

Post-Traumatic Stress and Physical Disability: Two Sides of the Same Coin

Umer Ilyas¹, Syed Asadullah Arslan¹

¹ Department of Physical Therapy and Rehabilitation Sciences, Faculty of Allied Health Sciences, Superior University, Lahore, Pakistan.

* Correspondence: Umer Ilyas, umerilyas158@yahoo.com



EDITORIAL

The classical clinical paradigm has traditionally included the Post-Traumatic Stress Disorder (PTSD) as an entirely psychiatric injury of the mind. However, recent data in the world and neurobiological studies are beginning to point towards physical disability and PTSD as not two co-morbid conditions but in reality, two faces of the same neuro-physiological coin. By 2019, PTSD and/or Major Depression had impacted an estimated 316 million adult war survivors in the world, with the majority of them living in Low- and Middle-Income Countries (LMICs) (1). In America alone, the COVID-19 pandemic triggered a huge jump in the number of people affected in the population, with the post-traumatic stress sufferers reaching about 12 million. The justification of a revised rehabilitation model is based on the fact that PTSD is a manifestation of functional physical disability. The disorder goes way beyond the psychological distress to affect the immune system, change the structure of the brain, and cause chronic illness throughout the system. To approach PTSD as a purely cognitive phenomenon is to overlook that there is a physical aspect to the lives of the survivor. Thus, rehabilitation has to shift towards a multidisciplinary approach, which acknowledges somatic and structural changes, which are caused by chronic trauma.

Traumatizing of the Physicality and Biological Function. The essence of the argument that PTSD is a physical disability is anchored on the extent of its effects on the neuroanatomy integrity. Persistent exposure to traumas does not merely give rise to intrusive thoughts; it entails structural deterioration, which is evident in the brain. To be specific, studies that have been conducted using magnetic resonance imaging (MRI) have indicated that the volume of hippocampal is reduced by 8% in veterans who are severely affected by PTSD compared to the control groups. Moreover, recent cohort studies have found out that there is a substantial reduction of the volume of 22 thalamic nuclei in patients with PTSD (2). These are not changes in the mind, but physical changes that render vital processes like concentration, attention and mental agility impaired. In addition to the brain, PTSD causes a cascade of dysfunction of systems. A dysregulated hypothalamic-pituitary-adrenal (HPA) axis is common in people who are survivors, resulting in the abnormality of cortisol and norepinephrine (3). The resulting chemical imbalance, as a co-morbidity of immune and endocrine disorders, is shown in the form of cardiovascular problems, excessive blood pressure, and inflammatory complications such as pains in the joints or chronic headaches. The sources also suggest that close to 70 percent of the gendered groups of women who are afflicted with post-traumatic disorders that are severe enough eventually attain such physical challenges. This biological erosion illustrates that the stress of PTSD is a physical mechanism that has the ability to harm the physical structure of the circulatory and immune systems of the body in a physical manner. In addition to this, the disability of memory is referred to as an emotion-based memory trade-off and this demonstrates the operational impact of PTSD as a cognitive utility of the survivor. The neutral memories are often lost in favor of emotional memories related to the trauma, which compromises the working capacity of patients on a daily basis. The presence of the dose-response type of relationship that was present in Adverse Childhood Experiences (ACEs) intensified this impairment. The extent and frequency of childhood maltreatment have been found to be directly related to the severity of psychiatric and physical disability in the adult population. As an

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example, intimate partner violence (IPV) exposes children to nearly three times (OR = 2.96) increased chances of acquiring PTSD that commonly led to subsequent physical health issues and suicide attempts in adulthood. Lastly, the sector will need to address the socio-structural disability caused by PTSD since human beings are social beings, and how a survivor interacts with people and their cultures will define the course of recovery. The absence of trained professionals and financial resources in war-afflicted LMICs makes it a giant mental load (massive mental health burden), which cannot be resolved only with individualized Western therapies. The millions of survivors around the world will still be physically and socially incompetent to their environment and not only their neurobiology as there is nothing scalable like community based interventions or primary care integration. Conclusion and Future Prospect.

The facts are obvious regarding PTSD is that it is a severe mental disorder that impairs the nerves and influences the physiological functioning of a human body. The need to treat PTSD as a physical disability is imperative to enhance rehabilitation and make the disorder less invisible in the variable that tends to make it be ignored or not treated. In the future, the international community needs to move to the stage of a trauma-informed policy regarding the state of public health where the early childhood protection is the best means of residual disability prevention. Studies should also shift to come up with conclusive tests in medicine diagnosis that transcend the limitations of clinical interviews and questionnaires which are prone to recall bias. Through a combination of both biological, social and physical therapies, we will be able to transition to a more holistic rehabilitation paradigm, which recognizes that the mind and the body are not discontinuous, but a part of a system that fractures and mends together(2).

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DECLARATIONS

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