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Treatment modalities of post-traumatic stress disorder (PTSD)

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Introduction

Some individuals, particularly those who have been exposed to or have experienced horrific or traumatic events, are more likely to develop a kind of anxiety known as post-traumatic stress disorder (PTSD). In spite of the fact that post-traumatic stress disorder, often known as PTSD, is a devastating anxiety illness that may cause significant suffering and an increased use of health resources, the condition is frequently misunderstood. Around seven to eight percent of the population of India will get post-traumatic stress disorder (PTSD) at some point in their lives; around twenty-five percent of individuals who go through very terrible experiences will also develop PTSD. The three primary mental and physical signs of post-traumatic stress disorder include reliving the horrific experience, avoiding tasks of daily life, and experiencing heightened levels of arousal. In order to establish a diagnosis of post-traumatic stress disorder (PTSD), there has to be an adequate disruption of everyday functioning and it needs to last for more than a month. A second mental health issue is present in over eighty percent of those who suffer from post-traumatic stress disorder (PTSD). The most common dual diagnoses are those involving depression, addiction to substances, and various forms of anxiety disorders. During the course of treatment, patients may engage in psychotherapy, cognitive-behavioral therapy, or both, in addition to taking medication. When it comes to medical treatment, selective serotonin reuptake inhibitors are considered the gold standard. When the upsetting after-effects of a traumatic incident persist, causing considerable impairment in daily functioning for at least one month, a diagnosis of post-traumatic stress disorder (PTSD) may be made. People who have recently undergone a traumatic event but have now recovered sufficiently to function might be diagnosed with acute stress disorder (ASD), a transient anxiety disease. The patient must also have at least three dissociative symptoms in addition to the PTSD symptoms. Acute posttraumatic stress disorder is diagnosed when symptoms last less than three months. There is a "delayed presentation" of PTSD when symptoms don't develop until six months or longer after the stressful incident.

There are a lot of factors that might make a PTSD diagnosis challenging. However, despair, substance abuse, or other comorbidities, or the patient's fear of disclosing the traumatic event, may obscure the presentation. It may take some time to determine if a traumatic event was really the cause of a patient's symptoms. Patients' silence about the occurrence can be reasonable. When taking a patient's medical history, clinicians should ask questions that are straightforward, compassionate, and nonjudgmental. The doctor could inquire, "Have you ever been assaulted or threatened?" if he or she has reason to believe the patient has been subjected to physical violence. similarly to "Have you ever been through a major disaster?"

Attributing a patient's symptoms to a traumatic event that happened during childhood may be very difficult. Starting with a question like "Do many individuals worry about bad events they experienced as children?" may be an excellent way to establish rapport and build trust. Do you find yourself dealing with this frequently?

Some studies have indicated as high as a 98% diagnosis accuracy rate for PTSD screening questionnaires. Questions such as "Do you have trouble expressing your emotions to other people?" The questions "Do you find it difficult to sleep?" and "Do you find it difficult to participate in activities that you previously enjoyed?" are other good examples.

Etiology

Although the exact cause of PTSD is unknown, the vast majority of studies agree that a genetic predisposition is required for symptoms to manifest after exposure to a stressful event. True, only a small percentage of individuals have clinically significant symptoms after suffering trauma. Those who suffer from depression or anxiety already or who come from a long line of worried, neurotic ancestors are at a higher risk of acquiring post-traumatic stress disorder.

The body's incapacity to return to its pretraumatic state is one physiologic difference between PTSD and a normal fear response. The "fight-or-flight" mechanism is activated in the normal "fight-or-flight" reaction the moment fear sets in. Increases in the stress hormones cortisol and catecholamines are proportional to the severity of the stressor. Corticotropin-releasing factor stimulates cortisol release through the hypothalamic-pituitary-adrenal (HPA)

axis, which in turn suppresses sympathetic activity and further cortisol release in a negative feedback loop.

Patients with PTSD have been shown to have lower-than-normal ambient cortisol levels, a phenomenon associated with "adrenal exhaustion" owing to the protracted suppression of the HPA axis from persistent, acute anxiety. However, new data21 shows that those who subsequently acquired PTSD had much lower cortisol levels in the immediate aftermath of a vehicle incident. Similarly, women who had been raped in the past had lower cortisol levels in the hours after a sexual attack. It has been hypothesised that PTSD develops when the hypothalamic-pituitary-adrenal (HPA) axis and the sympathetic nervous system become disconnected, leading to an uncontrolled release of catecholamines that may influence memory formation during the traumatic event and may exacerbate symptoms when the individual is exposed to cues that trigger memories of the event.

Prognosis

Even very young infants are not safe from getting post-traumatic stress disorder (PTSD). The amount of time that symptoms continue to be present is determined by a variety of different variables, such as how recently the traumatic event happened, how severe it was, and whether or not there are any underlying mental health disorders present. A patient's reactions to a traumatic event are influenced not only by the event itself but also by the patient's interpretation of what happened. People who are receiving treatment often continue to experience their symptoms for an average of roughly 36 months. In the absence of treatment, patients often have symptoms for a longer period of time, on average sixty-four months. A little less than one-third of those with a diagnosis of PTSD will never feel better.Immediate treatment, early and consistent social support, avoiding retraumatization, retaining good premorbid functioning, and the absence of comorbid mental health issues or substance abuse are all related with a better prognosis.

Treatment

The treatment of people who suffer from PTSD requires a strategy that takes into account several dimensions. The patient is educated, they get social support, and they may control their anxiety via psychotherapy and psychopharmacologic intervention. These are all treatment alternatives. Education of the patient and social support are two crucial early treatments that are necessary in order to

engage the patient and lessen the effects of the traumatic incident. The stigma associated with mental health diagnoses may be reduced with the assistance of local and national support groups. These organisations may also underline that the symptoms of PTSD entail more than simply a response to stress and that they need treatment. The compassion and acceptance that might help survivors feel less guilty are fostered by having the support of their families and friends.

Studies have shown that cognitive-behavioral therapy is an effective method for reducing the symptoms of post-traumatic stress disorder (PTSD). The percentage of patients who attained positive end-state function in a study of patients receiving various forms of cognitive-behavioral treatment in nine sessions spread out over a period of six weeks ranged from 22 to 44 percent. Positive end-state function was defined as a reduction of 60 percent in the severity of PTSD symptoms. A research that was quite similar to this one found that between 30 and 50 percent of patients who had 15 cognitive-behavioral therapy sessions spread out over the course of 15 weeks were able to attain good end-state function.

The treatments known as cognitive therapy, exposure therapy, and stress inoculation training are all examples of specific sorts of behavioural cognitive therapy. These treatments help patients address their fears and establish coping mechanisms for anxiety by focusing on methods for them to do so. Individually or in combination, the several cognitive-behavioral therapy modalities often have an efficacy that is comparable to that of the other. In the treatment of post-traumatic stress disorder (PTSD), other types of therapy, such as group therapy, eye movement desensitisation therapy, and reprocessing therapy, may have a part to play. Despite this, cognitive-behavioral treatment continues to be the primary mode of therapy used because the efficacy of these other types of therapy has not been sufficiently demonstrated.

Roughly ten percent of people who are being treated for PTSD decide to stop receiving psychotherapy. The largest dropout rates are seen during exposure treatment, which suggests that many patients have problems with reliving the

traumatic event. The attending physician is able to give effective therapeutic intervention by using their attentive listening skills and compassionate support. In the event that the patient does not experience relief from their PTSD symptoms after receiving early assistance and medication, it may be necessary to send them to a therapist.

As an addition to the individual treatment of a patient suffering from post-traumatic stress disorder (PTSD), it may be necessary to engage in family or other types of group therapy. This is due to the fact that PTSD may have a devastating impact on the patient's loved ones.

Large prospective double-blind placebo-controlled clinical studies using selective serotonin reuptake inhibitors for the treatment of PTSD symptoms have been sparked by the renewed focus on this disorder's therapy. Over the last several years, researchers have been conducting these clinical studies. The Indian Drug Control Authority has narrowed the list of approved PTSD medications to only paroxetine and sertraline (Indian Drug Controle authority). Two trials, each lasting 12 weeks and using a placebo control group, found that paroxetine and sertraline were both effective in the short-term therapy of PTSD symptoms. Sixty percent of those given 20 milligrammes of paroxetine responded well, whereas 50 percent of those given 40 milligrammes did. As a contrast, just 37% of patients who received a placebo had any form of reaction. Positive reaction was 50% greater among those given the mean daily dosage of sertraline compared to those given a placebo.

After 24 weeks of acute therapy for PTSD, a further experiment indicated that sertraline was useful in preventing a recurrence of symptoms throughout a 30-week maintenance phase. Additionally, this study found that maintaining treatment with the correct dosage of sertraline was more successful than the placebo in preventing relapse (relapse rate = 26%). There have been other clinical trials conducted, including two controlled studies of fluvoxamine and six open studies of the drug. The results of these studies suggest that a combination of SSRIs may be useful for alleviating PTSD's acute symptoms.

The majority of investigations on the effects of neuroleptic drugs on people with post-traumatic stress disorder have consisted of case studies (PTSD). About % of individuals diagnosed with PTSD are prescribed antipsychotic medication. There

is a higher likelihood that these people may have more severe and pervasive PTSD symptoms than other patients with PTSD.

Moderate success with tricyclic antidepressants and monoamine oxidase inhibitors compared well to placebo in the treatment of post-traumatic stress disorder (PTSD). However, these drugs are now only regarded second- or third-line medicines owing to their side effect profiles. In open-label trials, mood stabilisers such lamotrigine, valproate, and carbamazepine have been proven to be effective in reducing PTSD symptoms (PTSD). Individuals with post-traumatic stress disorder have also been proven to benefit from the anti-anxiety properties of buspirone and clonazepam (PTSD). New pilot study suggests that propranolol may have a protective effect against the onset of post-traumatic stress disorder (PTSD).

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