Why is Post Traumatic Stress Disorder so topical?

On the 23rd of March 2020 Her Majesty's Government announced strict curbs on the free movement of the population as a response to the COVID-19 pandemic. People are only allowed to leave home to exercise once a day, travel to and from work when it is "absolutely necessary", shop for essential items and fulfil any medical or care needs. Premises such as libraries, playgrounds and places of worship are ordered to close and people with significant health issues are asked to shield for up to three months.

This triggered a dramatic change in the day to day routines and quality of life of a significant part of the UK's population: millions of people lost their job or were furloughed, work from home became commonplace and people were suddenly confined to their homes with all members of the household constantly present, all within the back drop of a deadly viral, airborne disease that can spread via asymptomatic patients, increasing uncertainty and anxiety. For some, there may be a conspicuous absence of a family member, such as NHS workers living in hotel accommodations. While for the greater public good, these measures may create heavy psychological, emotional, and financial problems for some people.

We know from past pandemics such as SARS and H1N1 that the uncertainties and health anxieties in such times can increase stress symptoms and the incidence of post-traumatic stress disorder, depression and adjustment disorders for patients, their loved ones and those in lockdown. The uncertainties around peoples' own and their family's health, financial worries, boredom have created a potentially toxic environment for some families. There has been a significant increase of contact with abuse charities and reported domestic abuse which will likely increase the amount of trauma in the general population.

For health care staff, these stressors are present as well, but in addition they are potentially exposed to frequent traumatic and morally injurious events. Studies following up health care workers after past pandemics reported frequent concerns regarding their health and their families' health, high levels of psychological distress, worries about their ability to work and fears of stigmatisation.

The initial response after traumatic events

There is clear evidence that traumatic events witnessed during a pandemic can lead to the development of a range of psychological and mental health issues, such as adjustment and anxiety disorders, depression, and post-traumatic stress disorder (PTSD). While the spectrum of responses to these traumatic events is broad, they will nevertheless impact on peoples' functioning, their relationships and their ability to work and socialise. Some of those exposed will experience only a short-term period of distress, but those who do not recover may develop more serious mental health problems.

Primary care is facing significant and unprecedented demands in these difficult times, but nevertheless for many patients their general practice team will be their first point of call. While the vast majority of GPs will be familiar with the signs and symptoms of the aforementioned mental health problems, the diagnosis of post-traumatic stress disorder (PTSD) may be missed or attributed to depression or other anxiety disorders.

When assessing anxious, traumatised and stressed patients face to face or remotely, it is important for us to let them express their concerns and feelings and acknowledge that it is normal and

acceptable to be anxious and upset in these difficult times. The so-called 'normal' response can vary considerably: some patients will develop a marked reaction that resolves over a few weeks, while others have no or very little symptoms. Gently enquire about feeling of guilt and shame that might have accumulated during the period of stress or trauma: avoiding discussion about these can lead to poorer outcomes. Avoid using benzodiazepines as they are contraindicated, but if the traumatic experiences have induced depressive symptoms, SSRIs may be helpful. Other psychotropic medications should be initiated by the specialist team.

How prevalent is PTSD after traumatic events?

PTSD in primary care is common, but underdiagnosed: the prevalence of current symptoms depends on the population sampled, but in a survey of an inner city population in the United Kingdom the average rate was 5.5%, while the Adult Psychiatric Morbidity Survey 2014 reported a nationwide incidence of 4.4%. The highest rate of PTSD is found in people who witnessed or experienced violence, injury with a weapon, physical and sexual abuse or who emigrated for asylum or political reasons. Likely more than 40% of Women exposed to domestic violence are reported to develop PTSD. A recent, not yet peer reviewed population based survey - sampled in late March 2020, during the beginning of lockdown - found higher levels of anxiety, depression and trauma symptoms compared to previous population studies, particularly in those whose income has been affected, who have children living in the home and who have pre-existing health conditions. This makes it more likely that we will see patients with trauma induced symptoms in primary care.

When should we suspect PTSD?

If the patient does not improve after four weeks and the feelings and memories are becoming more intrusive, PTSD should be considered. The ICD 11 criteria for PTSD are listed here, so take a minute to remind yourself of them.

The primary care PTSD screening test has good accuracy as a screening tool in both military and civilian settings in high risk populations, is easy to administer in just a minute or two and is a good start to come to a formal diagnosis. You can find the link to it in the references section.

Most people exposed to trauma will be fine and do not need treatment in the first four weeks but should be actively monitored. Only those patients who are likely to have acute stress disorder will need early treatment in the first few weeks and trauma focussed -CBT should be the model used. For patients beyond the first month with an established diagnosis of PTSD, patients should be referred for trauma-focused CBT or EMDR, depending on the availability of PTSD-focussed care in your patch.

Key workers and PTSD

The COVID-19 pandemic and the resulting lockdown is an anxiety filled time for the whole population, but keyworkers at the frontline of the national response are particularly exposed. Whether it is paramedics, pharmacists, social care workers, nurses or doctors, all of us will be exposed to traumatic events and moral injuries at work. Add to that psychological, relational and

financial stressors due to the unusually demanding and difficult work, it is likely that some of us will feel down, stressed and unhappy after a string of particularly bad shifts or an upsetting event.

How do we look after ourselves

For those of us who have been involved in traumatic events at work or outside the workplace, it is important to realise that we are not immune to stress, anxiety, depressive and trauma disorders, insomnia, addictive and risk-taking behaviours. Studies examining the PTSD rates among emergency medicine and other hospital practitioners found the numbers to be around 12-13%, higher than in the general population. Having psychological symptoms resulting from the things we have been exposed to at work is therefore not unusual but if they persist for weeks on end and impair your ability to function, don't self-medicate but seek help from your own GP (or the NHS GP Health Service) and get advice, treatment and if necessary, take some time off. Remember that working when unwell risks not only your health and wellbeing, but potentially undermines the care you give to your patients. If necessary, arrange an occupational health assessment to get advice on a sustainable way back to work.

Thank you for listening and stay safe and well.