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Case Report

Posttraumatic Stress Disorder and Major Depression Disorder: A Case Report of Yemeni Woman

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Abstract

In-depth interview was used to gain qualitative data and insight into the personal experiences of a Yemeni woman refugee after death of her mother. The case reported here was manifested by nightmares and periods of unreality associated to problems in concentration and social isolation. Suffering professional harassment while civilian war in Yemen and losing her mother who had dementia. Therefore, she opened up to us about her experiences in Yemen detailing her experiences of trauma as a result of war and we learned about her feelings after her divorce when she discovered the reality that her husband is homosexual. This case study meets both criteria of posttraumatic stress disorder and major depression disorder.

Keywords: Post traumatic stress disorder; Major depression disorder; War; Civilians

Case Presentation

A Yemeni woman was in 30 presented to our emergency unity *via* the general physician in the residence hall where she is living. She settled in Morocco about one year ago to continue her studies to achieve the equivalence of her diploma of neuro-physiologist which she obtained in Yemen.

After a long struggling with managing dementia in her mother the three last years, she was alone in front of that, her father went and married again, her brother traveled to Malaysia and lost his novella. She had in the same time conflicts with her husband because she discovered he is homosexual which impacted her a lot. The health of her mother became critical and the situation became more delicate with the war ambiance. Our patient had material difficulties to cover the hospitalization needed to her mother, and she was jobless too, she was victim of moral harassment in university where she was teaching neurophysiology. Her mother dead because of bed rest complications. After death of mother, she vended all what she had as goods to start her life in Morocco.

In-depth interview was used to gain qualitative data and insight into her personal experiences as a Yemeni woman refugee after death of her mother. The case reported here was manifested by nightmares and periods of unreality associated to problems in concentration and social isolation. Suffering professional harassment while civilian war in Yemen. Therefore, she opened up to us about her experience after her divorce when she discovered the reality that her husband is homosexual. We found Major Depression Disorder's (MDD) criteria associated to Post Traumatic Stress Disorder's criteria. (DSM-5).

She experienced sleep disturbance, anhedonia, and concentration difficulties.

A psychopharmacological treatment based on Sertraline was started with 50 mg and we increased the posology treatment to 100mg per day beside an anxiolytic treatment based on alprazolam which was effective in 4 weeks of treatment. Our patient starts to feel good with disappearance of sleep disorder and nightmares. In addition to medication, our patient received psychotherapy by psychologist in our institution, and she reported by herself that the combination of both medication and supportive psychotherapy was beneficial for her.

Discussion

To examine the mental health and cognitive effects of war trauma on war survivors in Yugoslavia, Başoğlu et al found that 33% of survivors suffered from PTSD [1]. De Jong et al attempted to study the impact of trauma in post conflict low-income countries where people have survived multiple traumatic experiences. They found the prevalence rate of assessed PTSD to be 37.4% in Algeria, 28.4% in Cambodia, 15.8% in Ethiopia and 17.8% in Gaza [2].

In this case it is illustrated the co-occurring PTSD and MDD. In previous studies that examined the prevalence

and predictors of PTSD or depression in countries that had experienced war atrocities. It's found that the

Prevalence of co-occurring PTSD and depression (9%) was higher than that of PTSD (8,8%) or depression alone (5,6%). [3]

The most common long-term symptoms of PTSD were related to low mood and cognition. Several studies have shown the co-occurrence of depressive symptoms and PTSD early on after trauma. Furthermore, research has shown that the occurrence of depression during the months that follow a traumatic event is an important mediator of chronicity in PTSD. [4]

Previous research studies assert that female sex is a risk factor for PTSD. The reason for this excess risk in women is not clear; however, some have proposed that women are more likely to perceive threatening events as stressful compared with men, and consequently, this may affect their mental health [4].

Treatment of PTSD and comorbid MDD is complex. The recommended medications are antidepressants; current guidelines for the treatment of PTSD recommend the initiation of a selective

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serotonin reuptake inhibitor (SSRI, e.g. paroxetine, sertraline, or fluoxetine) or serotonin-norepinephrine reuptake inhibitor (SNRI, e.g. venlafaxine). In the case of our patient sertraline was the antidepressant used [5].

Prazosin may be added as adjunctive therapy if the presentation of PTSD includes nightmares. If the initial trial of an SSRI or SNRI is not effective after 4 to 8 weeks, consideration of another first-line SSRI/SNRI or mirtazapine is warranted. Again, Prazosin can be added as an adjunctive medication when nightmares are present. A recent meta-analysis showed that the effect sizes for pharmacological treatments for PTSD are low (although comparable to effect sizes for MDD) and do not fare well relative to effect sizes for PTSD psychotherapies. With respect to PTSD/MDD comorbidity, Bernardy and Friedman report that there is some evidence to suggest that people with PTSD and comorbid depression respond more poorly to antidepressants than people with PTSD alone. However, they posit that people with comorbid PTSD/MDD who also report suicidal ideation and childhood trauma exposure may account for poor response to treatment [5].

With respect to psychotherapies, treatment recommendations for PTSD and MDD are distinct and there are no clear guidelines for treating the comorbidity. Treatment for PTSD includes trauma-focused therapies, which if effective, will also be associated with change in symptoms of depression, particularly if the depression is mild in severity. Prolonged Exposure (PE) and Cognitive Processing Therapy target avoidance, now considered by DSM-5 to be essential for diagnosis [5].

The panel recommends the use of the following psychotherapies/interventions for adult patients with PTSD: Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), Cognitive Therapy (CT), and Prolonged Exposure Therapy (PE). The panel suggests the use of Brief Eclectic Psychotherapy (BEP), Eye Movement Desensitization and Reprocessing (EMDR), and Narrative Exposure Therapy (NET) [5].

Conclusion

Post stress traumatic disorder is a mental health disorder that often follows war events and awareness of the possibility of dual diagnosis with major depressive disorder is recommended during managing civilians patients.

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