PTSD Transcript.
November 2021
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0:01Chair: Good afternoon everybody and welcome to our live webinar on mental disorders associated with stress. I'd like to welcome back our speaker, Dr Ian Collins who is consultant psychiatrist and who has already done a series of mental health issues for us. Today he is going to talk to us on mental disorders associated with stress.

0:37 Speaker: Thanks very much. Nicola, I feel like an old friend. And now you're probably getting tired of me doing all of these webinars. Thank you for the introduction and nice to have so many people and calling in to this webinar today. Yes, I'm going to talk today about mental disorders associated with stress. And the main one I'm going to focus on today is post-traumatic stress disorder, and there are other disorders that I just need to flag you and that fall in this category of ICD-11, these mental disorders associated with stress.

So I'm going to start as I always do and with a bit of a brain teaser. And there's a bit of interactivity as we go through this presentation today, so forgive me. This question is related to a 26 year old man who complains of insomnia. He states that whenever he tries to go to sleep relives his experience as a hostage during a bank robbery three months ago. He is easily startled and feels estranged from his family. He has avoided returning to the bank and refuses to discuss the incident.

What is the first line pharmacological treatment for this man?

These are the options.
Carbamazepine,
Imipramine,
Prazosin,
Mirtazapine and
Risperidone?

It's kind of a trick question. I hate to be like to give you trick questions at the beginning, but I'll explain why it's a kind of a trick question, but I'd be keen to hear from you as to what you would consider would be the first line treatment for this gentleman.

And whilst you're voting, of course, first line treatment for this gentleman should be psychological therapy, but as I mentioned in the vignette there, he doesn't want to talk about it and that's one of the reasons to offer pharmacological interventions as a first line if someone doesn't want to engage in psychological therapy.

Yeah, it was a bit of a trick question, and I'll tell you why it's a bit of a trick question. And there's increasing evidence that Prazosin is actually very effective for the treatment of nightmares associated with PTSD and is often increasingly being used as a first line treatment, particularly if that individual has predominance of nightmares. However, the majority of you answered Mirtazapine, and I would agree with you there. I think particularly as Prazosin is used more in secondary care at the moment, I would certainly suggest that in primary care, Mirtazapine is first line treatment. But keep an eye out for Prazosin. There is increasingly good evidence for it.

4.18 Speaker: OK, so what am I going to talk to you about today? Well, if you're into diagnostic classification systems like we are as psychiatrists, you'll know that ICD-10 has been updated to ICD-

11 in the last couple of years. And what was previously under the category of neurotic, stress related and somatoform disorders in ICD-10 (I hate that term neurotic. I'm glad they dispensed with it) is now in its own category of disorders associated with stress in ICD 11.

And these are the main disorders in the ICD 11 category of mental disorders, which are disorders associated with stress:

- PTSD,
- Complex PTSD,
- Prolonged grief disorder and
- Adjustment disorder.

There are a couple of others in this category as well, but I don't want to go on and talk about those. I wanted to focus on these four areas. And actually, I'm really going to major today on PTSD with literally a small discussion about those other conditions. The focus for today's session is going to be post-traumatic stress disorder. Of course, you know, you can't have any of these disorders, you can't diagnose any of these disorders unless you have a stressful experience that precipitates the development of these disorders.

So you need to have that stressful experience and obviously the nature of the stressful experience points you towards thinking of what potential of these diagnoses the patient has. So you need to have that stressful experience. Yes, there are predisposing factors related to these conditions. You are more like to get it if you have certain factors, but the stressful experience is the main one; the main the precipitating factor for the development of all of these mental disorders.

6.34 Speaker: So I've already said that I'm going to focus today's discussion on post-traumatic stress disorder. I'll briefly talk about classification, clinical features, diagnosis, aetiology, epidemiology and management, but really focus on PTSD because that's the most common presentation of these range of mental disorders that you will get in primary care and in secondary care as well.

7.07 Speaker: So I'm going to talk about adjustment disorder first. Adjustment disorders occur when an individual suffers a life event. So we're not talking about the exceptionally catastrophic or life threatening stressors associated with post-traumatic stress disorder. We're just talking about the normal day to day life events that we all have to experience and deal with. So loss, for example, breakdown of relationships and those kinds of life events. And an adjustment disorder, I suppose, is the psychiatric term to describe both the individual's predisposition to the impact of that life event and also the presentation, the clinical features, the experiences that person has in relation to that and life event. So an adjustment disorder is this subjective state of distress and emotional disturbance. Think about it when you see someone who's been through a bereavement or a breakdown in a relationship. Their emotions are all over the place and they have a range of emotions. And what happens in adjustment disorder is those emotions will fluctuate quite markedly in the space of minutes, hours or days. But generally, with an adjustment disorder, it's self-limiting. You experience the psychological and sometimes physical symptoms associated with the life event. They gradually improve over time and you get through the other side. And really, there's no intervention required from either yourselves in primary care or me as a psychiatrist. It's generally self-limiting.

However, we know that some people are more predisposed to these life events, to the impact of these life events than others. I suppose, (though, I hate the word) you might call that resilience. Others are more likely to succumb to the sort of physical and psychological impact of a life event. When it starts becoming of interest to us in primary or secondary care, is when it starts to have a significant impact on that individual. For example, it interferes with the social functioning and or they start to develop comorbid symptoms that would point you to a comorbid mental disorder. So,

you know, an adjustment disorder and a depressive disorder, for example. And you know, in a lot of people, the features associated with adjustment disorder can be very brief. In some they can be very prolonged. And like I said, in those individuals, they may require intervention from primary or secondary care. You have to take adjustment disorder seriously, particularly if they present. And, you know, as a psychiatrist, you always remember the very first suicide you had of a patient, particularly, you know, since I've become a consultant and that was back in 2013, of a gentleman actually that was diagnosed with an adjustment disorder. His wife left him and for his best friend and subsequently got pregnant by his best friend after they had previously had difficulties having children. And he presented with all those classic fluctuating features of adjustment disorder but tragically committed suicide about four weeks after being in hospital. So you do have to take it seriously, particularly for presents to you in primary or secondary care.

But generally. It's self-limiting. We psychologically need to adjust to these life events and to get through. You have to go through the process. However, if the individual with the adjustment disorder has symptoms that would meet the diagnostic classification for an anxiety disorder or for a depressive disorder on top of the adjustment disorder, then you want to treat those disorders following the appropriate treatment pathways, you'd want to treat those disorders. So that's just one disorder.

12.03 Speaker: Let's talk about prolonged grief disorder now. Now again, this is a challenge. This is difficult to think about in terms of it being a mental disorder because of course, grief is entirely normal and an appropriate and correct process that individuals go through when they've suffered from a bereavement. And the important thing as, you know, there are five stages of grief and the important thing is with the vast, vast majority of people who suffer bereavement, they navigate those stages completely normally and reach that final stage of acceptance and move on with their life. However, in a small subsection of people who experience bereavement, they may end up having this prolonged grief disorder. And the key things about this prolonged grief disorder is it's persistent. You have to think about this in that individual's context, their social context, perhaps their religious context, their cultural context. Because within some cultures they have a prolonged period of grief and they may have excessive preoccupation with the person that's passed away or excessive longing. So you have to factor in that cultural, religious, social context when you're thinking about diagnosing prolonged grief reaction. But generally, when you have factored all of those things in, if the condition remains persistent and pervasive in terms of and grief is pervasive, but we're talking about something that has been pervasive for a longer time than you would expect, then you want to start thinking about prolonged grief reaction. And also you get this excessive longing preoccupation and this intense emotional pain. Like I said, it's atypically long and that is atypically long for that person's context.

And there isn't really medication treatment for a prolonged grief reaction but there's increasing evidence for cognitive behavioural approaches with a sort of grief specific element. Again, you know, if you get a look at pharmacological treatment for something like this, you'd really need to be meeting the criteria in addition to this for depressive disorders or anxiety disorders in addition to the prolonged grief reaction, because of course, they can go hand-in-hand. So that's the grief prolonged grief reaction. Again, a whistle stop tour of that.

15.03 Speaker: I want to focus on post-traumatic stress disorder. I appreciate you may well be eating your lunch, but these are sort of two questions I just want to pose, and you can answer these questions in the chat box if you like.

1. When did the term PTSD first get used?
2. How long have PTSD symptoms been recognised in history?

So I'll give you a minute if you fancy writing something in the chat box related to some of those questions, the history of PTSD is interesting. Hence, why I've asked those questions. Khryia you're right in some respects, it was, after a war. So the term PTSD was first used in the early 1980s following the Vietnam War. And all wars are horrific but there was something about the Vietnam War that was even more horrific. It was the first war that was really properly televised. And there were really horrific egregious war crimes on both sides in the Vietnam War. Think of the napalm bombing of villages. Think of a torture and all of these kinds of things and all these things happen in all wars, but I suppose it was the first war that was really televised, and it was close. It was hand-to-hand combat as well.

And Raj, I'll come to this shortly. But to get some good points, you've raised there.

And it was when all of these Vietnam War veterans were coming back to the United States and taking themselves off and living these lonely lives in forests and away from family that researchers started to increasingly explore the phenomenon. And PTSD was originally coined in the early 1980s to describe the cluster of symptoms that you get in people that have suffered an exceptionally life threatening, catastrophic experiences.

But if you go through history and PTSD has been recognised from thousands and thousands of years ago, it has just been called different things historically and all of those things that you're typing in the chat box that are correct and they've been called all of these things. And we recognise that as far back to ancient Greece and earlier actually and in writings that we that's been studied. So some of you might know this is a picture of the first passenger railway in England. The Stockton to Darlington Railway, and because it was early 19th century and the railway was in its infancy in terms of technology, I mean, look, these people just sat on these open carriages here on this train. The early railways were prone to accidents. You know early technology, lots of accidents. And from all of these early railway accidents, a term emerged called railway spine. And it was discussed amongst doctors at the time. What is this condition? These patients, these people who had been involved in railway accidents were presenting with weird and wonderful symptoms, but no organic, no physical symptoms. Just sort of, I suppose, psychological type symptoms. And this is just another example of how PTSD has been referred to in history. You know, early 19th century, we called it railway spine.

19.01 Speaker: And as you can see here, the term has been used throughout history, ranging from this term nostalgia in ancient Greek text, through to railway spine, irritable heart 'DA costa syndrome' was used in the American Civil War. And there's a bit of an overlap between a somatic, psychiatric disorder here, where you get sort of chest pain and cardiac symptoms, and there's no cause. But still there's quite a lot of overlap between that and PTSD. Shell shock in First World War. You know, people were court martialled for desertion because of shell shock. We now know that one of the core features of PTSD is avoidance. People want to run away from the things that they have been traumatised by. And, you know, deserters were shot after the First World War because they suffered from PTSD. Combat neurosis then in the Second World War and the Korean War. And then of course, they development of PTSD. So the important thing is that this condition has been around a long time, just called different things. And don't get sort of, you know, led down the path that it only occurs to people who are soldiers. PTSD happens to anyone who have experienced catastrophic, exceptional stress.

20.25 Speaker: And here are the typical clinical features that we look out for in PTSD. We have to have the stressful event, and that event has to be, as I've said, the exceptionally threatening or catastrophic. You know, we're not talking about life events here. We are talking about catastrophic trauma or exceptionally threatening trauma where that individual thought they were probably going to be very seriously hurt or even die. So you need that. You can't diagnose PTSD without that

stressful event. And in terms of clinical features, I suppose you're cluster those clinical features into roughly three areas.

- The first area is the sort of those re-experiencing phenomenon. And like the chap in the vignettes at the beginning, those can be nightmares. It can be just thinking about it a lot, having intrusive thoughts and not being able to push these thoughts out of your head. But at its most extreme, it can be flashbacks. And we use flashbacks quite a lot in modern kind of parlance, but a real flashback, is like that individual is back there. It's a kind of what we call a dissociative phenomenon where the person dissociates, isn't aware of their own surroundings and is immediately transported back to the experience the event. And what often happens is things can trigger flashbacks. Sights, smells, tastes, words sometimes can trigger flashbacks. And it's like being transported back; it has that real quality to it. You really have to be clear that patients are experiencing flashbacks where they're back in the midst of the traumatic experience, feeling the same thing, seeing the same thing, smelling the same thing. And these are an important part of these re-experiencing phenomena.
- The second main symptom of PTSD is avoidance. So people will do anything to avoid experiencing these intrusive thoughts, nightmares or flashbacks or anything that reminds them of the stressful events. Say somebody has been involved in a car accident and you know, that could be in its lowest sense avoiding the place where it happened if you're still driving. Doing a detour around where that car accident was. The most extreme is not even being able to get into the car. So there's this avoidance. And of course, with treatment of PTSD, it's helpful to try and overcome that avoidance because I'm sure when you came to my previous talks on OCD and anxiety disorders, avoidance is a key feature in those conditions as well. But treatment is about confronting, if you like, the thing that leads to the avoidance. So this is an important part of therapy.
- And then there's those other symptoms, particularly that a sense of numbness, emotional blunting, detachment, wanting to be away. You know, you get these American war vets after Vietnam kind of going off into forests and living in log cabins away from society. And this is the typical presentation. You get this detachment and this sense of numbness. Also in some patients, you get this hypervigilance, so people are always on high alert looking out for the next trauma. And also, you get this exaggerated startle i.e. people will jump out of their skin even with the slightest noise. And this is probably related to some amygdala dysfunction, which I'll talk about shortly.
- And then you get those other associated features - low mood, anxiety, suicidal ideation. Alcohol misuse is fairly common in these patients because they want to try to manage some of these re-experiencing phenomena.
- Onset of PTSD can happen within weeks or months of the traumatic event. Usually, if the traumatic event had been within the last four weeks you usually just watch do some watchful waiting, because most people after the traumatic events of this nature will have nightmares or think about it a lot or not want to go there or think about or avoid certain situations. That's kind of quite normal. If those symptoms continue, then after a month you start getting into the realm of PTSD. But even if the symptoms continue to be fairly minor and self-limiting, watchful waiting is recommended for these patients. So that's how you diagnose. You need those symptoms, and it needs to be over a month from the trauma. But the onset of symptoms can be after many weeks or even many months, but sometimes very rarely after many years.

25.41 Speaker: And here's a bit on epidemiology. It’s more common in females. So you need to remember going back to what I said earlier, it's not just soldiers who get PTSD. It's anyone who faces these kinds of exceptionally catastrophic, stressful events. Clearly, it's higher in certain groups, particularly groups that are likely to be subject to these kinds of exceptionally catastrophic events. So sexual assault victims, Vietnam War veterans and lots and lots of research was done following the

World Trade Centre attacks actually around PTSD. And you can see from studies the prevalence of PTSD. If you take concentric circles increasing distance from the World Trade Centre, you can see the prevalence of PTSD. It's high, but it falls depending on how far away from it you were. There's also a lot of evidence from the World Trade Centre attacks that people watching it on television, it was so catastrophic and so exceptionally threatening, that even those people ended up suffering from PTSD after that event. So, you know, lots of research. You've got to think about those high risk groups in terms of the development of PTSD and the NICE guidelines talk about screening those high risk groups - that could be asylum seekers or after sexual assault. So that's the epidemiology PTSD.

27.15 Speaker: I'm just going to quickly touch on aetiology, because that's quite important to understand treatment. I'm not going to go through all of these different aetiological factors, but I'm going to talk about some of them, just in the interests of time. And obviously, you can have PTSD without the traumatic event. So that's a fairly important precipitating factor here. Also important when you think about PTSD and its treatment is the hippocampus and amygdala dysfunction, which may well be a predisposing factor for why some patients are more likely to suffer from PTSD than others. And what I mean by that is hippocampus is part of the brain responsible for the short term memory and the amygdala is your fright sensor of the brain. Makes you jump in a scary movie. But also the amygdala holds the emotional content or the emotional responses to some of those memories.

And what we increasingly think is that firstly, there's likely to be a defective process in terms of processing memories. And also this hippocampus and amygdala dysfunction. So when we have a traumatic experience, for a while it remains in our short-term memory. And when we think about it, we remember in detail. And there's also quite a lot of emotional attachment to that memory. It makes us angry. It makes us am happy. It makes us anxious. If you think about something that's been traumatic, that's happened to you and you obviously haven't developed PTSD, if you think about it after a year or two, you'll remember it. You don't remember in detail you just remember the high level stuff that happened. And there's this emotional loading associated with it if you haven't got PTSD. And what there seems to be an issue with is processing those memories, those traumatic memories from the short term to the long term. Because when we move the memory from short term to the long term memory, we jettison the detail, and we jettison the emotion as well. And there may be a defective memory process related to people who are more prone to PTSD. And this is where we come to when we talk about treatment, which I will talk about in a second. Also important to just mention this, that the noradrenaline and serotonin systems in terms of desensitisation and how you might by potentiating, by firing, causing those systems to fire with SSRIs, potentially you've got a treatment for PTSD. And I'm not going to talk about the detail of the psychosocial factors involved in PTSD, but clearly in terms of how we appraise trauma, how we believe or thinking around how trauma impacts us, clearly has a role to play in terms of development of post-traumatic stress disorder. And right down the bottom there, I talk about avoidance. That is one of the most powerful perpetuating factors of PTSD in terms of preventing people getting better, as is unhealthy rumination about the trauma, though saying that, of course, we want the person to relive the trauma as part of therapy, but it's done in a kind of constructive, healthy, supportive, informed way rather than a sort of unhealthy rumination. So that is the aetiology factors in a nutshell.

31.03. Speaker: So let's talk about management of PTSD now. Clearly NICE guidelines talk about screening high risk groups, and I mentioned that before. So being more aware in those groups that PTSD may be something that you need to monitor for is really important. Clearly, it's about recognition in primary care and the general rule of thumb is that you treat PTSD, unless there are any co-morbidities or if the co-morbidities are severe and you might want to focus on treating those first. For example, if someone has PTSD and meets the diagnostic criteria for a depressive disorder or anxiety disorder - treat that first. Or if they have really bad substance misuse problems, you might

want to try and get in support recovery for that before you turn to PTSD because you know, the treatment of PTSD, particularly psychologically, is challenging. And like with all psychological treatments, is likely to make the condition a bit worse before it makes it better. It's important to consider risk issues with PTSD. I mentioned the increased risk of suicide. But if you think about what I've said about the features of PTSD with regards to increased starts and hypervigilance that potentially can increase risk to others. And of course, you hear about stories of people with PTSD, because they're startled and they are hypervigilant, will harm. I mean, it's impulsive. It's not planned. Perhaps family members/loved ones related to the PTSD. And remember if the symptoms have only just started after the event and we're still within a month of the trauma, leave it. Just watchful waiting. Unless this sort of serious issues, psychological psychiatric issues going on generally, recommendation is watchful waiting. So if someone comes to your practice, recent trauma, recent traumatic events, experiencing flashbacks or nightmares or avoidance - watchful waiting unless there are risk issues or it's very severe.

33.20 Speaker: And of course, like with all anxiety disorders, for the stress related disorders, the PTSDs you should really consider psychological therapy first before pharmacological therapy. And the main psychological therapies, evidence based psychological therapies for PTSD are trauma focussed CBT. Same as normal CBT, but just has a trauma focus. And the person is actually asked to write an account of the trauma in detail and record that account in their own narrative and then listen to it over and over again whilst engaging in cognitive sort of techniques that the therapist has taught the patient and also relaxation techniques. And the whole idea of reliving it over and over again in a healthy way in a therapy context, helps to reprocess that memory, move it back to the long term memory in very sort of simple sort of terms.

And then there's the EMDR, which is a very interesting therapy. Eye movement, desensitisation and reprocessing. EMDR was developed by a lady called Francine Shapiro, an American psychologist who one day happened to be walking in the park and was looking at something in the distance, something that involved sort of rhythmically movements, perhaps some traffic going along the road or something like that and she started to kind of get the feeling that some of her own traumatic memories were starting to sort of feel calmer in her mind. It's funny how experiences like this can lead to development of a treatment that is actually very effective. And she developed EMDR out of this. And the premise behind EMDR is that rhythmical eye movement - it doesn't have to be eye movements, it can be hand movements, repetitive one left, right, left, right - activate both hemispheres and support (I'm not going to go into the neuroscience of it because I'm not a neuroscientist) the reprocessing of the memories back into the long term memory. So again, a very effective treatment, on the same lines of the effectiveness as trauma-focussed CBT and 8-10 sessions for uncomplicated PTSD without any co-morbidities caught early enough, is usually sufficient to help that patient recover.

36.04 Speaker: Oh, that's really interesting, Raj. I would be interested to hear more about that, actually. So very effective particularly if the PTSD is caught early.

36.19 Speaker: And then his pharmacological treatment. There are obviously a range of situations when you might want to pick pharmacological treatments. We are going to come to a question about that shortly. But if you look at the NICE guidelines, their recommendation is Mirtazapine Paroxetine in primary care and Amitriptyline or Phenelzine under specialist care. Actually, what that means is any SSRI, preferably not Paroxetine actually, would be my recommendation. And actually, there's some evidence for Venlafaxine and Quetiapine, which is an antipsychotic. You know, I think the NICE guidelines need to be updated, quite frankly. I don't know of many people that prescribe Paroxetine anymore. It has such a short half-life and it's prone to quite severe discontinuation symptoms when you come off it. And of course, you know, there has been some evidence in the past

of increasing suicidal ideation. Actually in practise any SSRI other than Paroxetine, I'd recommend first line pharmacological treatment. Or Venlafaxine and then maybe second line Quetiapine. And again, at the same doses as you would for antidepressants, for depression. And then as I said earlier, there's increasing evidence for Prazosin for the treatment of PTSD, particularly PTSD, associated with a lot of nightmares. That seems to be very effective in dampening down the nightmares, and I've just put an indicative dose there, that you might want to consider because obviously, you know, you want to monitor for hypertension and hypotension and various other issues when you start Prazosin. So a low dose to start off with.

That's the sort of pharmacological management. Generally stick with the necessary same dosage you want for anti-depressants.

Could you combine Prazosin with an SSRI? I don't see why not. They're very different mechanisms of action, so you shouldn't interact. So you potentially could do that. Again start low with the Prazosin just in case somebody has postural hypotension, I guess. But yeah, I don't see why not.

38.34 Speaker: I have got a question for you now. I've already told you psychological treatment is first line, but in what situations might you offer medication first line? In what situations might you offer medication first line? These are your options:

- Lack of appropriate psychological services.
- Severe PTSD
- Patient chooses medication
- PTSD and severe depression
- All of the above

I'm sorry to play it, to put in a sort of kind of trick question. But actually all of the above.

I'm sorry to say that unfortunately in the modern context that we have to manage our patients in, lack of psychological services/services you have to wait 18 months for, I think it's important to consider medication in those. If someone has severe PTSD, absolutely, because you might want to go with a two pronged approach with medication to try to improve things slightly and then go in with the psychological treatment. If a patient doesn't want to engage in the psychological therapy because it can be quite challenging - it does involve the patient confronting the trauma, less so with EMDR. Whereas trauma-focussed CBT approach is more about writing an account because you get listening to over again whilst doing cognitive exercises and/or relaxation techniques, EMDR only requires the patient to think about the traumatic event whilst watching the screen or doing rhythmical hand movements. So patient choice. Like I said, if PTSD is in addition to a severe depressive disorder because of the risk, I suppose to suicide, you'd want to try and start or treat the depressive disorder before going into psychological therapy to treat PTSD. So all of the above. They are all reasons to consider pharmacological treatment before psychological treatment.

41.00 Speaker: What about prognosis for PTSD? Well, the same applies to PTSD as all mental disorders, really. The earlier you identify and treat the more likely of a full remission. Prognosis is improved if that person has good premorbid adjustment, resilience if the trauma is brief or of limited severity. However, if the trauma is complex and repeated i.e. continuous, then the prognosis is likely to be worse. And if there's no psychiatric or family history and that individual has really good support networks, then that is a really positive prognostic factor. And if you get in early, you treat based on evidence based medicine. Up to 65% may recover in 18 months. For those who don't recover and you kind of have a chronicity of post-traumatic stress disorder symptoms. Sometimes a bit better, sometimes a bit worse. You have a chronic kind of course with PTSD. So that's the sort of prognosis.

42.18 Speaker: I want to talk now in the last few minutes about complex PTSD and I could probably do a whole hour on this because it's a phenomenon that is becoming increasingly recognised and wasn't in ICD-10 or the previous ICDs. It's only been something that has been put in ICD-11. And there's a huge overlap here between what we now understand is complex post-traumatic stress disorder and emotionally unstable personality disorder. Because if you think about an emotionally unstable personality disorder, people that go on to develop emotionally unstable personality disorder have suffered trauma in their younger lives. Often sort of emotional, physical, sometimes sexual trauma, and that trauma is often quite catastrophic, and that trauma is often been repetitive and repeated. And they then go on to develop the kind of classical symptoms that you get with emotionally unstable personality disorder. But if you were to kind of combine those PTSD symptoms that I've already mentioned with some of the features you classically see in a person with emotionally unstable personality disorder, you know, impulsivity, affective instability, short, fiery, intense relationships, those kinds of features you get complex PTSD. And it's becoming increasingly recognised, if you like, as a diagnostic entity in itself. You know, you think of it as a Venn diagram, and you think about the features of emotional unstable personal disorder and PTSD. Both have similar roots in terms of trauma, you know, catastrophic trauma. You can understand where this kind of paradigm, this shift is coming from. This kind of increasing emergence of complex PTSD.

44.32 Speaker: The specific clinical features here for these traumatic events that are very threatening and horrific. And you know, there's nothing more horrific than enduring emotional, physical or sexual abuse constantly through childhood. Interestingly, the other caveat here is that the person can't escape from that. So it could apply as well to someone that as an adult endures repetitive trauma in the sense of maybe hostage and torture, that kind of thing. So escape is difficult or impossible. And as well as those traditional symptoms, you get PTSD, re-experiencing phenomenon, avoidance, the hypervigilance, the startle. You also get those classic symptoms of emotionally unstable personality disorder - effect regulation problems, the core beliefs are affected about themselves. So there's really low self-esteem, difficulty sustaining relationships. And you have to have significant impairments as well - psychosocial impairments in different domains really to have complex PTSD. And your approach to the treatment of complex PTSD is very similar to your approach for the treatment of PTSD - a psychological first line, possibly medication, antidepressants, SSRIs as second line. So a similar approach. Of course, there's going to be a lot of crossover between this and personality disorder. So, Dialectical Behavioural Therapy (DBT) also an evidence based treatment for personality disorder and possibly complex PTSD as well.

46.26 Speaker: Just a few things to think about in terms of referring to secondary care. Remember I said watchful waiting is quite important if it's low level and it's immediately after the event. Again, if mild symptoms, watchful waiting. Primary care is really important in identifying people who may well be more prone to developing PTSD and recognising that and being someone of being able to monitor for that. But if someone comes into your clinic door or you have a telephone conversation with somebody who's experiencing exceptionally life-threatening or catastrophic trauma if that was repeated or severe trauma, if they are presenting with a high acuity in terms of the psychiatric symptoms, if there is comorbid substance misuse or depression, or if you're concerned about risk issues, or if this picture is a chronic picture despite treatment from yourselves, then of course I'd encourage you to refer into secondary care or local primary mental health support services for psychological therapy.

47.38 Speaker: So that's it in a nutshell. We've spoke at about the main conditions related to stressful psychiatric conditions related to stressful events particularly PTSD, but also be aware increasingly of complex PTSD. You do require this stress. The aetiology is complex, but it's basically around how you process memories. More common in women. First line psychotherapy and good prognosis if caught early.

48.14 Speaker: And I just want to give you some sort of signposting if I may. So some good websites Combat Stress. PTSD UK. I would also commend to you the All Wales Traumatic Stress Quality Improvement Initiative, led by Professor John Bisson at Cardiff University. They are developing this intervention called SPRING, which is an online computerised CBT programme for people with PTSD and really good information also on the Royal College website. And finally, I didn't get a chance to put a picture of this in the presentation, but I'd recommend this book as well. It's something that I'm reading. I don't know if you can see the book. And it's by **Bessel van der Kolk**, who's a psychiatrist in New York called **'The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma'.** Fascinating. I wish I could tell you more, but I'm only on page 50 of it but I'd really recommend it. If you're interested in trauma, I would encourage you to read this book 'The Body Keeps the Score'.

So thank you very much. I've learnt my lesson and I finished in good time, so I'm really happy to take any questions from the audience, Nicola.

49.33 Chair: Thank you, Ian. Somebody has just asked whether it's possible to have a chance to review the recording of the session. So just to remind them because they weren't here at the beginning that it will be available sometime in the next week or two on demand from the HEIW CPD website. And hopefully, if you're happy Ian, the presentation, can be emailed out as a PowerPoint?

We've got a question from Terry - Do you have any experience or opinion about people who have been drugged when out socialising? He's come across it several times.

50.20 Speaker: I actually don't have any experience, Terry. I know this has been something that has been sort of increasingly recognised even worse in the last few weeks where people are actually being injected with stuff so no longer just having things slipped in the drink but injected with stuff. I think you need to treat it as a trauma and particularly if there had been consequences to that individual in terms of sexual assault, for example. Obviously, you need to treat trauma. I talked about early identification and recognition of those that may be at higher risk. I would certainly agree that those people that have been spiked and injected, and you need to perhaps keep those under close review because it could be that they've experienced trauma whilst under the influence of whatever drug they've been spiked with. But those kinds of memories will only emerge maybe after a period of time. So I have no experience myself, but just be cognisant in terms of the increased likelihood of later development of post-traumatic stress disorder, particularly when memories start to emerge.

51.37 Chair: Any more questions, anybody? If you have one, please put it in the comment box on the right hand side. I'll give you a couple of minutes to see if anybody has any burning issues. I have to say Ian I think the first thing I learnt when I saw the first slide was that we weren't just going to be talking about post-traumatic stress and in fact, its mental disorders associated with stress, which encompasses a lot of other things that I certainly see regularly.

52.04 Speaker: There are other disorders actually in IC11 that I still haven't talked about related to stress, some attachment disorders, for example. But I didn't want to talk about those today. I wanted to focus on PTSD.

52.16 Chair: Yeah, no, no, that's fine. But you know, even the ones that we were talking about, the prolonged bereavement ones? I certainly see lots of patients with that. So it's reassuring to have some idea now on how we can better manage them.

52.04 Speaker: Yes. I don't think we're very geared up for monitoring or supporting people with those prolonged grief reactions. And obviously there are organisations out there that support people like Cruise, for example. Though, having said that, I think Cruise has particularly long waiting lists at the moment for bereavement. So there's challenges that in terms of having to wait. But you know, the take-home message is, if someone has got that I think sometimes people wonder what on earth is going on and I think to help them to understand that this is something that can happen and almost to normalise that it can happen to some people would probably help. And of course, if there is evidence that that person is depressed or anxious and they meet the classic diagnostic classification for that then treat, you know, use antidepressants if they don't want to have psychological therapy or if you're not able to access.

53.16 Chair: Brilliant. Thank you very much. We are just having comments thanking you for your presentation. Many thanks. Very informative. Still no more questions. So I think you must have covered everything for us all. Once again, thank you very much Ian and I look forward to hopefully persuading you to do another talk in the future.