Post-traumatic stress disorder (PTSD) was first included as a diagnosis term in DSM-III in 1980, although under other names (e.g. traumatic neurosis), it has a much longer history in European psychiatry. It is now widely recognised as a major cause of distress and suffering following traumatic events.

Common symptoms of PTSD include recurring recollections and dreams related to the traumatic event, avoidance and numbing, and hypervigilance. Recent reviews have consistently recommended trauma-focused psychological therapies as a first-line treatment for PTSD, although pharmacological treatments have also been found to be effective in some cases.

This module introduced the different biological, psychological and social models of PTSD in adults. It also provided up-to-date information on the epidemiology of PTSD and outlined steps to help prevent and treat the condition.

Models of PTSD

- re-experiencing, numbing, avoidance and hyper-arousal are typical symptoms of PTSD
- classical conditioning was the original psychological theory of PTSD
- recently, the cognitive model of negative appraisals and overgeneralisation has had great influence
- the amygdala, hippocampus and medial prefrontal cortex are believed to be involved in PTSD
- low cortisol levels have been linked to PTSD, although other neurotransmitters are thought to be involved.

Epidemiology, prognosis and prevention

- experience of PTSD symptoms straight after traumatic events is common (but does not necessarily indicate that a disorder is present as symptoms often fade away)
- the lifetime prevalence for PTSD is thought to be around 6.8%, and 12-month prevalence 3.5%
- there is a high comorbidity rate of around 80%
- formal single-session interventions aimed at preventing PTSD should not be given following trauma.

Treatment

- Trauma-focused cognitive behavior therapy (TFCBT) and eye movement desensitisation and reprocessing (EMDR) are the first-line treatments for PTSD and the only psychological treatments recommended by NICE
- there are conflicting recommendations for pharmacological treatment
- direct comparisons between psychological and pharmacological treatments are not yet available
- 8–12 sessions of TFCBT or EMDR are recommended in the NICE guideline (although there is some evidence that longer treatment is helpful), with medication given as a second-line treatment.
Further reading


Australian Centre for Posttraumatic Mental Health
European Society for Traumatic Stress Studies
International Society for Traumatic Stress Studies
University of Queensland PTSD pages
UK Psychological Trauma Society