

Guest editorial

Implementing NICE guidance for post-traumatic stress disorder in primary care: a new set of criteria for quality assessment

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Primary care is currently struggling with profound, interrelated questions of identity and what constitutes quality within its very broad range of provision. In clinical general practice, key markers of quality are to be found within the core medical services; this includes the assessment of symptoms and signs leading to a correct diagnosis and to pharmacologically based treatments that eliminate pathology or restore health. In several important clinical areas (e.g. anxiety and depression), the evidence of attained quality provision, using these criteria, is at best equivocal.¹ This is because primary care consultations are also concerned with associations between psychosocial problems and health for individuals as well as families. Clinical aims in this aspect of care are, in many instances, different from standard medical practice, being limited to containment or alleviation of distress evoked by social inequalities and other factors such as bereavement, unemployment etc.²

The daily work of general practitioners (GPs) and their support staff typically involves both of the above, albeit in various combinations depending on patients' particular presentations and whether reported problems are acute or chronically persistent. Some of the challenge of achieving high standards and quality in primary care therefore centres on recognising the optimal matching of the various complementary perspectives (biomedical to psychosocial) that address patients' needs.

National Institute for Health and Clinical Excellence (NICE) guidance seeks to balance the diverse considerations that are integral to quality in primary care. At one extreme are the coherent medical management plans for chronic obstructive pulmonary disease (COPD), which carry positive prognoses.³ NICE guidance for resolving mild and moderate depression in primary care falls at an intermediary point involving both medication and psychosocial interventions.¹

At the far, non-biomedical extreme is NICE guidance for post-traumatic stress disorder (PTSD).⁴ Being a persisting condition or state usually precipitated by a single material event (road traffic collisions, accident at work, assault), NICE recommendations for trauma survivors embrace psychological and social formulations of patients' adjustment difficulties. In consequence, guidance emphasises practical support for survivors through phases of crisis resolution. Interventions, when used, comprise psychological therapies with a proven record of effectiveness.

NICE guidance for PTSD during the first month after trauma advises against conducting one-off psychological debriefing consultations. It advocates assessment, reassurance, agreeing a follow-up interview at about one month post-incident, and to wait 'watchfully'. Medications, as well as psychological therapies, are typically contraindicated at this early stage.

Past practices involving talking in detail about a trauma are now known to carry risks of poor long-term outcomes. The actual imperatives for survivors is more likely to involve re-establishing a sense of safety or security and lower levels of psychophysiological arousal typically evoked by trauma. To achieve this change, survivors vouch for coping and adjustment strategies that recognise the value of intimacy with close ones, use of wider social support, rest and relaxation, resumption of routines, re-establishing a sense of control and being moderately active.⁵ Medication should be considered only exceptionally, if trauma survivors make a particularly convincing case of immediate need.

The interventions of choice after one month, and only if evoked reactions are persistently intrusive to the point of causing significant disruption of personal, familial, social or occupational functioning, are either brief trauma-focused cognitive behavioural therapy (tfCBT) or eye movement desensitisation and reprocessing (EMDR). Both involve systematic techniques

presumed to achieve desensitisation or habituation to fear-evoking stimuli linked to memories of trauma, dreams or nightmares. Medication may be considered as a temporary complementary therapeutic measure if psychological therapy fails to engender improved adjustment. Persistence of trauma reactions beyond the intermediate term, or failure of psychological therapies to modulate recurrent and intrusive re-experiencing of the trauma, should prompt primary care practitioners to undertake more detailed assessment of needs and enter into constructive dialogue with patients about practical measures to address current adjustment difficulties. This may also include chronic hyper-arousal and avoidance of trauma reminders through emotional numbing or behavioural over-control. Referral to secondary care services for longer-term therapy and support may be indicated.

Practical problems encountered in securing prompt access to staff trained in psychological therapies, like tfCBT or EMDR, is a contentious point in the ongoing debate about quality in primary care.⁶ Some concerns may have been allayed by funding allocated to train more graduate mental health workers, community psychiatric nurses (CPNs), counsellors etc. With respect to post-trauma care, practitioners should bear in mind that demands for psychological therapy beyond one month after exposure are likely to be limited. The number of patients requiring onward referral with acute or chronic reactions will be a small proportion of the total number who survive trauma. Kessler *et al* found a lifetime incidence of significant personal trauma in approximately 70% of a population representative sample, but less than 10% of these had ever sought expert professional help to overcome evoked reactions.⁷

The quality challenge for primary care in implementing NICE guidance for PTSD therefore centres on establishing roles and functions that are welcomed as distinctively helpful for one-off trauma survivors. Provision should be cognisant of the fact that primary care is, for most survivors, but one element within a multifactorial and multifaceted conduit that sustains individuals in crisis. Staff should recognise that the predicament of suffering is not a static state, nor is the resolution of distress necessarily promoted by submitting to NHS treatment.⁸ GPs' and their colleagues' dialogues with recent trauma survivors should be informed by a recognition that the typical, natural course of evoked reactions is to fade with the passage of time.⁹ Anguish, fear, despair and intrusive reminders of trauma are inconvenient impediments to optimal functioning but should not, in the acute phase, be construed as symptoms of underlying psychopathology. Distress is not a disorder.

Survivors are usually not passively dependent individuals entirely at the mercy of their circumstance. More likely, they are actively engaged in a process of

progression through phases of natural adjustment and readjustment. Significant life-changing events test the human propensity to first address imperatives conducive to survival before moving on through stages of accommodation, adjustment and eventually resumption of a mode of living broadly commensurate with that which prevailed pre-trauma.¹⁰ The misguided eagerness with which early, one-off, post-trauma interventions were advocated during the 1980s and 1990s might have been tempered had survivors' resilience, resourcefulness and access to informal care networks been acknowledged. Also, clinical interventions to modulate natural, progressive processes of accommodation, adjustment and adaptation may cause unintended hindrances to resolution.¹⁰

Criteria for service quality pertaining to patients presenting with organic illnesses are unlikely to be similarly relevant to recent trauma survivors. For those who consult primary care staff at times of personal crises, the professional imperative is to acknowledge distress, offer reassurances about its probable limited duration and advise about the need to secure practical support and care from family, friends, colleagues etc. NICE guidance on PTSD prompts primary care to confront the challenge of reconciling itself with two new premises for service planning and delivery, audit and quality assessment. First, GPs' expectations, especially during initial consultation with recent trauma survivors, should be that patients will come to terms with what has happened without professional help! Doctor-patient dialogues should recognise evoked distress and fear, while also emphasising survivors' personal resourcefulness especially when strengthened by informal support networks provided by family and friends. Unless proven otherwise, an assumption should prevail that, on balance, trauma survivors are well placed to know what is in their own best interest and that this can be secured through planned action by self and others. Presumptions of patient dependency on professional treatment in the early aftermath of trauma are usually misplaced.

By way of illustration, consider that demonstrations of the clinical effectiveness of tfCBT or EMDR co-exist with consistent findings that by far the most powerful predictor of successful resolution of trauma reactions is availability of social support in the recovery environment. This single variable accounts for more of the statistical variance than all other variables combined!¹¹

The second new premise for quality in primary care is that although initially felt distress after trauma may be intense, pervasive and disruptive, these reactions should not be construed as indicative of underlying psychopathology. In the aftermath of recent trauma, evoked reactions are more usefully construed as functional adaptations to adversity.¹⁰ Reactions typically comprise phased signals that initially promote survival,

e.g. by attracting help from others, as a precursor to survivors once again becoming active agents in support of their longer-term aim of achieving satisfactory re-adjustment. For instance, crying is an effective and efficient signal to self and others. It expresses distress, which engages powerful, primitive responses in listeners. Crying is difficult to ignore and thereby assists with the location of survivors who need help. Similarly, the exhaustion of physical strength associated with recent trauma may ensure that rest is taken. From this perspective 'watchful waiting' is sensible guidance.

The premise of patient resourcefulness and phased adaptations to adversity help primary care articulate a rationale for moderating its propensity to intervene with or treat human distress. Suggestions to do neither is clearly contrary to informed, quality conscious practice for some acute medical conditions. But to the extent that patients' complaints may be adaptations to actual adversity, as with acute reactions to trauma and mild-to-moderate anxiety or depression,¹² the case for routine medical interventions is tenuous. Most especially if non-intervention carries a good prognosis.⁹ NICE guidance on PTSD invites primary as well as secondary care to recognise that quality comes with knowing when not to intervene as much as when to treat actively.

Clinical or professional insecurities engendered by the seemingly minimalist guidance to start with 'watchful waiting' and resist inclinations to intervene clinically, are understandable at times of significant transitions or uncertainty in primary care. But such concerns have no reality base. Professionals who harbour reservations about watchful waiting or non-prescription might wish to consider the extent to which they would be well advised to integrate new ideas into their modes of practice. Fears of litigation for clinical negligence are also unfounded if NICE guidance is adhered to.

NICE guidance on PTSD for children, adolescents and adults supports primary care in its management of survivors of recent, one-off trauma. The guidance documents a generally positive prognosis for PTSD both for those who do and those who do not require referral for psychological therapy. While this is true for most survivors of one-off trauma, primary care practitioners also know that such optimism is misplaced for patients whose life experience is of repetitive trauma, protracted exposure (flooding) and neglect especially during important phases of personal development. This NICE guidance does not help GPs with the clinical management of those service users whose trauma histories are complex and whose current life circumstances are characterised by threat, assault, violence or insecurity as well as continuing abuse and neglect. These patients require onward referral, irrespective of diagnosis, with an expectation they will remain frequent attenders with a multitude of medical,

personal and social needs. Although their recent trauma may result in symptoms consistent with differential diagnoses of acute or chronic PTSD, clinical management will have to be based on established need rather than limited to this NICE guidance.

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