Case report

Management difficulties in a patient with post-traumatic stress disorder and role of trauma focused cognitive behavior therapy

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Summary

Post-traumatic stress disorder is not uncommon but in practical ground it is really difficult to treat these patients. Multiple treatment options are in hand but psychological treatment is the first recommendation. Initially after the exposure or incident symptoms may be severe. In case of severe agitation, self-destructing behavior, intense psychological distress, extreme sleep disturbances or anger outbursts, pharmacological intervention as early as possible is needed. Stress coping skills, relaxation therapies, psychological first aid and trauma focused cognitive behavior therapy (CBT) are important to treat the patient and get back full functional state. Prevention of suicide and self-harm is vital. Risk assessment, presence of hostility and complete personal history guide psychiatrist to take measures. The case described below was a good example resolution by trauma focused CBT. In this case patient had severe symptoms, aggression and self-destructive behavior. By using pharmacological intervention and using all available resources of psychological therapy, patient improved.

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Introduction

Post traumatic stress disorder (PTSD) is one of the common trauma and stress related disorders. The lifetime incidence of this disorder is estimated to be 9 to 15 percent and the lifetime prevalence is estimated to be 8 percent in general population. Moreover, the lifetime prevalence rate is 10 percent in women and 4 percent in men. It is associated with significant functional impairment.[1] PTSD is most likely to occur in those who are single, divorced, widowed, socially withdrawn or of low socio economic level but anyone can be affected. Co-morbidity is high among these patients most commonly depressive disorders, substance related disorders, anxiety disorders and bipolar disorders.[2] Early work on the epidemiology of PTSD demonstrated greater prevalence in high-income countries and female sex as well as the associated significant subsequent morbidity and comorbidit.[3] In a large cross-national study, it was found that trauma exposure itself has downstream effects on physical health independent of PTSD effects. The effect was linked to the number of traumatic events an individual was exposed to, with exposure to four or more traumatic events being associated with a wide range of chronic physical conditions including arthritis, back and neck pain, frequent or severe headaches, heart disease, high blood pressure, asthma, peptic ulcers, chronic lung disease and stroke.[4]

As the management of PTSD is much challenging, extra attention needed to treat the co-morbidities accentuate the difficulties of overall management.[5] Pharmacological intervention, proper assessment, counseling, relaxation therapy, exposure therapy, developing of coping skills, group therapy, family therapy and trauma focused cognitive behavior therapy (CBT) are important where therapeutic relationship and empathy plays the key role.[6] Here we presented a challenging case of PTSD following sexual violence who improved after inpatient and subsequent follow up interventions.

Case summary

An 18-years-old unmarried Muslim lady having was presented to one stop crisis center (OCC) of a medical college hospital in Bangladesh on early January of 2023 with the history of physical assault and sexual harassment 10 days back. She was restless, irritable, anxious and had sleep disturbance. Subsequently, in the psychiatry ward, the patient complained recurrent distressing dreams, fearfulness and sleep disturbance. Along with this, she developed self-injuring behavior as she tried to harm herself by biting. She also attempted suicide by hanging for 3 times. Moreover, she frequently stated that she had lost her honor and so worth of living. On query, she mostly denied to think about the traumatic experience as well as could not recall the detail scenario when tried. Examination revealed some bruise on arm,

forearm and leg. On mental state examination, she was moderately groomed and was less interested in the interview. Her rapport was not well established and mood was irritable. After one month of the traumatic event, the diagnosis was confirmed as PTSD according to Diagnostic and Statistical Manual, fifth edition (DSM 5). After performing routine investigations, mirtazapine 15 mg per day was prescribed. Lithium sulfate 400 mg daily was prescribed targeting anger outburst, self-destructing behavior and suicidal ideation. For agitation and sleep disturbance, short course benzodiazepine was offered. Dose was gradually increased as there was little response and low dose risperidone was introduced. Psychotherapy was not initially possible due to lack of rapport and presence of irritability. Few more days later, the patient started proper eye to eye contact and rapport was maintained for the first time. Psychotherapy was initiated soon with empathy and proper privacy. Her weakness and strength were identified. Six psychotherapy sessions comprising trauma focused CBT, problem solving counseling and coping skill were applied during hospital stay. Psycho educations to family members as well as family counseling were given to solve the issues related to it and handle the patient. Family members realized the necessity of managing her carefully with respect. Her condition gradually improved. Medication was reduced keeping only mirtazapine. After 45 days of admission, she was discharged from the hospital with significant improvement. She agreed to attend further psychotherapy sessions.

Discussion

Treatment of post-traumatic stress disorder was very much challenging specially when intense psychological symptoms or aggressive and violent behavior is present. As this disorder was related to different types of social problem, personal loss and sudden intense stress so symptoms became more severe and aggressive treatment protocol was needed.[7] When our patient came to psychiatry department already 15 days after incident was passed, there was no option for psychological first aid. Patient's symptoms were severe and, on that time, already patient had self destructive attempt. For treating this patient at first pharmacological therapy was introduced earlier because patient had severe symptoms and there was no rapport initially. At first antidepressant mirtazapine and then lithium was prescribed for flashback and hostility. Antipsychotic and in short course benzodiazepine were also given. When patient's restlessness was reduced, hostility and self-destructive behavior were subsided and rapport was established then started psychological intervention in full swing.[8]

A dysfunctional therapeutic relationship was detected as a major barrier for initiating psychological treatment and better outcome of PTSD. Gaining trust and allowing patient to take time is important. As patient had a history of sexual assault and continuous threat was given to her family from the offender so respectful doctor patient relationship was challenging. Thus greater time, attention and empathy were invested there and finally a stable therapeutic relationship was established. After ventilation of emotion and proper evaluation of the problem patient was able to rediscover the meaning of life. After introduction positive reappraisal and explanation of the real scenario of the society patient agreed that she should talk more freely. The patient became free to discuss and gradually began to accept changes. In trauma focused cognitive behavior therapy at first, the session was started with information about the stress and response to it. Obviously, ice melting was done with proper permission and introduction because it was the prerequisite for treating PTSD.[9] Then discussion was done regarding confrontation and memories related to trauma. Initially patient was rigid about her pessimistic thought and was fearful. Then the importance of self-monitoring of symptoms was described. Exposure in imaginations was done and avoided situations where explained.[10] Then patient was asked to recall the incident fully but she could not. Finally after several sessions patient was able to remember and recall the event and other related contents. Thereafter, the evidences for and against the appraisals and assumptions which was the key mechanism for effective CBT was discussed.[11] Sometimes patient said that there is no need to recall the incident and sometimes she denied to follow the instructions about relaxation and problem solving. But proper counseling and explanation made her calm and quiet. Problem solving counseling was given to combat adverse situations.[12]

As she accepted that confrontation as better coping strategy, her usual avoidance might be reduced. Moreover, family counseling was given to minimize unfavorable circumstances which made it easier to counsel the patient. After several sessions, patient started to make a plan for further life ahead, get the courage to continue fight for justice and avoid self-harm. As there was continuous threat from the offender, discussion was carried out about the proper use of law and role of law enforcing agencies. As patient had good pre-morbid personality, no co-morbidity, no history of substance use, no personality disorder and proper evidence based treatment was given, so the patient was expected to improve further. Social, financial and legal support as well as good housing, healthy environment and regular follow up was important to bring better outcome.

Conclusion

An effective therapeutic relationship and introduction of trauma focused CBT plays the key role to treat the challenging case of PTSD. Social support, stigma, role of law enforcing agencies in the intervention of the disorder should be studied more.

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