# Managing the risk of post-traumatic stress disorder (PTSD): best practice for prevention, detection and treatment

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In this issue, Bonde and colleagues [1] present a comprehensive systematic review of the time course of symptoms in post-traumatic stress disorder (PTSD) with delayed expression. Finding that in most cases PTSD is preceded by traumatic stress symptoms during the first year, they conclude a need to monitor traumatic stress symptoms after trauma exposure to identify those at risk of developing PTSD. This work draws attention to the prevalence of traumatic stress symptoms after trauma exposure, as well as indicating the potential to identify those likely to develop PTSD at a later point in time based on earlier symptoms. This indicates the value of revisiting what we know about best practice in managing the risk of PTSD.

Decades of research pointing to the potential for negative psychological outcomes from trauma has motivated the development and implementation of interventions that aim to ameliorate initial distress and mitigate lasting impact. 'Psychological debriefing' was developed with the aim of circumventing maladaptive trauma responses by promoting cognitive and emotional processing in the immediate aftermath of trauma to reduce the opportunity for disordered cognitive and behavioural patterns becoming ingrained [2]. Despite being widely advocated for use after traumatic events in the 1980s and 1990s, it has largely been discredited. Contrary to its aims, reviews of the evidence suggest debriefing could interfere with the natural recovery process and heighten the risk of PTSD. This led to

calls for routine debriefing to cease, although there is some evidence for more positive effects of debriefing as a cohesive group, as in the case of military personnel [3].

Naturally, there has been considerable interest in the development of effective alternatives to psychological debriefing. Over the past two decades, a variety of psychological approaches have been developed for delivery soon after trauma, based mostly on cognitive behavioural therapy (CBT) [3,4]. Although there is some evidence for the beneficial effects of multi-session early CBT with a trauma focus (CBT-TF) for individuals with traumatic stress symptoms, it is recommended that these interventions are reserved for those who fulfil diagnostic criteria for acute stress disorder or PTSD [5].

Given the available evidence, there is little support for the indiscriminate delivery of psychological interventions to everyone involved in a traumatic event [3,4]. However, doing nothing risks creating a perceived lack of social support, which has been associated with the development of PTSD following traumatic events [6]. Clinical guidelines for the management of PTSD caution against doing nothing in the aftermath of trauma, instead advocating the delivery of practical and pragmatic support without formal psychological intervention. The need to provide support, combined with the apparent potential for harm associated with formal psychological intervention has led to an interest in Psychological First Aid (PFA). PFA is an evidence-informed set of principles that provides immediate support to affected individuals with the aim of reducing distress, promoting adaptive functioning, enhancing resiliency, and mitigating the negative psychological sequelae of trauma [7]. Despite the acceptance of PFA and its consistent recommendation, there is a dearth of evidence regarding its effectiveness [8]. Even though there are inherent difficulties in the evaluation of PFA, there is an urgent need to build an evidence-base to support its ongoing implementation. For the time being, approaches based on the PFA principles represent widely accepted best practice in terms of the immediate response to trauma.

A broad spectrum of psychosocial needs emerge in the aftermath of traumatic events, and as outlined by Bonde and colleagues [1], only a small proportion of affected individuals develop PTSD and require support from specialised services. Well validated methods of screening for PTSD are available

that can reasonably accurately identify the sub-group that need formal intervention once symptoms have developed [9]. Despite this, there is currently insufficient evidence to advocate for routine screening following traumatic events and, indeed, some evidence to caution against its use. Follow-up data following the London Bombings suggested that screening resulted in people being detected and treated who would not have come forward otherwise [10]. There has, however, been little high-quality research into screening following traumatic events and a large cluster randomised controlled trial of UK military personnel found no evidence of increased detection or treatment with post-deployment screening [11]. The true effectiveness and cost-effectiveness are not known and it seems wise to remember that screening is not without risk, including raising expectations, not having sufficient staff to cater for demand, the consequences of false positive findings, and the opportunity costs associated with deploying resources in this way. Despite a similar dearth of evidence, a more prudent approach may be public health campaigns that raise awareness of the sequelae of trauma and educate the general population on signs to look out for and guidance on when and how to seek clinical advice. Campaigning for better recognition of the potential consequences of trauma by those likely to encounter people at risk of PTSD, such as primary and secondary care practitioners may also be warranted. PTSD should be explored as a possible diagnosis when patients disclose a trauma history, or when they describe characteristic symptoms of PTSD.

Once identified, PTSD is a treatable condition. A robust and growing body of evidence supports the efficacy of several forms of psychological therapy for PTSD. A recent meta-analysis found the strongest evidence for the effect of cognitive behavioural therapy with a trauma focus (CBT-TF) and eye movement desensitisation and reprocessing (EMDR) [12] and these are recommended internationally by clinical practice guidelines [13]. Specific pharmacological interventions are also recommended, albeit to a lesser degree due to lower effect sizes [14]. Since there is evidence for the efficacy of many psychological and pharmacological treatments, the evidence-base should be used to guide shared decision-making between patient and clinician. Ideally, intervention should be preceded

by detailed assessment, followed by discussion surrounding the evidence, resulting in the co-production of treatment plans that consider patient-preference [15].

Despite a robust evidence-base supporting several modalities of treatment, there are factors that limit the extent to which positive outcomes are realised. Although the interventions with the strongest evidence have large effect sizes, not everyone responds, and residual symptoms are common. A greater understanding of the mechanisms of effect of specific treatments is required to inform the development of novel interventions and adaptations of existing ones to ensure they are optimally effective. Since PTSD is a highly heterogeneous condition it is unlikely that one size fits all in terms of treatment and there is a need to consider predictors of outcome that may indicate the suitability of treatments for specific subgroups of patients. In addition, evidence-based psychological therapies are not always widely available or accessible. However, there is a growing evidence in support of group and internet-based therapies [12], which have scope to widen access to low-cost treatment and facilitate efficient dissemination at scale. In addition, further research is needed to evaluate existing treatments among those with complex PTSD, and to modify or develop new therapies, as appropriate.

Trauma exposure is common [16], and as indicated Bonde et al's review [1], a substantial minority of affected individuals go on to develop PTSD. Although it may be possible to identify those likely to develop delayed onset PTSD based on earlier symptoms, evidence does not support routine screening, preventative strategies, or early intervention for those without a diagnosable disorder. Campaigns to raise awareness of PTSD and its symptoms may represent the best strategy to optimise the early identification of people with PTSD who would benefit from receipt of evidence-based treatment.

## References


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