Trauma & Resilience: The Nexus Between Trauma and Mental Health

https://www.mhpn.org.au/podcasts

Release date:	Wednesday, October 7th 2020 on MHPN Presents
Presenters:	Professor Mark Creamer, Clinical and Consulting Psychologist Dr Paula Schnurr, Executive Director (National Centre for Posttraumatic Stress Disorder) Professor Jonathan Bisson, Professor in Psychiatry (Cardiff University)

Disclaimer: The following transcript has been autogenerated and may contain occasional errors or inaccuracies resulting from the automated transcription process.

Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary, collaborative mental health care.

Professor Mark Creamer (00:18):

My name's Mark Creamer, and in this second episode of our series looking at trauma, mental health, and resilience, we're going to look more closely at the kinds of difficulties that people may develop when they've been through an extremely frightening or distressing event. I do want to emphasise at the outset that the majority of people who experience a traumatic event actually do not go on to develop long-term mental health problems. Human beings are often remarkably resilient and we'll be talking about the whole area of resilience in the next episode. I think actually, as mental health professionals, we tend to only see those people who've been affected badly by their experience, and there's a danger that we may forget about the large number of people who do recover with just their existing coping skills, and the support of family and friends. But the fact remains that a significant number of people do develop mental health problems following trauma, and it's really important to understand what kinds of problems might develop, and how they might affect the person's quality of life.

(01:20):

Joining me to explore the issues raised in this episode are two of the leading clinical researchers in the trauma field. Jonathan Bisson is Professor of Psychiatry at Cardiff University in the UK, and director of the All of Wales Traumatic Stress Quality Improvement Initiative. Paula Schnurr is Executive Director of the American National Centre for PTSD and a professor at Dartmouth Medical School. As I was saying in my introduction there, Jonathan, the majority of people who experience traumatic events do not end up developing long-term mental health problems, but a significant proportion do. And when we're thinking about those people, I guess the first thing that springs to mind is Post-Traumatic Stress Disorder or PTSD. But that's not the only mental health problem that might develop, is it?

Professor Jonathan Bisson (02:05):

No, not at all. And I mean probably if you look at the literature, and the research in this area, then it's not the commonest either. Certainly, it's a common mental disorder, and one of the ones that you would expect to come across. But other common conditions such as depression, anxiety disorders, and also something that we label as an adjustment disorder, where often individuals have symptoms, perhaps depressive symptoms, anxiety symptoms, and some traumatic stress symptoms, but not at the severity that one would expect to find in a post-traumatic stress disorder.

Professor Mark Creamer (02:41):

And I guess there's perhaps a temptation, isn't there, to kind of look for PTSD immediately because it gives an automatic link to the trauma, even though as you rightly point out, that might actually blind us to a better diagnosis sometimes.

Professor Jonathan Bisson (02:56):

Well, I think that's right, and it's a big issue I think, and I think that a number of people will be wrongly labelled with post-traumatic stress disorder when it isn't their primary difficulty. And that clearly can lead to inappropriate treatments being offered to the person. I'm a great believer, to be honest, in making sure that we do properly assess people when they present to us. And I think that means having an open mind, and recognising that post-traumatic stress disorder isn't the only condition that can occur. Clearly, it is one of the key conditions, and it's really important that people are fully aware of it, that they can detect it and diagnose it and know how to treat it appropriately. But I don't think that you're going to be able to help people appropriately who are involved in traumatic events unless you are aware of the full range of different conditions, and able to diagnose and help people manage those as well. And I guess the final point in answering that question really, is that comorbidity is very common. So, these aren't mutually exclusive. People don't have post-traumatic stress disorder and nothing else, or depression and nothing else. Indeed, most research shows that you've got over a 50% chance of having another condition in addition to post-traumatic stress disorder, if that is indeed what you've got.

Professor Mark Creamer (04:21):

Yeah, absolutely. So, if I could turn to you, Paula, Jon was talking there about depression and anxiety being common as well as PTSD, but we also see substance use problems, don't we, in the aftermath of trauma?

Dr Paula Schnurr (04:33):

Absolutely. And there's actual evidence, even in adolescents as well as adults, that you can see the onset of the substance use after a traumatic experience has occurred. So, something that's important to understand, however, is that most of these disorders don't exist on their own without PTSD. There's been a lot of interest in the question of whether, oh, if it's not PTSD, what might it be? But usually if there's depression, anxiety, substance use, there is PTSD. So, it seems quite central to the development of these other disorders,

Professor Mark Creamer (05:15):

But, highlighting the point, that comorbidity in a very kind of complex clinical picture is probably the norm rather than the exception.

Dr Paula Schnurr (05:24):

Absolutely,

Professor Mark Creamer (05:24):

Yeah. And I guess that we might speculate that substance use is in part a kind of self-medication, a way of managing their own symptoms?

Dr Paula Schnurr (05:35):

It's often thought of serving that function, especially because of the timing, but substance use also can take on a life of its own. So, what causes a person to initiate substance use may not be what's maintaining it. So, in a clinical setting, the self medication may not even be the driver anymore, and it may be the full-blown substance use disorder that needs attention.

Professor Mark Creamer (06:02):

Yeah, yeah, absolutely. Okay, coming back to you, Jon, let's just pick up on this idea then, that there's a whole range of different mental health problems that someone might develop. The other thing I'd comment on, I guess observe, is that even within the diagnosis of PTSD, we can see quite different clinical presentations. Some might present with an anxiety type of PTSD and some with a depressed, miserable kind of PTSD and some with an angry aggressive kind of PTSD. So, have you got any ideas about what determines whether someone's going to develop depression, or a depressed type of PTSD, or someone's going to get angry or whatever? What do you think is driving that?

Professor Jonathan Bisson (06:40):

Well, I think there's various factors, in that ever they tend to be factors within the individual and factors on the outside, more environmental factors, including the nature of the traumatic events itself. So, for example, in my experience, individuals who are exposed to a major, one-off, very frightening incident such as a sudden workplace related event, for example, the initial reaction is often very fear-based, because the individual was petrified of losing their life at the time. For individuals who I see who've unfortunately been subjected to repeated sexual abuse as a child, for example, then that initial mark

fear isn't always as marked. It certainly can be present, but there's often more depressive symptoms coming through, feelings of shame, guilt, dirtiness, which gives a different complexion to the individual symptoms that you are being presented with. Although nevertheless, in both of those examples, core symptoms include things like nightmares, distressing flashbacks to what's happened, avoidance of thinking or talking about the events, and also hyper arousal symptoms. So, feeling very on edge hypervigilance, if you like.

Professor Mark Creamer (08:04):

Yeah, yeah. And while we're talking about different types of traumatic experience, there's a lot of interest nowadays in this idea of moral injury, isn't there, that sometimes some events really challenge fundamental moral beliefs that the person has, another kind of reaction, I suppose?

Professor Jonathan Bisson (08:24):

Yes. I mean, I think certainly in the military now that's being well recognised and discussed, and if an individual is doing something, for example, that is contrary to some of their inner moral beliefs, then they feel very bad about that. I mean, I think it's really important to distinguish between moral injury and post-traumatic stress disorder. Again, they're not mutually exclusive, but I wouldn't actually classify them in the same way. And indeed, moral injury per se, I wouldn't classify as a psychiatric disorder. Indeed, it's not classified as such at the moment.

Professor Mark Creamer (09:03):

No, quite. Coming back to you, Paula, and still focusing on some of the potential effects of severe trauma. We've been talking about what we might loosely call mental health problems, but there's an increasing body of evidence, isn't there, around the kind of quite serious physical health problems that people with PTSD and related conditions might develop. Can you just tell us something about that body of literature?

Dr Paula Schnurr (09:30):

Sure. And it's important to understand that PTSD can affect all aspects of a person's wellbeing and functioning, including their physical functioning. And so, the experience of any kind of stressor has been, with significant severity and significant chronicity, has been linked to a range of physical health problems. So, it's logical to think that something as significant as PTSD could lead to health problems. And the short answer is yes. What we see in people who have PTSD is decreases in physical functioning, decreased reports of the perceptions of health, as well as actual morbidity and even mortality. Now, we think there are a number of reasons for this. One being, the use of substances that is comorbid with PTSD because the substances themselves can lead to these health problems. But there may also be biological changes associated with PTSD, such as the hyper reactivity, often being startled, having intrusive recollections and so on, leading to over reactivity to even ordinary stressors. So, people who are in high alert all of the time, as many people with PTSD are, are stressing the stress response system that is designed to turn on and off and not be constantly on.

Professor Mark Creamer (11:02):

And that's being reflected in higher rates, for example, of things like cardiovascular problems?

Dr Paula Schnurr (11:09):

Cardiovascular in particular has been investigated, and I think there's a very clear association there, but there's other disorders. It seems that there is a link with disorders such as arthritis, that might have a link to immune functioning, diabetes. The data on cancer are much more mixed, but even some data suggesting that cancer may be associated with PTSD. It's across the board right now, so it's hard to map the biological changes or the behavioural changes we see in PTSD with the physical changes that we see in PTSD.

Professor Mark Creamer (11:47):

Yeah, okay. And what about depression? Do we see physical health impacts there also?

Dr Paula Schnurr (11:53):

Depression has effects that are really similar to those in PTSD. Now, when people who have both, let's say that we're examining the effects of PTSD on cardiovascular disorder and we statistically adjust for depression or take it into account, we typically will still see unique effects of PTSD. So, it's not just the depression in PTSD that is the driver, but quite honestly, depression and also serious mental illness is linked to a range of very significant health problems.

Professor Mark Creamer (12:28):

Yeah, it's so important, isn't it? And I do think often we tend to forget that actually. But okay, let's go on and talk about, a bit more about the impact of trauma exposure on a person's life. Paula was saying just earlier about the impact on physical health being enormous, but what about things like socially and occupationally? Do you think these post-traumatic mental health problems, well we know they do, have those kinds of impacts also?

Professor Jonathan Bisson (12:56):

Yes, no massively so, for many individuals I found that there's a kind of a drift downwards with complex post-traumatic stress disorder. So, an individual may have a job that approximates, to them, achieving their potential, or they look as if they're on a trajectory to achieve their true potential occupationally, but actually that doesn't last and they lose jobs, perhaps have regular changes of jobs. So, sadly, for a lot of people with post-traumatic stress disorder, I think the occupational impact is very strong.

Professor Mark Creamer (13:32):

Yeah, absolutely. So, that's occupationally. What about the social impact?

Professor Jonathan Bisson (13:37):

So, many individuals suffer from significant social impairments as a result of their post-traumatic stress disorder. In general, with the condition, individuals tend to cut off, become somewhat more isolated as a result of their symptoms and their ongoing difficult experiences, and clearly avoiding situations that remind them of the traumatic event can have a marked impact on their social functioning.

Professor Mark Creamer (14:05):

Yes, yes, absolutely. So, we might see a broad range of functional impairment. Paula?

Dr Paula Schnurr (14:12):

PTSD affects all aspects of a person's functioning and wellbeing. So, what we know is that not only do people have the symptoms, which are bad enough in their own right, but people may experience decreased ability to function in their social roles, their parental roles, their occupational roles, and overall their life quality may be reduced. We find that many times why people with PTSD will want to seek treatment is not specifically because of the symptoms, but rather because of the effect of symptoms on their life. It can be as simple as saying things like, I want to be able to go out to dinner with my wife, or I want to be able to go to my daughter's piano recital. I want to be able to hold a job. Those are the kinds of things that may drive people to treatment, and they all reflect the pervasive effects that PTSD can have on an individual and an individual's social network.

Professor Mark Creamer (15:20):

So, let's come back to individual differences in terms of clinical presentation. So, I'm thinking not only about whether someone develops symptoms or not, but also about the type of problems that might emerge, and presumably, Jon, what the person was like beforehand will influence the kinds of symptoms that might develop?

Professor Jonathan Bisson (15:42):

Yes, no, totally. I mean, I think if an individual has a history, for example, of a recurrent depression or recurrent feelings of depression and tends to deal with stressful situations by becoming more depressed, then they're more likely to have a depressive reaction following a major traumatic event. And certainly that may well colour their presentation of post-traumatic stress disorder. Likewise, somebody who's very anxious, on edge, fearful may develop a post-traumatic stress disorder that's more coloured with those sorts of elements. The environment after the traumatic event is of vital importance too.

Professor Mark Creamer (16:22):

Yeah, absolutely. The recovery environment, do you want to just expand on that briefly?

Professor Jonathan Bisson (16:27):

Yeah, so briefly then, an individual's perception of the level of social support they receive following a traumatic event has long been one of the key factors associated with a better or worse outcome. If you feel well supported, you tend to do better than if you don't. And clearly, feeling poorly supported after an event can lead to very specific symptoms. So, for example, in people that I see, anger can be quite prominent. If an individual feels very poorly supported by an employer, for example, or a government after a major traumatic event, depression, again, or depressed features would be things that I would associate more with this perception of poor social support after a traumatic event.

Dr Paula Schnurr (17:15):

Actually, some research that has looked longitudinally at the relationship with PTSD and social support has found that the direction of influence changes over time. So, initially it looks like PTSD, or I'm sorry, it looks like social support can help decrease PTSD, but as a person lives their life with PTSD, they may actually ruin their social support, so that at a certain point, the PTSD is then causing a decline in social support.

Professor Mark Creamer (17:50):

That's a very nice study, isn't it, because that just makes great intuitive sense. But just to go back a touch, I was talking to Jon there about the factors that might influence the type of clinical presentation, the kinds of symptoms that might develop, but the fact is, of course, that the majority of people don't go on to develop problems, as we were mentioning earlier. So, what can we say about what differentiates those who do and do not, for example, who do and don't develop PTSD? And I should foreshadow the fact that in the next episode we're going to talk about resilience per se, but more broadly, what do we know about these perhaps risk and protective factors for developing PTSD?

Dr Paula Schnurr (18:31):

Well, what we know is that a range of factors related to who a person is, in terms of their personality, their genetics, their experiences, the event they experience as well as their recovery environment make a difference. So, there are many, many factors that go into determining whether any individual will develop PTSD. So, for example, one that is quite consistent but not well understood is gender. Among people who are traumatised, women are more likely than men to develop PTSD. Now, some of this seems to be due to the differences between men and women, and the types of traumas they experience. Women are more likely than men to develop, to experience the kind of traumatic events that can especially lead to PTSD such as rape and sexual assault. But even when we take that into account, there seems to be an increased likelihood for women. So, is it biology, is it psychology, is it culture? Probably all of the above to some extent, but at this point we haven't identified a full explanation.

Professor Mark Creamer (19:42):

Yeah, yes. But that gender difference is fascinating, isn't it? But you mentioned genetics there, Paula, just to come back to that briefly, is genetics going to give us some answers?

Dr Paula Schnurr (19:54):

Well, I think if genetics were the answer, it might be an easy answer. It might be an elegant answer, but it wouldn't be the right answer. And what I mean by that is, we know that factors far beyond genetics, having a lot to do with the environment, for example, the recovery environment, the social support that people have, the stress that they have after a traumatic experience can have very substantial influences on the likelihood of them developing PTSD. So, given that so much of what seems to predict PTSD is not genetic, I have hopes that we will have greater understanding of the role of genes. But I don't imagine that genes will tell us the whole story, and that in fact we will need to look to a variety of factors, and especially what interests many people in the field, is the kind of factors that can be manipulated in order to mitigate risk. So, for example, social support, which can be enhanced. Decreasing stress, which can be

decreased. Those are the kind of things that matter in terms of trying to promote recovery from a traumatic experience.

Professor Mark Creamer (21:09):

Yeah, yeah. Okay. So, the bottom line is that there are a multitude of reasons why some people develop PTSD and others don't. And just thinking about that, I wonder if there's a risk that that might be used to somehow blame people who develop problems.

Dr Paula Schnurr (21:28):

So, it's really important for anyone looking at this, to understand that developing PTSD, even though most people don't develop it, it's not a sign of being weak or defective in some way because there are so many factors that are related, and especially the recovery environment, having good social support, having fewer stressors or no stressors after the experience can make a big difference.

Professor Mark Creamer (21:55):

Yes, yes, indeed. And in fact, we talked earlier about downward spirals and how people may recruit more symptoms and functional impairment over time. So, this is really where the recovery environment becomes crucial, doesn't it, Jon?

Professor Jonathan Bisson (22:09):

No, absolutely. Right. And so I think this all points to really early detection and intervention to try and prevent that downward spiral from occurring. Certainly in my experience, if you can get in there early and people are willing to engage with you at that early point, then you can make a real difference. And the kind of secondary consequences of post-traumatic stress disorder, be those social, occupational, or in other areas of one's life, those impacts can be ameliorated to a degree.

Professor Mark Creamer (22:44):

Yeah, yeah, quite. And that really is the big challenge, isn't it? Being able to do that routinely. And I do think that the key high risk organisations like the military and the first responders and so on, they are beginning to get more on board with this, aren't they? So, I suppose there's some cautious optimism there in terms of early intervention?

Professor Jonathan Bisson (23:03):

Yeah, I think very much so. I mean, as we both know, sadly, there's very limited evidence for a lot of the early intervention techniques that are being adopted, and they perhaps have face validity and some anecdotal evidence of effect. But I think that doing things that aren't going to cause harm early on is the right way to go. I'm not keen on over intervention or over formal intervention straight after a traumatic event because I think that that can, or has the potential, to adversely impact the normal coping mechanisms that we all have. In fact, practical, pragmatic support in an empathic way provided by those who are nearest and dearest to us, and also those people that are in positions to look after us, such as our employees, our work colleagues, are the types of interventions that I think are most likely to be most beneficial. So, interventions based on the principles of psychological first aid, if you like, rather

than trying to manufacture a very specific intervention that we deliver to every individual following a traumatic event, which I think does have risks of pathologizing normal reactions.

Professor Mark Creamer (24:23):

Yeah, absolutely. When we do a podcast on early intervention, Jon, we'll get you back, but look, I guess early recognition is important for physical health outcomes also, Paula?

Dr Paula Schnurr (24:35):

Absolutely. And the reason is that some disorders, even if you treat PTSD and the PTSD goes away, if the disorder is established, for example, coronary artery disease, once you have it, getting treated for PTSD isn't likely to reduce the coronary artery disease, you will now need treatment for that disorder. In contrast, something like diabetes, where behavioural management can be so key, the extent to which you are able to manage your symptoms with things like diet and exercise, following whatever advice the doctor gives you, could help reduce the problems you have from things like diabetes. So, what I'm saying is, that the effects on some health problems may be independent of the initial effects of PTSD, and therefore treating PTSD early before some of these health problems develop is key.

Professor Mark Creamer (25:32):

Yeah. The final thing that I'd like to talk to both of you about in this episode, Jon and Paula, is the diagnosis of PTSD. And I don't want to go too far down into the weeds here. I know people like us who specialise in PTSD find this question fascinating. So, just in broad terms, how good is our current PTSD diagnosis and in fact, can we even agree on what PTSD is?

Dr Paula Schnurr (25:57):

I think the diagnosis of PTSD is pretty good, and the reason I say that is that when it was first proposed in 1980, it helped unify a number of different aspects of the mental health field. People looking at Holocaust survivors, veterans, rape trauma survivors and such. In some cases, naming what they were looking at by the event that had been experienced, like Holocaust survivor syndrome, rape trauma syndrome, and helping us understand that these were, looked like, all the same thing. The other reason PTSD I think is a pretty good diagnosis is that we see it cross-culturally. We see it in first world countries, and in third world countries, and it seems to capture an important part of the human reaction to trauma.

Professor Mark Creamer (26:54):

Yeah, absolutely. And in fact, Sandy was making similar points in our last episode. But what about you, Jon? Do you think we've got the diagnosis right yet?

Professor Jonathan Bisson (27:02):

Well, I think diagnoses do change over time, and it's very important to recognise that essentially at any one time, a diagnosis is the best approximation to reality that's been agreed by a committee of experts using whatever evidence is available to them. And I do truly believe that the individuals on these committees try their hardest and do their best to come up with meaningful diagnoses that are going to

be helpful. One of the big issues we've got in the traumatic stress field at the moment is that the two main classification systems, the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5 produced by the American Psychiatric Association and the International Classification of Diseases 11th Edition produced by the World Health Organisation, have diverged in their approach to the diagnosis of post-traumatic stress disorder. Now, this may be helpful in terms of academia and just trying to find out the truth as we move forward, but I think there are risks to that, to the general public, for example, in terms of their understanding of the condition.

Professor Mark Creamer (28:24):

I was just going to say that if we just boil that down to the nuts and bolts, essentially DSM-5 is trying to describe, it seems to me, the whole clinical condition, a sort of kitchen sink kind of job, whereas ICD has tried to hone it down to just what is really the core components that unique to PTSD. Would that be a fair description?

Professor Jonathan Bisson (28:43):

No, I think that is a fair description. So, the ICD-11 is very much focused on clinical utility, so how useful the actual diagnostic criteria are to a clinician to help an individual. And I think by having a more refined way of looking at post-traumatic stress disorder is a sensible way to go.

Dr Paula Schnurr (29:06):

I think the ICD is too narrow in terms of picking the symptoms that are hallmarks, and it's not a surprise, consequently, that we see lower prevalence of ICD diagnosed PTSD than DSM diagnosed PTSD. I think that what we need to do, however, is more research to understand, ultimately, which is the better way to characterise it, and then also how to characterise the people who have something that is not one or the other of these diagnoses. Because if you look in the DSM-5, PTSD moved from a category of anxiety disorders to a category of disorders that are recognised to be caused by events. And so if a person has had a traumatic experience, they're very significantly impacted and they don't meet the diagnostic criteria, maybe they have something that's important, and diagnostically sometimes we call these things something not otherwise specified. I think we can probably do better than that, but we need to study it in order to better characterise the flavour of reactions and the range of reactions we see to traumatic experiences.

Professor Mark Creamer (30:23):

I guess the bottom line is, that however we go about our diagnosis, the purpose of making the diagnosis is really to drive treatment. It's to decide on our treatment plan and so on. So, even though there is some disagreement in the field, it's still very important for clinicians to try and make a valid diagnosis, isn't it? In order to drive treatment.

Professor Jonathan Bisson (30:43):

I think it's important to make a valid diagnosis. I mean, I think you open up a very interesting topic of conversation, and the fact is that increasingly, my belief is that it's not really the diagnosis that should be driving us into exactly what form of treatment to provide an individual. We need to be much more precise about this. And I've already spoken to the fact that there are these two distinct diagnoses now

within ICD-11, and I think that most of us would not be offering exactly the same treatment to somebody with PTSD and to somebody with complex PTSD. There may be common elements, and there probably are common elements to those treatments, but we'd probably take a different approach depending on what the prominent features an individual is presenting with. So, I think we're going to be moving more towards modular, perhaps phase treatments in some instances for individuals, so that we're actually looking to come up with a more personalised approach to the management plan that's agreed in conjunction with the individual with PTSD or complex PTSD.

Professor Mark Creamer (31:56):

Yeah, I agree entirely, and in fact, that links very nicely to something that we said and we heard in the last episode from Meaghan O'Donnell, who was talking about transdiagnostic approaches and so on. And that does allow us then to tailor treatment to meet the individual, more than just being driven blindly by the diagnosis. What about you, Paula? Do you reckon there's a future for that dimensional kind of approach?

Dr Paula Schnurr (32:19):

Well, I think there's a future for understanding it. I don't know how the evidence will fall out. And I think, in my own career, I've gone both sides of this, thinking we really should throw out the categories, the edges, and just think about dimensions, and then finding the value of using these categories. And I think, accepting that there are not firm lines in many cases, that diagnostically people might be right on the edge of something and look a little bit more like something else. But understanding the heuristic value of having the categories, to me is very important for helping patients understand their experiences, and for helping us understand them. Now, maybe there'll be a day when we can live only in dimensions, and what I just said will not matter, and that understanding where you are on five or six different dimensions may be fully satisfactory for any provider to treat you, or for you to understand your experience. But for right now, I think that's not where the evidence is. And I've come down to accepting the limits, but really embracing the strengths of the diagnostic categories.

Professor Mark Creamer (33:46):

Yes. Yeah, sure. But I guess however we describe these reactions, either categorically or dimensionally, the primary goal is going to be to improve treatment and perhaps to promote some cautious optimism?

Dr Paula Schnurr (33:59):

Yes. Part of what our national centre has been trying to do is get across the message that PTSD is not a chronic disorder, and you can see big differences when people get these largely trauma-focused treatments, usually cognitive behavioural, but also EMDR is another effective treatment, getting the right treatment can be a game changer for people.

Professor Mark Creamer (34:23):

Absolutely. Absolutely. And that's such an important message there, isn't it? And it's a very nice positive note to end on. I'm sure we could talk about these issues for hours, but we need to draw the discussion to a close. So, I'd like to thank you both very much indeed, Professor Jon Bisson and Professor Paula Schnurr, for sharing your insights with us in this episode.

Dr Paula Schnurr (34:44):

Okay, thank you, Mark.

Professor Mark Creamer (34:45):

So, to sum up what we've been discussing today, it's clear that most people who experience trauma are able to recover without professional assistance, but a significant minority will develop conditions like PTSD, depression, anxiety, and substance use disorders. And it's not just mental health problems. We've also seen that serious physical health problems often develop in people who've experienced trauma and PTSD. We've seen that these problems are not only very distressing, but they also often lead to long-term impairments in social and occupational functioning and of course, in quality of life. There are many reasons why some people seem to be affected while others are not, and why someone might develop one type of problem instead of another. And it's clear that there is still some debate about exactly what constitutes PTSD. In the next episode, the final one in this three-part series, we'll go on to look at the concept of resilience, as well as other ways in which we might be able to prevent the development of post-traumatic mental health problems, and to facilitate recovery. I'm Mark Creamer, and I hope you'll join me again for that third and final episode in this three-part podcast series on trauma, mental health and resilience.

Host (36:03):

Visit mhpn.org.au to find out more about our online professional program, including podcasts, webinars, as well as our face-to-face interdisciplinary mental health networks across Australia.