BROADER HORIZONS

Post-traumatic stress disorder

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Broader Horizons is a series of short papers on topics that are outside the field of bereavement, but linked to it. The aim is to give some information about subjects allied to bereavement that readers may find relevant to their work, eg. cognitive behavioural therapy, nutrition and mental health, therapies for children, how to use a library/the web, the Cochrane reports, family therapy, EMDR, or psychological trauma.

Post-traumatic stress disorder (PTSD) is the term given to a constellation of symptoms that can follow exposure to a traumatic event, and may cause clinically significant distress or harm in social, occupational, or other important areas of functioning. After accidents or disasters involving death, survivors may have to deal with both bereavement and the traumatic experience. It may be difficult for shocked and disturbed survivors to grieve for a loved one as this frequently involves recalling images of the deceased, and when such recall is especially distressing, mourning may be inhibited.

During the 20th century, war has been a major influence on the development of the concept of post-traumatic stress disorder. In the First World War (1914–1918), the belief that the psychological responses to terrifying experiences were the result of physical injury or dysfunction of the central nervous system was strongly held and described as 'shell shock.' The involvement of the USA in the Vietnam War (1964–1975), during which 20% of combatants witnessed atrocities or abusive violence, provided further stimulus to study and led to the development of the concept of PTSD. By the end of the 20th century, post-traumatic stress disorder and other psychological after-effects had been reported in both adults and children after a wide variety of traumatic events, including man-made and natural disasters, kidnapping, sexual assault, torture and road traffic accidents, as well as after domestic violence, and even after childbirth.

The diagnostic criteria for PTSD are presently defined by the American Psychiatric Association in their *Diagnostic and Statistical Manual of Mental Disorders* or *DSM-IV-Text Revision* (2000), and by the World Health Organization in the *Classification of Mental and Behavioural Disorders – 10th edition* (1992). The two definitions vary somewhat but, essentially, post-traumatic stress disorder can be described as a delayed and/or protracted response to a traumatic or stressful event or situation, either short or long-lasting, of an exceptionally threatening or catastrophic nature, including serious accidents.

Typical symptoms include:

- episodes of repeated reliving of the trauma in intrusive memories or dreams; acting or feeling as if the traumatic event were recurring; intense psychological distress or other symptoms when exposed to cues that symbolise or resemble an aspect of the traumatic event
- avoidance of activities and situations that are reminiscent of the trauma and thoughts, feelings, conversations or other stimuli associated with it
- increased arousal (not present before the trauma), as indicated by difficulty falling or staying asleep, irritability or outbursts of anger, concentration problems, over-vigilance for possible dangers, and an exaggerated startle response
- a persisting background sense of numbness, emotional blunting and detachment from other people, eg. unable to have loving feelings; a markedly diminished interest or participation in significant activities, an inability to enjoy life
- inability to recall an important aspect of the trauma
- anxiety, depression and a sense of a foreshortened future may also be present.

The onset follows the trauma after some time, a period that may range from a few weeks to months (but rarely exceeds six months). The symptoms should have lasted more than one month and be causing clinically significant distress or difficulty in coping. In *DSM-IV-TR* (2000), PTSD is described as being 'acute' when the duration of symptoms is less than three months, and 'chronic' when the symptoms have lasted three months or longer. For 'delayed onset,' at least six months have passed between the traumatic event and the onset of the post-traumatic symptoms.

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From the above, it should be clear that it is not appropriate to make a diagnosis of PTSD in the first hours and days after a disaster or trauma. Symptoms such as nightmares, poor sleep and so on may occur in the immediate aftermath and individuals may appear dazed and disorientated, but so long as this resolves within a few days it is better described as an 'acute stress reaction.'

It is important to remember that post-traumatic stress disorder is a developing concept. The diagnostic criteria are not 'written in stone', but continue to evolve in the light of clinical experience and information from research. One difficulty with the present systems of classification is that they assume that disorder is either present or absent, with no opportunity to consider severity. Another difficulty is that, sometimes, one traumatic incident may appear to 'sensitise' an individual who, after another trauma (perhaps years later) then develops post-trauma symptoms that seem related to the original trauma. Also, PTSD may occur after seemingly minor accidents and indeed, the concept has been criticised by some as representing 'the medicalisation of distress.' What is important to remember is that diagnostic criteria are clinical guidelines, not simply a checklist; clinical judgment is essential in their use.

Epidemiological studies suggest that PTSD or sub-threshold PTSD may be present in a significant proportion of a population, although it may not be recognised as such. It may co-exist with other psychiatric conditions, particularly depression. The concept of PTSD has now been extended to include children, although it is still uncertain to what extent the developmental status of the child or other factors (such as the child's perception of its family's reaction to the disaster) influences the symptoms (Sheeringa *et al*, 1995).

What is the explanation of PTSD?

No single model offers a comprehensive view of post-traumatic stress disorder. Psychodynamic models, behavioural models, and cognitive models have been proposed. Some researchers have found changes in the way parts of the brain (such as the hypothalamus) and brain chemicals (such as encephalins) work in traumatised individuals. It has also been suggested that an understanding of memory may assist in the understanding of the various responses seen after traumatic events. Research continues, and it is to be hoped that a clearer understanding of the origins of PTSD will help in the development of effective therapeutic techniques.

Interventions and treatment

When treatment for PTSD is indicated, a variety of approaches are presently used, both in adults and in children. Such interventions should be undertaken only by those with the necessary training and professional qualifications. In adults, behavioural and cognitive approaches have been increasingly used over the past 15 years or so, usually involving exposure (either real-life or imagined), cognitive therapy, or anxiety management training. Psychotherapy may be individual, group, or with a family. A further technique, eye movement desensitisation and reprocessing (EMDR), has been reported as useful by many therapists, both in adults and in children, although it remains unclear how it works. There is little evidence that drug treatments have a central role in the treatment of PTSD but they are indicated when there is associated psychiatric disorder, such as depression.

Most treatment plans for children should involve both families and schools. This may be especially relevant when the adults have themselves experienced the traumatic event. Distress in the adults may mean that they are less able to recognise distress in the children for whom they have responsibility or that they are relatively unavailable to respond to the children's needs.

This is a short review of PTSD but those interested in reading more may wish to refer to previously published articles in *Bereavement Care*. Turnbull and Gibson (2001) have outlined the

diagnostic criteria and Parkes (2001) discussed how the recognition of PTSD as an illness acknowledges the part that life events may play in the onset of disorder. In 2002 (Newman, 2002) I reviewed the history of attempts to describe responses to trauma and considered how this related to the experience of bereavement. An additional source of information is the Clinical Guideline on PTSD, published by the National Institute for Clinical Excellence (NICE) in March 2005 (available at www.nice.org.uk). As the *Bereavement Care* articles make clear, the way in which responses to trauma are understood and explained has, to a large extent, reflected beliefs prevalent in society at the time. ■

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Forthcoming events

Managing bereavement in schools. Course for professionals to raise awareness of grief, loss and bereavement in schools and to help teachers support pupils in class who have experienced bereavement. 22 May. Belfast. £90. Education Department, Northern Ireland Hospice Care, Belfast, Northern Ireland. *Details* www.nihospicecare.com; *Email* education@nihospicecare.com; *Tel* +44 28 9078 1836

Cross-cultural issues in death, grief and bereavement. International conference. 31 May–3 June. Madison, WI, USA. *Details* www.uwlax.edu; *Email* Gerry Cox cox.gerr@uwlax.edu

Young people facing bereavement. 7 July. Multi-professional course for those working directly with young people about their needs in facing loss and bereavement. £90. St Christopher's Hospice, London, UK. *Details* www.stchristophers.org.uk/education; *Email* education@stchristophers.org.uk; *Tel* +44 20 8768 4656

Cruse Bereavement Care Golden Jubilee international conference. 16–17 July. University of Warwick, Warwick, UK. Keynote speakers: Robert Neimeyer, Memphis University, USA; Brett Kahr, Centre for Child Mental Health, London, UK. *Details* conference@cruse.org.uk; *Tel* +44 20 8939 9530

Emotion and identity in death, dying and disposal. Ninth international death, dying and disposal conference. 9–12 September. Durham University, Durham, UK. *Details* www.dur.ac.uk/cdals; *Email* conferenceadministration.service@durham.ac.uk