Post-traumatic stress disorder (PTSD) affects an estimated 1 in 10 people, according to the charity PTSD UK. In much the same way as attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder is a very real, but often misunderstood, condition.

The term was officially recognised in 1980 by the American Psychiatric Association, in its third edition of the Diagnostic and Statistical Manual of Mental Disorders, a tome (now on its fifth edition) used across the world to classify psychiatric health conditions. Before this, people who were struggling after experiencing some form of trauma – military combat being a common culprit – were often doubted, shunned or feared.

The defining characteristic of PTSD is that it develops after an event involving high levels of stress or threat; for example, a serious accident or assault, abuse, torture, intensive care admission or traumatic childbirth.

The Royal College of Physicians highlights that it is possible to experience something that is overwhelming or frightening – particularly individuals whose work involves dealing with these situations on a regular basis, such as police officers, fire fighters, paramedics and army officers – and get over it without any help.

In order to meet the diagnostic criteria for PTSD set out in the tenth edition of the World Health Organisation’s International Classification of Diseases, the patient will also be experiencing:

• intrusive recurring thoughts or images of the traumatic event, which they may describe as flashbacks, memories or dreams, or may manifest as obsessively trying to address issues around the occurrence, such as how it could have been avoided or prevented, or what else could have happened
• avoidance of anything associated with the event (not present beforehand)
• hyperarousal; for example, difficulty sleeping, irritability, outbursts of anger, concentration problems, hypervigilance
• reduced emotional responsiveness; depression is very common, as is social withdrawal

There are several points worth noting in relation to the above:
• symptoms usually develop immediately after the event, but for some (up to 15%) onset can be delayed by months or even years. This does not affect treatment, but can make diagnosis more difficult
• children may present differently, re-enacting the experience repetitively or talking about frightening dreams without being able to describe the content, which again can make diagnosis difficult
• concurrent problems are common, particularly mental health conditions.

Complex PTSD tends to affect individuals who have experienced repeated trauma; for example, abuse, neglect or violence, and may be more severe if the events happened during childhood, a parent or carer was involved, the person was alone when the incident(s) happened, and/or there is still contact with the aggressor.

Behaviour and self-confidence – understandably – may be altered. Children with complex PTSD can be regarded as difficult or challenging, while adults may have issues with trust – such as feeling that nobody can understand what happened to them. Dissociation is not uncommon, as well as physical symptoms – such as headaches, chest pain and stomach ache – and destructive or risky behaviours, such as substance misuse, self-harm and suicidal thoughts.

A sufferer of PTSD will not necessarily seek help directly, but instead may be recognised during another medical intervention; for example, during treatment for an assault or accident, or when someone discloses having experienced trauma, such as childhood sexual abuse or domestic violence.

It is a condition for which age is no barrier: the National Institute for health and Care Excellence (Nice) states in its recently updated guidance (that can be found at tinyurl.com/CDptsd) that around 25-30% of people experiencing a harrowing episode will go on to develop PTSD, as will up to 30% of children attending A&E departments for a
There can sometimes be a significant shift in behaviour as a result of the attacks.

- **Specific phobias** manifest as fear and avoidance of certain situations.
- **Adjustment disorder** can develop after less severe stressors than those present in PTSD (for example, bereavement, separation or retirement), or as a less severe response compared with that of PTSD; for example, low mood, anxiety, a sense of not coping, finding it hard to plan ahead, some impairment in completing everyday tasks.
- **Conduct disorder** is a condition that can affect some young people, and manifests as fighting, refusing to follow rules, and sometimes truancy and staying out all night.
- **Dissociative disorders** involve partially or completing losing the usual integration between memories of the past, awareness of identity and immediate sensations, and ability to control body movements. There are a number of conditions that fall under this umbrella, including dissociative amnesia and multiple personality disorder. Onset may be abrupt or gradual, and duration transient or chronic.\(^6\)

### How is it managed?

Nice describes several key components of care with regards to PTSD:

- **Assessment** should be comprehensive and include evaluation of the patient’s physical, psychological and social needs.
- **Patients** (and loved ones) should be reassured that PTSD is treatable.
- **Care plans** should: take into account the individual’s specific needs (school children, for example, have very different requirements to those of asylum seekers); minimise movement between different services or providers; offer flexible modes of delivery (for example, video consultations and messaging) or care in non-clinical settings, such as schools or offices; and establish clear links to other pathways, such as for physical health problems.
- **Treatment** should not be delayed; for example, because of court proceedings, substance misuse or compensation applications.
- **Triggers** that could worsen symptoms should be avoided, such as noisy hospital wards, as they may deter patients from accessing treatment.
- **Consideration** should be given to the support of family members and carers.

For children with a diagnosis of PTSD or experiencing symptoms of the condition, an individual trauma-focused cognitive behavioural therapy (CBT) intervention is regarded as the most appropriate form of treatment. Nice guidance gives more specific recommendations with regards to age.

Pharmacological treatments are not generally advised, but eye movement desensitisation and reprocessing (EMDR) has a place for children who do not respond to or engage with trauma-focused CBT (see Therapies, p3).

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CBT intervention is also generally considered appropriate. EMDR has a place, as does supported computerised trauma-based CBT, and sometimes targeted CBT interventions for specific symptoms, such as sleep disturbances or anger, if the patient has residual symptoms after first-line CBT or is unwilling or unable to engage with such therapy.

Unlike in children, drug treatments do have a place for adults who want to pursue this route: venlafaxine or a selective serotonin reuptake inhibitor, such as sertraline, are the agents recommended by Nice. The organisation also states that antipsychotics, such as risperidone, can be used alongside psychological therapies for adults with disabling symptoms or behaviours that have not responded to other treatments.41

How can pharmacists and pharmacy teams help?
The role of community pharmacy is limited in the direct management of PTSD, but there is certainly the potential to provide general support and advice. The Royal College of Physicians describes some basic lifestyle measures that can be helpful – and are all too often overlooked – such as avoiding too much caffeine, alcohol and nicotine, making the effort to eat and exercise regularly, keeping life as normal as possible (for example, by going back to work), and trying relaxation techniques.

More specific points include:
• taking care when driving, as concentration may be poor
• not bottling up feelings, but instead speaking to a doctor and other trusted individuals
• spending time with people, rather than being alone for hours or days on end
• not setting unrealistic expectations with regards to ‘moving on’.
There is also a valuable role for pharmacy teams in supporting the friends, relatives and colleagues of PTSD sufferers. Some simple pointers outlined by the Royal College of Psychiatrists include not minimising the trauma, but instead giving the person time to tell their story without interruption. During this time, watch out for signs that they are not coping; for example, changes in behaviour, such as poor performance or attendance at work; or alterations in mood, such as anger, irritability or hopelessness.

Gently drawing attention to signs of stabilisation can be positive, for instance, highlighting how someone with PTSD is now able to tolerate longer periods without flashbacks or anxiety, and has started to disconnect physical symptoms from the memories that used to provoke them. You can also encourage grounding techniques, such as concentrating on how it feels to be in the present, as opposed to the trauma of the past.

Therapies
Trauma-focused CBT typically runs for six to 12 sessions, though more may be needed, and should be adapted to the individual’s requirements. It involves:
• psychoeducation about reactions to trauma
• strategies for managing arousal and flashbacks
• safety planning
• processing of memories and emotions, including shame, guilt, loss and anger
• help to overcome avoidance.

For adults, one of the focuses is on re-establishing adaptive functioning (for example, work and social relationships), whereas for children, parents or carers are likely to need to be involved. Booster sessions are often planned in, particularly in relation to significant dates.

EMDR involves the patient recalling distressing images while generating sensory stimulation, most commonly side-to-side eye movements, but sometimes sounds that alternate between left and right speakers or headphones, alongside physical movements such as finger tapping. It is believed that this therapy enables negative memories to be processed – without recalling the event in detail, as is the case with trauma-focused CBT – and reduces the level of psychological arousal associated with the recollection. Nice states that EMDR should typically be delivered over eight to 12 sessions, and have the same aims as trauma-based CBT.42

References
1. PTSD UK. Who is affected by PTSD?
7. NHS. Complex PTSD.
8. EMDR Institute: What is EMDR?
9. King’s College London. Troubling extent of trauma and PTSD in young people

More information
NHS Choices is a good first stop for patients: tinyurl.com/ptscpd7.
The mental health charity Mind has information on the condition: tinyurl.com/ptscpd8.
The Anna Freud National Centre for Children and Families is another useful resource, particularly for young people: tinyurl.com/ptscpd9.
Two of the organisations that may provide more specific support are The Survivors Trust, for those who have been through sexual abuse or violence (tinyurl.com/ptscpd10), and Combat Stress, for members of the armed forces (tinyurl.com/ptscpd11).
PTSD UK provides information about the condition and treatments available to patients: tinyurl.com/ptscpd13.
PTSD CPD – planned learning

What are you planning to learn?
I want to learn more about post-traumatic stress disorder (PTSD), including what it is, how it presents and other conditions it could be mistaken for. I want to learn about how PTSD can be managed and improve my knowledge of how pharmacists and their staff can support patients with this condition and those they are close to.

This learning will help me to refresh and maintain my existing skills and knowledge about PTSD and to be able to confidently provide advice to patients and carers, spot at-risk patients and know when to refer.

How are you planning to learn it?
- I plan to find out more about PTSD on the Mind website at tinyurl.com/ptsdcpd1.
- I plan to read more about eye movement desensitisation and reprocessing (EMDR) on the PTSD UK website at tinyurl.com/ptsdcpd6.
- I plan to find out about sources of information and support for patients with PTSD, such as PTSD UK at tinyurl.com/ptsdcpd3, The Survivors Trust at tinyurl.com/ptsdcpd4 and Combat Stress at tinyurl.com/ptsdcpd5.

Give an example of how this learning has benefited the people using your services
The mother of a young woman who had been attacked while walking home asked to speak to me about PTSD. Her daughter had been diagnosed with the condition after the attack and was having cognitive behavioural therapy (CBT), but her mother was very worried about her and wanted information about any help and support she could give. I was able to explain what CBT is and how it can help, and suggested they see their GP again if symptoms did not improve. I was also able to give some advice from the CPD article and signposted her to the Mind website, specifically the section for friends and family.

Take the 5-minute test online

1. PTSD develops after an event involving high levels of stress or threat. 
   True or false
2. Symptoms of PTSD include intrusive recurring thoughts or images of the traumatic event, hyperarousal and reduced emotional responsiveness. 
   True or false
3. In around 35% of cases of PTSD, onset of symptoms is delayed by several months or years. 
   True or false
4. Concurrent problems, such as mental health conditions, are common alongside PTSD. 
   True or false
5. Complex PTSD tends to affect individuals who have experienced repeated trauma – for example, abuse, neglect or violence. 
   True or false
6. Nice states that around 50-60% of people experiencing a harrowing episode will go on to develop PTSD. 
   True or false
7. For children with PTSD, the most appropriate form of treatment is trauma-focused CBT. 
   True or false
8. Eye movement desensitisation and reprocessing therapy is not suitable for use in children. 
   True or false
9. Amitriptyline is recommended by Nice for the first-line treatment of PTSD in adults. 
   True or false
10. Trauma-focused CBT typically runs for six to 12 sessions. 
    True or false

You can complete the quiz and logsheet by visiting bit.ly/UPDATE-PLUS and searching ‘1916’