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Research report

Trauma type affects recognition of Post-Traumatic Stress Disorder among online respondents in the UK and Ireland

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A R T I C L E   I N F O

A B S T R A C T

Background: Mental Health Literacy (MHL) predicts help-seeking for mental health difficulties. Public surveys show high recognition of Post-Traumatic Stress Disorder (PTSD) in relation to military contexts, but this has not been investigated with other sources of trauma.

Methods: A self-selecting sample of 2960 participants from UK and Ireland completed an online survey. Participants viewed one of three vignettes that described either a male or female character experiencing identical PTSD symptoms, that differed only by trauma source (military combat, industrial accident, sexual assault). Participants were asked to state i) whether a mental health problem was being experienced, ii) what it was, and iii) what help should be sought.

Results: Trauma type was a key predictor of classification as a mental health problem, correct identification of PTSD, and help-seeking suggestions. For participants shown the military scenario the odds of recognising PTSD were 5.2 times higher than for those shown the sexual assault vignette, and 2.2 times higher than for those shown the accident scenario. Age (younger), gender (female), education (university), and personal mental health experience were additional significant predictors of higher recognition of PTSD.

Limitations: Reasons for failing to recognise a mental health problem/PTSD were not explored. The online convenience sampling method may limit generalisability of results.

Conclusions: Recognition of PTSD is significantly affected by trauma source. The data confirmed the pervasive association with military combat and suggest under-recognition of PTSD from other traumas, particularly sexual assault. Awareness campaigns may aim to increase MHL of PTSD from diverse trauma sources.

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1. Introduction

Mental Health Literacy (MHL) refers to "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997). MHL comprises several components, including the ability to recognise disorders, knowledge about casual factors and treatment, and attitudes toward help-seeking (Jorm, 2000). It has been found that better MHL predicts greater intention to seek professional help for difficulties experienced (Smith and Shochet, 2011; Yap et al., 2012). MHL is therefore important for understanding why people experiencing difficulties may not seek help. Publicity campaigns to raise MHL have shown evidence of effectiveness (e.g. Li et al., 2013; Wang et al., 2013) and may therefore result in more people with mental health needs seeking evidence-based treatment for their difficulties.

Typically, MHL is investigated through surveys of the general population, though some studies address MHL with specific sample groups (e.g. health professionals). Participants are asked to identify a mental health condition from a description of a person experiencing symptoms associated with that condition. Depression is most widely recognised, with some studies suggesting around 75% correct identification from a vignette describing its symptoms (Wang et al., 2007). Reavley and Jorm (2012) found a recognition rate for depression in Australia of 73.9% in 2011, compared to 39.0% in 1995, suggesting recognition of depression may be improving over time. Schizophrenia is often correctly recognised (Furnham and Blythe, 2012), as is Obsessive-Compulsive Disorder (OCD), while social phobia, for instance, is rarely labelled accurately (Furnham and Lousley, 2013; Reavley and Jorm, 2011). Other studies have examined MHL by gender, with women consistently recognising mental health disorders more accurately than men (Bener and Ghuloum, 2010; Cotton et al., 2006), and vignette ('target') gender also affecting recognition (Swami, 2012). Higher levels of education have also been found to predict better MHL (Reavley et al., 2012).

Only a few studies to date have examined MHL of Post-Traumatic Stress Disorder (PTSD). Newly classified under DSM-V as a 'trauma- and stress-or-related disorder', PTSD comprises four

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clusters of symptoms: re-experiencing, arousal, avoidance, and negative cognitions and mood (APA, 2013). In DSM-IV-TR (APA, 2000) it was classified as an anxiety disorder, although others consider it to be more appropriately described as a disorder of memory (Brewin, 2001). PTSD was first added to the DSM in response to lobbying on trauma cases amongst Vietnam War veterans in the US, and has since been frequently associated with military combat in film, television and media (Brewin, 2003; Grey, 2007). The result is a PTSD-stereotype of the 'traumatised veteran' which traces its history back to 'shell shocked' troops fighting in the trenches during the First World War (Wessely, 2006).

Studies investigating MHL with PTSD have found comparatively high recognition rates amongst the general public. Reavley and Jorm (2011) reported that 37.5% of 1008 individuals interviewed in Australia were able to recognise PTSD from an audio vignette. Similarly, Furnham and Lousley (2013) found that 41.6% of 317 participants in UK could correctly identify PTSD from a printed vignette. These figures would place PTSD amongst the most widely recognised mental health conditions.

However, two smaller studies indicated limitations in MHL of PTSD even amongst primary care professionals in UK. A survey of 129 South London General Practitioners suggested a ten-fold under-estimation of the incidence of PTSD amongst their patients relative to epidemiological data on prevalence, and limited awareness of National Institute for Clinical Excellence (NICE) guidelines for evidence-based PTSD interventions (Ehlers et al., 2009). Similarly, Brewin et al.'s (2008) trauma screening work with survivors of the July 2005 London bombings suggested that PTSD may be under-recognised by family doctors. Only 14 survivors of bombings were referred by family doctors for psychological intervention, compared to 255 identified through the community screening programme. This was despite family doctors being explicitly advised about mental health risks for those affected by bombings. One reason for this apparent variability in findings may be the methodology employed. Both MHL studies with the general public used vignettes describing a stereotyped soldier who had experienced trauma in a military combat setting. By contrast, studies featuring health professionals in a 'real world' setting with actual patient populations addressed diverse causes of PTSD. This suggests that difficulties could be present in identifying PTSD which has resulted from non-military combat traumas.

Although popularly associated with military combat, PTSD can result from a range of traumas, including physical/sexual assault, robbery, road traffic accidents, other accidents, and natural disasters (Brewin, 2003). Given the relative scarcity of military combat experience amongst the general public, a wider understanding of the occurrence of PTSD from other trauma sources is important. In the case of sexual assault, not only is the incidence of the trauma far higher than military combat, but also the consequent risk of developing PTSD is substantially greater. Sexual assault (specifically rape) carries a conditional risk for PTSD of around 50%, compared to 10–20% for military combat trauma (Breslau et al., 1998; Norris and Sloane, 2007). Based on UK Government estimates of military deployment, and of rape, coupled with the conditional risk associated with these traumas, it can be estimated that the number of new cases of PTSD is likely to be approximately 15 times higher from rape than from military combat trauma.[1]

It is estimated that PTSD patients have, on average, taken ten years to access treatment (Kessler et al., 1995). Thus, improving MHL of PTSD could be of significant benefit to public health and wellbeing in terms of facilitating help-seeking as well as recognition by professionals. Given the statistical differences in prevalence of PTSD associated with different types of trauma, alongside the common association with one specific trauma type (i.e., military combat), this study aimed to investigate whether the recognition of PTSD from a vignette describing its symptoms varied according to the type of traumatic event described.

This study assessed recognition of PTSD resulting from three different trauma types: military combat, sexual assault (rape), and a serious industrial accident. Military combat was chosen to examine the 'combat veteran stereotype' of PTSD, and to facilitate comparison to previous studies. A serious accident was chosen because it carries the same conditional risk of developing PTSD as military combat (around 10–20%; Breslau et al., 1998) but, like sexual assault, has a far higher incidence than military combat. For example, there were 114,000 serious workplace accidents in UK in 2012 (Health and Safety Executive, 2013). It was hypothesised that those participants shown the military vignette would be more likely to classify the symptoms of PTSD as a mental health disorder [H1], and to identify PTSD correctly more often [H2] than those shown the other vignettes. It was also hypothesised on the basis of previous studies that more women would correctly identify PTSD than men, across all trauma types [H3]. The influence of gender of the character described in the vignette was explored with no specific *a priori* expectations. Suggestions for help-seeking were also recorded as free-text for exploratory analysis.

2. Method

2.1. Participants

A total of 2960 participants resident in UK and Ireland completed the survey online. Of these, 60.4% ($n=1789$) were female, 38.5% male ($n=1138$), with 1.1% ($n=33$) not stated. The modal age group of participants was 18–29 (39.7%, $n=1176$), followed by those aged 30–39 (27.2%, $n=805$) and 40–49 (22.2%, $n=656$). Only 10.8% of the sample ($n=319$) were older than 50. The majority (77.6%) of the sample gave their ethnicity as White British, 16.2% as White Irish, and 2.8% as White Other. The remaining 3.4% comprised Asian, Black, Chinese, Mixed and other ethnicities, as well as not stated. Over half of the sample reported having completed higher education to either undergraduate (39.3%) or postgraduate (20.2%) level, with a further 30.2% completing A-levels or high school diploma. The remaining 10.0% had completed only compulsory education. For subsequent analyses a binary variable was created that indicated whether a university level education had been obtained or not.

2.2. Survey and procedure

Participants were a self-selecting online sample that responded to advertisements posted on social media websites and one general interest website for older adults. The study was voluntarily publicised by writers, arts performers and television presenters. No remuneration was given for participation, but those completing the survey were invited to enter a prize draw for a £20 voucher. Ethical approval was given by a university research ethics board.

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[1] The British Government estimates that 85,000 women and 12,000 men are raped each year in England and Wales (Ministry of Justice and Home Office, 2013), in addition to approximately 2000 reported rapes per year in Scotland and Northern Ireland. This gives a total estimate of 99,000 rapes in the UK every year. Given the 50% conditional risk of PTSD (Breslau et al., 1998; Norris and Sloane, 2007), up to 50,000 new cases of PTSD resulting from rape would be expected in UK every year. The total size of the UK armed forces is 178,000, of which a maximum of 15,800 could be on duty in combat zones per year at current deployment levels (House of Commons, 2013). If all service personnel were exposed to a 'Criterion A' traumatic incident, between 1580–3160 soldiers would

(*footnote continued*)
be expected to develop PTSD. Therefore, an estimate of the number of new cases of PTSD from rape each year in UK would be approximately 15 times higher than that expected from military combat.