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Case Report

Post traumatic stress disorder

Lt Col Jyoti Prakash^{a,*}, Lt Col A. Saha^b, Brig R.C. Das^c,
Kalpana Srivastava^d, Lt Col R. Shashikumar^b

^a Classified Specialist (Psychiatry), Command Hospital (Eastern Command), Kolkata, India

^b Associate Professor, Dept of Psychiatry, Armed Forces Medical College, Pune 411040, India

^c Professor & Head, Dept of Psychiatry, Armed Forces Medical College, Pune 411040, India

^d Scientist F & Clinical Psychologist, Armed Forces Medical College, Pune 411040, India

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Introduction

Post-traumatic stress disorder is an illness in which following exposure to a stressful event of exceptionally threatening nature individual presents with persistent remembering/“reliving” of the stressor by way of intrusive flash backs, vivid memories, or recurring dreams. They would experience distress when exposed to similar circumstances and avoid circumstances resembling or associated with the stressor.¹

PTSD has now been brought under rubric of Trauma & stress-related disorder in DSM V and not the anxiety disorder in which these used to be.² PTSD is common in war and military scenario but has not spared chronic persisting stress like abuse, rape, domestic violence etc. Post traumatic reaction which fails to exceed the PTSD diagnostic threshold has also been known to lead to high prevalence of depression,

more health problems and poorer quality of life has been seen in these people.

The illness is associated with significant co morbidities; depression being the commonest. Chronic PTSD lasts longer and has poorer prognosis. An early diagnosis and timely intervention is important therefore for better remediation and prevention of any further complication.³ It is equally important to have keen eye and sound clinical judgment as some may feign the disease for financial gain or shirking away from duty.⁴ Longitudinal observation and collateral history taking is the key to holistic diagnosis and management.

An individual reported with disabling symptoms in the background of a life threatening event. An empathic interview brought out the details of his suffering. It also gave an understanding how a combat environment can be important in precipitation or perpetuation of the illness. The case is reported for its relevance in our setup, lucidity of the presentation and nuances of management.

Case report

A 16 year old male patient of foreign origin, under training at a military training academy was transferred from peripheral service hospital for psychiatric evaluation after he had voiced suicidal ideation to his superiors and had reported sleep disturbance, vivid dreams and frequent recollection of a traumatic event since May 2012 to the authorized medical attendant. He had expressed demotivation for military training and desire to quit training.

* Corresponding author.

E-mail address: drjyotiprakashpsy@yahoo.com (J. Prakash).

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History from the patient revealed that he was working as an interpreter to peace keeping forces since 2009 in his country and had been apparently asymptomatic till May 2012. In May 2012 he was in a convoy when his tank and tank ahead got hit by missile of the rebel forces. He was dazed and disoriented for few minutes. When he regained his composure he saw that the tank ahead was badly hit and every soldier had died. He saw the torn off remains of the tank and mutilated body of the dead soldiers in the splatter of blood, viscera and detached body parts.

The whole scene was horrifying, beyond his imagination and much harsher than any event he had faced or witnessed earlier. He was one of the few who survived the attack and had to witness such a near death gory incident. He had also sustained minor injuries for which he was treated in nearby hospital. He was initially in shock about the whole event which improved in 3-4 days; however he often thought about the incident. After treatment he was discharged from the service due to his poor mental condition. He felt relieved about being away from such duty but sad at the same time about losing job. He often kept to himself and thought about the event in which he managed to survive. He would fear at the uncertainty of life and helplessness of the situation.

Within 2-3 weeks he developed sleep disturbance in which he would have difficulty falling asleep. He would see the same sequence of missile burst and the death of the soldiers. Often he would get up during the sleep with these dreams and would find himself sweating and tremulous and develop palpitation. Anxiety/palpitation would subside in 10-15 min but he would have difficulty going back to sleep. All these things gave him horror and distress. He would often get up from sleep and scream.

Apart from these, gradually he also started seeing other fearing situations like room getting blown apart. These dreams would be vivid and often wake him up. At times he would get up from the sleep but he would continue to be in the same environment. Gradually he started experiencing these events even with eyes open, in day-time and while awake. He would have vivid recollection of same events. These would come as lifelike images in front of him. These recollections would be frequent and would come even when he was not thinking of the event. He would try to shrug these memories off but they would not go despite significant effort. At times he would feel that the whole event is occurring here and now. He would feel as if he is in a trance and whole thing is again occurring around him. The whole event used to be lifelike and he felt incapable from escaping from the situation despite knowing what is going to come. These experiences used to be very distressing.

Because of these he started avoiding people or situations which would remind him of the event. He would keep to himself and remain withdrawn. He would refuse to talk to people on these issues. He would interact less with people as they might ask him about the event. He felt victim of the event and subsequent circumstances. He became philosophical and would become emotional on why people fight/go to war.

Simultaneously he became very conscious of events happening around him. He would get startled when somebody suddenly opened or closed the door. He would get episode of extreme anxiety whenever a train whirled past. He would

move away and abruptly when somebody called his name or tapped from behind. He found his reactions unreasonable but beyond his conscious control.

Because of these distressing experiences he felt helpless and sad. He felt death as an escape and twice tried to kill himself. Once he tried to kill himself with local rifle but could not gather courage, other time he was caught by his family member in the act. He consulted a psychiatrist for these symptoms, who started him on some medication; details of which are not known to him. He did not find much relief and discontinued the medication within three weeks. He gradually improved over next 2-3 months. The frequency came down to 1-2 times per week.

He came to the military academy for training as he was made to understand that he will have a cushy desk job after completing the training. However symptoms resurfaced in familiar military circumstances. He felt incapable of going through the training which has made his experience come alive. He also felt sad because of the distress. He became de-motivated and developed frequent suicidal ideation. In the 3rd week of training he expressed suicidal ideation to superior authorities which necessitated psychiatric referral.

There is no history of any neurological or psychiatric illness in the past. Father is a farmer, mother a housewife. He is 2nd of 3 siblings. Patient gave history of psychiatric illness in his uncles and grandfather; details of which are not available. Birth and early childhood were uneventful. Educated till 12th standard. Financial stressors were present. He took the job of interpreter in 2009 to supplement family income. Patient is unmarried and denies any sexual exposure or substance abuse.

Relevant general and systemic examination was unremarkable. Mental status examination revealed a kempt cooperative patient who cried twice during the history taking as he found the recall painful. Mood was tense with anxious affect. He was preoccupied with the resurgence of symptoms in the background of training and thought of quitting the training to get rid of the same. No disorder of thought or perception seen. There were no major depressive features or active suicidal ideation. Sensorium was clear with intact cognition, insight and judgment. He had initial insomnia and sleep fragmentation. Appetite and energy were normal.

Ward observation revealed the patient to be generally anxious, remaining withdrawn, avoiding movies/TV programs showing violence and avoiding talking about missile explosion in May 2012.

Relevant investigations including thyroid profile were within normal limit. MRI Brain was done in the light of history of vivid visual experiences; which also was normal. He had high scores on Impact of event Scale-(Revised). Avoidance was 12, Intrusion 9 and hyper-arousal 14. BDI score was 5.

After exclusion of organicity and other possible syndromal diagnosis and on basis of positive findings he was given a provisional diagnosis of Post Traumatic Stress Disorder. He was managed with six session of Trauma focused Cognitive behavior therapy by trained psychologist, SSRI (Tab Paroxetine CR 25 mg) and other supportive measures. Patient responded

satisfactorily to treatment. Avoidance score came down to 2, intrusion to 3 and hyperarousal to 2. He was repatriated back at his own request with advice of regular review by local psychiatrist.

Discussion

The patient saw and witnessed an acute, life threatening event. He experienced fear, helplessness and horror which were very distressing. He had traumatic nightmares, which are core feature of PTSD and seen in up to 90% of individuals. These nightmares had great resemblance to the actual traumatic event and predicted later posttraumatic symptoms. Intrusive recollections were images and thoughts which kept coming to the patient despite his efforts to avoid the same. Images were sensory memories of short duration which had a here and now clarity. It lacked context. He had flashbacks which occurred in the dream, immediately on waking up and even while awake. Often he did not have clear memory or recall of the event (dissociative flashback). He avoided triggers (situations, thoughts etc) which reminded him of the traumatic event. He displayed exaggerated emotional and physiological response to triggers which reminded him of the traumatic event (hyperarousal).^{5,6} Brain structural imaging was within normal limit. Structural imaging in general has revealed smaller hippocampus volume however they have not been replicated to the level of evidence.⁷ Psychometry confirmed the presence of PTSD in the index case. Scales specific to PTSD are Impact of Event Scale, Post-traumatic Diagnostic Scale, Davidson Trauma Scale, PTSD Checklist etc. Trauma symptom inventory is also good in differentiating malingered PTSD; thus has forensic application.⁵ A meta-analysis by Ozer et al.⁸ based on community and clinical samples identified seven empirically based risk factors for PTSD: peritraumatic dissociation, peritraumatic emotional responses, trauma severity, history of trauma/victimization, psychiatric history, family psychiatric history, and posttrauma social support. The patient had genetic loading, had gone through severe emotional trauma and had less social support; which amplified his risk to fall prey to this illness. Psychotherapy is generally the first line in management of PTSD. Common modalities are Trauma focused Cognitive Behaviour Therapy (Trauma CBT) and Eye Movement Desensitization and Reprocessing (EMDR) etc.^{3,9} In medication SSRI is the drug of choice. Commonly used are Paroxetine, Sertraline and Citalopram. Olanzapine and Risperidone has been used as an adjunct.^{3,10} Propanalol has been used for anxiety and intrusive memory.¹¹ Prazosin has been found useful for nightmares.¹² The patient responded adequately to treatment and returned back to his country for recuperation.

Conclusion

Post Traumatic Stress Disorder is a disabling illness which may relapse on triggers which could have been otherwise innocuous. It can lead to severe handicap in combat scenario and loss of job/manpower. Early identification and effective management are pivotal to good response. Psychotherapy and medication is effective for management and prevention of chronicity.

Conflicts of interest

The authors have none to declare.

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