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SPECIAL REPORT

Treating psychological trauma in the real world

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How are potentially traumatic events categorised?

How should a diagnosis of PTSD be confirmed?

What are the treatment approaches?

THE IMPACT OF TRAUMA IS DIVERSE, AT TIMES COVERT, AND CAN BE SEVERE. THERE ARE A RANGE OF possible trajectories after a potentially traumatic event (PTE). Many people will experience only transient distress or no distress at all. However, others will suffer considerable morbidity and may develop post-traumatic stress disorder (PTSD).

Trauma survivors may present in primary care with physical or psychological sequelae or both.

PTEs are not rare.[1] Major disasters or terrorist incidents are obvious PTEs but more common events such as road traffic accidents, assaults, industrial injury, critical illness, miscarriage or severe burns can be PTEs as well.

A PTE can also affect those witnessing or confronted by it (the ripple effect).[2] PTEs can be categorised as either type 1 or type 2 trauma.[3]

Type 1 trauma results from a single, sudden event, that is often well defined and more public (e.g. a serious accident), and can occur at any age.

Type 2 trauma involves repeated trauma occurring over extended periods, and committed covertly by an individual often in a care giving role with the individual, who is generally, though not always, a child (e.g. neglect, abuse). PTEs in families are often accompanied by other risk factors.[4] Abduction, being taken hostage or prolonged combat exposure are also categorised as type 2.

TRAJECTORIES OF PTSD

The lifetime prevalence of PTSD in community samples ranges from 1.9% to 8.8%. A large general population survey of adults found a prevalence of 3% in England.[5]

Up to 60% of patients recover from acute PTSD within three months,[6] and around 20% will recover over the ensuing 1-2 years.[7] However, others will have no remission over six years, with trajectories including chronic dysfunction, relapse/remitting, and delayed dysfunction.[7,8] Although patients who receive treatment have a shorter duration of symptoms[6] those whose need is greatest do not always seek treatment.

AETIOLOGY

Whether an event is traumatic or not is determined by the perception of the individual, not by the clinician; this is equally true for threat to life or injury severity. Crucially, due to the interplay of resilience and vulnerability factors,[9] no PTE — no matter how horrific — will cause post-traumatic psychopathology in everyone who experiences it.[10]
A challenge for any resilience training is that resilience is domain based rather than a global phenomenon. Previous trauma may potentially either 'sensitise' or 'inoculate' the individual depending upon their view of that event and their ability to cope with it.

Even under the most extreme circumstances many individuals do not develop PTSD, as people can be remarkably resilient, though crucially if an individual has sufficient vulnerability an event of low magnitude may result in PTSD and/or other psychological issues. While the PTE is a key risk factor for PTSD lack of social support and life stresses after trauma have been found to be more influential,[11] see table 1, p22.

Outcome after trauma is the result of a complex interaction between features of the trauma, the patient, and their circumstances, see table 1, p22. Research has not yet delineated whether risk factors are additive, as many will cluster and some will predispose to others.

PRESENTATION IN PRIMARY CARE

Individuals may present at any phase of their response to trauma or may not present at all even after major incidents[12] and attend for another related or unrelated reason. Much like the grief response, individuals can expect their symptoms simply to improve with time, which they may, and only present when this fails to happen. Clinically, normal and abnormal reactions to trauma lie on a »

continuum distinguished by the intensity, duration and frequency of symptoms.

GPs should be alert to the potential of psychological effects alongside physical injury after major trauma or after critical illness, with high rates of PTSD, depression and anxiety recognised.[13]

Psychological reactions to traumatic experience can range from brief self-limiting distress to acute stress reaction/disorder, grief reactions, adjustment disorder or brief psychotic disorders. If an individual presents early post-trauma it is important to remember that common early normal reactions include: numbness and denial, fear, depression, anger, guilt, impaired sleep, perceptual changes and flashbacks.[14]

The majority of patients can be reassured that their reactions are likely to be normal and the clinician can adopt a position of active monitoring (watchful waiting), encouraging the patient to return if symptoms persist or worsen. If symptoms are present at three months they are likely to persist for much longer. Both survivor and performance guilt have been shown to be associated with severe acute PTSD and enduring PTSD.[15]

Potential chronic disorders include PTSD, complex PTSD, depression, panic or generalised anxiety, specific phobias and/or alcohol or substance misuse, dissociative, somatisation or eating disorders. As the range of response is so variable it is vital to ask about the occurrence of a PTE. Patients with PTSD avoid thinking or talking about the PTE and emotions such as shame may further limit disclosure.

In around a third of cases the likely outcome following a PTE will either be PTSD alone or with comorbidity, though this varies depending on the type of traumatic event with rates of PTSD higher for type 2 trauma. Although PTSD symptoms can be present acutely; the diagnosis requires that symptoms have persisted for one month. PTSD often has an early onset (at four weeks) with many patients improving quickly (within 3-6 months).

The occurrence of PTSD in isolation is rare, with > 80% of individuals having at least one other diagnosis, and three or more being common.[6] The separation of chronic depression and PTSD when comorbid is likely to be arbitrary;[16] although comorbid depression is a potential risk factor for suicide after trauma.[17]

Both the DSM and ICD classification systems have been reviewed, with DSM-5 published in 2013 and ICD-11 coming into effect in January 2022 (with a preview in 2019 to allow its adoption). ICD-11 proposes two sibling diagnoses: PTSD and complex PTSD[18] with the core symptoms of PTSD very similar in each system with somewhat different emphasis; the symptoms according to DSM-5 are included in table 3, p23.

Accurate diagnosis is not assisted by the myriad combinations of symptoms that can achieve the minimum DSM-5 diagnostic criteria – an estimated 636,120 ways to achieve a PTSD diagnosis,[19] thus allowing two people to have the diagnosis while sharing no symptoms. The criteria for, and management of, complex PTSD has been covered in an earlier article.[20]

ASSESSMENT

While delayed presentation is common, the immediate response of clinicians/carers to individuals following PTEs may influence subsequent adjustment. The role of GPs, alongside other key figures such as family, friends or faith group leaders, should not be underestimated. It is also important to remember the potential ripple effect of PTEs and therefore assess the impact on the patient's partner and/or family.

As there is no single diagnostic test for PTSD, self-reporting and good clinical interviewing skills are key. Factors to consider when assessing an individual post-trauma are listed in table 2, p23. Neurobiological studies have supported clinical findings that assessment must be handled sensitively as constructing a narrative of traumatic experience can be difficult and often dysregulating, see table 2, p23. The assessment should include psychological, social and physical needs and a risk assessment;[21] be aware of potential for ongoing risk of trauma. Good social support is crucial, and its absence is a risk factor for PTSD.

The inclusion of the aetiological factor, the PTE, as a core criterion for diagnosis, sets PTSD aside from other psychiatric disorders. Emphasis is placed on the individual's subjective experience, and he or she must have been involved in or witnessed a PTE or learnt about a PTE occurring to someone close to them.

The core symptoms of PTSD are listed in table 3, p23, and they must be present for at least one month and cause functional impairment. Comorbidity and symptom overlap with depression or anxiety means that PTSD can be missed, or conversely because of the relative noise of PTSD, depression not identified.

There are numerous self-report measures that may help in the assessment of patients following trauma, each with strengths and relative weaknesses. Questionnaires are generally acceptable to patients and indeed some may prefer them to discussing their symptoms. The use of questionnaires may improve accurate identification of PTSD by non specialists. However, questionnaires may support diagnosis but are no substitute for a diagnostic interview. In primary care the Trauma Screening Questionnaire (TSQ), a free 10-item validated scale providing good specificity, can be useful.[22] The Impact of Events Scale-Revised Version (IES-R)[23] is another free, frequently used scale. These tools can be used in a similar fashion to the use of questionnaires for the detection and follow-up of depressive symptoms in primary care.

REFERRAL

As even resilient individuals may experience a brief period of distress after a traumatic incident, it can be challenging to distinguish them from those who are developing a significant acute or longer-term post-traumatic disorder. It is important to identify those actually requiring intervention and

Table 1

Risk factors for PTSD

Patient-related factors
- Acute stress reaction
- Family or personal history of mental disorder
- Perceived seriousness of physical injury*
- Past experience of trauma
- Age, race and gender (predictive in certain populations only)
- Early life adversity

Trauma-related factors
- Trauma severity
- Sudden, unexpected events
- Manmade rather than natural events
- Prolonged exposure
- Perceived threat to life*
- Multiple deaths and/or mutilation
- Personally relevant factors, e.g. the involvement of a child
- Proximity to the trauma

Environmental factors
- Lack of social support (or inability to utilise it)
- Ongoing life stresses
- Economic resources
- Lower educational and socioeconomic levels

* It is the patient's not the clinician's perception that is important and predictive

therefore target treatments, and not to intervene when people are adjusting appropriately.

Guidelines and expert opinion support the principle of active monitoring. Within the initial four weeks some individuals may develop a mental health disorder, such as acute stress disorder (ASD) and require earlier or urgent psychiatric/psychological assessment and intervention; for ASD this will be a trauma-focused cognitive behavioural therapy (TF-CBT) intervention.[21,24] Early diagnosis and intervention are important but accessing psychological therapy in that timescale may be difficult.

Many areas will have specific psychological therapy services that will typically offer NICE recommended treatments[21] though these may vary. Referral options will include referral to community mental health teams. When considering a referral it is worth noting that psychotherapy is considered first-line treatment for PTSD, though severity and complexity – including comorbidity – and suicidal thoughts (common) and/or homicidal thoughts will potentially necessitate an urgent referral and/or involvement of other disciplines. The input of psychiatry may also be needed if psychological intervention is unavailable, and medication considered for symptomatic relief or in the presence of comorbid depression.

In different areas of the UK there are specialist services for discrete trauma populations to whom people can be referred, see Useful information box, p25. This includes services for: former military personnel, blue light services personnel, refugees (in key areas) and intensive care follow-up clinics. It is also important to be aware that former military personnel are entitled, where appropriate, to treatment above and beyond typical NHS treatment through the Armed Forces Covenant, and many areas ask for confirmation of veteran status to allow priority to be given to these patients.

Delayed presentation is common, with those most needing treatment not always accepting it. The very resilience »

Table 2

Assessment post-trauma – features to consider

Timing of presentation	How long since the PTE? Longitudinal – what is the trajectory? Why presenting now – anniversary, specific reminder, functional impairment?
Range of possible reactions	Do not think just PTSD, remember comorbidity Do not think only core criteria PTSD (e.g. survivor guilt, traumatic bereavement, suicidal thoughts)
Taking the history	Do not push too fast – may be dysregulating Reassure the patient that an exhaustive description is not needed Do not open up issues if you personally are not going to work on them with the patient Be aware that an absence of emotion is not an absence of response – consider numbing, dissociation, part of the survival response (e.g. freeze)
Clinical assessment	When, how and where did the PTE happen? Who was involved? How did the patient react/how did others react?
Patient's recall	Any gaps in memory? How does memory progress - freeze frame or DVD? All sensory modalities Confirm what the patient remembers and what others have told them Patients will commonly get timing and order of events wrong. Usually not intentional, may be part of fear response (e.g. attention freeze)
Spouse or partner	Corroboration Explain typical reactions How they can help Identify any ripple effect

Table 3

Core symptoms of PTSD (DSM-5 diagnostic criteria)

Intrusive (re-experiencing) phenomena
One or more of:
- Recurrent distressing recollections (involuntary)
- Nightmares related to the PTE
- Flashbacks in any sensory modality
- Distress triggered by reminders
- Physiological reactions to internal or external cues to the PTE

Persistent avoidance of reminders of the PTE
One or both of:
- Avoidance of external reminders (e.g. people, situations, activities)
- Avoiding thinking about or remembering the event

Negative alterations in cognition and mood associated with the PTE
Two or more of:
- Amnesia for important aspect(s) of the event
- Persistent and exaggerated beliefs about self, others or the world
- Persistent, distorted cognition about cause or consequences of the PTE (self-blame, locus of control shift)
- Persistent negative emotional state (fear, horror, anger, guilt or shame)
- Loss of interest or participation in significant activities
- Feeling detached or estranged from others
- Emotional numbing – unable to feel positive emotion

Hyperarousal symptoms
Two or more of:
- Sleep disturbance
- Irritability/angry outbursts
- Reckless or self-destructive behaviour
- Concentration difficulties
- Hypervigilance
- Exaggerated startle response

Symptoms for at least one month

Functional impairment

which enables individuals to survive trauma (e.g. self-reliance) may mean they are less likely to access treatment. Primary care is ideally placed to review the response to treatment proactively; of course, patients may avoid GPs too.

'The very resilience which enables individuals to survive trauma (e.g. self-reliance) may mean they are less likely to access treatment'

MANAGEMENT

Treatment is difficult for patients post-trauma for many reasons, including unrealistic expectations of treatment (it will not wipe the slate clean); premature discontinuation of therapy; comorbidity, or intense feelings of shame or guilt undermining engagement as they may feel unworthy or not deserving of treatment. It is important to provide sufficient accurate information during early sessions but also to be wary of overloading the patient.

Comorbidity is the norm rather than the exception. The NICE guideline for PTSD suggests that the PTSD should be treated first, but the relative severity of the comorbid disorders and/or risk of self-harm will need to considered. Flexibility within psychotherapy is vital and often an adjunctive approach of medication alongside therapies will be necessary. Disengagement from TF-CBT is a risk where significant depression is present and will likely facilitate later trauma therapy.[25]

Trauma experts have suggested a range of therapeutic approaches for PTSD, but there have been few empirical studies. As a result the NICE guideline, updated in 2018, accepts that the majority of evidence is low or very low quality with a handful of exceptions.[21,26]

Psychological therapies

NICE recommends that all patients should be offered trauma-focused psychological interventions.[21] TF-CBT for which there is the most evidence should be the first choice and eye movement desensitisation and reprocessing (EMDR) second choice. EMDR is currently recommended for non-combat related PTSD as NICE considered the benefits as not significant for combat-related PTSD. The use of internet or computer-based therapies may offer new ways of delivering therapy.[27] TF-CBT also provides some clinical benefits for depression and anxiety symptoms.[28]

The strong recommendations by NICE are surprising as there has been a lack of studies comparing effectiveness of psychological and pharmacological treatment or indeed a combination of these, making definitive conclusions difficult.[29] The difference between effect sizes for therapies and medication may be methodological artefact, and of course guidelines are not mandates.

Both the BAP guidelines[29] and The Matrix, in Scotland,[30] highlight pragmatic considerations such as service availability and patient choice. Attempting to generalise from studies showing efficacy in research settings to clinical effectiveness is fraught with pitfalls and the exclusion of patients with complexity of presentation including comorbidity or suicidal intent places these patients beyond the guidelines and encourages primary care and perhaps some secondary care clinicians to seek a specialist opinion.

Pharmacological treatments

The updated NICE guideline describes medication as a second-line approach. Medication should therefore be considered when psychotherapy is contraindicated (e.g. because of an ongoing threat), declined, unavailable or ineffective.[31]

Moreover, some patients are beyond the scope of the guideline because of comorbidity and/or treatment resistance, and thus expert opinion will need to guide treatment.

The updated NICE guideline recommends an SSRI or venlafaxine; a change from the 2005 guidance (which suggested paroxetine or mirtazapine for general use or amitriptyline or phenelzine by specialists).[32]

Risperidone, a second-generation antipsychotic was recommended for severe hyperarousal.

As the NICE guideline only measures PTSD outcomes in generalities i.e. improvement in global PTSD symptoms, the mounting evidence for prazosin, an alpha-1 adrenoceptor antagonist, specifically for PTSD nightmares and sleep disturbance was not included.[33]

Clinical experience has long shown that some individuals will manage psychotherapy only after successful pharmacotherapy but this is not captured in the revised NICE guideline.[21]

Cautions with medication include sexual side effects and sedative effects but it should be noted that few psychotherapy studies report adverse effects. However, the wrong therapy or therapist at the wrong time may be psychonoxious, i.e. psychologically harmful to the patient.

MONITORING AND FOLLOW-UP

Guidelines are vital but inherent within all guidelines is the caveat of patient preference. Having been injured already, being shoe-horned into an algorithm of care or model of follow-up will be perceived as a further insult (a secondary wounding). Moreover, the fact that many patients have lost trust in authority or authority figures may impact on their engagement in services if an autocratic position is taken.

Where management is shared with secondary or tertiary care there should be clear agreement about which service/individual is undertaking monitoring and follow-up.[21] It is often helpful to check that the stated care plan of treatment matches what the patient reports receiving. Transitions in treatment (of therapy, medication, therapist, or between services) can be challenging and support will be needed. Risks, including suicidality and homicidality, need to be assessed and reviewed.

Avoidance is a core PTSD symptom – in fact avoidance is essential for PTSD diagnosis in DSM – so the assumption that non-attendance equates to all being well should not be made.

'Many patients with PTSD suffer from incapacitating anxiety so may avoid engagement in treatment, and assertive follow-up will probably be necessary'

Also, many patients with PTSD suffer from incapacitating anxiety therefore they may avoid engagement in treatment, and assertive follow-up will probably be necessary. This should be explored as part of the referral and flagged up as there may be a means of facilitating engagement.

key points

SELECTED BY

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There are a range of possible trajectories after a potentially traumatic event (PTE), with many individuals experiencing either no distress or only transient distress, while others suffer considerable morbidity and may develop post-traumatic stress disorder (PTSD). PTEs can be categorised as either type 1 or type 2 trauma. Type 1 trauma results from single, sudden events and can occur at any age. Type 2 trauma involves repeated traumatic experiences occurring over extended periods.

If someone presents early post-trauma it is important to remember that common early normal reactions include numbness and denial, fear, depression, anger, guilt, impaired sleep, perceptual changes and flashbacks. The majority of patients can be reassured that their reactions are likely to be normal and the clinician should adopt a position of active monitoring (watchful waiting), encouraging the patient to return if symptoms persist or worsen. However, some individuals may develop a mental health disorder, such as acute stress disorder (ASD), within the initial four weeks and require urgent psychiatric/psychological assessment and intervention; for ASD this will be a trauma-focused cognitive behavioural therapy (TF-CBT) intervention.

Approximately one-third of people experiencing a PTE will develop PTSD, though this varies depending on the type of traumatic event and rates of PTSD are higher with type 2 trauma. Although PTSD symptoms can be present acutely, the diagnosis requires the persistence of symptoms for at least one month and the symptoms should cause functional impairment. PTSD in isolation is rare, with > 80% of patients having at least one other diagnosis.

The core symptoms of PTSD are classified by DSM-5 as: intrusive (re-experiencing) phenomena, persistent avoidance of reminders of the PTE, negative alterations in cognition and mood associated with the PTE, and hyperarousal symptoms. For non specialists the use of a screening tool such as the Trauma Screening Questionnaire may facilitate accurate identification. However, although questionnaires may support a diagnosis, they are no substitute for a diagnostic interview.

NICE recommends that all patients should be offered a psychological intervention. TF-CBT should be the first choice but eye movement desensitisation and reprocessing is an option for non-combat-related PTSD. Medication should be considered when psychotherapy is contraindicated (e.g. because of an ongoing threat), declined, unavailable or ineffective. NICE recommends either an SSRI or venlafaxine. However, in view of the lack of studies comparing the effectiveness of psychological and pharmacological treatment, other guidelines recommend a pragmatic approach based on service availability and patient choice.

CONCLUSION

The exposure to traumatic events can trigger a range of psychological responses, ranging from transient distress to long-term psychological disorders such as PTSD. There are effective treatments, and the management of an individual should prioritise psychological interventions alongside the physical but not simply blindly follow guidelines.

Competing interests: None

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Useful information

UK Psychological Trauma Society
www.ukpts.co.uk

British Association for Behavioural and Cognitive Psychotherapies
www.cbtregisteruk.com

EMDR
www.emdrassociation.org.uk/site.php/profile/categories

Former Service Personnel (Veterans)
Many areas/health boards now have a lead practitioner or Forces Champion

Confederation of Service Charities
www.cobseo.org.uk

Veterans Scotland
www.veteransscotland.co.uk

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