key points

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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.