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Research Paper

Low recognition of post-traumatic stress disorder in primary care

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Key messages

- Post-traumatic stress disorder (PTSD) can be effectively treated with trauma-focused psychological interventions (NICE, 2005)
- PTSD is currently under-recognised in primary care.
- Few patients with PTSD identified in primary care currently receive or are referred for trauma-focused psychological treatments.
- Screening questionnaires (for adults and children) and self-referrals through IAPT services (currently adults only) may facilitate prompter access to treatment.

Why this matters to us

PTSD is a disabling condition that impacts on patients' relationships and their ability to work. Secondary problems such as depression, alcohol- and drug abuse, social isolation and financial hardship are common if the condition remains untreated. These can be prevented if patients access effective psychological treatments promptly.

ABSTRACT

Post-traumatic stress disorder (PTSD) is a common and disabling disorder that develops as a consequence of traumatic events and is characterised by distressing re-experiencing of parts of the trauma, avoidance of reminders, emotional numbing and hyperarousal. The NICE guidelines for PTSD (2005) recommend trauma-focused psychological therapy as the first-line treatment. A survey of 129 GPs in south London investigated the recognition and treatment of PTSD in primary care. The majority of GPs underestimated the prevalence of PTSD. Most PTSD patients seen in GP surgeries currently do not receive or are not referred for NICE recommended psychological treatments. Medications, especially SSRIs, appear to be more commonly prescribed than recommended by NICE. Efforts to disseminate information about PTSD and effective treatments to both patients and GPs are needed to increase recognition rates and prompter access to treatment. The Improving Access to Psychological Therapies (IAPT) programme will make the NICE recommended treatments more widely available and will allow self-referral by adults with PTSD to trauma-focused psychological therapy.

Keywords: cognitive-behaviour therapy, mental health, NICE guidelines, post-traumatic stress disorder, psychological treatments

Post-traumatic stress disorder (PTSD) is a common and disabling disorder. It develops as a consequence of traumatic events such as interpersonal violence, disaster, severe accidents, or other life-threatening experiences. PTSD is a common consequence of sexual assault, and has also been observed after life-threatening medical problems such as heart attacks; or frightening complications during medical procedures such as incomplete anaesthesia or complicated childbirth. The most characteristic symptoms of PTSD are the re-experiencing of symptoms. Patients involuntarily re-experience aspects of the traumatic event in a very vivid and distressing way. This includes: flashbacks in which the person acts or feels as if the event were recurring, nightmares and intrusive images or other sensory impressions from the event. For example, a woman who was assaulted kept seeing the eyes of the perpetrator looking through the letterbox before he broke into her house, and a child involved in a bombing kept hearing the sound of the explosion. Patients with PTSD show periods of hyperarousal and numbing; and avoid situations or stimuli associated with the event (see Box 1). The patients' emotional state ranges from intense fear, anger, sadness, guilt, or shame to emotional numbness. Social and occupational functioning are often severely impaired. If PTSD remains untreated, secondary problems such as depression, alcohol- and drug abuse, social isolation (school refusal in young people) and financial hardship are common.

PTSD occurs across the age range. Large-scale epidemiological studies have shown 1-month prevalence rates for PTSD in adults of between 1.5 and 3.6 %[1–3] and a lifetime prevalence of 7.8%.[4] Prevalence rates are similar in childhood.[5] The risk of developing PTSD varies with type of trauma and gender. In adults, interpersonal violence is associated with a greater PTSD risk than accidents. Women (and girls) have a greater risk of developing PTSD than men, regardless of trauma type.[4,6] Epidemiological studies also showed that the average time it takes before adult patients receive treatment for PTSD is 10 years.[4]

In 2005, the National Institute for Clinical Excellence (NICE) published guidelines for the treatment of PTSD on the basis of the available evidence (see Box 2).[7] The guidelines recommend that patients with PTSD should be offered a course of trauma-focused psychological therapy (trauma-focused cognitive behaviour therapy, TF-CBT, or eye movement desensitisation and reprocessing, EMDR). Treatment comprises 8–12 individual treatment sessions (more sessions are needed for multiple traumas). If the trauma is discussed in the session, sessions should last 90 minutes. The guidelines also state that non-trauma focused psychological treatments such as non-directive counselling or relaxation training should not be routinely offered to patients with PTSD.

Box 1 Symptoms of PTSD

Re-experiencing symptoms
- Intrusive images or other sensory impressions, intrusive thoughts about the trauma
- Flashbacks (the person acts or feels as if the event were recurring)
- Nightmares or other bad dreams
- Strong emotional or physiological reactions to reminders

Avoidance and numbing
- Efforts to avoid activities or situations that remind of trauma
- Efforts to avoid thinking or talking about the trauma
- Inability to recall an important aspect of the trauma
- Feeling detached from other people
- Loss of interest in previously significant activities
- Restricted range of affect
- Sense of foreshortened future

Hyperarousal
- Difficulty sleeping
- Irritability
- Difficult concentrating
- Hypervigilance to potential threat
- Easily startled

The NICE guidelines further recommend that medication should *not* be used as a treatment for children or adolescents with PTSD. They should *not* usually be used as a first line treatment for adults with PTSD, but may be indicated if the patients does not want or respond to psychological treatment or lives under serious current threat of further trauma. Medications recommended for adults with PTSD by NICE include paroxetine, mirtazapine for general use and amitryptyline and phenelzine for initiation by mental health professionals. Other recent guidelines have recommended a broader range of serotonin reuptake inhibitors (SSRIs).[8]

The NICE guidelines state that for patients presenting in primary care, GPs are responsible for the recognition of PTSD and the initiation of treatment. Results from the recent Mental Health Response to the London Bombings Programme[9] suggested that PTSD may be under recognised in primary care. A 21-month outreach programme identified 184 patients who were involved in the London bombings and required treatment for PTSD. In the same period, only 14 patients were referred to the participating trauma clinics by their GPs. The aim of this survey was to explore whether GPs are aware of PTSD and the NICE PTSD guidelines, and whether patients are currently offered treatment in accordance with NICE guidelines.

Box 2 NICE recommended Treatments for PTSD (2005)

Trauma-focused cognitive behaviour therapy, including:

- Exposure therapy: focus on repeated confrontation with trauma memories and trauma reminders
- Trauma-focused cognitive therapy: focus on changing problematic meanings of the trauma such 'The event shows I am a bad/inferior/inadequate person,' 'I cannot trust anyone' or 'I will die soon'; and changing problematic coping responses such as thought suppression, rumination or selective attention to threat.
- Recommended for adults and children with PTSD

Eye movement densensitisation and reprocessing

- Bilateral physical stimulation (most commonly eye movements) while patient focuses on trauma memory and associations
- Recommended for adults with PTSD

Medication

- **Not recommended** for treatment of PTSD in children and adolescents
- **Not recommended** as first-line treatment for adults with PTSD
- Indications: Adults with PTSD who do not want psychological treatment or do not respond to CBT or EMDR, those who live under severe ongoing threat or have severe depressive or hyperarousal symptoms interfering with their ability to benefit from psychological treatment:
  - Paroxetine and mirtazepine for general use
  - Amitryptyline and phenelzine for initiation by mental health professionals

Method

Questionnaires were sent to 720 GPs practising in the geographical area served by the South London and Maudsley NHS Trust (Southwark, Lewisham, Lambeth and Croydon) in November 2006. One hundred and twenty nine returned the questionnaire (18% response rate). The questionnaire asked GPs to indicate whether they were aware of PTSD among their patients and the NICE guidelines, and what treatments patients with PTSD were currently offered. Questions and results are shown in Table 1.

Results

GPs had a reported mean of 4612 patients on their lists. Epidemiological data[1–5] would suggest that a list of 4600 patients includes approximately 69–166 patients (adults or children) with current PTSD, and 278–360 with either a current or past history of PTSD.

GPs estimated that they had a median of ten patients with PTSD on their list, corresponding to a median prevalence estimate of 0.2% (2 in 1000). Twenty percent of the GPs estimated the PTSD prevalence among their patients below 0.1%. Only 15% estimated the prevalence at 1% or greater.

Nearly a third of the GPs (27%) reported that they had not seen any adults with PTSD in the past three months. More than two-thirds (71%) said they had not seen any children with PTSD in the same time period.

More than half of the GPs (55%) reported that they were aware that the NICE PTSD guidelines had been published, but only 15% had read them (although 95% reported to have read other guidelines). Only 27% were aware that the guidelines included recommendations for children with PTSD.

GPs reported that they prescribed medication for about half of their PTSD patients. Nearly all (96%) mainly prescribed SSRIs. Other prescriptions included other antidepressants (24%), sleeping tablets (25%) or painkillers (8%). None prescribed antipsychotics for PTSD.

If patients were offered psychological treatment in primary care, this was predominantly supportive counselling (78%). This was often given in combination with other interventions including versions of CBT (55%), stress management (30%), psychodynamic counselling (17%), EMDR (1%) and other unspecified treatments (9%). CBT or EMDR were rarely offered as the main interventions. The majority of the GPs reported (75%) that treatment length for psychological therapy for PTSD in primary care was less than eight sessions. Furthermore, treatment sessions usually lasted for less than 1 hour (93%). Only 11 % of the GPs reported that their patients with PTSD were receiving 8–12 sessions of CBT or EMDR in primary care.

GPs were asked to rate the likelihood of referring a patient with PTSD to particular services. GPs said they were most likely to refer to CMHTs and CAMHS or to undertake the treatment themselves. A subgroup of 75 GPs specified reasons for decisions not to refer to specialist trauma services. The most common was long waiting times (79%), the availability of a therapist in their surgery (64%), the expectation that patients would get better on their own (36%), and not being aware of such services (38%).

Table 1 Results of GP survey about PTSD

Question	Yes (%)	Median (Md) or Mean (M) and Range
Are you aware that the NICE PTSD guidelines have been published?	55	
Are you aware that the guidelines also address children?	27	
Have you read the NICE guidelines for PTSD?	15	
Have you read the NICE guidelines for other conditions?	95	
Would you like to receive more information on the treatment of PTSD?	65	
Would you like further information/ training on how to diagnose PTSD?	54	
How many patients in total, approximately do you have on your list?		M 4612 (400–9800)
How many patients with PTSD, approximately, do you have on your list?		Md 10 (0–1015)
What percentage of these are refugees?		Md 4% (0–99%)
Prevalence estimate (PTSD patients/ numbers on list)		Md 0.2% (0–27%)
In the past three months, how many patients with PTSD did you see in your practice?		
none	26	
1–2	39	
3–5	27	
6–10	6	
10+	2	
Approximately how many were under the age of 18?		Md 0 (0–90)
If the patient has PTSD, where do you refer for treatment? (1-never, 2-sometimes, 3-often, 4-always)		
treated by GP in your surgery		M 2.2
treated by primary care mental health worker in surgery		M 1.8
referred to local CMHT/ CAMHS		M 2.5
referred to specialist NHS services		M 2.0
referred to private therapists/clinics		M 1.4
referred to others		M 1.5
What percentage are prescribed medication?		M 52
Please specify the type of medication that you most commonly use		
SSRIs	96	
other antidepressants	24	
sleeping tablets	25	
antipsychotic medication	0	
painkillers	8	

Table 1 Continued

Please tick what approach your primary care mental health worker uses in treating PTSD	
supportive counselling	78
cognitive behavioural therapy	55
EMDR	1
stress management	30
psychodynamic	17
Please indicate how many sessions of therapy the patient will usually receive	
1–2	1
3–4	9
5–7	66
8–12	24
12+	1
Please specify the average duration of a session	
less than 30 min	2
30–45 min	25
45–60 min	66
longer than 60 min	7
Is the outcome of the treatment measured?	51

Discussion

The first main finding of the survey was that the majority of GPs underestimated the prevalence of PTSD among their patients compared to what is known from epidemiological data. This result is in line with the low recognition of London bombing survivors with PTSD in primary care observed in a previous study.[9] It is also in line with reports that PTSD is commonly under-recognised in public mental health services.[10, 11]

There may be several reasons for the low recognition rate in primary care. These include a range of potentially relevant patient factors, and time constraints and lack of information in GP surgeries. Patients with PTSD may hesitate to inform their GP about their traumatic experience and/or symptoms for a range of reasons. They find talking about their traumatic event very distressing and often fear that their symptoms are a sign that they are going mad or are weak or inadequate. Many feel ashamed about what happened or about their symptoms. Patients may also feel that they need to overcome their problems on their own. Children and adolescents may hide their symptoms from parents to protect them from upset. Across the age range, patients may also not be aware that PTSD is a common and treatable condition. Readily available information about the symptoms of PTSD and treatment options such as the information for the public published by NICE[12] may help educate patients (and parents) about the condition and treatment options. Furthermore, patients dislike telling their distressing story repeatedly to different people, and may thus only be willing to disclose their traumatic experience to a health professional who can offer them a course of treatment. In this context, it is of interest that the Government's Improving Access to Psychological Therapy (IAPT[13]) initiative will allow adult patients with PTSD to self-refer for NICE recommended psychological treatments, and it remains to be seen whether this will increase the rate of PTSD patients identified in the NHS.

Patients with PTSD often have comorbid conditions such as depression, insomnia, somatic complaints or chronic pain.[4,14,15] Given the time-constraints for each consultation and the patients' multiple complaints, GPs may mainly focus on the comorbid conditions when diagnosing and treating these patients. GPs may also be reluctant to probe for traumatic events and to ask detailed questions about patient's (and other family members') reactions to such events. GPs may also be concerned that they may trigger strong emotional reactions if they ask about the trauma or its effects. Valuable time could be saved by using validated questionnaires (both self- and parent-report versions) that screen for trauma history and PTSD symptoms.[16] Box 3 lists examples.

The second main finding of this survey was that most PTSD patients seen in GP surgeries currently do

Box 3 Screener questions and questionnaires for PTSD

Useful questions

- Did (symptoms such as your sleep problems, your problems concentrating, your depression, your panic attacks) start after a very upsetting experience? For example, an event where you feared for your life such as an accident, bombing, disaster or fire? Or where people were violent to you or forced you to have sex with them? Or someone close to you got hurt?
- Do upsetting memories of this event pop into your mind when you don't want them to?
- Do reminders make you upset or bring up the feeling that it is all happening again?
- Have you changed your life to avoid reminders of the event?
- Have felt unable to have feelings since the event or been less interested in things you used to enjoy?
- Do you find that you are more irritable or more aware of dangers since it happened?
- Do you have difficulty concentrating and sleeping since it happened?

Questionnaires

Adults:

- Trauma Screener Questionnaire – 10 items screener www.lancashiretraumaticstressservice.nhs.uk/trauma-screening-questionnaire.htm (recommended cut-off is 6)
- PTSD Checklist: 17 item measure of PTSD symptoms www.dvs.virginia.gov/woundedwarrior/pdf/3-PTSDCheckListScoring.pdf
- Impact of Event Scale- Revised – 22 item measure of PTSD symptoms www.atft.org/research/Impact%20of%20Event%20Scale%20–20Revised.htm

Children:

- Children Impact of Event Scale – 13 items www.childrenandwar.org/Default.aspx?ID=17

not receive or are not referred for NICE recommended psychological treatments. Among adults, medications, especially SSRIs, appear to be more commonly prescribed than the NICE guidelines recommend. The psychological treatments offered in primary care were mainly *not* trauma-focused and shorter than recommended by NICE. Long waiting times were cited as one of the reasons for the GPs' reluctance to refer for trauma-focused treatments. With the establishment of IAPT services, waiting times for these treatments will be reduced for adults and they will become more widely available in the NHS. Similar NHS programmes are needed to increase the availability of evidence-based treatments for children and adolescents with PTSD. Furthermore, some GPs reported that they were not aware of specialist trauma services, indicating that information about the current availability of the NICE recommended trauma-focused psychological treatments across services would be helpful.

A limitation of the study was the low response rate. However, it seems a reasonable assumption that the respondents were on average more interested in mental health and PTSD than non-respondents. It is therefore unlikely that the low recognition of PTSD or low availability of NICE recommended treatments is an artefact of the low response rate. It is also seems unlikely that the GPs who did not respond are identifying significantly more patients with PTSD and/or offering treatment according to NICE guidelines. Patients exposed to trauma are likely to benefit from further efforts to disseminate knowledge about the assessment and treatment of PTSD in primary care.

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