

THE CONCEPT OF POST TRAUMATIC STRESS DISORDER TODAY

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The concept of psycho-trauma in development of psychiatric disorders, has been in vogue in psychiatry, in the last few decades.¹ The recent interest in PTSD, started with the Vietnam Veterans in USA. The veterans, displayed a characteristic array of symptoms, which needed a diagnostic category, this led to the impetus for the development of PTSD. Since that time, there is increasing recognition that adults and children can develop severe and debilitating reactions to traumatic events.

PTSD first appeared in DSM-III in 1980. The DSM-IV-TR, describes, three symptoms clusters in PTSD: persistent re-experiencing of the trauma (intrusive memories & flashback experiences, often triggered by exposure to traumatic reminders and recurring trauma related nightmares); avoidance of traumatic reminders (including places, people and conversations) and a general numbing of emotional responsiveness; chronic physiological hyper-arousal, including sleep disturbances, poor concentration, hyper-vigilance to threat. In addition it is specified into acute PTSD, if the duration of symptoms is less than three months and chronic PTSD, if duration is three months or more.

Since the recognition of PTSD, as a diagnostic entity in early 1980, significant advances have been made in its, recognition, measurement and management.² Much of the earlier work, was done on combat veterans, and relatively less attention was paid on civilian populations. It has been known that pathological stress response syndromes can follow war, sexual assault and other types of trauma.³

Disasters whether natural catastrophes, (earthquakes, cyclones, snow storms, floods) or disasters affecting large populations in different parts of the world (wars, bomb blasts, ethnic or political violence) always, result in tremendous death & destruction among the affected populations. Traumatic events & the coping strategies of people in such circumstances have a vital role in development of Post-Traumatic Stress Disorder (PTSD) and other psychiatric disorders like: major depressive disorders, (MDD) generalized anxiety disorders (GAD), somatization & dissociative disorders.⁴

Epidemiological data, mostly comes from USA³⁻⁵ & Australia⁷ Distinct absence of quality research data from other countries, particularly the developing countries in the recent past has led to erroneous assumption that PTSD does not exist.⁷ The last two decades, natural disasters like earthquakes, floods & tsunami havocs in South Asia, have led to a series of research work on PTSD. The earthquake in Pakistan & Kashmir, on October 8th, 2005, led the Indo-Pak psychiatrists, to observe the psychiatric sequelae in the earthquake survivors, first hand. For some time it is known that, earthquakes are life-threatening, unpredictable, uncontrollable disasters, which can lead to widespread death, displacement & devastation in large populations. The prevalence rates of PTSD, in communities exposed to earthquakes have only recently started to attract the researchers world wide.

The result of several studies in the last decade suggest that PTSD symptoms are common in earthquake survivors.⁸⁻¹³ A community survey reported 50% life time PTSD in survivors of the 1998 earthquake in Armenia.¹⁴ In two other epidemiological studies¹⁵ of survivors of the 1998 earthquake in Turkey, current rates of PTSD for those living at the epicenter

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and those living at 100 km distance from the epicenter were 23% and 11% respectively. These studies are significant, as they involved a large probability samples & based their estimation of PTSD on structured diagnostic interviews¹⁴ or validated diagnostic instruments.¹⁵ Authors recent data(accepted for publication) on earthquake survivors in NWFP of Pakistan (Balakot, Mansehra) indicates:

PTSD and co-morbid depression, 26% and PTSD alone 37%, the study sample, from a Tent Relief Camp.^{16,17} PTSD and comorbid depression 94%. PTSD alone 95%,depression, 81% fear & avoidance, 80% in a sample of destitute women's shelter home, in NWFP, Pakistan. In the developing world, both natural & manmade disasters are common. The Vietnam War, followed the Palestine War, the Middle East War, Gulf War, Afghanistan War, Iraq War & recently the Lebanon War. The Tsunami in the Far East; Several earthquakes in Japan ,Iran, Turkey, Armenia and Pakistan and Kashmir have led mental health professionals, to realize the aftermath of these catastrophes, not only leads to a high toll on the society in terms of devastation of infra structure, lives,& physical disability but also a gamut of mental health problems.

The validity of PTSD as a distinct entity is beyond doubt, with the large number of studies on earthquake survivors in the recent past & the 2005 earthquake in Pakistan & Kashmir. Evidence is accumulating that post traumatic stress disorder is a discrete diagnostic entity with biochemical, neuro-anatomical and phenomenological characteristics that differentiate it from other major psychiatric disorders.⁶ Like any other genuine diagnostic entity, post traumatic stress disorder does meets the requirements of the classification systems of facilitating communication between clinicians and researchers, promote research activity, encourage the development of specific treatments, provide information about prognosis, and allow service to be developed.

Mental services & policy development in rehabilitation of survivors from earthquakes, must keep provision of long term management

of PTSD, to ensure quick recovery and quality of life of these traumatized populations.

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