Exposure to traumatic events such as serious accidents, physical or sexual assault, or abuse is sadly not uncommon. Approximately one in three people in the UK report experiencing a significant traumatic event during the course of their life, although this figure is likely to be considerably higher for those working in trauma-exposed occupations such as the military, emergency services or in many health-related professions, and in less developed countries where trauma is more commonplace.

Many individuals will experience short-term distress symptoms post-trauma; however, most will recover over time without the need for formal psychological treatment. In a minority of cases, trauma exposure can lead to psychological injury that may manifest as adjustment disorder, depression or post-traumatic stress disorder (PTSD).

Individuals who develop PTSD can experience significantly reduced quality of life as a result, with symptoms potentially impacting their relationships with others, their performance at work, as well as sleep patterns and daily functioning.

**Diagnosing PTSD**
Diagnosing PTSD requires an individual to have been exposed to ‘actual or threatened death, serious injury or sexual violence’ either through direct contact, witnessing, by indirectly learning that a very close family member/friend has been exposed to a violent or accidental trauma, or from an accumulation of direct or indirect exposure to aversive details of traumatic event(s) – usually through the course of professional duties (eg personnel working with child abuse cases). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes four core symptom clusters that must be present to make a diagnosis of PTSD (see Table 1).

These symptoms must have been experienced for more than one month to meet diagnostic criteria. When assessing for PTSD, the National Institute for Health and Care Excellence (NICE) guidelines recommend healthcare professionals ask questions about trauma exposure – giving the patient examples of traumatic events, as well as whether specific symptoms (eg avoidance, dissociation, hyperarousal, etc) are being experienced.

Complex PTSD, described in the International Classification of Diseases (ICD-11), may develop in a subset of individuals who are either particularly vulnerable or where trauma exposure is often prolonged or repetitive, from which escape is difficult or not possible (for example, torture, slavery, prolonged domestic violence, childhood sexual/physical abuse). Complex PTSD requires the diagnostic requirements for PTSD to be met, as well as the criteria outlined in Box 1.

Importantly, all forms of PTSD require the individual to experience significant impairment in personal, social, educational, occupational or other important areas of functioning. Symptoms in the absence of such impairment does not constitute a diagnosis of PTSD.

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**Table 1. DSM-5 PTSD Diagnostic Criteria**

<table>
<thead>
<tr>
<th>Criterion A</th>
<th>Traumatic stressor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criterion B</td>
<td>Intrusive re-experiencing of the event (such as traumatic nightmares or flashbacks)</td>
</tr>
<tr>
<td>Criterion C</td>
<td>Avoidance of reminders of the traumatic event</td>
</tr>
<tr>
<td>Criterion D</td>
<td>Alterations in arousal and reactivity (such as hypervigilance, exaggerated startle response or irritability)</td>
</tr>
<tr>
<td>Criterion E</td>
<td>Negative alterations in mood and cognition (such as persistent negative affect or self-perception, or amnesia for key parts of the trauma not caused by alcohol, head injury and/or drugs)</td>
</tr>
</tbody>
</table>

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Victoria Williamson, Postdoctoral Research Associate; Neil Greenberg, Professor of Defence Mental Health, King’s Centre for Military Health Research, Institute of Psychiatry, King’s College London
diagnosis of PTSD, although they may warrant other diagnostic labels, such as a trauma-related adjustment disorder.

**PTSD prevalence and risk factors**

The prevalence of PTSD in the UK is estimated at 4.4%. Comorbidity rates are often greater than 80%, with the most common comorbid conditions being depression, anxiety, and substance misuse.

Rates of PTSD differ considerably between occupational groups, with prevalence rates of up to 20% of ambulance workers, 33% of security contractors, 20% of war reporters, and between 7–30% of combat troops. Rates of PTSD and other psychological problems are often higher in UK military veterans and reservists compared with those who are still serving, potentially due to a lack of social support and difficulties transitioning into civilian life. Research also suggests that rates of PTSD are highest in veterans who had recently deployed in a combat role to Iraq or Afghanistan.

While anyone can develop PTSD following trauma exposure, incidence increases with trauma severity. Other risk factors can include: previous psychiatric disorder; subsequent life stress post-trauma; a history of childhood adversity; low educational attainment; appraisals of the work in operational theatre as being above an individual's trade or experience; and low unit/organisation morale or poor social support.

**Treatment**

Formal therapeutic intervention is often unnecessary in the first month following trauma exposure. Indeed, the early provision of psychological debriefing or trauma counselling is contraindicated as it may increase the likelihood of longer-term mental disorder. Instead, the provision of social support and a temporary reduction in exposure to stressors may facilitate recovery in many cases.

NICE advocates active monitoring of distressed trauma-exposed personnel in the first month after an incident.

Several psychological interventions have been developed for PTSD, including exposure therapy, trauma-focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR). The NICE guidelines (see Figure 1) recommend TF-CBT for individuals who present with PTSD one to three months post-trauma, although individuals with PTSD symptoms that persist for longer than three months post-trauma should also be offered TF-CBT, with additional sessions provided if needed.

TF-CBT has been found to be effective for improving PTSD symptoms following exposure to a variety of trauma types, including combat trauma. EMDR is also a mainstream PTSD treatment. Both treatments are usually delivered as 8 to 12 weekly sessions. While medication for PTSD is not recommended as a routine first-line treatment strategy it can often have a role in treating symptoms and comorbid depression, or severe hyperarousal.

NICE guidelines advise that venlafaxine or a selective serotonin reuptake inhibitor, such as sertraline, is considered for adults with a diagnosis of PTSD if the patient has a preference for drug treatment.

**Box 1. ICD-11 complex PTSD criteria**

1) Meets diagnostic requirements for PTSD
2) Problems in affect regulation
3) Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event
4) Difficulties in sustaining relationships and in feeling close to others

Asking about prior exposure to trauma sensitively and enquiring about associated symptoms (as described above), as well as the impact the trauma has had on their lives, should be within the capability of all healthcare professionals. Those identified as having PTSD should be provided with appropriate information (for example, the Royal College of Psychiatrists’ PTSD information leaflet) and directed to attend a formal assessment, particularly where there are concerns about persistence or severity of symptoms.

Information should also be provided to families/caregivers who may help encourage individuals to attend formal assessments, as avoidance is a key PTSD symptom and unfortunately most people in the UK who have PTSD do not receive any professional intervention at all.

Particularly for workplace trauma, there is good evidence that peer support programmes may be especially effective in promoting recovery.

Within the UK military, research has found that investment in improving informal and formal support to trauma-exposed troops is successful, both in protecting the mental health of service personnel and in reducing the stigma around mental health problems within the forces. Therefore, it may be worthwhile for healthcare professionals to provide information regarding local organisations and peer support groups, such as MIND or the Veterans Gateway for military veterans.

It should be noted that while the media often portrays emergency
Adult with post-traumatic stress disorder (PTSD) or clinically important symptoms of PTSD presenting more than one month after traumatic event

- Trauma-focused cognitive behavioural therapy
- Eye movement desensitisation and reprocessing
- Supported trauma-focused computerised cognitive behavioural therapy
- Cognitive behavioural therapy for specific symptoms
- Drug treatment

Figure 1. NICE Flowchart for PTSD treatment

Service personnel/veterans with PTSD can experience significant mental health difficulties, including secondary PTSD symptoms and emotional dysregulation problems, as a consequence. The provision of psychoeducation to families, an assessment of families’ own needs, as well as practical and emotional support, may be beneficial to support familial coping. Military-affiliated charities, such as the Royal British Legion, Help for Heroes or Combat Stress, may be particularly well placed to provide military-connected families with targeted advice and support.

Summary
While most people exposed to traumatic events may experience short-term distress, the minority who develop PTSD can experience a debilitating condition that affects not only their lives, but the lives of their families, colleagues and friends. In the initial days and weeks after a traumatic event, most people benefit from access to good social support and a temporary reduction in the stress they are experiencing. PTSD prevalence rates are similar between adult men and women in the UK general population (4.4%). Young women (16–24 years old) have been found to be more likely to meet PTSD criteria (12.6% compared with 3.6% of men of the same age), although this effect declines with age.

For the minority who do develop PTSD, there are evidence-based talking therapy treatments available that can improve functioning. While it is ideal to access such treatments within months of a trauma so that the negative impact on someone’s life is minimised, the good news is that treatment can be effective even after a delay – allowing people with the condition to continue to lead fulfilling lives once again, even if the full resolution of symptoms is not possible.

Declaration of interests: none declared.

References