COMMENTARY

Navigating the complexities of post-traumatic stress disorder and its variants[†]

David Trickey

SUMMARY

In this issue of *BJPsych Advances* Siddaway explores the challenges of assessing and treating post-traumatic stress disorder (PTSD) and complex PTSD. In this commentary I reflect on those challenges, not least of which is the need for a thorough understanding of different approaches to diagnoses. The very concept of diagnostic classification systems can be problematic, but when used sensitively they can aid communication, assessment and treatment. The relatively new diagnosis of complex PTSD may serve as a more accurate and more useful description of some psychological difficulties, leading to better treatment decisions. Good assessment, leading to accurate diagnosis, useful formulation and effective treatment takes time, and adequate resources should be allocated. Professionals can help patients to make well-informed choices about treatment options and they should offer evidence-based treatments without unnecessary delay.

KEYWORDS

Post-traumatic stress disorder; complex post-traumatic stress disorder; assessment; diagnosis; therapy

Post-traumatic stress disorder (PTSD) might appear relatively straightforward: psychometrically robust questionnaires are available to help with assessment and diagnosis, and interventions have proven to be effective. However, Siddaway (2024, this issue) helpfully explains that the reality is far more complex. The basic task of determining whether a patient has PTSD can be challenging, given that DSM-5-TR (American Psychiatric Association 2022) and ICD-11 (World Health Organization 2019) provide different definitions. Siddaway encourages professionals to be familiar with all definitions of PTSD (and complex PTSD), and provides insightful guidance, direction and cautionary advice to help navigate the intricate processes of assessment, diagnosis and treatment.

Diagnosis – good, bad or ugly?

There are of course potential risks in the use of any diagnostic criteria: they can pathologise or stigmatise what could be considered to be natural reactions to overwhelming events; they may not fit with a patient's culture and view of mental health and illness; they can unhelpfully reduce complex reactions to a simple 'yes' or 'no'; they may imply that no diagnosis means no problem (and hence there may be no treatment offered); they may be clung to by professionals or patients even when no longer accurate or useful; and they can reduce curiosity, options and hope. However, when used carefully and compassionately, diagnoses have the potential to offer explanations of distressing symptoms to patients and those around them, which can normalise and validate experiences and instil hope that things can change.

The enhanced precision provided by a shared diagnostic system can aid communication, advance research and improve the understanding of what reduces symptoms. This, in turn, enables more informed and specific decisions regarding appropriate interventions.

Complex PTSD and personality disorders

Siddaway describes the importance of meaning and appraisal of potentially traumatic events. Similarly, the meaning of a diagnosis, to both professionals and patients, can make a huge difference. With the inclusion of complex PTSD in ICD-11, it is more important than ever that assessments are undertaken carefully so that accurate differential diagnoses are made. The differences between complex PTSD and personality disorders are described by Brewin (2020), and some patients may now find themselves with a diagnosis of complex PTSD rather than a personality disorder. For professionals, an accurate diagnosis of complex PTSD can lead to more appropriate treatment offers. Patients may find it preferable to have their difficulties described as reactions to what has happened to them (very often what someone else has done to them), for which effective interventions are available, rather

David Trickey is a consultant clinical psychologist at the Anna Freud National Centre for Children and Families (London, UK) who has specialised in working with traumatised children, young people and families for more than 20 years. He leads a multidisciplinary National Health Service (NHS) team working with children and young people in care, and is co-director of the UK Trauma Council.

Correspondence David Trickey. Email: mail@davidtrickey.com

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than something intrinsic about them and their personality.

Comprehensive and meticulous assessment

Siddaway urges 'comprehensive and meticulous' assessment, particularly in relation to the work of expert psychiatric witnesses, and provides principles and guidance that will assist in such work. Expert witness assessments for civil or criminal courts typically require several sessions and significant time – the Legal Aid Agency suggests that an assessment of one patient by a psychiatrist or psychologist may ordinarily take up to 15–25 h, including the writing of a report (Legal Aid Agency 2024). In contrast, health services rarely allocate this amount of time for assessments of patients before making critical decisions about diagnoses, formulations and offers of treatment. Rushed and incomplete assessments may lead to an inaccurate description and understanding of difficulties, resulting in unsuitable and inappropriate interventions being offered. If health services genuinely want to 'get it right first time' (NHS England 2016) then it is crucial that sufficient time and resources are invested in 'comprehensive and meticulous assessment'.

Avoidance

PTSD (both ICD-11 and DSM-5-TR) and complex PTSD (ICD-11) include symptoms of avoidance. And as Siddaway notes, effective interventions for PTSD and complex PTSD involve memory processing and reconsidering appraisals and beliefs. (One of my patients described this as 'changing the format of the memory file' so that it operated differently, took up less room on his 'hard-drive' and 'stopped making the whole thing crash'. He went on to say that by deliberately bringing the event to mind he was able to 'recalibrate the message'.) In other words, the intervention involves helping, enabling and supporting patients to do the very thing that they do not want to do – focus on the trauma and what it means for them so that the nature of the memory can change, and the appraisals and beliefs become more balanced and helpful. However, professionals can sometimes respond unhelpfully to patient avoidance.

Some may be over-enthusiastic and inadvertently coerce the patient into the trauma-focused work. It is important to note that many of the traumatic events that led to the PTSD will have involved adults in positions of authority making the patient do something that they did not want to do. And it is crucial that professionals do not repeat this with their approach to trauma-focused work. The patient must freely choose whether to consent to and engage with the intervention, or not. However, their decision should be fully informed, and professionals play a crucial role in this. Patients should be aware of how effective interventions can be; of what the intervention will involve; of how much control they can have over how it is done; and that although spontaneous recovery may be relatively common in the first few months, after 6 months their symptoms are unlikely to remit on their own (Hiller 2016).

Other professionals may match patients' avoidance with their own and withhold the offer of trauma-focused intervention. They, and indeed their patients, may be concerned that a trauma-focused intervention will exacerbate symptoms. Even professionals who do offer trauma-focused work, in an attempt to reassure patients, may tell them that things might get worse before they get better. It might be more useful, and indeed more accurate, to explain that although it is of course possible that symptoms will worsen with trauma-focused interventions, research shows they are just as likely to worsen without such interventions (Larsen 2016). Professionals must of course be careful when considering trauma-focused interventions and there may be occasions when it is necessary not to progress with trauma-focused work. But the UK Psychological Trauma Society advises that 'Trauma-focused therapy should not be unnecessarily delayed or avoided' (McFetridge 2017: p. 46).

In essence, while navigating the complexities of PTSD and its variants, a meticulous and patient-centred approach remains paramount to ensure accurate diagnosis and effective treatment.

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Declaration of interest

None.

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