

## EDUCATOR INDUCED POST TRAUMATIC STRESS DISORDER (EIPSTD) IN A 6 YEAR OLD BOY

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### ABSTRACT

Post-traumatic stress disorder (PTSD) is a delayed and/or protracted response to exceptionally threatening or catastrophic events. The event is persistently remembered or relived with concomitant distress sometimes even leading to harmful life-long psychological sequelae. We present a 6-year old boy who developed the classical syndrome following corporal punishment at school when his class teacher injected an empty syringe into his gluteal region.

**Keywords :** Post-traumatic stress disorder, trauma, stressor, corporal punishment

### INTRODUCTION

A number of case reports and retrospective reviews have linked corporal punishment with development of post-traumatic stress disorder and other psychiatric illnesses in children<sup>1,2,3</sup>. The nosology of Post-traumatic Stress Disorder (PTSD) is based on adult psychopathology, child vulnerabilities are different. Childhood maltreatment has profound impact on the emotional, behavioral, cognitive, social and physical functioning of children. Developmental experiences literally determine the organizational and functional status of the mature brain and, therefore, adverse events can have a tremendous negative impact on the development of the brain<sup>4</sup>. Corporal punishment – a common form of childhood maltreatment – is commonplace among children both at home and in schools as highlighted by the South Asia Report of UNICEF (2001)<sup>5</sup>. It is often considered necessary in Asian cultures to children's upbringing, to facilitate learning and to instill discipline.

One-half of students who are subjected to severe punishment develop an illness called Educator- Induced PTSD (EIPSTD)<sup>6</sup>, a symptomatology analogous to the PTSD. PTSD requires the presumptive cause of trauma of which the initial view was war experience but the notion later extended to natural disasters, catastrophes<sup>7</sup>, physical attacks<sup>8</sup>, rape<sup>9, 10</sup>, child and wife battering and sexual abuses also medical events such as traffic accidents<sup>11, 12</sup>, heart attack, cancer or even hospitalization

following resuscitation<sup>13</sup>. The emotional responses<sup>14</sup> and threat to perception of self as an autonomous human being<sup>15</sup> play a significant part in PTSD-type response to any event.

15 years ago children were considered to respond to acute traumatic events with transient brief reactions however increasing data with full syndrome in childhood proves contrary. We present a case of a 6-year old boy who developed a full syndrome after receiving punishment from his class teacher.

### CASE STUDY

"M", a 6-year-old boy belonging to Sanghar, was brought to the outpatient clinic by his father and uncle with a 4-month history of aggressiveness, night terrors, disturbed sleep/appetite and school refusal. Immediate preceding development of these symptoms, the boy's teacher had injected an empty syringe into his buttock as punishment for misbehaving in class. Since then, he had become stubborn, aggressive and very demanding. There were frequent complaints from school of his poking others with pointed objects. At home he would wake up in the night crying, his appetite reduced to small demands like chocolates. "M" experienced flashbacks of the same event and refused school. His parents changed his school but he remained fearful, lacked interest in learning and avoided activities previously enjoyable.

He started school a year back. He belonged to an extended family setup with both parents illiterate. He is the elder of two siblings. His father is a businessman.

On examination he had low weight for his age and was unkempt, hyperactive and restless. It was difficult to establish rapport with him. Frequent staring/blinking of eyes was observed.

A diagnosis of post-traumatic stress disorder was

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made. He was prescribed Imipramine 25 mg /day increased to 50 mg/day(antidepressant) as he needed a sedating anti-depressant for sleep disturbances. Risperidone 0.5 mg/day(atypical antipsychotic) was added for agitation in a small dose and gradually tapered off in two weeks. He was advised regular follow-up every two weeks in which graded exposure was planned. Gradual improvement was observed over the next 2 months to complete return of functioning.

## DISCUSSION

PTSD is an anxiety disorder that stems from memories of a traumatic event. Signs and symptoms typically appear within three months and include flashbacks and distressing dreams of the event (in which the memories may themselves be a distorted form<sup>16</sup>), efforts to avoid thoughts and feelings related to the trauma and feelings of estrangement from others, hopelessness about future and physical/psychological hypersensitivity. In “M’s” case, the traumatic event being the punishment, all of the above immediately followed.

Age-specific symptoms of PTSD are now recognized<sup>17</sup>. Younger children may report more generalized fears such as stranger or separation anxiety, avoidance of situations that may or may not be related to the trauma, sleep disturbances, and a preoccupation with words or symbols that may or may not be related to the trauma. They may display posttraumatic play in which they repeat themes of the trauma and may lose an acquired developmental skill (such as toilet training) or show regression<sup>17</sup>. M re-enacted by poking his peers with pointed objects. Clinical reports suggest that elementary school-aged children may not experience visual flashbacks or amnesia for aspects of the trauma. However, they do experience “time skew” (mis-sequencing trauma related events when recalling the memory) and “omen formation” (a belief that there were warning signs that predicted the trauma). School-aged children also reportedly exhibit posttraumatic play or reenactment of the trauma in play, drawings, or verbalizations<sup>17</sup>.

Research on etiology focuses on psychological and biological mechanisms. Psychological mechanisms supported are fear conditioning<sup>18</sup>, negative appraisals of the event<sup>19</sup> and certain behaviors that maintain the state such as safety behavior, suppression, dissociation and drug abuse<sup>20</sup>. The boy had developed the habit of frequent staring and blinking. Certain biological characteristics have also been related such as enhanced negative feedback of the hypothalamic-pituitary-adrenal axis, evidence of sensitization of adrenergic and serotonergic systems<sup>21,30</sup>, a rise in endogenous opiates and increased levels of corticotrophin-releasing

factor<sup>22</sup>. Neuroimaging studies show reduced hippocampal volume, decreased blood flow in middle temporal lobes and increased flow in the limbic system<sup>23</sup>. This points towards a possible abnormal amygdala response.

Co-morbidity<sup>24</sup> is noted with affective disorders, other anxiety disorders, substance-use disorders and somatization. PTSD in children is often misdiagnosed as Attention-Deficit Hyperkinetic Disorder, childhood onset depression and conduct disorder. Pre-morbid anxiety and depression may prolong symptoms beyond 6 weeks. There is future risk of depression, eating disorders and cardiovascular disease with childhood maltreatment<sup>25, 26</sup>.

A cumulative risk model incorporating failure to thrive and maltreatment during early childhood is currently supported to be detrimental to child development<sup>27</sup> consistent with previous studies relating environmental risks to negative consequences. It is reported that 50 per cent recover within a year but one-third may not recover for many years. Such children may later on express antisocial tendencies, intense dislike for authority, school-dropout and evidence of high-risk adolescent behavior.

Best treatment options are cognitive-behavior therapy<sup>28</sup> in combination with SSRIs<sup>29</sup>. The former contains education of symptoms and treatment rationale, narrative-exposure, cognitive restructuring, stress inoculation and eye-movement desensitization reprocessing (EMDR). However a tricyclic anti-depressant was used for its sedation (the boy was having sleep disturbances). A small dose of anti-psychotic was used for agitation and tapered off in 2 weeks time.

Finally, research into the phenomena of corporal punishment and the root causes of violence in our society is needed and would pivot promotion of child mental/emotional health.

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