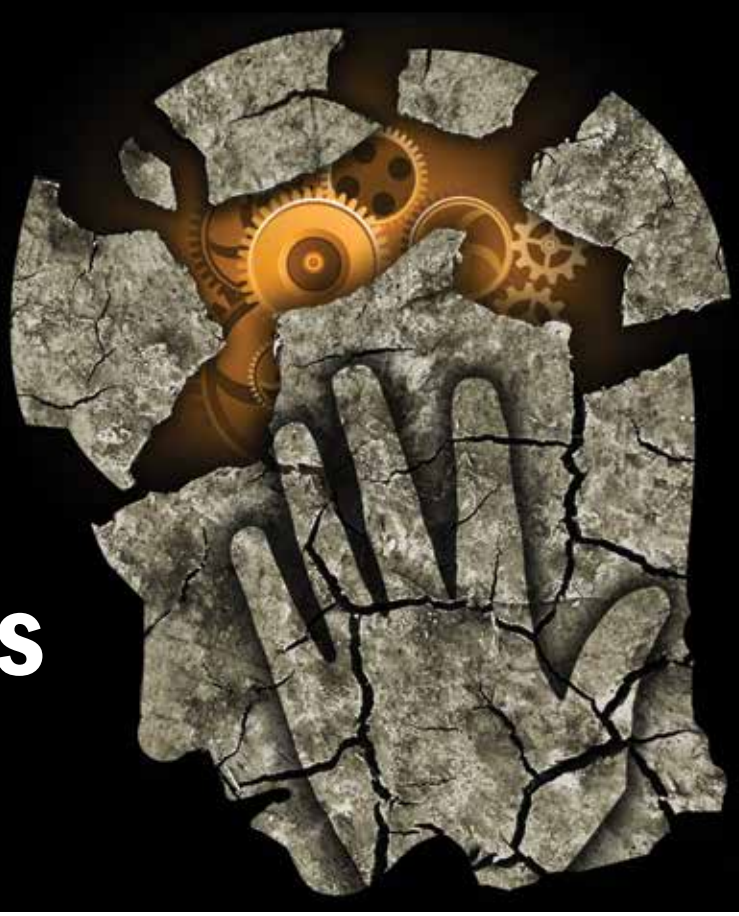

Recognising and managing traumatic stress reactions and PTSD

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GPs have an important role in recognising traumatic stress symptoms and aiding natural recovery in patients who have experienced a traumatic event. GPs are also ideally placed to identify patients with severe or persistent symptoms and to guide them to appropriate treatment for acute stress disorder or post-traumatic stress disorder.

Exposure to traumatic events (in which someone experiences or observes a severe threat to life or limb, or learns that this occurred to someone close to them) is the norm, with 75% of Australians exposed to at least one such event during their lifetime.[1] GPs are well placed to assist patients in the aftermath of traumatic events (either single events or those that are more prolonged, such as domestic violence) and to recognise and help manage traumatic stress reactions. Recognition of potential traumatic stress reactions in primary care may be especially important, as individuals may seek medical care after trauma but not necessarily assistance for mental health.[2,3]

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What to expect in the aftermath of trauma

Common stress reaction symptoms after experiencing a traumatic event include low mood, anxiety, teariness, arousal symptoms (including elevated heart rate, muscle tension, disrupted sleep and impaired concentration), intrusive memories and thoughts about the event, distress at reminders and an urge to avoid associated memories. For most people, these symptoms settle in the few weeks after the traumatic event, as they re-engage with social support and gradually resume their usual daily activities.[4] Patients with stress reaction symptoms should be asked about their duration. If symptoms persist for four weeks or longer then the diagnosis of post-traumatic stress disorder (PTSD) should be considered.

How to assist in the aftermath of trauma

Core principles in the management of patients after a traumatic event are to promote a sense of safety, calm, personal effectiveness, connection with others and hope. Recommended steps include the following.[5]

- Assess physical health – conduct an appropriate assessment of any physical injuries and provide treatment as needed.
- Ensure patient safety – depending on the trauma type (e.g. interpersonal assault, natural disaster or accident), ongoing physical risk should be determined and appropriate safety actions taken (e.g. helping the individual avoid personal danger). Risk of harm to self or others should be checked to enable appropriate referral to specialist support services.
- Assist the patient to meet basic life needs – depending on the trauma, a person's access to housing, finance,

1. SUGGESTED ADVICE FOR PATIENTS ABOUT EMOTIONAL HEALTH AFTER A TRAUMATIC EVENT

- Allow yourself to feel emotions that commonly follow trauma, such as sadness, anxiety and distress. These are normal and often pass
- It is normal to have unpleasant thoughts, memories or nightmares about what happened. Discuss how you feel and what happened if you want to, but only if you feel comfortable
- Allow sufficient time for sleep/rest, maintain regular healthy meals, try to resume a normal routine gradually as you feel able and engage in exercise and pleasurable activities. Planning your day may be helpful
- Avoid using drugs and alcohol as a means of coping
- Seek support from trusted others as needed
- Practice controlled breathing to manage your physical feelings of anxiety:
  - breathe in slowly through your nose for approximately 3 seconds
  - hold for 1 to 2 seconds
  - breathe out slowly through your mouth for approximately 3 seconds through pressed lips (thinking the word 'relax' while doing this may be helpful)
  - pause for 1 to 2 seconds
  - repeat for as long as necessary when needed and aim to practice for approximately 5 minutes, three times daily

transport, employment, food and other necessities may be affected, and they will need relevant community support services.

- Provide education on common trauma reactions – patients should be informed that it is common to experience distress after significant trauma, which may show as any of the symptoms described above. Patients should also be informed that these symptoms typically settle in the days and weeks after the event as they resume their usual activities.
- Advise the patient on managing current emotional health – suggest techniques to manage arousal symptoms (Box 1).
- Undertake watchful waiting – review the patient within one month.

When traumatic stress symptoms are severe and less than four weeks has passed since the trauma, a diagnosis of acute stress disorder (ASD) should be considered. Referral to a psychologist or psychiatrist with specialist training in assessing and treating traumatic stress may be appropriate. Consider this referral earlier when the patient is extremely distressed or has a history of previous trauma.

2. PRIMARY CARE PTSD (PC-PTSD) SCREEN[11]

In your life, have you ever had any experience that was so frightening, horrible or upsetting that, in the past month, you:

- have had nightmares about it or thought about it when you did not want to? YES / NO
- tried hard not to think about it or went out of your way to avoid situations that reminded you of it? YES / NO
- were constantly on guard, watchful or easily startled? YES / NO
- felt numb or detached from others, activities or your surroundings? YES / NO

Although provision of practical and emotional support may be helpful soon after trauma, individuals should not be encouraged to focus specifically on their trauma memory as part of routine care at that time.[6] This may interfere with natural recovery.

The above strategies may be helpful for patients who have experienced a trauma regardless of the time since the trauma but may be most relevant within the first four weeks. Exercise judgement on whether and how to communicate this information to patients who have experienced more enduring symptoms.

Recognising and managing PTSD

For a minority of people, traumatic stress reaction symptoms do not remit within the few weeks after the trauma, and a diagnosis of PTSD should be considered. PTSD can be chronic when untreated, with 50% of cases persisting up to 14 years.[7]

PTSD is characterised by at least four weeks of:

- ongoing re-experiencing of the traumatic event (e.g. through distressing memories, nightmares, flashbacks or distress at reminders)
- elevated arousal (e.g. muscle tension, disturbed sleep, memory or concentration, elevated startle response or hyperalertness to threat)
- avoidance behaviour (e.g. avoiding situations, conversations, memories or feelings that act as reminders of the trauma)
- negative mood and thought content.

Feelings of anger, shame, guilt or sadness are common. Full diagnostic criteria can be found in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (*DSM*-5) and the *International Classification of Diseases, 10th revision* (*ICD*-10).[8,9] There is some evidence for a subtype of PTSD, often referred to as complex PTSD, with additional difficulties of emotion dysregulation, identity disturbance and interpersonal functioning. This can be (but is not always) associated with exposure to severe prolonged trauma (e.g. child sexual abuse).[10] Patients with suspected complex PTSD require appropriate assessment through expert referral.

3. HELPFUL RESOURCES ON TRAUMATIC STRESS

Information on treatment and guidelines

- *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder.* Melbourne: Phoenix Australia – Centre for Posttraumatic Mental Health; 2013 (http://phoenixaustralia.org/wp-content/uploads/2015/03/Phoenix-ASD-PTSD-Guidelines.pdf)[6]
- *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)*[8]
- *International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10)*[9]
- *Management of Mental Disorders.* 5th ed. Andrews G, Dean K, Genderson M, et al. Sydney: UNSW Australia; 2013[4]
- THIS WAY UP program. Clinical Research Unit for Anxiety and Depression (https://thiswayup.org.au/how-we-can-help/courses/posttraumatic-stress-disorder-ptsd-course)
- Practitioner and patient information. Phoenix Australia – Centre for Posttraumatic Mental Health (http://phoenixaustralia.org)

Self-report screens and measures

- Life Events Checklist for DSM-5 (LEC-5) (http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp)[13]
- Primary Care PTSD Screen (PC-PTSD) (http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp)[11]
- PTSD Checklist for DSM-5 (PCL-5) (http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp)[12]

Information for the public

- For people affected by trauma. Phoenix Australia – Centre for Posttraumatic Mental Health (http://phoenixaustralia.org/recovery/fact-sheets-and-booklets)
- For survivors of sexual assault. NSW Government Justice Victims Support and Services (http://www.victimsservices.justice.nsw.gov.au)
- For people exposed to combat-related trauma. Australian Government Department of Veterans' Affairs (http://at-ease.dva.gov.au/veterans/recognise-the-signs/common-mental-health-disorders/post-traumatic-stress-disorder)
- For people who have experienced a motor vehicle accident. NSW Government State Insurance Regulatory Authority (http://www.sira.nsw.gov.au/motor-accidents/injury-advice-centre/emotional-recovery)

Standardised measures can be used to help screen patients for PTSD. The Primary Care PTSD Screen (PC-PTSD) is a brief four-item questionnaire requiring yes/no responses (Box 2).[11] If an individual answers 'yes' to at least three items then formal assessment for PTSD is indicated. The PTSD Checklist for DSM-5 is a 20-item questionnaire to which the individual responds on a five-point scale to indicate the disturbance posed by each PTSD symptom.[12] A total score of 33 suggests the presence of PTSD.[12] Appropriate referral and treatment should be considered for patients with possible PTSD.

Some helpful resources regarding traumatic stress, ASD and PTSD are listed in Box 3.[4,6,8,9,11-13]

Treatment of PTSD

Trauma-focused cognitive behavioural therapy (CBT) is considered the gold standard in treatment of patients with PTSD and has strong research support.[14] The theoretical underpinning for trauma-focused CBT proposes that PTSD is maintained by unhelpful beliefs and patterns of avoidance that preclude processing of the trauma memory. Therefore, recommended treatment components include gradual, prolonged exposure to the trauma memory to enable mastery of the memory and associated distress, as well as modification of unhelpful beliefs. Additional useful components include dearousal skills (e.g. controlled breathing) and graded exposure to avoided situations associated with the trauma.

Adjunctive selective serotonin reuptake inhibitors (SSRIs) may be considered to treat comorbid depressive symptoms or when patients are unwilling or unable to engage in psychological treatment, but are not a recommended first-line treatment for people with PTSD. Benzodiazepines are also not a recommended first-line treatment and can interfere with trauma-focused CBT. However, they may be considered for judicious, intermittent use for sleep disturbance persisting more than one month that has been unresponsive to sleep hygiene and psychological interventions, provided that tolerance and dependence are assessed and closely monitored.[6]

Referral options

Patients with suspected PTSD should be referred to a psychologist or psychiatrist trained in assessing trauma-related stress disorders and in delivering trauma-focused CBT for PTSD.

Conclusion

Although exposure to traumatic events is common, most exposed individuals typically recover without intervention. GPs are in an ideal position to facilitate this recovery and also to identify people who are not recovering and guide them to helpful treatment services. MT

References

A list of references is included in the website version of this article (www.medicinetoday.com.au).

COMPETING INTERESTS: The Clinical Research Unit for Anxiety and Depression, where Dr Allen and Professor Andrews work, receives money from sales of *Management of Mental Disorders* and patient enrolments in cognitive behavioural therapy courses available at the website www.thiswayup.org.au. Dr Allen also organises mental health training workshops from which he derives financial benefit.

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References

1. Mills KL, McFarlane AC, Slade T, et al. Assessing the prevalence of trauma exposure in epidemiological surveys. Aust N Z J Psychiatry 2011; 45: 407-415.
2. Bryant RA. Early intervention after trauma. In: Schnyder U, Cloitre M, eds. Evidence based treatments for trauma-related psychological disorders: a practical guide for clinicians. Cham, Switzerland: Springer International Publishing; 2015. p. 125-142.
3. Schnurr PP. Understanding pathways from traumatic exposure to physical health. In: Schnyder U, Cloitre M, eds. Evidence based treatments for trauma-related psychological disorders: a practical guide for clinicians. Cham, Switzerland: Springer International Publishing; 2015. p. 87-103.
4. Andrews G, Dean K, Genderson M, et al. Management of mental disorders. 5th ed. Sydney: School of Psychiatry, UNSW Australia; 2013.
5. Forbes D, Lewis V, Varker T, et al. Psychological first aid following trauma: implementation and evaluation framework for high-risk organizations. Psychiatry 2011; 74: 224-239.
6. Phoenix Centre – Centre for Posttraumatic Mental Health. Australian guidelines for the treatment of acute stress disorder and posttraumatic stress disorder. Melbourne: ACPMH; 2013.
7. Chapman C, Mills K, Slade T, et al. Remission from post-traumatic stress disorder in the general population. Psych Med 2012; 42: 1695-1703.
8. Diagnostic and Statistical Manual of Mental Disorders, 5th ed: DSM-5. Arlington, VA: American Psychiatric Association; 2013.
9. International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10). Geneva: WHO; 1992.
10. Bryant R. The diagnostic spectrum of trauma-related disorders. In: Schnyder U, Cloitre M, eds. Evidence based treatments for trauma-related psychological disorders: a practical guide for clinicians. Cham, Switzerland: Springer International Publishing; 2015. p. 107-124.
11. Prins A, Ouimette P, Kimerling R, et al. The primary care PTSD screen (PC-PTSD): development and operating characteristics. Primary Care Psychiatry 2003; 9: 9-14.
12. Weathers FW, Litz BT, Keane TM, Palmieri PA, Marx BP, Schnurr PP. The PTSD checklist for DSM-5 (PCL-5). National Center for PTSD, US Department of Veterans Affairs; 2013. Available online at: http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp (accessed January 2017).
13. Weathers FW, Blake DD, Schnurr PP, Kaloupek DG, Marx BP, Keane TM. The life events checklist for DSM-5 (LEC-5). National Center for PTSD, US Department of Veterans Affairs; 2013. Available online at: http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp (accessed January 2017).
14. Watts BV, Schnurr PP, Mayo L, Young-Xu Y, Weeks WB, Friedman MJ. Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. J Clin Psychiatry 2013; 74: e541-e550.