**PSYCHIATRY:**

**CASE 1:**

CASE TWELVE A CASE OF MODERATE DEPRESSION FOLLOWING DIVORCE

Name: DS Hospital No: 344281

Age: 34 years Occupation: Admin officer

Educational status: Tertiary Parity: p1+0

Sex: Female Tribe: Yoruba

Address: Olowo-Ira; Lagos-State Marital status: Divorced

Religion: Christianity Date seen:16/9/2022

Informant. Patient.

Presenting Complaints: Feeling of sadness, loss of energy and poor sleep, all of 5 months duration.

History of Presenting complaints: D.S noticed a change in her mood as she was sad most times of the day. She also noticed she easily got tired when she tries to carry out her daily chores. She was always lost in thought, having low mood and occasional crying spells. She often had early awakening around 2-3 am as against the usual 6 am still feeling unrefreshed. She was noticed to have developed loss of interest in her usual pleasurable activities, reduced appetite, and poor concentration at work as she found herself going about her daily tasks sluggishly and was unable to focus on tasks at hand. The sadness was hinged on marital separation worsened by financial difficulty.

The onset of her symptoms was about 2years ago when she got separated from her husband but had gradually became worse about 5 months ago after her marriage was dissolved by the court, sequel to a suit filed by her husband for alleged irreconcilable differences. Prior to the divorce, she had suffered emotional and physical abuse in the marriage. Her husband was a womanizer who also abused substances and loved wild partying with friends and each time she confronted him with evidence of his extra-marital affairs or advised him to desist from it, he had denied it and had resorted to beating her seriously to deter her from making further claims. She had discovered these habits during their courtship period but she didn’t really mind because he was rich and had hoped that he would change after settling down. She had also tried to report him to his relativeswho unfortunately, had taken sides with him blaming her for not adapting to him in all aspects. Since the separation the financial support she received from the husband despite court injunction has greatly reduced. She made an attempt to start a side hustle with the little money she had been able to gather which failed cause of lack of proper monitoring and inexperience. She blamed herself for the divorce because she felt she could have handled the situation with more wisdom as she really loved her husband and also feared she might have to raise her daughter as a single parent.

There was no history of feeling of hopelessness and never has she contemplated suicide. She had no previous history of undue sadness, loss of interest in pleasurable things, reduced energy level for a sustained period. She had no history of undue excitement or irritability, nor over inflated self-esteem or increased activity level.

She had no history of hearing of voices others do not hear or seeing things other people do not see in clear consciousness. She does not believe that her thought, action, and impulses were under external control. There was no history of use of psychoactive substances, alcoholic beverages, caffeine, or other substances. There was no history of head trauma, fever, or neck swelling.

When the symptoms began, she purchased over the counter medication (name unknown) which only improved her sleep pattern for a few days but the sadness persisted. She subsequently attended different churches where she was prayed for but symptoms persisted. She was advised by her sister to come to the hospital for treatment.

Review of Systems: She had no respiratory or gastrointestinal symptoms. There was no history of palpitation, chest pain, dyspnoea or dyspepsia. She fears that she could lose her sanity if these feelings persisted, she believed that her casewas complicated by financial-instability. The illness had affected her functioning, as she could no longer carry out her daily chores effectively. At work, her boss noticed and gave her time off to seek medical attention.

Past psychiatric history: She had no previous episode of mental illness.

Premorbid personality: She was an out-spoken and outing lady who enjoyed the company of her friends, singing, cooking and other outdoor activities.

Gynecological history: She attained menarche at 12 years of age and menstruated for 3 days in a cycle of 28 days. There was no history of dysmenorrhea, dyspareunia or menorrhagia. She had knowledge of contraceptives but had not used any.

Obstetric history: She is P1+0, her first pregnancy was in 2018. The pregnancy was booked and carried to term. She had a spontaneous labour and vaginal delivery of a live female baby. She had no history of post-partum depression

Past Medical And Surgical History: She had no previous surgeries or blood transfusion. She had no previous hospital admission. She was not a known hypertensive or diabetic.

Drug history: She was not on regular medication and had no drug allergy.

Family and social history: She is the second child in a monogamous setting of five children, father is 70 year retired civil servant with secondary level of education, mother is a 62-year-old trader with primary level of education. She is an OND holder, working as an Administrative officer in a private firm. She and her child lived with her parent, in good cordial relationship in their rented 3-bedroom apartment, their source of drinking water was borehole, they had water closet toilet facility. Her monthly income was seventy thousand naira. Her source of health care financing was out of pocket.

Sister

Mother

Fellowship

Brethren

DS

Father

Daughter

Brothers

Friend

Husband

In-laws

Fig -- : Family circle of D.S drawn on September, 2022.

NOV. 2018

JULY 2017

SEPT. 2022

APRIL 2022

JAN 202

JUNE 2021

CLINIC

SYMPTOMS

LOST MONEY

SEPERATED

DS DAUGHTER

MARRIED

Fig -- :Timeline of DS as at September 2022.

Forensic history: No history of problem with law enforcement agencies.

Mental state examination: She was appropriately dressed and looked-well kempt. She had a down casted countenance. [mood 3 out of 5]. Her speech was slow with decreased tone, volume and rate but cooperative. She intermittently tearful unprovoked. Her affect was congruent with her mood. She was well oriented in time, place and person. Her short and long-time memories were intact though she took a long time to answer questions. These answers were short and monotonous. She had good judgment and insight into her problem. Patient Health Questionnaire: Her PHQ-9 score was 14/27 (Moderate depression)

Physical examination: She was not ill-looking, afebrile (axillary temperature, 36.3oC), not pale, anicteric, had no significant peripheral lymphadenopathy or pedal oedema.

Cardiovascular System: Her pulse rate (PR) was 70beats per minute (bpm), regular, normal volume. Her blood pressure (BP) was 110/70mmHg. Apex beat was located at the fifth left intercostal space along the mid-clavicular line. Only the first and second heart sound only was heard.

Respiratory System: Her respiratory rate (RR) was 18 cycles per minute (cpm). She had equal chest expansion, resonant percussion notes and vesicular breath sounds bilaterally.

Abdomen: Her abdomen was full and moved with respiration. There was no tenderness. The liver and spleen were not palpable. The kidneys were not ballotable. Her bowel sounds were normal.

Central Nervous System: She was fully conscious and alert. She had no obvious neurological deficit

Diagnosis: Using the Diagnostic and Statistical Manual of Mental Disorders (DSM – IV) Multiaxial Classification: Axis I: Moderate depression

Axis II: No personality disorder

Axis III: There was no medical condition.

Axis IV: Marital harmony, reduced financial income

Axis V: Global assessment of function - 60% functional.

Differential werean anxiety disorder and hypothyroidism.

Psychosocial assessment: Stigma of divorce, worries about single motherhood in a woman with good family support.

Management: The diagnosis was explained to her and her elder brother. They were told that the illness could be treated with some drugs and cognitive behavioural theraphy. They were also informed that the benefit of the drug therapy may not be fully felt until about two to three weeks after commencing treatment. Possible side effects of the drugs were explained to them like dry mouth, indigestion, increased sweating. They were also told that the drug therapy may be continued for as long as six months to one year depending on her response. The brother was also told that all the family members should show love and understanding. They understood and consented to treatment. The following tests were requested as baseline investigations, fasting blood sugar (FBS) to assess her glycaemic level due to her complain of weakness, full blood count (FBC) to assess for anaemia her haematologic profile, thyroid function test (TFT) as a low serum assay of thyroid hormones could mimic depression. Her packed cell volume (PCV) was 36%, white cell count was 4300/mm3 with differentials of neutrophils 72% and lymphocytes 28%. Her FBS was 92mg/dl (normal); the TFT was normal. She was placed on tablet Fluoxetine 20mg to be taken in the mornings and tablet Nitrazepam 5mg at night for 2weeks to improve her sleep before the action of fluoxetine will be apparent. The role of supportive measures in helping her to recuperate faster such as listening to Christian music and watching Christian movies and support from her spiritual leaders’ and friends. She was referred to the clinical psychologist for psychotherapy in our facility. She was given a 4-week appointment but was asked to present if there was the need to before the next appointment.

First follow-up visit (13/10/2022): She was accompanied by her sister who attested that better [she was scored 8 out of 10]. She has been able to sleep better since onset of treatment. She was continued on Fluoxetine and was given 6weeks appointment.

Second follow-up visit: six weeks later (24/11/2022): DS, accompanied by her elder brother and mother came for follow-up as scheduled. She was calm and had a cheerful, [scored 8 out of 10]. Her pulse rate was 72bpm, blood pressure was 118/68mmhg, she had returned back to work and she was continued on tab fluoxetine and given another 6weeks appointment.

Third follow-up visit (05/1/2023): she came with her elder brother and was cheerful. She was sleeping and eating well. She said she was much better and appreciative of the care she had received. She was assessed to have improved and was advised to continue her medication and was given 6 weeks’ appointment.

Fourth follow-up visit (16/02/2023): The patient came with her elder sister as scheduled. She looked more cheerful. Her elder sister was counsel on self breast awareness and papsmear. She had resumed most of her normal activities and was interacting well with her family members and friends. She had no complaint, She was assessed to have improved and was advised to continue her medication and was given 6 weeks appointment.

Fifth follow-up visit (30/03/2023): She came back for follow-up after 6 weeks alone. She had no complaint. She was taking her drugs regularly. She was assessed to be responding to treatment and was encouraged to engage in regular enjoyable activities. The dose of tablet Fluoxetine was tapered over 6 weeks and she was educated on the withdrawal symptoms that it may lead to her experiencing some of her presenting symptoms. She was asked to visit the clinic if this happened. She was then given a 4 weeks’ appointment.

Sixth follow-up visit (27/04/2023): She came alone after 4 weeks. She had no complaint and was found to be happy and cheerful; she had no withdrawal symptoms. She was assessed to be well. She was counseled and medication was stopped. She was followed up for up to a year and follow up visits were uneventful. She was also counselled on the need to agree on a visiting schedule between the father and the child and also child support from the father.

Summary. She was a 34-year-old divorcee who had low mood, poor sleep and low energy. She had financial struggles with affected her performances at work and interaction with close associates. A diagnosis of moderate depression was made, and she had good recovery with pharmacotherapy and psychotherapy.

Discussion: The last decades of research have consistently found strong associations between divorce and adverse health outcomes among adults.1 The index patient is a 34-year-old female who presented with depression of 5 months’ duration due to a divorce which she blamed herself for. Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. The American Psychiatric Association’s Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) classifies the depressive disorders into Disruptive mood dysregulation disorder; Major depressive disorder; Persistent depressive disorder (dysthymia); Premenstrual dysphoric disorder; and Depressive disorder due to another medical condition.2,3 D.S had disruptive mood or dysregulation disorder otherwise known as moderate depression. Depression is a major contributor to the global burden of disease; affecting people in all communities across the world, it is a common mental disorder affecting more than 264 million people worldwide, ranking third after cardiac and respiratory diseases as a major cause of disability. More women are affected by depression than men.4 D.S is a woman, hence an identifiable risk factor for her case. The etiology of major depressive disorder is multifactorial with both genetic and environmental factors playing a role. First-degree relatives of depressed individuals are about 3 times as likely to develop depression as the general population; however, depression can occur in people without family histories of depression.5 D.S had no family history of depression. Neurodegenerative diseases (especially Alzheimer disease and Parkinson disease), stroke, multiple sclerosis, seizure disorders, cancer, macular degeneration, and chronic pain have been associated with higher rates of depression. Life events and hassles may also operate as triggers for the development of depression. Traumatic events such as the death or loss of a loved one, lack or reduced social support, caregiver burden, financial problems, interpersonal difficulties, and conflicts are examples of stressors that can trigger depression.6 Studies also, have shown a higher prevalence of depression among women. Several factors explain this phenomenon, as women in either abusive relationships or married to controlling husbands have higher odds of psychological distress.7 A statistically significant relationship have been found between family functioning and depression. One study reported that depressed patients who had unhealthy family functioning were three times more likely to experience depressive illness compared to their counterparts who were from healthy functional family.8 D.S suffered ill treatment and physical abuse from her philandering husband which eventually led to their separation for which she blamed herself. The Patient Health Questionnaire (PHQ-9) is a multipurpose tool that has been extensively used to detect depression and has been statistically validated for use in screening, diagnosing, monitoring, and assessing the severity of depression.9 This questionnaire was used for the assessment of the index patient and her score suggested moderate depression. D.S PHQ-9 score was 14/27 (Moderate depression). The investigation into depressive symptoms begins with inquiries of the neurovegetative symptoms which include changes in sleeping patterns, appetite, and energy levels. Positive responses should elicit further questioning focused on evaluating for the presence of the symptoms which are diagnostic of major depression.6 The DSM-5 have listed nine symptoms which includes: Sleep disturbance, interest/pleasure reduction, guilt feelings or thoughts of worthlessness, energy changes/fatigue, concentration/attention impairment, appetite/weight changes, psychomotor disturbances, suicidal ideation and depressed mood. Of these nine symptoms, five must be present to make the diagnosis.3 (one of the symptoms should be depressed mood or loss of interest or pleasure). All these symptoms were present in D.S except suicidal ideation and weight loss. The diagnosis of depression is based on history and physical findings. No diagnostic laboratory tests are available to diagnose major depressive disorder. Laboratory studies are, however, useful to exclude medical illnesses that may present as major depressive disorder.6 Some of the laboratory investigations carried out on D.S werefull blood count (FBC), thyroid function test (TFT) and serum electrolyte, urea and creatinine (E/U/Cr). D.S had a clinical diagnosis.10 Management of depression involves comprehensive assessment and proper establishment of diagnosis. According to the American College of Physicians (ACP) guideline on using second-generation antidepressants, usually 2–12 weeks (at a therapeutic dose and adherence to the regimen), are needed for a clinical response to become evident.11 The choice of medication should be guided by anticipated safety and tolerability, which aids compliance. Often, treatment failures are caused by medication non-compliance, inadequate duration of therapy, or inadequate dosing Selective serotonin reuptake inhibitors (SSRIs) are greatly preferred over the other classes of antidepressants for the treatment of depression. SSRIs have the advantage of ease of dosing and low toxicity in overdose.12 Fluoxetine, an SSRI was used in the management of DS with good response. The index patient was co-managed with a clinical psychologist. in which a collaborative bond is established between a patient and a provider (a psychologist or a suitably trained health professional) is also an important aspect of managing depression. It is aimed at reducing the gravity of the symptoms of depressive episodes/disorder and attaining a better level of functioning.6,11 Even after symptom resolution, patients being treated for depression should be monitored monthly for 6 to12 months and up to two years for those being treated for a recurrence.12

Lesson Learnt: Depression is globally on the rise. A World Health Assembly resolution has called for a comprehensive and coordinated response to mental disorders.1 Family physicians (as coordinators) are ideally placed to meet this gap in management of mental health patients in primary care, implement appropriate interventions and to refer to more specialized psychiatric services when necessary. This case also highlights the importance of a strong support structure in management of patients.

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**CASE 2:**

POST TRAUMATIC STRESS DISORDER IN A YOUNG BANKER FOLLOWING CAR ACCIDENT

Name: GE Marital Status: Married Managed At: GH, Lagos

Age: 29 Address: Ajao Estate, Lagos Hospital Number: 12831

Sex: Male Religion: Christianity Date First Seen: 16/09/2022

Occupation: Banker Tribe: Yoruba Date Last Seen: 18/2/2023

Presenting Complaint: Intense fear, poor sleep and flash backs x 5 month

History of Presenting Complaints: GE presented at the clinic on account of recurrent flash backs resulting in intense fear with occasional nightmare of about 5-month duration. The symptoms started one week after the incident. There was no history of being physically or verbally aggressive. GE was unable to initiate sleep early enough at night. He went to bed between 11PM and 12 MN because while on bed, he keeps ruminating over the past incident. He said the flashback of the occurrence resulted into occasional palpitations and difficulty in breathing which resolved spontaneously. There was no history of use of psychoactive substances.

There was no history suggestive of visual or auditory hallucination or poor hygiene. He had no history of low energy, low mood, or loss of interest in formerly pleasurable activities. There was no history of suicidal ideation.

He feared that he was going to have complications following the incidence despite reassurance from the previous physicians that attended to him post incidence that he was alright. He had idea that his symptoms were related to the event and feels guilty about the death that occurred. The symptoms made him to keep to himself and he doesn't always relate with his colleagues as much as before.

Review of Systems: There was no history of chest pain, cough or leg swelling. There was no history suggestive of paroxysmal nocturnal dyspnoea or orthopnoea.

Past Psychiatry History: There was no past history of psychiatric illness

Past Medical and Surgical History: He was not a known hypertensive, diabetic, asthmatic or peptic ulcer disease patient. He had no previous history of hospital admission or surgery.

Drug and Allergy History: He was not on any routine medication and had no known allergy.

Family and Social History: GE was single, but in a serious relationship. He's a banker. His mother is a 54 yrs. old business woman (trades in clothes), his dad is a 60 yrs. old pharmacist. He had a younger brother who is a lawyer and is doing well. They all had good relationship. There was no family history of psychiatric or chronic illness. GE lived in a two-bedroom flat in Magodo. He is in a stable relationship. GE’s monthly income was about 300,000. Their waste disposal was via LAWMA and source of potable water was table water.He neither drank alcohol nor smoked cigarette.

Personal History: He grew up in a highly functional family.

Forensic History: GE never had any case with a law enforcement agency.

General Examination: GE was not in obvious distress, he was afebrile, not pale, anicteric, not dehydrated, had no pedal oedema. he weighed 74kg, was 1.60m tall with a BMI of 22.92kg/m2.

Mental State Examination: GE had a friendly disposition, calmed but looks bothered. He was appropriately dressed and looks well kempt. He was co-operative and his speech was coherent. There was no abnormal perception or thought disorder. His mood was congruent, was well oriented in time, place and person. Immediate recall, short and long term memories were intact. Concentration was partial (He got 4 out of five steps of serial 7 test). His intellect and judgement were good. He was insightful.

Central Nervous System: G.E was conscious and alert. There was no cranial nerve deficit. The power was five in all the limbs and the tone and reflexes were normal across all joints. Cardiovascular System: The pulse rate was 84 bpm. The BP was 125/70 mmHg. The apex beat was located at the 5th LICS, MCL. First and second heart sounds only were heard.

Respiratory System: The respiratory rate was 18cpm. The trachea was central. The tactile fremitus and vocal resonance were equal on both hemithorax. The breath sound was vesicular.

Abdomen: The abdomen was full and moved with respiration. There was no area of tenderness. The liver and spleen were not enlarged and kidneys were not ballotable.

Diagnosis: Post traumatic stress disorder (PTSD) following a car accident which claimed a live

Differential Diagnosis: Panic attack

Management: The diagnosis of PTSD was explained to GE. This was because his symptoms started following a traumatic experience. It was explained to him that it was expected for him to have acute stress reaction following the incident but his symptoms that had lasted for more than four months made it a PTSD. He was told that he would benefit from psychotherapy and medications. Hepatitis B, C, HIV screening (after pre-test counselling) and Pap smear were requested. He understood and agreed with the line of management.

First Session of Psychotherapy (19/09/2022): The Psychologist was invited to the GOPC. Cognitive restructuring and prolonged exposure therapy which are types of Trauma focused therapy were done for him. He was further educated on the symptoms by the Psychologist. He was told that it was normal for him to have acute stress response to the event but his negative thought and feelings about himself, his neighbors and life had caused the exaggerated response which was worsened by the avoidance of the related memories and place of the event. The cognitive restructuring was to help him recognize his negative thoughts, reprocess them in a way that would enable him think positive about the incident. The prolonged exposure would expose him gradually to the happenings surrounding the incident through writing about it, narrating it verbally and mentally visiting the place of the incident. He was told that he would have need sessions of psychotherapy which was scheduled with the psychologist. He was told that he would need the support of his family. The Author and the Psychologist encouraged him to carry out the assignment he was given. He understood the line of managements and was ready to keep up to his appointments. He was given three days’ appointment.

First Follow-up Visit (22/09/2022): GE was seen with his friend. He just concluded the second session of psychotherapy. He had no complaint. Hepatitis B and C were negative; HIV was not reactive. The diagnosis of PTSD was explained to his friend. The need to complete all the sessions of the psychotherapy was explained to him and his friend. It was also explained to them that BS would need the support of the family members. He was given one-week appointment.

Second Follow-up Visit (29/09/2022): G.E had completed four sessions of psychotherapy He got good support from his friend and wife. He was relieved his sleep had improved. He could talk and write about the event vividly. He was given one-month appointment.

Third Follow-up Visit (28/10/2022): GE had completed all the sessions of psychotherapy. His relationship with his colleagues,neighbours and extended family members had gone back to normal. He could concentrate and focus better at work because he slept well at night. He was given two months and six months’ appointments respectively which he adhered to.

Summary: GE was a 29-year-old banker who presented with nightmares, recurrent flashbacks and occasional nightmares of fivemonths duration and associated insomnia following an RTA in which a youth copper they lifted died. He was managed for PTSD. He had sessions of psychotherapy with good outcome.

Discussion: GE was managed for post-traumatic stress disorder (PTSD), which is a psychiatric disorder resulting from witnessing a traumatic event. This disorder is common in people after being victims of incidents like natural disasters, a serious accident, a terrorist attack/war/combat, rape, or a life-threatening experience.1 GE was involved in a car accident whilst returning from to his hometown 5 month prior to presentation. PTSD develops in about 1 in 3 people who experience severe trauma.2 It was reported during a given year in the U.S that about 8 million adults had PTSD.3 Nigerian studies reported high rates among community samples, ranging from 42% in Jos to 60% in the Niger Delta region.4,5 A study found women to be twice as likely as men to have PTSD.6 A clear reason for this has evaded researchers, but several explanations have been proposed. One theory is that men and women are exposed to different types of traumas. A few studies have interestingly found no gender differences in PTSD prevalence.7 GE was a man with a severe traumatic experience, hence a level of risk of PTSD. Risk factors for development of PTSD includes biological and psychological factors like gender, childhood adversities, pre-existing mental illness, low socio-economic status, lack of social support, the nature and severity of the trauma.2,5 Types of events that can lead to PTSD are serious accidents (as seen in GE), physical or sexual assault, abuse, serious health problems such as being admitted to intensive care, childbirth experience such as losing a baby, war, conflict or torture.1,2 GE was involved in an accident which claimed the lives of some of the passengers in the vehicle he boarded. An overwhelming experience like witnessing the death of people in such manner brings tremendous stress on its victims.2,4 Some of the features of PTSD are experiencing or witnessing a stressful event, re-experiencing, avoidance and hyperarousal, negative alterations of cognitions and mood.8 GE presented with irritability, insomnia, self-blame, and avoidance of moving around in cars since the incident. To make a diagnosis of PTSD, symptoms must last for more than one month and must impair daily functioning.9 GE symptoms lasted for three months, and it affected his disposition towards work, marriage and other aspects of his life including sleep. Managing PTSD can be achieved by pharmacological, or psychotherapy means or a combination of the two.9 Trauma focused therapies and other psychotherapies should continue to be recommended as first line in all patients with PTSD.8,9 GE was managed with cognitive restructuring and exposure based therapies which are forms of cognitive behavioral therapy. Medication should be used in cases where psychotherapy is not available, unsuccessful, patient’s requests or when there is a compelling indication.10 GE had no indication for pharmacotherapy.

The family physician is uniquely placed in the recognition and management of patients with post-traumatic stress disorder.

Lesson learnt: A careful history to ascertain features suggestive of PTSD should be adequately taken in patients with severe traumatic life experiences to facilitate early diagnosis and treatment and total recovery.

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