

# THE SYMPTOMS AND RECOGNITION OF POST-TRAUMATIC STRESS REACTIONS

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## Introduction

Military personnel are, by the nature of their role, exposed to traumatic events in the course of their duties, together with fire fighters, members of the police service and ambulance personnel. Although there are clinical definitions and classifications for the responses to stressful events described within both ICD10 and DSM-IV, not all reactions to stressful events are abnormal.

The frequency of the most severe reactions is low. Turner et al (2005) found the rate in repatriated cases from Telic 1 to be 3% for a combat stress reaction, with over 85% having an adjustment disorder. Similarly low rates of post traumatic stress reactions have also been recorded in operational settings too, McAllister et al (2004), Hacker Hughes et al (2005). This short article sets out the signs and symptoms of the disorders associated with experiencing traumatic events.

## Normal Reactions

There is a routine pattern to the response to traumatic events, which is outlined below. Most people will feel anxious initially, can be restless or dazed for a few hours afterwards, and then recover: Some, however, have prolonged symptoms, which constitute an abnormal reaction.

There are only subjective cut-offs between what are considered normal and abnormal responses to traumatic events, with individuals having different thresholds dependent upon previous experiences as well as on differing perceptions of the event. Grief is a normal reaction to bereavement, and only a small proportion of people have a prolonged or severe response. (Parkes 1985).

There are three sub classifications of reactions to stressful events: Acute Reactions; Post-Traumatic Stress Disorder and Adjustment Reactions.

## Acute Reactions

These are immediate and short-lived responses to sudden extreme stressors in someone without any other psychiatric disorder at that time. The ICD-10 definition outlined below requires a short duration from a few hours to no more than three days. The same phenomenon in DSM-IV is classed as acute stress disorder, but requires a duration of between two days to four weeks, and therefore excludes conditions that within the ICD-10 criteria would be considered to be an acute stress reaction.

In the UK Armed Forces the management of combat stress reactions is shared by both the Chain of Command and the Medical services. The Chain of Command have a duty to care for their troops and a close and long-term relationship exists

between them and the Medical Services with the Medical Services having a duty to provide expertise and support to the Chain of Command.

The definition of an acute stress reaction in ICD-10 is "A transient disorder that develops in an individual without any other apparent mental disorder in response to exceptional physical and mental stress, and which usually subsides within hours or days. Individual vulnerability and coping capacity play a role in the occurrence and severity of acute stress reactions. The symptoms show a typically mixed and changing picture, and include an initial state of 'daze' with some constriction of the field of consciousness and narrowing of attention, inability to comprehend stimuli and disorientation. This state may be followed either by further withdrawal from the surrounding situation (to the extent of a dissociative stupor (F44.2) or by agitation and over activity (flight reaction and fugue). Autonomic signs of anxiety (tachycardia, sweating, flushing) are commonly present. The symptoms usually appear within minutes of the impact of the stressful stimulus or event, and disappear within 2-3 days (often within hours). Partial or complete amnesia (F44.0) for the episode may be present."

The diagnostic criteria for research, using ICD-10 are as follows:-

- The patient must have been exposed to an exceptional mental or physical stressor with exposure to the stressor being followed by an immediate onset of symptoms (within one hour).
- Two groups of symptoms are given; the acute stress reaction is graded as: F43.00 – mild (only criterion 1 below being fulfilled); F43.01 – moderate (criterion 1 is met and there are any two symptoms from criterion 2) and F43.02 – severe (either criterion 1 is met and there are any four symptoms from criterion 2 or there is a dissociative stupor).
- Criterion 1 states that Criteria B, C and D are met for a generalized anxiety disorder (F41.1) while the following symptoms are stated for Criterion 2: Withdrawal from expected social interaction; Narrowing of attention; Apparent disorientation; Anger or verbal aggression; Despair or hopelessness; Inappropriate or purposeless over activity and Uncontrollable and excessive grief (as judged by local cultural standards)

It is stated that the reaction must occur in the absence of any other concurrent mental or behavioural disorder in ICD-10 (except for F41.1 Generalized anxiety disorder), and F60. - (personality disorders)), and not occur within 3 months of the end of an episode of any other mental or behavioural disorder.

The core symptoms of the acute response to stress are those seen in anxiety or depression. The former occur in response to threat and the latter in response to loss. Clearly there can be a mixed-type presentation when the even has combined threat and loss, e.g. contact by enemy forces, and loss of a comrade in the contact.

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Other symptoms include: numbness or feeling dazed; Insomnia; Impaired concentration, restlessness and physical symptoms of autonomic arousal, i.e. sweating, tremor, palpitations etc.

The initial psychological response may include coping mechanisms such as avoidance or denial. Avoidance involves avoiding talking or thinking about the event, and avoiding things that serve as reminders of the event, whereas denial is either a belief that the events did not really happen, or else an inability to remember them. As the anxiety symptoms abate, patients become increasingly able to speak and think about what happened.

Some coping mechanisms can become maladaptive, such as the continued use of alcohol or medication to reduce distress.

## Post-traumatic stress disorder

Current diagnostic criteria as set out in DSM-IV require a person to have been exposed to one or more traumatic events where they felt that their life or someone else's life was under threat or that they or others were going to be injured and where, at some stage, they felt helpless or terrified. It is the phenomenon of suddenly realising that one is going to die or become seriously injured, accompanied by strong feelings of terror and/or helplessness, that produce the features of PTSD. These symptoms may appear soon after the event or at some time later.

Diagnostic criteria as set out in DSM-IV require symptoms to be present for four weeks or more before a diagnosis can be made with problems emerging before this time either being acute stress disorder or what are termed as "adjustment" reactions or disorders. Not all patients suffering from acute stress disorder, which requires a certain degree of post-traumatic dissociation to be present, go on to develop PTSD and many later go on to develop PTSD without prior acute post-traumatic dissociation. If symptoms do not materialise before six months then a delayed onset is said to have occurred (and these forms of PTSD are usually the more difficult ones to treat psychologically) and if the symptoms last for more than just one month, then the disorder is said to be chronic.

## Symptoms

### *Re-experiencing / Intrusion*

There are three types of symptoms with which PTSD sufferers present in differing combinations and at least one of each and in some cases more, must be found to be present before a diagnosis can accurately be made. The first group of symptoms are re-experiencing symptoms occurring as nightmares or disturbing dreams, unpleasant thoughts, emotions or physiological reactions to sights, smells, sounds or other cues reminding the patient or client of the original or traumatic event or, less often, as the classic 'flashback' which, again, can occur in any one of a number of sensory modalities. At least one of these symptoms must occur if a diagnosis is to be made.

### *Avoidance*

The second group are symptoms of behavioural or cognitive avoidance (avoiding people, places or activities that remind the client of the event) or making efforts to try to avoid remembering or thinking about the traumatic event. There is often diminished interest in activities that the client used to enjoy before the event and sometimes there is a partial or complete inability to be able to remember some of the details surrounding the traumatic event. There is also a recent literature on the possibility of people experiencing posttraumatic symptoms following an event such as, for example, a road accident where there has been a loss of consciousness. Three symptoms of increased avoidance are required by DSM-IV.

### *Hyperarousal*

Thirdly, the changes that occur in the autonomic system after massive psychological trauma produce a number of symptoms of increased arousal. People typically report memory difficulties and difficulties in concentrating on, for example, the plot of a television programme or the thread of a novel. However, a number of other problems also occur including sleeping difficulties, increased hypervigilance and startle responses and an increase in anger control problems. These latter problems are, again, extremely difficult to treat and often require additional psychological treatment even after the nightmares and avoidance has resolved. DSM-IV requires at least two symptoms of increased arousal if diagnostic criteria are to be satisfied.

### *Impairment*

The final requirement is that the patient or client must be experiencing substantial and significant impairment in one or more areas of their life as a result of the problems which they are experiencing following their exposure to trauma. These problems may be occurring in their work, home lives, relationships, leisure activities or, indeed, in all the aspects of their post-traumatic life.

As with acute stress reactions there can be maladaptive coping strategies to deal with posttraumatic symptomatology. There is seen to be an increase in problem drinking, increased risk taking and increase in deliberate self-harm rates. (Kessler et al, 1995).

The onset of symptomatology of PTSD may begin rapidly, at least within a few days. There is a view that a delay of up to six months in the onset of symptoms may occur (McNally 2003). This is not to be confused with the delay which often occurs in presentation of symptoms to health professionals; 'Combat Stress' the ex-Services mental health charity state that the average time between event and presentation to them is 14 years (Combat Stress Press release 2007). Thankfully, evidence suggests that the odds of successful treatment of PTSD do not decrease with time elapsed since the traumatic event (Gillespie et al 2002).

Severity of the trauma is not a good predictor of persistent PTSD (Murray et al 2002). Detection of symptoms in those who have been traumatised is best done by those who know the individual and who are able to detect a number of potentially subtle changes. This is particularly so, given the stigma surrounding the issue of presenting with mental health problems, both within the military and outside.

There is a role for commanders and peers who know their troops well in noting changes in irritability, concentration, detachment etc. The better one knows the individual the more likely one is to detect changes. For example, patients often present at the insistence of their partners.

### *Adjustment disorder*

Adjustment Disorder is a more gradual and prolonged response to a stressful event. In both ICD-10 and DSM-IV, Adjustment Disorder is further subdivided according to prominent symptoms of anxiety, depression, mixed, behavioural changes etc. This term, Adjustment Disorder, is used to describe psychological reactions to new circumstances. Adjustment Disorders may be provoked by life events such as divorce or marital separation or a major change in employment.

The key feature of Adjustment Disorder is the proportionality of the reaction (in both relation and proportion) to the stressful experience, taking into account the patient's personality and previous exposure. The symptoms of an adjustment disorder include anxiety, worry, poor concentration, depression and irritability, together with some physiological symptoms such as tremor or palpitations. There can also be dramatic outbursts such as deliberate self-harm, or abuse of alcohol or drugs.

The onset of Adjustment Disorder is more gradual than in an acute stress reaction, and equally the course is more prolonged. Both ICD10 and DSM-IV require an onset within three months of the event, and ICD10 suggests that onset usually occurs within a month, often accompanied by impaired social function.

A stressful event may be a precipitant of an episode of significant mental illness, such as major depression, anxiety or psychotic episodes. Therefore the diagnosis or formulation must not be made if the diagnostic criteria for a major psychiatric illness have been met.

ICD10 divides adjustment disorders (F43) as in Table 1:-

F43.20	Brief depressive reaction	A transient mild depressive state of a duration not exceeding 1 month
F43.21	Prolonged depressive reaction	A mild depressive state occurring in response to a prolonged exposure to a stressful situation but for a duration not exceeding 2 years
F43.22	Mixed anxiety and depressive reaction	Both anxiety and depressive symptoms are prominent, but at levels no greater than those specified for mixed anxiety and depressive disorder (F41.2) or other mixed anxiety disorders (F41.3)
F43.23	With prominent disturbance of other emotions	The symptoms are usually of several types of emotion, such as anxiety, depression, worry, tensions and anger. Symptoms of anxiety and depression may meet the criteria for mixed anxiety and depressive disorder (F41.2) or for the mixed anxiety disorders (F41.3) but they are not so predominant that other more specific depressive or anxiety disorders can be diagnosed.
F43.24	With predominant disturbance of conduct	The main disturbance is one involving conduct, e.g. an adolescent grief reaction resulting in aggressive or dissocial behaviour
F43.25	With mixed disturbance of emotions and conduct	Both emotional symptoms and disturbances of conduct are prominent features.
F43.28	With other specified predominant symptoms.	

Table 1. ICD10 divides adjustment disorders (F43)

## Summary

The three most common clinical sequelae of trauma have been outlined above. However, the vast majority of cases will produce a normal reaction, which would not fulfil any of the diagnostic criteria. Overall, therefore, clinically significant traumatic responses are rare in the military environment, and for the most part short lived.

For the conditions that are not self-limited, there are effective treatment options available which will be outlined later in this series.

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