

key points

SELECTED BY

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Most people experience at least one potentially traumatic event (PTE) during their life. Many will develop only transient distress and not a psychological illness. Even the most inherently horrific event does not invariably lead to the development of a psychological disorder while an individual with sufficient vulnerability may develop post-traumatic stress disorder (PTSD) after what appears to be an event of low magnitude.

The lifetime prevalence of PTSD in community samples ranges between 1.9% and 8.8%. A large general population survey of adults in England found a current prevalence of 3%. Up to 60% of patients recover from acute PTSD within three months, but for some there will be no remission by six years.

The diagnosis of PTSD differs from most psychiatric disorders as it includes an aetiological factor, the traumatic event, as a core criterion. The DSM 5 core symptoms of PTSD are grouped into four key symptom clusters: re-experiencing, avoidance, negative cognitions and mood, and arousal. Symptoms must be present for at least one month and cause functional impairment.

It can be difficult to distinguish the early reactions of resilient individuals who are experiencing temporary distress from others who have an acute or a developing longer-term disorder. The majority of individuals will not require treatment and watchful waiting rather than treatment is recommended during the initial four weeks. Treatment options include referral to mental health specialists or the prescription of medication if psychological intervention is declined or there is comorbid depression.

NICE recommends that all patients should be offered trauma-focused psychological interventions, with the greatest evidence base for trauma-focused CBT and eye movement desensitisation and reprocessing. The usual medication of choice is an SSRI (paroxetine or sertraline). PTSD patients can avoid engaging in treatment and assertive follow-up may be necessary.