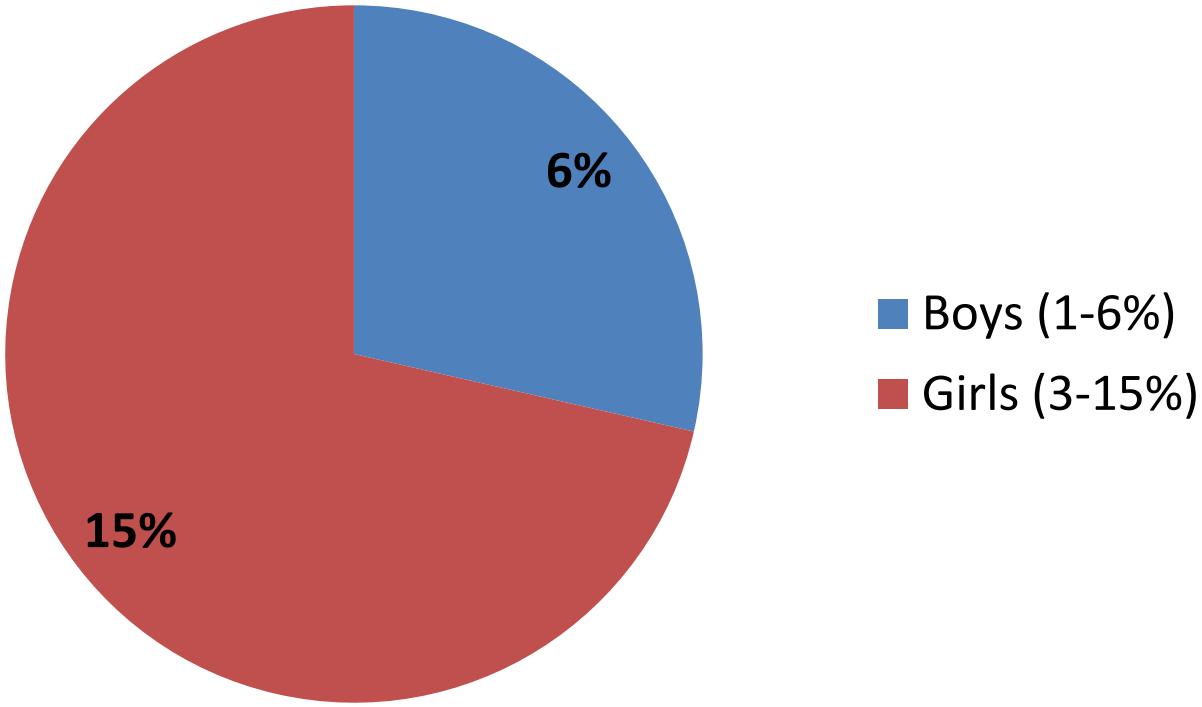
  Median onset age : 23

  Inter quartile range : 15-39

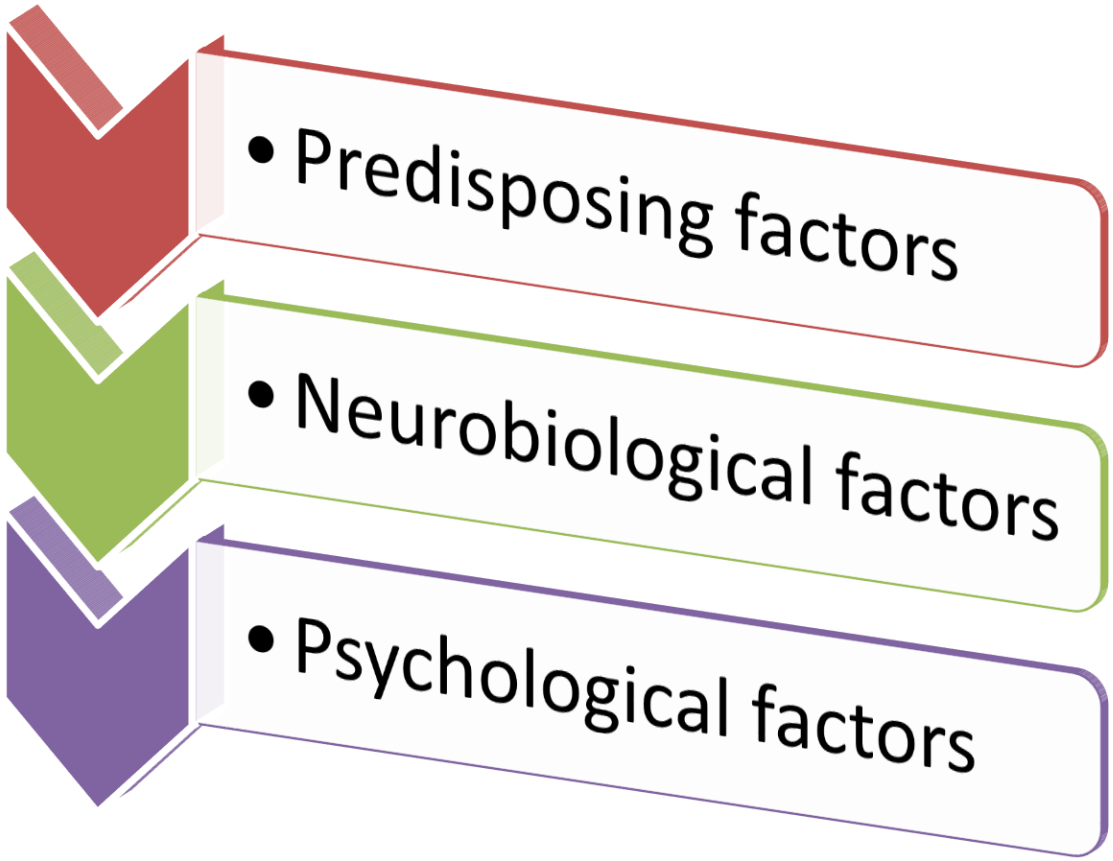
- Age of onset in child and adolescent group :

  6 years.

Prevalence of PTSD in child and adolescent group :



Etiology


• Predisposing factors
• Neurobiological factors
• Psychological factors

Predisposing factors are also called individual factors.

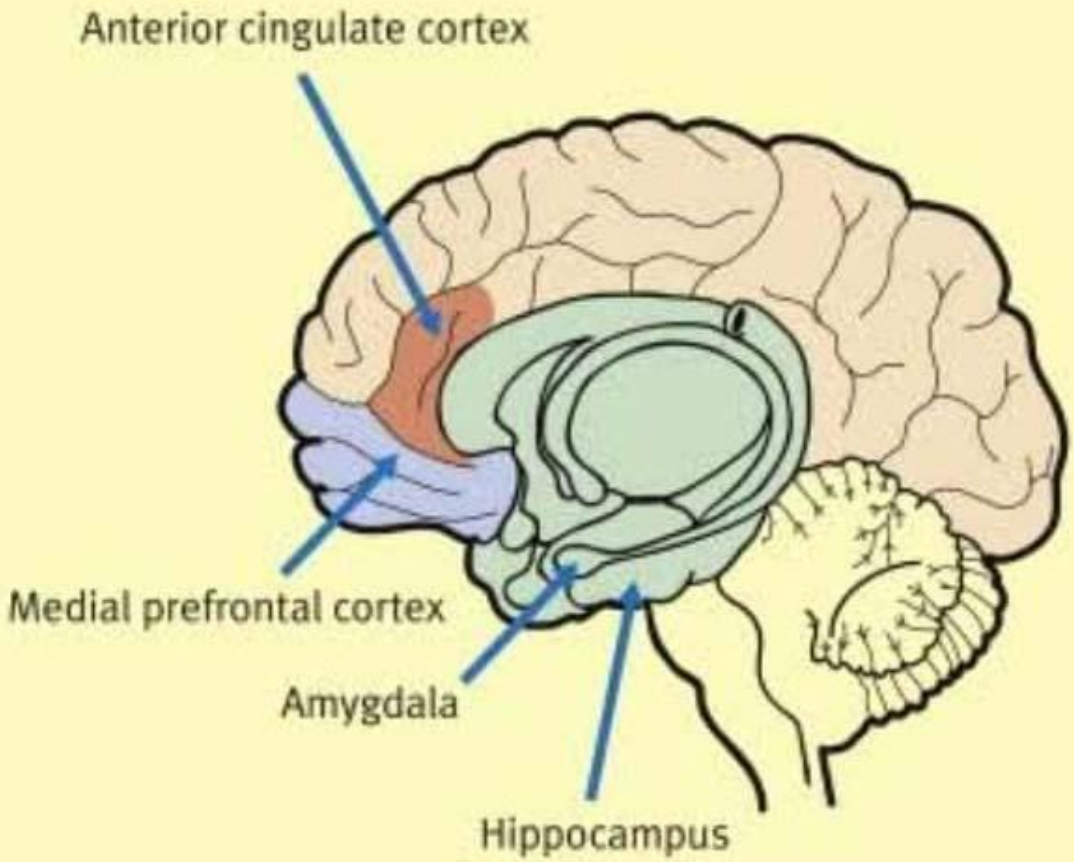
a) Personal history of mood and anxiety disorders
b) Previous history of trauma
c) Female gender
d) Neuroticism personality trait
e) Lower intelligence
f) Lack of social support

[Ahmed et al., 2007]

Neurobiological correlates are associated with

- Monoamine NT
- HPA axis

Brain areas implicated in post-traumatic stress disorder



Psychological factors :

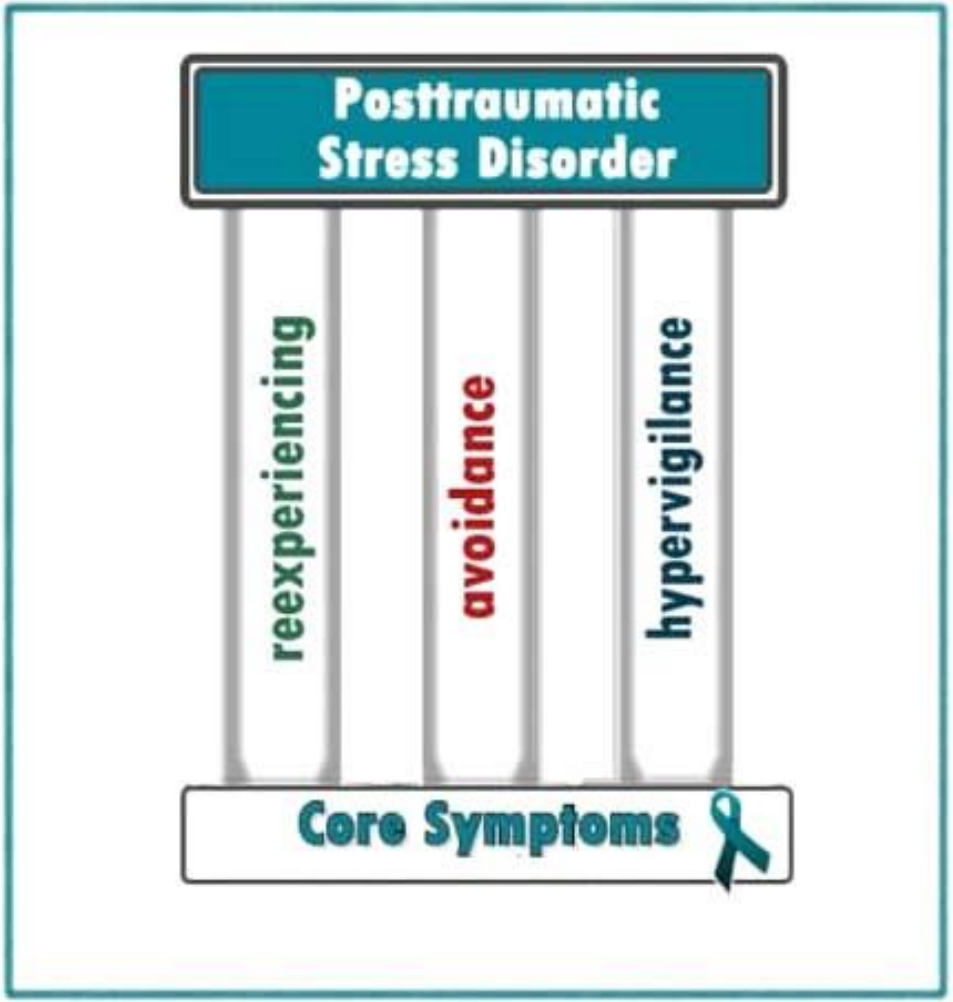
Fear conditioning

Diagnostic criteria
Clinical pictures

DSM-5 criteria for PTSD

Trauma exposure	
Trauma	Actual or threatened violent death, serious injury or accident, or sexual violence
A. Exposure	Via any of the following: 1. Directly exposed to trauma 2. Eyewitness (in person) to others directly exposed to trauma 3. Learning of direct exposure to trauma of a close family member or close friend 4. Repeated or extreme exposure to aversive details of traumatic event (eg, trauma workers viewing human remains or repeatedly exposed to details of child abuse), in person or via work-related electronic media
Symptom groups B to E (symptoms beginning or worsening after the traumatic event)	
B. Intrusion	*≥1 intrusion symptoms:* 1. Recurrent, involuntary, distressing trauma memories 2. Recurrent, distressing trauma-related dreams 3. Dissociative reactions/flashbacks related to trauma 4. Intense or prolonged psychological distress to trauma reminders 5. Marked physiological reactions to trauma reminders
C. Avoidance	*≥1 avoidance symptoms:* 1. Avoidance/efforts to avoid distressing internal trauma reminders (memories, thoughts, feelings) 2. Avoidance or efforts to avoid distressing external trauma reminders (people, places, activities)
D. Negative cognition and mood	*≥2 negative cognition/mood symptoms:* 1. Amnesia for important parts of trauma exposure 2. Persistent, exaggerated negative beliefs about self, others, or the world 3. Persistent, distorted trauma-related cognitions leading to inappropriate blame of self/others 4. Persistent negative emotional state (eg, fear, horror, anger, guilt, shame) 5. Loss of interest or participation in significant activities 6. Detached/estranged feelings from others 7. Persistent loss of positive emotions (eg, happiness, satisfaction, love)
E. Hyperarousal	*≥2 marked alterations in trauma-related arousal and reactivity:* 1. Irritability and angry outbursts with little/no provocation (eg, verbal/physical aggression toward people/objects) 2. Reckless or self-destructive behavior 3. Hypervigilance 4. Exaggerated startle 5. Concentration problems 6. Sleep disturbance (eg, difficulty falling or staying asleep, restless sleep)
Additional criteria	
F. Duration	>1 month
G. Distress/ impairment	Clinically significant distress; social/occupational/other important functioning impairment
H. Not attributable to another disorder	Independent of physiological effects of a substance (eg, medication, alcohol) or another medical condition

Clinical Pictures



Co-occurring conditions

Assessment Management

Box 7.6 National Institute for Health and Care Excellence (NICE) guidance for the management of PTSD and related traumatic syndromes

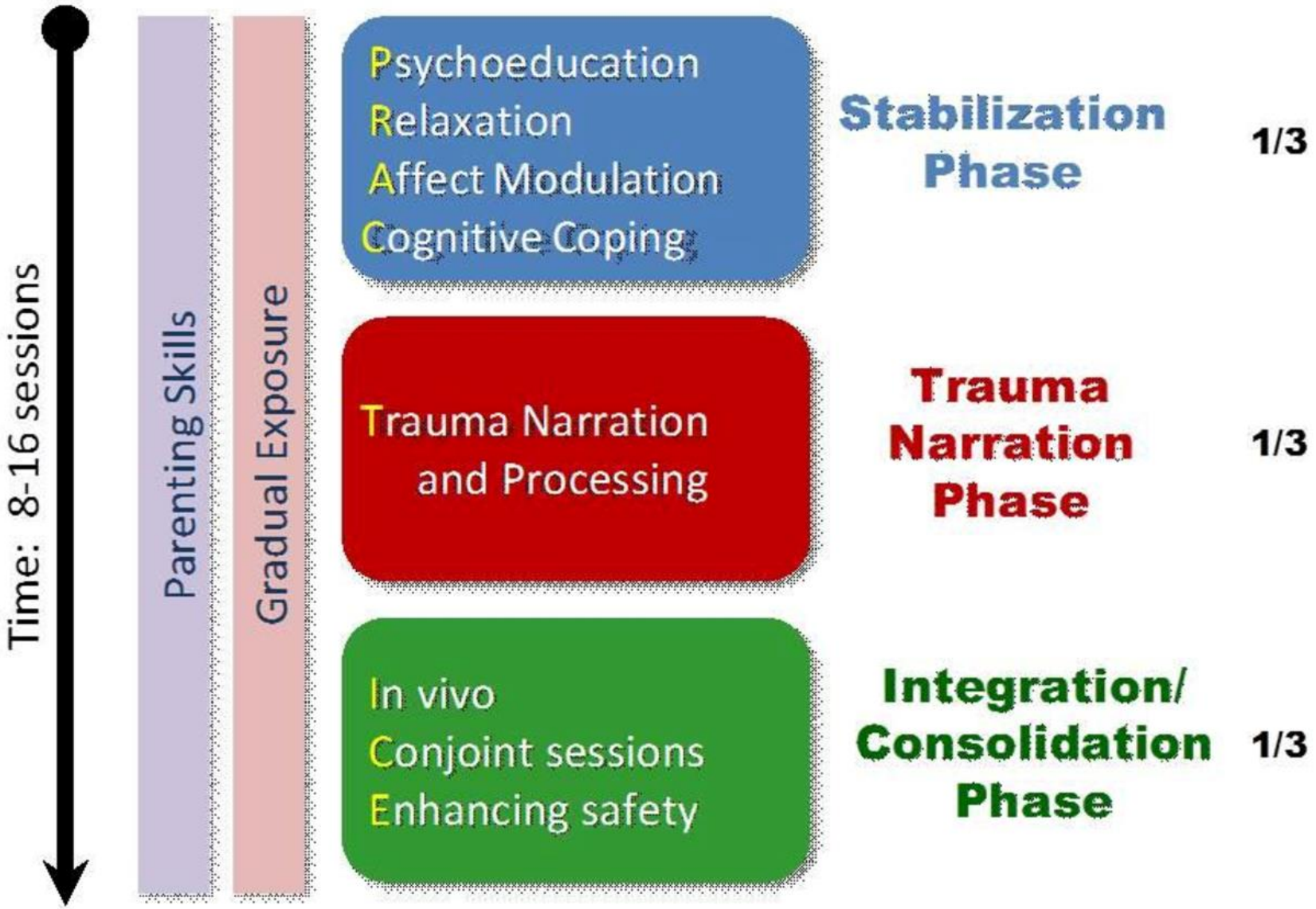
1. The routine use of a brief screening instrument for PTSD at 1 month post incident should be considered for all people who have been involved in a major disaster.
2. Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting—as a way of managing the difficulties presented by individual sufferers—should be routinely considered by healthcare professionals. A follow-up contact should be arranged within 1 month.
3. Trauma-focused cognitive behavioural therapy should be considered for those with severe post-traumatic symptoms during the first month after the traumatic event. All PTSD sufferers should be offered a course of trauma-focused psychological treatment.

These treatments are usually given individually on an outpatient basis.

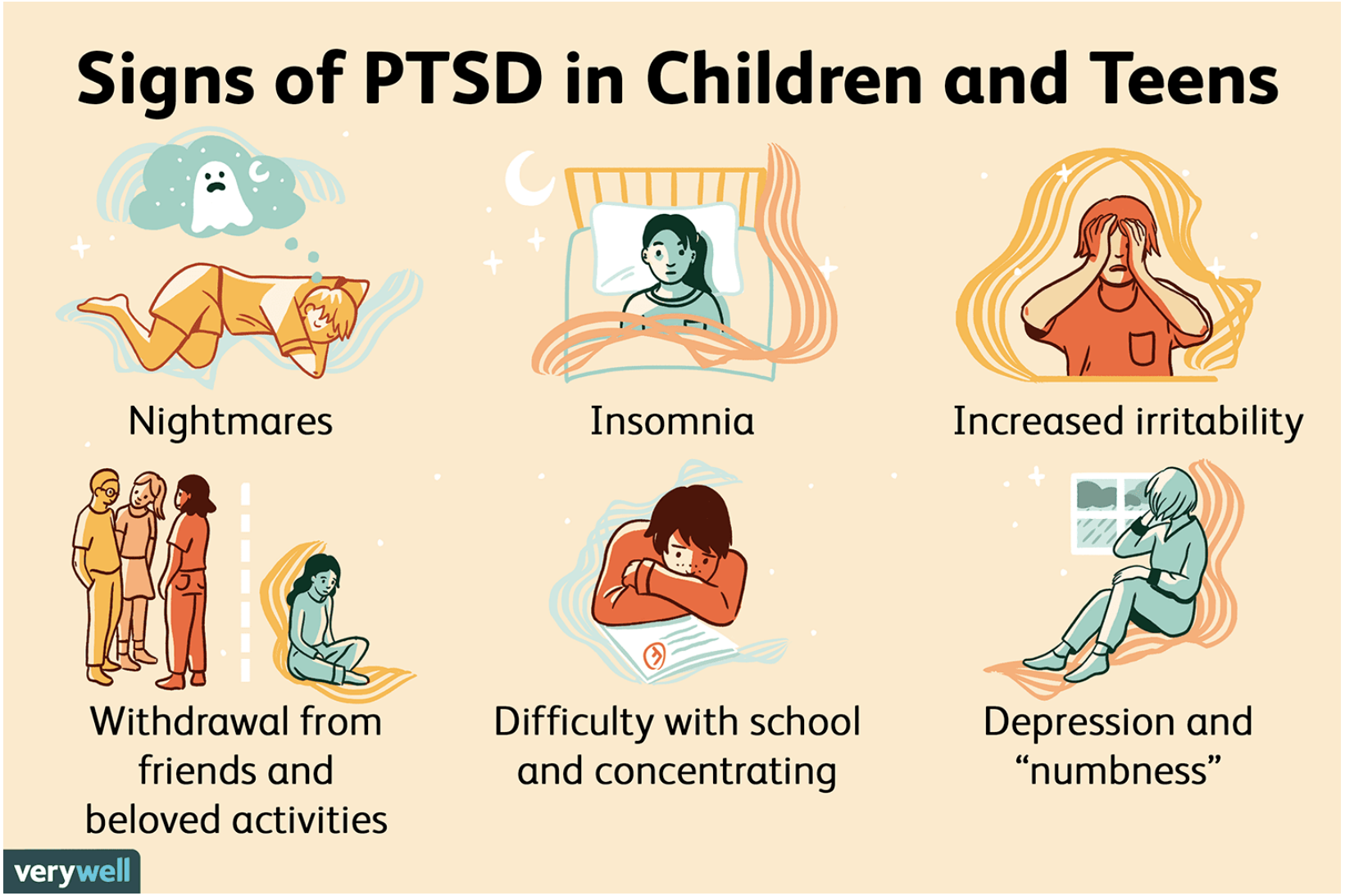
4. Drug treatments for PTSD should not be used as a routine first-line treatment in preference to a trauma-focused psychological therapy.
5. Drug treatments such as paroxetine, mirtazapine, amitriptyline, and phenelzine (the latter supervised by specialists) should be considered for the treatment of PTSD where a sufferer expresses a preference not to engage in a trauma-focused psychological treatment, or such treatment has proved ineffective.

Source: data from the National Institute for Health and Care Excellence, Post-traumatic stress disorder (PTSD), Copyright (2013), National Institute for Health and Care Excellence.

TF-CBT Proportionality



PTSD in Child and Adolescent Group:



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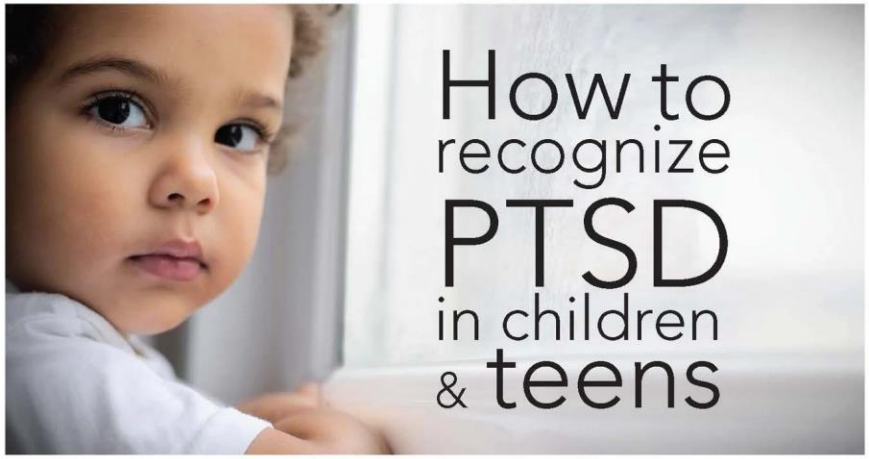

How to recognize PTSD in children & teens

Acute Stress Reactions

It's not unusual to have acute stress reactions occurring within 4 weeks of exposure to a trauma.

PTSD symptoms usually begin within 3 months after the traumatic event, but may appear years after the event, often in response to another life stressor.

Symptoms in children often differ from those of adults.

Common Symptoms in Children

Recurrent, distressing dreams or recollections of the traumatic event.

Physical symptoms such as stomach aches and headaches.

Difficulty sleeping alone.

Generalized nightmares of monsters, of rescuing others, or of threats to self or others.

Extra fears or aggressive behaviors in response to stress.

Co-occuring depression and substance abuse is not uncommon.

Separation anxiety.

For more information, contact Maryvale's Community-Based Services at (626) 263-9133 or maryvale.org/community-based

- 15-43% of child and adolescent group go through different serious manmade trauma, such as,
  a) Sexual violence : rape, molestation, stalking, incest
  b) Physical abuse
  c) Domestic violence
  d) Violent crime
  e) Severe bully victim
  f) School shooting

- Clinical Features : same as adult
- Outcome : 15-30% of child and adolescent with PTSD suffer from,
  - MDD
  - Personality Disorders : BPD
  - Anxiety Spectrum Disorders : Panic Disorder, Specific Phobia, Social Phobia
  - Alcohol and other Substance Abuse

- In their late childhood and adolescent age they suffer from,
  - Behavioral disturbance (ODD, Conduct Disorder)
  - Developmental Regression
  - More Generalized Fear
  - Separation Anxiety Disorder
  - Somatic Pain (Headache, Stomach ache)
  - Social withdrawn
  - School Phobia

Post-Traumatic Stress Disorder (PTSD) in Children and Adolescents

Comprehensive assessment includes:

- Use of standardized measures:
  - Juvenile Victimization Questionnaire (JVQ)
  - Trauma History component of the University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-PTSD RI)
- For specific PTSD symptoms, clinicians may use self-report and parent report measures:
  - University of California at Los Angeles Posttraumatic Stress Disorder Reaction index for DSM-5.
  - Child PTSD Symptom Scale for DSM-5
- Assessment of ongoing trauma in the context of the environment including history of abuse (physical, sexual, neglect), traumatic life events, domestic violence, economic instability, court involvement, etc.
- Address all safety concerns (i.e., child abuse), report to the appropriate agencies and/or make any mandated reports based on history.
- A comprehensive assessment of psychiatric symptoms and co-morbidities, as well as impairment from these symptoms and disorders.
- Thorough assessment of developmental, medical history, family structure, and parent-child relationship.
- An assessment of family psychiatric history, including: past and current history of parental psychiatric illnesses, substance abuse and treatment history of parents, parental figures (e.g., step parent), siblings, and other relatives.

The greatest level of evidence supports exposure-based therapies, of which Trauma-Focused CBT (TF-CBT) has the most data and is the most widely used.

In children under 6 years old, may consider TF-CBT (4 months) or Child Parent Psychotherapy (CPP) (6 months) as first line treatment.

Treat comorbid conditions optimally.

- Treatment Options :
  - Trauma Focused Cognitive Behavior Therapy (TF-CBT)
  - Narrative Exposure Therapy (KID-NET)
  - Supportive Psychotherapy
  - Mindfulness Meditation, Yoga, Dance
  - Peer Support

REFERENCE

- A Short Textbook of Psychiatry, 20th Edition
- Shorter Oxford Textbook of Psychiatry, 7th Edition
- Kaplan & Saddock's Comprehensive Textbook of Psychiatry, 10th Edition

RELATED ARTICLES


Thank
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