There is no question that South Africa is a country that is marred by crime and violence. The most recent statistics suggest an average of 45 murders per day and that 20% of people are at risk of experiencing an aggravated robbery, indicating that there is a high likelihood that many of our patients will have been exposed to a traumatic event. However, we need to remember that it is not simply violent crime that we need to look out for when thinking about trauma presentations. Patients may have experienced a sudden bereavement or a car accident and very often they will be coming to us for a presenting problem that is seemingly unrelated to any traumatic incident.

Understanding trauma and diagnosing PTSD
The word trauma is used commonly in our everyday language and tends to be used to refer to any highly stressful event. In initial DSM III formulations, a traumatic event was conceptualised as a catastrophic stressor that was outside the range of normal human experience. Traumatic events were clearly differentiated from the more typical stressors of life, such as divorce, failure, rejection, serious illness, financial crisis etc. However, we now know that the key to understanding traumatic events is that these are events of extreme stress that overwhelm a person's ability to cope. It is important to remember that there are individual differences regarding one's capacity to cope with catastrophic stress and as such, some people exposed to traumatic events will not develop psychopathology.

We now know that the key to understanding traumatic events is that these are events of extreme stress that overwhelm a person's ability to cope.
whilst others will develop full blown Post Traumatic Stress Disorder (PTSD). These observations of clinical difference have led to the assertion that trauma, like pain, is not an external phenomenon that can be completely objectified. Like pain, the traumatic experience is filtered through cognitive and emotional processes before it can be appraised as an extreme threat. Due to individual differences within the appraisal process, different people appear to have differing trauma thresholds, where some people are more resilient and others are more vulnerable to developing clinical symptoms after exposure to extremely stressful situations.

We can see from the above that it is not necessary for an individual to have been a direct victim of a traumatic event for it to have a lasting psychological impact. Watching or even hearing about the death or serious injury of someone close to the individual carries the same risk. However, in order to determine a diagnosis of PTSD, a cluster of associated symptoms need to persist once the traumatic event has ceased. These include the following; intrusion symptoms associated with the traumatic event(s) (Criterion B), avoidance of associated stimuli (Criterion C), negative alterations in cognitions and mood associated with prevalence of PTSD, indicating that most people do not always develop PTSD following a traumatic event. Additionally, PTSD is not the only possible psychological consequence of trauma with elevated rates of Major Depression, Panic, and Substance Abuse commonly observed in traumatised populations. As such, research has attempted to identify additional factors that increase the risk for PTSD following a traumatic incident.

It has emphasised environmental and demographic factors, personality and psychiatric history, dissociation, cognitive and biological systems, and genetic or familial risk.

PTSD is not the only possible psychological consequence of trauma with elevated rates of Major Depression, Panic, and Substance Abuse commonly observed in traumatised populations.

According to the DSM V, the following diagnostic criteria have to be met in order for an individual (older than 6 years) to qualify for a diagnosis of PTSD:

- An individual must have been exposed to actual or threatened death, serious injury, or sexual violence by either;
  - Directly experiencing the traumatic event(s)
  - Witnessing, in person, the event(s) as it occurred to others
  - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse)

the traumatic event(s), beginning or worsening after the traumatic event(s) (Criterion D), and marked alteration in arousal and reactivity associated with the traumatic event(s) (Criterion E).

Importantly, the duration of the disturbance (Criteria B, C, D & E) has to have been for more than 1 month and must be causing clinically significant distress or impairment in social, occupational, or other important areas of functioning. In addition, the disturbance must not be attributable to the physiological effects of a substance or other medical condition.

Risk factors
Studies investigating the epidemiology of PTSD have demonstrated that the rate of exposure to trauma far outweighs the

When we are consulting with a patient where there is the possibility of a trauma-related diagnosis, it is essential to consider the following risk factors which have consistently been identified as increasing the likelihood of developing PTSD in the wake of a traumatic experience:

- A previous traumatic incident
- Prior psychological difficulties
- Family history of psychological difficulties
- The extent to which there was a threat to life during the traumatic incident
- Perceived support following the traumatic event
- The emotional response during the traumatic incident (fear, helplessness, horror, guilt, shame)
- Dissociation at the time of the traumatic incident
<table>
<thead>
<tr>
<th>Trauma-focused Cognitive Behaviour Therapy (TF-CBT)</th>
<th>Eye Movement Desensitisation and Reprocessing (EMDR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT is a short-term therapy that theorises that our thoughts and mood have an impact on our behaviour. With regards to trauma, CBT asserts that it is the cognitive dissonance that occurs when thoughts, memories, and images of trauma cannot be reconciled with current meaning structures, that causes distress.</td>
<td>EMDR is a shorter-term comprehensive, integrative psychotherapy approach that contains elements of many effective psychotherapies in structured protocols which are designed to maximise treatment effects. It is an information processing therapy which uses an eight phase approach to address the experiential contributors of a wide range of pathologies. It attends to the past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviours and mental health.</td>
</tr>
<tr>
<td>There are three central tenets of intervention within the TF-CBT approach, namely;</td>
<td>During treatment various procedures and protocols are used to address the entire clinical picture. One of the procedural elements is ‘dual stimulation’ using bilateral eye movements, tones or taps. During the reprocessing phases the patient attends momentarily to past memories, present triggers, or anticipated future experiences whilst simultaneously focusing on a set of external stimulus. During that time, patients generally experience the emergence of insight, changes in memories, or new associations. The clinician assists the patient to focus on appropriate material before initiation of each subsequent set.</td>
</tr>
<tr>
<td>1. Exposure</td>
<td>Any therapist offering this intervention needs to be trained in the protocols and as such will be registered with the international EMDR institute and can be found on their website here: <a href="http://www.emdr.com/find-a-clinician.html">http://www.emdr.com/find-a-clinician.html</a></td>
</tr>
<tr>
<td>a. Imaginal (to the memory of the trauma and related cues)</td>
<td></td>
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<tr>
<td>b. In vivo (actual exposure e.g. going to the place where the trauma occurred)</td>
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<tr>
<td>2. Cognitive restructuring: targeting distorted automatic thoughts, maladaptive assumptions and dysfunctional schemas associated with the trauma</td>
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<td>3. Anxiety management</td>
<td></td>
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<tr>
<td>Any therapist intending to employ TF-CBT needs to be familiar with the triad of exposure techniques/anxiety management methods and cognitive restructuring as there is evidence that the combination of these elements is optimal to recovery.</td>
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</tbody>
</table>

**Treatment Options**

As we have already determined, not every person exposed to a traumatic event will go on to develop PTSD, and even where a diagnosis has been made, international guidance suggests that a number of sufferers with PTSD may recover with no or limited interventions. However, without effective treatment, many people may develop chronic problems over several years.

One of the most common early intervention options that has routinely been advocated for those who have experienced a traumatic incident is Critical Incident Stress Debriefing (CISD) or Psychological Debriefing (PD). However, cumulative evidence for the neutral effect of CISD/PD has strengthened and there is little evidence that it is an effective use of resources as it is not a psychological treatment itself, nor is it a substitute for psychological treatment. As such, the International Society for Traumatic Stress Studies (ISTSS) recommends that individual CISD/PD should not be used following traumatic events and that there is unlikely to be a beneficial effect of group CISD/PD therefore it is not advocated.

Recommendations from the National Institute for Health and Care Excellence (NICE) suggest that, where symptoms are mild and have been present for less than 4 weeks after the incident, *watchful waiting*, as a way of managing the difficulties presented by individual sufferers and should be considered by healthcare professionals. A follow-up contact should be arranged within 1 month and if symptoms have persisted, psychological interventions should be offered. Both the NICE guidelines and the World Health Organisation recommend that advanced treatments such as trauma-focused Cognitive Behavioural Therapy (TF-CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) should be considered for people suffering from PTSD as both of these therapeutic interventions facilitate a reduction in vivid, unwanted, repeated recollections of traumatic events. The guidelines further recommend that non-trauma focused interventions such as relaxation or non-directive therapy, which do not address traumatic memories, should not routinely be offered to patients who present with PTSD.
Pharmacotherapy

It is very likely that when a patient presents, they may already be self-medicating and/or may request medication for symptoms that have been generated by the traumatic response.

International guidelines suggest that medication should only be prescribed if the patient has chosen not to engage in trauma-focused psychological treatment (either TF-CBT or EMDR), where psychological treatment would not be effective because there is an ongoing threat of further trauma (such as domestic violence), where the patient has gained little or no benefit from a course of trauma-focused psychological treatment, or where there is an underlying medical condition, such as severe depression, that significantly affects the patient’s ability to benefit from psychological treatment.

According to the International Society for Traumatic Stress Studies (ISTSS), there is a strong rationale for pharmacotherapy as an important treatment in PTSD as there appear to be alterations in a number of key neurobiological mechanisms associated with the disorder. These include dysregulation of adrenergic, hypothalamic-pituitary-adrenocortical (HPA), serotonergic, glutamatergic, gamma-aminobutyric acid (GABA)-ergic and dopaminergic systems. In addition, there is considerable overlap between symptoms of PTSD, Depression, and other Anxiety Disorders. PTSD is frequently co-morbid with psychiatric disorders that are responsive to pharmacological treatment (e.g. Major Depression and Panic disorder). The ISTSS therefore recommend that medication be prescribed where the patient prefers medication over psychotherapy, where medication is the only option available, or where there is no trauma-focused specialist therapist in the area, which is often more of a problem in South Africa.

With regards to the use of Benzodiazepines, there is consensus in the literature that evidence suggests that they are not useful in the treatment of PTSD and both the ISTSS and the World Health Organisation recommend against their routine prescription for this disorder.

Recent studies have been investigating the use of beta-blockers in the treatment of trauma. There is a link between commonly prescribed beta-blockers and the storage of strong, emotionally charged memories and research is suggesting that taking beta-blockers may allow one to dull the emotional trauma of an event by creating a less emotional memory experience. A study in 2010 found that taking an initial dose of 40 mg of Propranolol immediately after a trauma followed by 80 mg 90 minutes later attenuated the emotional aspect of the memory without affecting the memory itself. The authors therefore concluded that they were making the memory less emotionally stressful. This is an exciting area within the pharmacotherapy research for PTSD but is controversial and requires further investigation and replication.

In conclusion, given the South African environment, it is likely that a large proportion of our patients will have experienced a traumatic incident prior to attending a consultation. It is important therefore that we give due consideration to the diagnostic criteria of PTSD as well as other traumatic-stress related diagnoses and that we use best practice when referring patients for psychological intervention and/or prescribing medication.

A final note for those of us working with a traumatised population - it is important to remember to take care of ourselves. Vicarious traumatisation is a common result when working with this client group and it refers to a transformation in the self of a trauma practitioner that results from empathic engagement with traumatised clients and their reports of traumatic experiences. The hallmark of vicarious traumatisation is a disruption in the practitioner’s perceived meaning and hope which can lead to compassion fatigue (otherwise known as Secondary Traumatic Stress) and burnout.

**SADAG is able to assist and refer patients to Trauma experts near to their location in many cases. 0800 20 50 26. 8am to 8pm. Seven Days a week.**