PSYCHIATRIC REPORT

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RAWLINSON
HEALTH CONSULTING

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[Client Address]

Dear [Client's name]

**Re: [Client's name] [DoB]**

I saw XXXXXXX on 13 February 2025 for a psychiatric assessment as part of the care provided by Rawlinson Health Consulting. XXXXXXX is a XX year old who lives with his family and children. The assessment was conducted over Zoom. The assessment took 2 hours 50 minutes (planned for 2-3 hours). He also completed 13 standardised questionnaires, 9 prior to the assessment interview, and 4 afterwards. We had had a preliminary telephone conversation lasting 50 minutes on XX XX 2024 to discuss the process and to gather preliminary information, and had agreed an initial assessment appointment at that time on XX XX 2024.

The purpose of the assessment was to develop a plan going forward to "lose dependency on alcohol", and to identify strategies as part of an evidence based care plan to support and encourage him to get away from alcohol. He has not had a detailed psychiatric or psychological assessment before, and has never seen a psychiatrist or psychologist before. However both a friendly GP and his counsellor have said that he has PTSD. I have not had an opportunity to see a summary of his GP records, so my assessment should be viewed in this light and any diagnoses should be considered provisional.

At the start of the assessment he met with myself and Michael Rawlinson for 10 minutes, before Michael left and we did the assessment interview. I further explained that although the assessment was primarily for his benefit, that I would normally send a copy to his GP, although this was his choice. XXXXXXX said that if he wished for his GP to see the report, that he would want to give it to the GP himself. He has not given permission for any information to be shared with his family.

**Summary of findings:**
XXXXXXX has a clinical diagnosis of PTSD (Post-Traumatic Stress Disorder) related to a series of incidents over the last 5 years, a number on ongoing physical health complaints and describes a mild dependency on alcohol, early morning waking, nightmares and several anxiety symptoms.

*Diagnoses based on this mental health assessment:*

- Post Traumatic Stress Disorder (PTSD) (code 6B40 in ICD-11, F43.1 in ICD-10, 309.81 in DSM-5).
- Alcohol dependence syndrome – currently using the substance without physical symptoms of withdrawal (code 6C40.20 in ICD-11, F10.240 in ICD-10, 305.00 or 303.90 in DSM-5 for mild or moderate dependence with the presence of 3-4 of 11 symptoms in the last 12 months).

*Possible diagnoses:*

- Another stress response syndrome, such as 'partial PTSD' where most symptoms of PTSD are present, but not enough to meet the criteria for the 'full PTSD' diagnosis.

*Diagnoses considered very unlikely:*

- Complex post-traumatic stress disorder (complex PTSD) (code 6B41 in ICD-11), but this is very unlikely as he recovers relatively quickly after experiencing flashbacks.
- Generalised anxiety disorder (code 6B00 in ICD-11, F41.1 in ICD-10, 300.02 in DSM-5) (symptoms more likely to be due to PTSD anxiety).
- Depressive disorder with early morning waking (symptoms more likely to be due to PTSD anxiety).
- Obsessional compulsive disorder, as although he does report intrusive symptoms, including flashbacks, these are much more likely to be due to PTSD.

**Medication:**

- Bisoprolol 10mg in the morning for high blood pressure.
- He was previously on a range of other medications for blood pressure, but these were stopped 2-3 months ago.
- Piriton (Chlorphenamine) 4mg at night on average once a week to help sleep.

**Allergies:**

- None:

**Physical health:**

- *Acute Covid-19:* XXXXXXX describes catching when Covid-19 hit the country in 2020.
- *Long Covid:* XXXXXXX said he recalls the day at the end of a Covid-19 lockdown, when he went for a walk and felt very ill and short of breath, and had to sit down. He described this as the start of a health nightmare, with a tachycardia of 150-160 bpm, feelings of exhaustion, muscle pains and aching in his legs, feeling dreadful, with its severity slightly coming and going, but overall being "absolutely debilitating". He feels that he is now 80% better from it, but is still left with some tiredness and muscle fatigue. On the SBQ-LC, he reported 'moderately' for fatigue (feeling of physical or mental exhaustion that does not improve with rest), low energy (being interested and wanting to do things but not having the energy), tiredness (need for sleep), aching all over the body, muscle stiffness and joint pain. He also reported 'mildly' for worsening of his symptoms following simple physical or mental activities, muscle pain, muscle weakness, joint stiffness, muscle twitching and, tingling and numbness (pins and needles) in his arms and legs.
- *Pneumonia, liver and kidney problems:* Not long after recovering from acute Covid he developed pneumonia and then kidney failure and was taken by ambulance to hospital, where he was told that there was a 15% chance that he would die. He found the experience in hospital very traumatic, as he felt very unsafe there, as he did not feel that he was being well cared for, and on day 3 he went to sit in the waiting room, and then discharged himself from hospital.

- *Heart, blood pressure and joint problems:* Following the treatment for kidney failure, he was told he would normally have to wait 3 months before he could have the hip replacement, despite being in a lot of pain and hardly being able to walk. He was advised to take paracetamol for the pain, get on the waiting list to repair his mitral valve and get his high blood pressure under control with medication.
- *Recent vasovagal episode with concussion:* XXXXXXX says that one week ago as he had only had one whisky that night. His partner had called an ambulance, but he said "thank goodness they didn't come", and he believes they didn't come because they could hear him saying "I haven't fallen". He feels that the fall was purely related to postural hypotension. He has since had a heart monitor (and is awaiting the results), and has an appointment to see a neurologist next week. On the SBQ-LC, he confirmed that he had felt faint in the last 7 days.
- *Unsteadiness on his feet:* XXXXXXX describes a "bizarre unsteadiness" on his feet which has been present for the last few months, and been worse recently. He feels unsteady on his feet and may stagger, which his family attributes to drinking, but which he says occurs even when he has not been drinking. He has blacked out at home on several occasions when getting up from the sofa, and hit his head when he hit the floor. He says he was confused for about an hour afterwards, and has no memory of the event. He does not think it was related to drinking. An MRI scan of the brain which showed no brain injury but the presence of some atheroma.
- *Other physical symptoms:*
    - *Liver function tests:* XXXXXXX said that his liver had been slightly affected, and that he has a fatty liver.
    - *Reduced appetite and nausea:* XXXXXXX describes his appetite as "very very low", but that his weight as stable at 73-74kg. He says that his appetite is worse now than it has been for a long time. He has lost interest in food and eats only one meal a day. He doesn't think his appetite is affected by his alcohol consumption. He also reported having severe nausea (urge to vomit), and a moderate level of indigestion and heartburn.

**Previous and current treatments:**

- *Psychiatrist or psychologist contact:* He has never seen a psychologist or psychiatrist in the past.
- *Counselling:* XXXXXXX has been seeing a counsellor two weekly for the last 2-3 months, who he has found very helpful. They have talked about alcohol more recently, and she has said that he shouldn't stop it overnight, but suggested he wind it down slowly.
- *Strategies used to manage drinking:* XXXXXXX has been reducing his alcohol consumption gradually over the over the last 6 months or more. He uses cognitive strategies (self-talk) to make a rational argument about why to not drink, and uses other things to occupy his mind and calm himself such as drinking a cup of tea, drinking water, reading, or taking a medication to aid sleep.

**PTSD (Post-Traumatic Stress Disorder):**

- *Intrusive symptoms:* XXXXXXX describes having flashbacks where he feels like he is back in the traumatic situation and he thinks "Oh my God, I'm there again", and also thinks "Its almost like I'm there again". The flashback only lasts for a moment, but he feels very anxious for about half an hour until he has calmed down again. The flashbacks cover a range of situations, including the neighbour shouting and the fighting in the street, and him trying to persuade health professionals to give him more effective treatment for the pain. He has no dreams directly related to the traumas, but does have anxious type nightmares. On the IES-R and ITQ questionnaires, he described "quite a bit" having trouble staying asleep; "moderately" having powerful images or memories that sometimes come into his mind in which he feels the experience is happening again in the here and now, that any reminder brought back feelings about it, other things kept making him think about it, that he found himself acting or feeling like he was back at that time, and that he had dreams about it; and "a little bit" that

he had upsetting dreams that replay part of the experience or are clearly related to the experience, that he thought about it when he didn't mean to, pictures about it popped into his mind, and that he had waves of strong feelings about it.

- *Avoidance symptoms:* He has been avoiding things, including the street where the fighting and assault happened. He has been down the street again but describes feeling uneasy as he gets there because of what he suffered there, although the feeling passes in seconds. He has no problem recalling the events of what happened. On the IES-R and ITQ questionnaires, he described "moderately" trying to remove it from his memory; and "a little bit" on avoiding letting himself get upset when he thought about it or was reminded of it, feeling as if it hadn't happened or wasn't real, trying not to think about it, being aware that he still had a lot of feelings about it but he didn't deal with them, and avoiding internal and external reminders of the experience.
- *Autonomic arousal:* He describes awaking at 4.30am feeling anxious and agitated, but not anxious or agitated at any other time of day. He does have difficulty concentrating on some days, but describes no irritability, and no startle response or hypervigilance. On the IES-R questionnaire, he described "moderately" that reminders of it caused him to have physical reactions such as sweating or trouble breathing or nausea or a pounding heart; and "a little bit" that he had trouble concentrating, and had trouble falling asleep.
- *Dissociation:* PTSD develops as a result of dissociative processes. People develop dissociative symptoms of different severity, and once they have a significant dissociative disorder (e.g. PTSD) are more likely to have other dissociative phenomena, with the risk being higher when that person is going through a period of increased stress in their life. XXXXXXX describes a single dissociative episode lasting 10-15 minutes while he was driving approximately one year ago, which sounds like an episode of transient global amnesia. He was driving to go to visit a friend, and the next thing he knew he was on a road he did not recognise in a place he had never been to before, about 10-15 minutes drive from where he had been planning to go. He also got a speeding ticket. It was not thought to be associated with the use of GABAergic drug use (e.g. alcohol, benzodiazepines, Z-drugs), and seems to have occurred before most of his traumatic medical experiences. He says that he had not been drinking at the time, and that it occurred completely out of the blue, and had not occurred before and hasn't reoccurred since. Transient global amnesia can occur for no easily identified reason, and is not necessarily associated with PTSD or another disorder, and in such cases is not considered to be indicative of any underlying pathological process. I did not use a standardised measure of dissociation in XXXXXXX's case, because of the low severity of symptoms and the lack of dissociative phenomena.
- *Triggers:* XXXXXXX said he was not thrilled when he sees things that remind him of what he went through, but he copes with it. These trigger distressing memories for him, but he shakes them off in a few seconds. I asked XXXXXXX if talking about what had happened to him with me would trigger him, and he said that it did not.

**Sleep and nightmares:**

- *Sleep generally:* XXXXXXX describes that he goes to bed after the 10pm news. He goes to sleep quickly within half an hour. He often feels like he needs a whisky to get to sleep, and says that if he doesn't have a whisky it takes longer for him to go to sleep, but he still goes to sleep relatively quickly. About once a week on average he will take the sedative antihistamine (Piriton) to help with sleep. He gets up at 4.30am. He has never napped in the day, and doesn't feel like napping, and indeed does not often feel tired in the day. He has not tried melatonin to help him sleep.
- *Awaking at 4.30am:* For the last 18 months, he has been awaking at 4.30am, feeling anxious and agitated. He will get up, pass urine and make a cup of tea, sit down and read something, and these things have the effect of calming him down. He says that half the reason why he awakes at this time

to pass urine. He used to drink whisky at 4.30am to take the agitation away, but has been trying to avoid doing so. If he were to stay in bed or go back to bed, he would toss and turn every 30 seconds. The awaking occurs whether or not he has been drinking the day before.

- *Sleep and alcohol:* Alcohol in the day or evening typically increases the need to get up to pass urine during the night, and also increases alertness during the night which increases the risk of waking (even in the absence of alcohol withdrawal symptoms during the night). XXXXXXX reports that his night time awaking is not affected by his drinking, as it is no different on the days that he does not drink at all.
- *Sleep and hip pain:* When he was in a lot of pain from his hip, this disturbed his sleep. He would sleep downstairs, as he couldn't climb the stairs. After the hip operation, his sleep continued to be disturbed until the pain resolved.
- *Dreams and nightmares:* XXXXXXX describes having recurring nightmares at least twice a week, which involve him being chased by people who are trying to kill him. He said it is always the same sort of dream, and that he does not recognise the people in the dream or their characteristics. He doesn't have nightmares about what happened to him. The nightmares may cause him to awake in the night, earlier than 4.30am, but have been a bit less frequent recently. On the IES-R and ITQ questionnaires, he described "moderately" that he had dreams about it; and "a little bit" that he had upsetting dreams that replay part of the experience or are clearly related to the experience.
- *Insomnia severity questionnaire (ISI):* XXXXXXX scored just below the score for clinically significant insomnia, with moderate 'problems waking up too early', being 'dissatisfied' and that he was "a little" worried/distressed about his current sleep pattern, and that it was interfering' "a little" with his daily functioning.
- *Other questionnaires:* On BDI questionnaire, he described waking up 1 – 2 hours early and not being able to get back to sleep. On GADI questionnaire, he described "very much" being wakeful at night, and "a little bit" having difficulty getting off to sleep. On the IES-R questionnaire, he described "a little bit" having trouble falling asleep, and "quite a bit" having trouble staying asleep. On the SBQ-LC, he reported 'sometimes for his sleep being shorter than usual, and how often his sleep was interrupted.

**Other Mental health symptoms and traits:**

- *Wellbeing and quality of life:* XXXXXXX obtained a very high score on the measure of Mental Well-Being (SWEMWBS) and a near maximal score on quality of life (ReQoL-10). He scored "often" on "I felt happy", "I've been feeling optimistic about the future", "I've been feeling relaxed", and "I've been feeling close to other people". He also described his life as "so hectic".
- *Mood:* XXXXXXX described himself as even tempered and equitable, and that it takes a lot to get him angry. He may get a day when he feels lower in mood at times. More recently 1-2 times a week he has felt sad, and recognises that since Covid time his mood has been flatter, and that it has been getting worse in the last few months. He has found it harder to get joy out of something, and has found it more difficult to get into a positive loving mode, and that it has been more difficult to feel love in the last few months. He scored "often" on feeling happy (ReQoL-10 questionnaire) and feeling close to other people (SWEMWBS questionnaire). On BDI questionnaire, he described waking up 1 – 2 hours early and not being able to get back to sleep, feeling more restless or wound up than usual, having less energy than he used to have, his appetite being somewhat less than usual, getting more tired or fatigued more easily than usual, and being less interested in sex than he used to be. On the SBQ-LC, he confirmed that he had a decreased interest in sex in the last 7 days. He also reported 'moderately' for feelings of sadness and being miserable. He also scored 'mildly' for lack of interest in things around him, and mood swings, and 'rarely' for feeling lonely or unsupported.

- *Optimism about the future:* XXXXXXX reported that he enjoyed his job and that he has been very privileged to have has the most fortunate career. He scored “often” on feeling optimistic about the future (SWEMWBS questionnaire).
- *Memory:* He reported that his memory was fine. On the SBQ-LC, he reported ‘mildly’ for difficulty remembering things, brain fog (feeling sluggish, jet-lagged, or blanking out), and difficulty planning.
- *Concentration:* This is generally good, and he tells me that he does difficult crosswords most days, and Sudoku most days. However his concentration can be reduced at times. On the SBQ-LC, he reported ‘rarely’ for feeling confused about what was happening around him, and difficulty concentrating. On the IES-R questionnaire, he described “a little bit” that he had trouble concentrating. On the BDI-II questionnaire, he reported that he could concentrate as well as ever.
- *Anxiety and agitation:* He only feels anxiety and agitation at 4.30am, but the rest of the day is fine. He is a bit of a perfectionist, is neat and tidy, and ‘quite a bit’ hates to throw old used things away (MMOCI questionnaire), but wouldn’t describe himself as obsessional, and is not concerned about germs or security. He scored “often” that he has been feeling relaxed” (SWEMWBS questionnaire). On the BAI questionnaire he reported “moderately – it was very unpleasant but I could stand it” on his heart pounding or racing, “mildly – it did not bother me much” on being unable to relax, indigestion or discomfort in abdomen, face flushed, and sweating (not due to heat). On the GADI questionnaire he reported “very much” that he is wakeful at night, “somewhat” that he is anxious on most days, feels ‘on edge’, fears losing control or passing out or going crazy, that he suffers from dizzy spells, and has difficulty controlling his anxiety. He also reported “a little bit” on suffering from a dry mouth, having difficulty getting off to sleep, and suffering with tense or aching muscles. On the SBQ-LC, he reported ‘moderately’ for anxiety.
- *Self*-criticalness: XXXXXXX said that he can be a bit critical of himself, and for example wishes that he had more energy and that he was achieving more. He is less physically active than he used to be. He says that he has allowed himself to slow down, but worries about whether this was the right thing to do or not. He said that he felt really annoyed and was ashamed that he was not in better health. He said that he didn’t like the fact that he doesn’t want to eat, was not more energetic, engaged and that he tired more easily.
- *Negativity:* He said that he can be quite negative about himself and other people, and this has been more so since his assault and a series of potentially life threatening medical events experiences, for example he wonders more how he is coming over to other people, whether he is giving a positive impression and being sufficiently entertaining or amusing, and whether his daughter loves him.
- *Blaming others for his experiences:* He said that he did not blame himself for what has happened to him. He does however blaming others for how they looked after him, such as them refusing to do the hip operation when he was in so much pain, telling him to go home, and wanting to give him renal dialysis when he didn’t need it.

**Personal history:**

- *Parents:* Both his parents are dead. His father died about 10 years ago, and his mother a few years prior to the Covid pandemic. He said that he had a poor financial start in life, as his parents did not have much money, as his father earned very little. This meant that he did go to bed a little hungry at times when he was a child.
- *Birth and early development:* Born in XXXXXX, with a normal delivery and developmental milestones. No fears or phobias as a child. XXXXXXX’s parents argued a lot which he found very distressing. Overall he said his childhood was unhappy. He was smacked by them from time to time, but they were not unjust in their punishments. He suffered no other trauma or abuse as a child.

- *Siblings:* XXXXXXX is the youngest of 2 brothers. His brother is 10 years older than him. He was not close to his brother when he was a child, as they had a big age gap and very different personalities. However he does now speak to him every few weeks on the phone.
- *Contact with relatives:* He has never had any contact with relatives. His brother did some research into them and found out who they were, and sent him some information about them, but XXXXXXX is not interested and hasn't looked at what his brother sent him.
- *Primary school:* Primary school was great and a very happy place. His parents sacrificed a lot to send him to a good school.
- *Secondary school:* He loved secondary school and had a good time at times. He took 5 A' Levels and had no problems with exams, and got a scholarship to XXXX university.
- *XXXX University:* XXXXXXX studied engineering at XXXX university and then did his apprenticeship at XXXX engineers in London. He said that at that time you worked hard with long hours but just got on with the job.
- *Apprenticeship with XXXX:* He did his apprenticeship with XXXX which is a very big engineering company, and after this went to an internally recognised engineering company. He knew he didn't want to be aeronautical, and the engineering department at XXXX was attractive to him.
- *Career as an engineer:* He has never regretted going into engineering, and really enjoys it. He feels that he has had the most fortunate career, and been very very privileged, and has worked on some well known major engineering projects.
- *Retirement from medical work:* He was off work for 9 months with a series of medical problems, as described above. When he was most unwell, he was thinking of retiring. However in the end, he decided to go back to work, and he took advice from colleagues who also thought it would be good for him to return to work. He is pleased that he did as he still enjoys it, but he has laid a retirement plan as he is thinking that he may retire in a couple of years time.
- *Current work:* He works 2-4 days a week as an engineer, and feels that this is a nice balance.
- *First marriage:* His first marriage was for over 20 years, and he has X children by his first partner. He says that he split up from his partner as he progressively found her increasingly boring, and his children also encouraged him to leave her.
- *Second marriage:* He met his current partner while working in a job for his company in France, and they married 10-11 years ago, about 4-5 years after he split up from his first partner. They have X son's who live at home. He describes his partner as being very sensitive to potential addiction issues, and very concerned about his drinking. He described having no issues in their marriage, and is not finding her at all boring.
- *Finances:* He has no financial worries.
- *Accommodation:* He has always lived in the UK, and has now paid off his mortgage.
- *Religion:* He doesn't follow any religion.
- *Hobbies:* He did a course in photography about 10 years ago, and used to do a lot of it, but has not picked up a camera since Covid. He goes for a walk daily of about 1 mile. He enjoys cooking and gardening. He used to paint water colours.
- *Forensic history:* None.

**Family psychiatric history:**

- None.

**Premorbid personally:**

- XXXXXXX described himself as mild and easy going, who very rarely gets angry, and never getting resentful. He says that where there is a difference of opinion, he can see the issue from both sides. He said he is not extraverted, but that he enjoys having friends over.

**Alcohol:**

- *Alcohol generally:* He has always drunk alcohol, and only drinks whisky. He never drinks wine or beer. He said that he has never had a hangover, a headache or felt bad the day after drinking. He says that when Covid-19 came, this tipped his drinking over the top, such that it became problematic. He was drinking heavily, and became bloated and gained 8kg in weight. This stopped when he was admitted to hospital with pneumonia and other health problems. He has never been violent or abusive when drinking. On the AUDIT questionnaire, he reported having a drink containing alcohol 4 or more times per week, and that daily or almost daily he was drinking 8 or more units of alcohol. He also reported drinking 7-9 units of alcohol on a typical drinking day, and that weekly he found that he was not able to stop drinking once he had started. On the SADQ questionnaire, he reported that he 'often' drank more than half a bottle of spirits per day.
- *Attitude to drinking:* XXXXXXX says he is trying to get away from drinking, and to no longer be dependent on using alcohol to cope. He feels that he is still a bit dependent on alcohol, but that it is better than it was. He said that it is "scary" that he may drink a whole bottle of whisky, and "hardly notices it".
- *Alcohol as a crutch:* XXXXXXX says he has used alcohol as a crutch to cope with pain, disrupted sleep, Covid, anxiety and the stress of what he is doing. He explained that he finds it very easy to use alcohol as a crutch, and that it is easy to drink as an excuse for his issues "because I can".
- *Stressful days:* On a stressful say he will drink a 70cl bottle of whisky, spread out through the day, but doesn't get intoxicated with it. This happens on 1-2 days a week, and especially on Saturdays and Sundays. Every 4-6 weeks, he will drink excessively starting at 8am in the morning on days when he is organising and hosting a weekend event for engineers. He says he feels agitated in his mind, and worries about how the weekend will go, feeling agitated about the organisation of it, such as whether he has got the right food and the right timings. He said that he is not conscious of feeling stressed but that he must be stressed as he "stupidly reaches for a drink". He is also not consciously feeling fearful that his guests might be critical, and says that it has never gone badly wrong in the past.
- *Other people's comments on his drinking:* He says his partner has been concerned about his drinking for 2-3 years, and attributes his staggering to alcohol. His partner does seem to notice that he has been drinking sometimes. His children have also commented on his drinking. However he does not believe that when his guests are staying for the weekend, that they are aware of his drinking, even after he has drunk a whole bottle of whisky. On the APQ questionnaire, he reported that his spouse has complained about his drinking, and that his children has criticised his drinking.
- *Seeking help for his drinking:* Although his partner has been concerned about his drinking for 2-3 years, XXXXXXX saying he delayed seeking help because he refused to admit to himself that it really was a problem, and felt that he should be able to sort it out by himself. He did however start seeing a counsellor 2-3 months ago, and they have discussed alcohol. He is seeking help from Rawlinson Health Consulting because he has been finding it harder to cut down that he expected.
- *Alcohol withdrawal symptoms:* He used to awake feeling sweaty when he was drinking more, but has not done so for a long time. He did not describe a history of seizures or DT's. On the SADQ questionnaire, after a period of heavy drinking in the last 6 months (prior to having his hip operation), he reported that the day after drinking alcohol he 'sometimes' woke up feeling sweaty, he liked to have an alcoholic drink in the morning, and he drank more alcohol to get rid of the shakes. If he had been completely off drink for a few weeks, and then drank very heavily for two days, then the morning after those two days of drinking he reported that he would be craving for a drink.
- *Craving for alcohol:* He used to have a craving to drink in the mornings. He said that he very rarely craves for alcohol now, and indeed can't remember the last time he craved for alcohol.

- *Drinking with others:* XXXXXXX said that he doesn't tend to drink with friends – ever. If he goes out, he will tend to have a non-alcoholic drink. He reported that his partner drinks virtually nothing at all. On the APQ questionnaire, he reported that he tend to drink more on his own more than he used to.
- *Enjoyment of drinking:* XXXXXXX describes having less desire to drink in the last 2-3 months, although he has no idea why this is the case. He describes not enjoying it as much now as he used to, and that he used to get "a real kick" out of it.
- *Days without drinking:* He will drink no alcohol at all on some days, and may not drink up to 3-4 days in a row. He has noticed that he feels better on days when he doesn't drink.
- *Events not thought to be related to his drinking:* XXXXXXX felt his collapse about one week ago associated with concussion and confusion afterwards was related to postural hypotension, as he only had one whisky that night. There was no mention of seizure like activity. The dissociative episode one year ago, occurred after he hadn't been drinking.
- *Strategies to manage drinking:*
    - XXXXXXX describes winding down the amount he drinks gently over the last 6 months or more. He plans to continue to reduce his drinking gradually.
    - If he has an urge to drink, he thinks about why it is present, and tries to make a rational argument about why to not drink, and most of the time he manages to avoid drinking.
    - He tries not to drink if he is working the next day, but sometimes does so. As he is working 2-4 days a week, this still leaves 3-5 days a week where he could drink.
    - He has been trying to avoid drinking when he awakes at 4.30am, but instead to drink a cup of tea, read or do some colouring.
    - He has been trying to avoid drinking whisky to speed up his going to sleep, and will take an antihistamine tablet (Piriton) once a week instead.
    - When feeling anxious, he is happy to have a cup of tea which he feels is calming for him and which he really enjoys.
    - When feeling thirsty, he is happy to drink water to solve his thirst.
    - When he has guests round for the weekend, he said he could drink a cup of tea rather than have a whisky when he feels stressed and agitated.

**Cigarettes:**

- None.

**Illicit drugs:**

- None.

**Gambling and behavioral addictions:**

- None.

**MENTAL STATE EXAMINATION:**

- *Appearance and Behaviour:* XXXXXXX was smartly but casually dressed with no psychomotor retardation or poverty of speech. He arrived exactly on time for the interview. He was open and forthright in his speech. He sat throughout the lengthy interview without a drink or a break in the 2

hour 50 minute interview. He was not hard to interrupt, but did not seem annoyed when I did interrupt him and the conversation flowed well. He did not appear restless or agitated, but about two-thirds of the way through the interview he put one leg over the arm rest of the leather chair, which I took to indicate that he felt reasonable comfortable during the process. He appeared to concentrate well. He was cooperative, polite and non-threatening throughout. Rapport appeared good, but I did not detect any emotional warmth. Eye contact was good, and he did not appear unsettled, distressed or angry at any point. He did not show any tremor of the hands, and his right hand was not sweaty when we shook hands at the beginning. I did not see any evidence of palmar erythema. It was possible he smelt of alcohol, but I could not be sure. There was no sign of intoxication. His face appeared to be a bit puffy, which can be associated with excessive alcohol use. He did not have rhinophyma (a red, bumpy or bulbous nose known as the drinker's nose). He seemed calm and unhurried during the interview, but once back in his car he seemed desperate to leave, but struggled to reverse out of the long drive. As he left, he apologised for putting the wrong stamp on the envelope when he sent his questionnaires in the post to me.

- *Speech (form and content):* XXXXXXX spoke with normal rate, rhythm, volume and modulation of tone. I identified no evidence of dyslexia or dysarthria in his speech. He answered all questions, including more complex ones, without my having to repeat anything.

- *Mood:*
    - *Smiling:* Objectively he had reduced variability of affect, as he did not smile or laugh during the assessment. Subjectively he described his mood as a little flattened.
    - *Mood change:* I observed no periods of mood change.
    - *Sleep:* He describes little difficulty getting off to sleep, but awaking during the night at about 4.30am feeling anxious and agitated, and then unable to get back to sleep. He does not nap.
    - *Eating:* He describes his appetite as very poor, with a lack of desire to eat, but no weight loss. He gets nausea briefly when he tries to swallow tablets.
    - *Energy:* He feels his energy level is still a little reduced, and he still gets aching in his muscles.
    - *Concentration:* Subjectively, he describes reduced concentration as he is easily distracted, He did appear to concentrate well during the interviews, and completed 4 questionnaires comprising roughly 80 questions in 10 minutes before he left (which was fast).

- *Abnormal ideas and experiences:* No abnormal experiences were observed. However XXXXXXX does describe a range of subjective experiences including:
    - *Delusions or hallucinations:* XXXXXXX expressed no delusional ideas or any hallucinatory experiences.
    - *Flashbacks:* He has a variety of flashbacks related to his traumatic experiences or lack of them, and says that it takes about half an hour for the anxiety to subside after them.
    - *Being triggered:* XXXXXXX describes distressing memories triggered by things that remind him of his traumatic experiences, but that these resolve quickly.
    - *Dissociating:* XXXXXXX describes no events that were typical of dissociative phenomena, other than one episode of probable total global amnesia lasting about 10-15 minutes about one year ago.

- *Thought Form:* This was logical, coherent and goal directed. No abnormality was detected.

- Thought content:

- *Suicidal ideation and self-harm:* He has no thoughts about killing himself or harming himself. When he was in severe pain from his hip, and was being refused the hip operation, he said he would rather die than live with that severity of pain.
- *Shame:* He feels ashamed that his health, including his energy levels are not better, and that he is 'pathetic' for not being like he was prior to Covid.
- *Self-criticism:* He felt really annoyed and was ashamed that he was not in better health, and that he didn't like the fact that he doesn't want to eat, was not more energetic, engaged and that he tired more easily.
- *Anger and irritability:* He does not feel irritable, and it takes a lot for him to feel angry.
- *Dreams and nightmares:* He describes nightmares at least twice weekly of someone chasing him and trying to kill him.
- *Sexual thoughts:* He describes reduced interest in sex.

- *Cognitive state*: XXXXXXX appeared to be well orientated in time, place and person. He came across as an intelligent man who had no difficulty grasping and responding appropriately to complex psychological questions. He appeared able to concentrate well during the lengthy interview, and completed four questionnaires quickly. It was however somewhat noticeable that he was often vague about dates or how long ago particular events had happened.

- *Insight:* XXXXXXX accepts that he is a level of alcohol dependence, although he feels that its severity has reduced since he has reduced his drinking. He is engaging with weekly counselling which he finds helpful and is seeking help and encouragement to cut down further and stop drinking completely.

**SUMMARY AND IMPRESSION:**

**Overall:**
XXXXXXX clearly has PTSD on the basis of my clinical assessment, in addition to a degree of alcohol dependence, and some ongoing physical health issues.

In my opinion, once the PTSD is effectively treated, XXXXXXX is likely to find it easier to cut down his alcohol consumption.

I have specified below under the "Treatability of PTSD" section, in the subsection "Prognosis of PTSD" what things are likely to improve, and what things are unlikely to improve following effective treatment for PTSD, but it is difficult to be certain until such time as the PTSD is effectively treated.

**SUMMARY AND DISCUSSION OF TREATMENT ISSUES:**

**Treatment and management of mental health and psychological issues:**

**Overall:**

XXXXXXX experienced a series of traumatic events related to being assaulted on the street and a series of potentially life threatening medical events and in my opinion meets the criteria for a clinical diagnosis of Post Traumatic Stress Disorder (PTSD), as he describes intrusive, avoidance, autonomic arousal. The intrusive symptoms are the strongest, and there are relatively few avoidance and autonomic (physiological) arousal symptoms.

**Evidence supporting a Post-Traumatic Stress Disorder (PTSD) diagnosis:**

- *PTSD as a diagnosis:* PTSD typically develops after exposure to one of more severely traumatic events. It is the result of the brain being overwhelmed emotionally, and therefore splitting the single perception of the experience into components, such as physical sensations, emotional feelings and cognitive thoughts about it. This process is the result of dissociation which reduces the immediate emotional burden of the experience, but typically results in intrusive symptoms about the experience, avoidance of triggers that can act as reminders of the experience and autonomic (physiological) arousal. These PTSD symptoms may persist for one's whole life, and many people have them for over 50 years. The diagnostic criteria from the formal classification systems are listed in Appendix 1.
- *PTSD Questionnaire responses:* On the IES-R questionnaire, XXXXXXX obtained a moderate total score of 24, where 33 and over is the normal cut-off used for PTSD, in relation being assaulted on the street. He also obtained a high average item score above 1.5 on the intrusion subscale, but below threshold on the avoidance and autonomic arousal subscales. On the ITQ questionnaire about the same experiences, he also scored above threshold on only the intrusion subscale, but below threshold for the avoidance, autonomic arousal, and functional impairment subscales
- *Diagnostic criteria for PTSD:* The criteria for PTSD are specified in appendix 1 of this document for both ICD-10 (1993) and DSM-5 (2013). The RDC for ICD-10 have been used as the basis for my assessment from what XXXXXXX told me against these criteria as specified below:
  - A. Yes – *Criteria:* Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.
    *Comment:* He reports a series of traumatic events related to his traumatic experiences which included an assault and a series of potentially life threatening medical events (pneumonia, renal failure etc), being told he had a 15% chance of dying, and being refused adequate analgesia and rapid access to operative treatment for severe hip pain.
  - B. Yes – *Criteria:* Persistent remembering or "reliving" the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.
    *Comment:* He has been having flashbacks of various events related to being assaulted on the street and a series of potentially life threatening medical events, where he feels like he is back there again. Although he reported no dreams directly related to the assault or his time in hospital, he does have anxious type nightmares at least twice a week, which involve him being chased by people who are trying to kill him. On the ITQ, he reported "a little bit" that he had upsetting dreams that replay part of the experience or are clearly related to the experience,

C. Yes – *Criteria:* Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).
*Comment:* He said that he does avoid things, and in particular the street where he was assaulted, unless he has to go there. If he does go there he describes feeling uneasy as he gets there because of what he suffered there, although the feeling passes in seconds. If he thinks about or is reminded of his hip pain, this triggers distressing memories for him, but he shakes them off in a few seconds. On the IES-R and ITQ questionnaires, he described "moderately" trying to remove it from his memory; and "a little bit" on avoiding letting himself get upset when he thought about it or was reminded of it, feeling as if it hadn't happened or wasn't real, trying not to think about it, being aware that he still had a lot of feelings about it but he didn't deal with them, and avoiding internal and external reminders of the experience.

D. Either (1) or (2):
(1) No – *Criteria:* Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor.
*Comment:* He reported no problem recalling the events of what happened to him during the assault or when he was admitted to hospital.
(2) No – *Criteria:* Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following:
*Comment:*
a) Yes – *Criteria:* Difficulty in falling or staying asleep;
*Comment:* He describes awaking at 4.30am feeling anxious and agitated, and does get dreams and anxious nightmares at least twice a week.
b) No – *Criteria:* Irritability or outbursts of anger;
*Comment:* He rarely expresses anger or irritability.
c) No – *Criteria:* Difficulty in concentrating;
*Comment:* His ability to concentrate is generally good, although he does have difficulty concentrating on some days. He is still able to do a difficult crossword and Sudoku. On the IES-R questionnaire, he reported "a little bit" that he had trouble concentrating,
d) No – *Criteria:* Hyper-vigilance;
*Comment:* He reports no hyper-vigilance.
e) No – *Criteria:* Exaggerated startle response.
*Comment:* He reports no startle response, not even to a loud unexpected noise.

E. Yes – *Criteria:* Criteria B, C and D all occurred within six months of the stressful event, or the end of a period of stress. (For some purposes, onset delayed more than six months may be included but this should be clearly specified separately).
*Comment:* The period in which he experienced traumas related an assault and a series of potentially life threatening medical events was prolonged, and his symptoms began within 6 months of the traumas ending following recovery from the hip operation.

**Evidence supporting a Complex Post-Traumatic Stress Disorder (complex PTSD) diagnosis:**

- *Complex PTSD as a diagnosis:* Complex PTSD typically develops following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible. The International Classification of Diseases 11th edition (ICD-11) which was released in Jan 2022 recognises Complex PTSD in addition to PTSD under the category of 'Disorders specifically related to stress'. Complex PTSD describes the more complex reactions

that are typical of individuals exposed to chronic trauma. Complex PTSD includes the three core elements of PTSD (intrusions, avoidance and autonomic arousal) as well as three disturbances in self-organisation that are pervasive and occur across various contexts: emotion regulation difficulties (e.g. problems calming down), negative self-concept (e.g. beliefs about self as worthless or a failure) and relationship difficulties (e.g. avoidance of relationships). There is substantial evidence supporting the difference between PTSD and Complex PTSD diagnoses. Complex PTSD is also associated with more severe impairment than PTSD indicating that people with Complex PTSD have greater difficulties in daily living. The diagnostic criteria from the formal classification systems are listed in Appendix 1.

- *Complex PTSD questionnaire responses:* On the ITQ Questionnaire XXXXXXX met criteria on only 1 of the 8 criteria, and so didn't meet the criteria for complex PTSD on this questionnaire. The criteria he met was related to intrusive experiences as associated with PTSD. On the ITQ questionnaire he did not meet the other criteria for PTSD, but the ITQ is a much less sensitive measure of PTSD than the IES-R (mainly because it asks so few questions). He met none of the additional 4 criteria related to complex PTSD.
- *Diagnostic criteria for Complex PTSD:* Complex PTSD describes the more complex reactions that are typical of individuals exposed to chronic trauma. All four criteria have to be met for the diagnosis to be made.
    1. No: *Criteria:* Severe and pervasive problems in affect (mood) regulation.
       *Comment:* He describes that he may get a day when he feels lower in mood at times and has found it harder to get joy out of something. More recently 1-2 times a week he has felt sad, and recognises that since Covid time his mood has been flatter, and that it has been getting worse in the last few months. These issues are of minor intensity and are neither severe nor pervasive.
    2. No – *Criteria:* Persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event or stressor.
       *Comment:* He does not see himself as worthless, although he does have some feelings of shame and describes himself as 'pathetic' in relation to certain things, such as not being as energetic as he used to be, and using relaxation exercises to help him relax. He said that he felt really annoyed and was ashamed that he was not in better health. He said that he didn't like the fact that he doesn't want to eat, was not more energetic, engaged and that he tired more easily. He also said that he can be quite negative about himself and other people, and this has been more so since his assault and the series of potentially life threatening medical events.
    3. No – *Criteria:* Persistent difficulties in sustaining relationships and in feeling close to others.
       *Comment:* He does describe finding it more difficult to get into a positive loving mode, and that it has been more difficult to feel love in the last few months, but he has no persistent difficulty in sustaining relationships and in feeling close to others.
    4. No – *Criteria:* These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.
       *Comment:* He reports no significant impairment.

**Discussion of PTSD, Complex PTSD and other Stress Response Syndromes:**

- *Summary of the evidence for PTSD:* Based on the evidence presented above, XXXXXXX does not quite meet the formal diagnostic criteria for PTSD, in that he meets 4 out of 5 main criteria for PTSD, and only one (rather than two) symptoms of persistent psychological sensitivity and arousal. The level of avoidance symptoms he has is also relatively low, and indeed he works close to where he experienced

some of the traumas. On the IES-R he scored just below the typical threshold for PTSD, but showed a high level of intrusion, but a relatively low level of avoidance and autonomic arousal symptoms.

- *Summary of the evidence for Complex PTSD:* Although he experienced trauma over a period of quite a few months, there is no significant evidence that XXXXXXX has complex PTSD. He does not have any major problems typical of complex PTSD. When he experiences a flashback, it will calm down in about half an hour. On the ITQ screening questionnaire for complex PTSD, he did not meet any of the additional four criteria for disturbances in the three areas for self-organisation and general functional impairment.
- *Evaluation of the evidence for PTSD, Complex PTSD or another stress response syndrome:* In my opinion it is highly likely that XXXXXXX has PTSD, and does not have Complex PTSD. This is because the questionnaires should only be considered as screening measures, and the diagnostic criteria as only applicable to the majority of people with trauma. XXXXXXX from the clinical point of view clearly has the three core features of PTSD (intrusions, avoidance and autonomic arousal). The intrusive symptoms he experiences are unlikely to be due to another cause, as he has a low score on the measure of obsessional symptoms, and therefore the intrusive symptoms are most likely to be due to the PTSD. He does have some anxiety symptoms, and so a diagnosis of generalised anxiety disorder needs to be considered. However the anxiety symptoms and mood symptoms he describes are more likely to be explained by the presence of PTSD (which is also classified as an anxiety disorder).
- *OVERALL IMPRESSION:* Despite not meeting the formal diagnostic criteria for PTSD, it is clear that XXXXXXX does meet a clinical diagnosis of PTSD. In summary it is highly likely that XXXXXXX has PTSD and very unlikely that he has complex PTSD. PTSD is characterised by intrusive symptoms, avoidance of reminders and being autonomically aroused which he clearly has. Although in my opinion he does have PTSD, there is a possibility that he may have another stress response syndrome, such as 'partial PTSD' as he could be considered to have most but not the full set of symptoms for PTSD. However it is likely that his returning to work ner when the traumas happened has contributed to the relatively low level of avoidance and autonomic arousal symptoms. He also comes across as a very stoical individual, which would mean that he would tend to report a lower level of symptoms than an individual who was not so stoical.

**Discussion of alcohol dependence syndrome:**

- *ICD-10 and ICD-11 diagnosis of alcohol dependence:* The dependence syndrome in the International Classification of Diseases, 11th Edition (ICD-11) states that the diagnosis of "alcohol dependence, current use, continuous" is made if during the past 12 months if alcohol use is continuous (daily or almost daily over at least the past 1 month), and certain criteria. A diagnosis of dependence requires that 3 out of 6 criteria have been present together at some point over the last 12 months. XXXXXXX describes experiencing craving, sweating and shaking as a withdrawal symptoms and difficulty reducing his alcohol consumption in the past. I did not elicit the other 3 criteria which are evidence of tolerance, persistent use despite being aware of harmful consequences or the progressive neglect of alternative pleasures or interests because of alcohol use. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) uses 11 criteria, by expanding on similar criteria to the ICD classification. It defines mild alcohol dependence where there are 2-3 criteria met, moderate dependence where there are 4-5 criteria met, and severe dependence where there are 6 or more of the 11 criteria met. XXXXXXX meets 3-4 criteria on this classification with experiencing craving, sweating as a withdrawal symptoms, difficulty reducing his alcohol consumption, and often drinking larger amounts or over a longer period than he intended. This last criteria I was uncertain about as although he said he did this weekly, I was uncertain whether this should count as often or not.

- *Severity of alcohol dependence:* XXXXXXX describes no craving or withdrawal from alcohol since he has reduced his level of drinking over the last 2-3 months. He describes trying to avoid drinking on the days prior to working, which is 2-4 days a week, but also drinking a whole bottle of 70cl of whisky (28 units) on roughly two days a week, spread throughout the day. He felt he now had a mild level of alcohol dependence. His SADQ score relating to a period when he was drinking more heavily was 7, which also indicates a mild level of alcohol dependence, and on that questionnaire he reported drinking more than half a bottle of spirits a day (and not more than one bottle of spirits a day), which is consistent with his self-report of his drinking. It is difficult to tell is someone is minimising their alcohol consumption or not, and minimisation of consumption verbally and on questionnaires is generally typical at an initial meeting before a trusting relationship has been established.
- *Risk of being positive to alcohol the day following drinking:* As alcohol is metabolised by a zero order process, that consumes about one unit of alcohol per hour, he could still be positive for alcohol the following day. For example if he drinks a 70cl bottle of whisky, which contains 28 units of alcohol, he is likely to be test positive on a breathalyser for the following 28 hours.
- *The Chief Medical Officer of England drinking guidelines:* The alcohol guidelines relate to the risk of physical damage to the body (not to the risk of developing alcohol dependence or other mental health problems). These guidelines specify that both men and women should drink no more than 14 units a week (i.e. an average of no more than 2 units a day), to make sure we have several drink-free days, to spread the drinking over three or more days a week and never binge drink. If we have one or two heavy drinking episodes a week, we increase our risk of death from long-term illness, accidents and injuries. The risk of developing a range of health problems including high blood pressure and cardiovascular disease and many cancers increases the more we drink on a regular basis, and for most disorders the risks increase exponentially as the amount we drink increases linearly. XXXXXXX's amount and pattern of drinking is in the very high risk drinking category, which relates to a high risk of physical health problems.
- *Alcohol consumption and hypertension:* Alcohol raises blood pressure (BP) and increases the risk of hypertension in a dose-dependent manner, and that the relationship is exponential for essential hypertension. It is estimated that 16% of all hypertensive disease globally is attributable to alcohol, and that 50% of all strokes are due to hypertension. The risk of haemorrhagic stroke increases exponentially and of ischaemic stroke increases linearly with the amount of alcohol consumed. Reducing ones alcohol consumption can significantly reduce the blood pressure, by 3 mmHg systolic and 2 mmHg diastolic, which may seem a small amount but which can be sufficient to take someone who is in the hypertensive range into the non-hypertensive range. Large scale observational studies suggest a reduction of 2mmHg in diastolic BP in the mean of the general population distribution could result in a 17% decrease in the prevalence of hypertension, a 6% reduction in the risk of coronary heart disease and a 5% reduction in the risk of stroke and transient ischemic attacks.
- *Neuroadaptation and severe alcohol dependence:* When someone has become alcohol dependent, the brain has become 'hijacked' and changed, such that following such alcohol dependence, the brain never quite goes back to how it was before – even after prolonged abstinence. This neuroadaptation means that it can be hard to reduce one's level of alcohol consumption (even when wanting to do so), and once abstinent one remains prone to relapse and that alcohol dependence develops again very quickly, and much faster than it developed the first time. Neuroadaptation involves both changes in brain structure and 'conditioned learning'. For example if the brain has learnt psychologically (through conditioning) that alcohol is a good way to respond to stress, even if this response is 'extinguished' as a result of no longer occurring for a significant period of time, the

response is never ‘unlearned’ but new healthier responses ‘laid on top of it’. However this hidden conditioned response can quickly become reactivated following the taking of a further drink. The presence of neuroadaptation means that someone who has been dependent and wishes to remain abstinent has to be constantly vigilant against taking that first drink, and such vigilance can be supported by attending a support or mutual aid group regularly.

- *Genetic* (inherited) *factors in alcohol use:* There are three types of predispositions to addiction - genetic, environmental and psychological. Genetics does not ‘cause’ mental health problems, but does ‘predispose’ people to develop them. In the population as a whole, all mental illnesses are 50% predisposed by genetics and 50% predisposed by the environment. Research has estimated that genetic factors contribute 48–66% of the vulnerability to alcohol addiction (with environmental factors contributing 34-52% too), i.e. slightly more genetic than environmental influence. However just because we are predisposed genetically does not mean we are powerless to do anything about it. The mechanism of this predisposition may relate to the natural dopamine levels in the brain. People with naturally low dopamine, often feel that their first use of alcohol (or drugs) makes them feel great, i.e. it gives them more intense pleasure than people with higher naturally occurring dopamine levels. The alcohol (or drugs) act to increase dopamine levels in the brain. I identified no evidence of genetic factors for XXXXXXX, as he reports no family history of mental health or alcohol problems.
- *Other familial factors in alcohol use:* Psychological strategies that have been modelled by the caregivers in the environment where one grew up can also predispose one to drinking alcohol, such as how the caregivers (parents in XXXXXXX’s case) coped with stress and problems. Low dopamine in the brain also occurs as a result of experiences of powerlessness in the upbringing (which is not a genetic effect). It is thought that psychological treatment through counselling can return the dopamine levels to normal, and that this results in a reduced liking for alcohol (and drugs). He describes that his parents would argue a lot, and that this distressed him, and it would depend on his perception of powerlessness at the time that would likely determine its impact on his dopamine levels. I did not specifically ask XXXXXXX about his perception of powerlessness at the time, so cannot comment on this further. XXXXXXX’s current job involves him being very influential, so this would be associated with lower levels of powerlessness, and most likely with higher natural dopamine levels.
- *PTSD as a factor increasing the risk of drinking:* Where PTSD is present, this can be a strong underlying driver for reducing the ability to manage stress effectively and therefore increases the risk of drinking. Where PTSD is present, as I believe it is in XXXXXXX’s case, effectively treating the PTSD is likely to have a significant impact on increasing his ability to reduce his level of alcohol consumption, and once abstinent to reduce his risk of relapse back to alcohol.
- *Positive and protective factors against relapse:* XXXXXXX does appear to have some factors more associated with people with a less severe level of alcohol dependence. He describes relatively low levels of craving, and withdrawal symptoms and describes not drinking on some days of the week. He has also been attending weekly counselling for 23 months and reports finding it very helpful. He has also been actively doing both cognitive and behavioural strategies to help manage his drinking, and is aiming to substitute other activities for his triggers to drinking. It is therefore possible that with the right treatment for PTSD, his ability to reduce his drinking will be markedly improved that and that once abstinent his risk of relapse will be relatively low compared to others who have a similar level of alcohol dependence.

- *Driving and the DVLA:* The DVLA produces guidance on driving in those who drink. It states in chapter 5 on "drug or alcohol misuse or dependence" (Feb 2024, pp. 100-106, see https://www.gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals) that those who persistently misuse or are dependent on alcohol must not drive and must notify the DVLA, where the misuse or dependence is confirmed by medical enquiry and/or evidence of otherwise unexplained abnormal blood markers. Those who identity the misuse or dependence must inform the person that they have a duty to inform the DVLA, and that if they have an accident then their insurance will be invalidated and they may face prosecution. When the DVLA is informed, the person's driving licence will be refused or revoked until after a minimum of 6 months of controlled drinking or abstinence, and normalisation of blood parameters for persistent alcohol misuse, or for dependence the driving licence will be refused or revoked until a minimum of 1 year's abstinence from alcohol consumption has been attained, and that continued licensing will thereafter require ongoing abstinence. In addition, licensing will require satisfactory medical reports from a doctor, the DVLA may need to arrange independent medical examination and blood tests, and that referral to and the support of a consultant specialist may be necessary.

**SUMMARY AND DISCUSSION OF TREATMENT ISSUES:**

**Treatability of PTSD:** Trauma syndromes are fully treatable, with the correct technique and appropriately trained therapist. PTSD with flashbacks may respond to treatment quickly, especially when complex PTSD is not present and when treated by EMDR (as described in more detail below). Treatment may result in a temporary increase in the level of PTSD symptoms (e.g. increased intrusions) as the memories are brought to the surface, prior to the fragments and components becoming integrated into a single memory of the traumatic experience.

- *Psychoeducation about trauma:* Learning about the pervasive effective of trauma and PTSD can be very helpful for people, in particular because it helps people understand that the trauma response is their brain responding normally to the traumatic events ("PTSD is a normal response to an abnormal event"), that they do not need to continue to blame themselves for how they responded and the struggles that they have as a result of it. It also provides insight into techniques that can be effective at overcoming trauma.
    - *PTSD as the result of dissociation:* Dissociation is a normal process in the human brain, and for example when driving somewhere familiar we may arrive somewhere and then realise we have no memory of part or all of the journey because we drove on 'automatic'. PTSD is a normal response to an abnormal event, which develops after the brain is exposed to one of more severely traumatic events. It is the result of the brain being temporarily overwhelmed emotionally, and the brain manages this by splitting the memories of the experience into components, such as the physical sensations, emotional feelings and cognitive thoughts about it. This splitting of the single memory into components (i.e. into a fragmented memory) is the result of dissociation which reduces the immediate emotional burden of the experience, but typically results in intrusive symptoms about the experience, avoidance of triggers that can act as reminders of the experience and autonomic (physiological) arousal. The threshold at which the brain is emotionally overwhelmed differs from person to person, and appears to depend on a range of factors, such that some people will develop PTSD only with a severely traumatic event, whereas others will develop it with relatively mild traumatic

events. The strongest predictor of the development of PTSD is the experience of previous trauma. In my view, XXXXXXX describes a severely traumatic series of events, by which I mean that in my opinion the majority (over 50%) of people who would have experienced the same series of events would have also developed PTSD.

- *The brain systems involved in PTSD:* In PTSD, it is thought that certain brain processes related to the traumatic events are blocked, which means that the trauma cannot be fully processed. We can only process trauma when we reexperience it while remaining sufficiently calm (which is referred to as keeping our brain systems 'online'). To process and treat trauma that has led to fragmented memories, it is necessary to ensure the brain structures that trauma has shut down are back online. This includes the brain region where we think, and where our feelings are put into words and which creates our sense of location in time (the frontal lobe), and the brain region that integrates the information from incoming sensations from both our external environment and internal mental and physical systems (the thalamus). The trauma triggers can be thought of as being like a smoke alarm, and when it goes off we leave the calm relaxed alert state and may go into fight/flight or freeze/withdrawal. The smoke alarm is there to detect if there is anything indicative of fire around, but does not distinguish between the smoke from burning toast and the house being on fire. When we are triggered by a reminder of trauma, our smoke alarm (which is our brain's amygdala) goes off in an attempt to keep us safe. Most of the time, it is a false alarm because the reminder is something innocuous, equivalent to the toast being burnt.
- *The autonomic nervous system and PTSD:* The autonomic nervous system is part of the nervous system that controls the automatic functions of the body, such as breathing, heart rate, blood pressure, sweating and digestion. There are two parts which normally work in balance, the sympathetic part or 'the accelerator' which activates our body, heightens our alertness, and releases adrenaline to prepare us to deal with any perceived threat; and the parasympathetic part or 'the break' (which includes the vagus nerve) which deactivates our body, calms us down and makes us less aroused as any threat is over, so we "rest and digest". Normally these two parts of the nervous system are in balance and we feel calm and alert (in the so called central zone). However when it is out of balance as in flight/fight where the sympathetic part predominates and we are hyperaroused, or in freeze/withdrawal where the parasympathetic part predominates and we are hypoaroused, we need to try to bring it back into balance. In fight and flight, we need to calm our mind and body down; and in freeze/withdrawal we need to raise our level of arousal. Managing our breathing is a relatively simple way to restore balance in the autonomic nervous system, as breathing air in stimulates the sympathetic nervous system and breathing air out stimulates the parasympathetic nervous system. In flight/fight, 'calming breathing', by breathing out for twice as long as we breath in, calms down the hyperarousal. In freeze/withdrawal, using grounding and 'box breathing' (e.g. breathing in to the count of 4, holding to the count of 4, breathing out to the count of 4, holding to the count of 4 and repeat) reduces the hypoarousal.

- *Psychological treatment:* The treatment of PTSD is primarily psychological. PTSD is often known as 'Simple PTSD' to distinguish it from 'Complex PTSD'. However it is typically not necessarily simple at all, although the treatment of 'simple PTSD' is typically significantly simpler than that of complex PTSD. Dissociation is a normal process in day to day life, and PTSD is primarily the result of dissociation, where the brain has coped by separating out different aspects of the trauma, so that it

is not overwhelming. Treatment involves bringing the different aspects of the experiences together while using techniques that avoid overwhelming the brain.

- *EMDR (Eye Movement Desensitisation and Reprocessing):* For simple PTSD where there are sensory, somatic or emotional flashbacks, EMDR can be very effective in a few sessions for a small number of traumas. EMDR can be curative, but other techniques can also help, although symptom resolution tends not to be so complete. If XXXXXXX does do EMDR, then he is may find some counselling to be of benefit to help him process his experiences, such as the shame. EMDR is a vey powerful technique for simple PTSD, and when effective does not mean that the PTSD was of minor significance. Some patients have a tendency to think that in hindsight they were just being a bit 'pathetic' if the treatment resolves the PTSD in just a few sessions. PTSD typically does not resolve without treatment, although people with PTSD gradually adapt their life to the presence of PTSD symptoms. EMDR can be effective with simple PTSD, even after the PTSD has been present for 50 years. EMDR is thought to work by bringing the different aspects of the traumatic memory (which are being stored separately in different areas of the brain) to the forefront of the mind, while using a technique which reduces anxiety while 'distracting the brain' and therefore allows the different aspects of the memory to be safely integrated. EMDR involves firstly identification of a safe place psychologically, and then bringing the flashback to mind with any thoughts and feelings, while following a moving object (often the therapists finger or a light on a light box) rapidly back and forth over the visual field where the flashback is being seen. In response to this process, the flashback gradually fades away or recedes into the distance and the different aspects of the memory are integrated into a single unified memory.
- *Other psychological therapies:* CBT-T or cognitive behavioural treatment for trauma and trauma counselling is also used for simple PTSD. The latter involves *v*erbally expressing the feelings, memories and sensations associated with the trauma, but talking therapies can only help if we can keep our brain systems on line while we talk through what happened, and we can only do this if we can learn to remain calm enough as the trauma is brought to mind. This means that counselling and Trauma Focussed CBT (Cognitive Behavioural Therapy) can help some of us feel better about what has happened to us, but for others it will just make us feel worse and not help at all. NICE recommends CBT-T as first line treatment, although it is typically not completely curative for simple PTSD.

- *Medication usefulness for PTSD anxiety:* Medication is used when physical symptoms are severe or frequent. Based on XXXXXXX's BAI-21 score and the severity of his PTSD symptoms, I would not expect medication treatment in the form of a SSRI or SNRI antidepressant for anxiety to be very effective. In addition, XXXXXXX has an aversion to taking tablets and so it is unlikely that he would want to take them. Typically medication treatment for anxiety and PTSD is most effective when there are moderate or high levels of somatic (physiological) symptoms of anxiety or autonomic hyperarousal symptoms present, but even then the antidepressants only take the edge off the anxiety – by reducing it by 5-25%. XXXXXXX reports relatively low levels of these somatic symptoms of anxiety and PTSD. As with most medications for mental health conditions, the benefit of these medications would be largely undermined by the use of alcohol. Medication can be helpful to take the edge off the physiological arousal associated with PTSD when such arousal is having significant functional impact, but the long term treatment of PTSD is through psychological interventions rather than medication. Low doses of antipsychotic medication may sometimes be used to reduce anxiety or mood instability in PTSD (e.g. quetiapine 25-50mg bd), but have a more adverse side-effect profile

than SSRI and SNRI antidepressants, so SSRIs and SNRIs are the favoured option. Again, I would not expect such medication to be desired or beneficial in XXXXXXX's case, unless he begins to experience much more severe levels of anxiety which seems unlikely to happen.

- *Prognosis of PTSD:* A full recovery from simple PTSD with flashbacks is expected with the most effective treatment, such as EMDR. Once the PTSD is resolved, I would expect that:
    - Other issues that are likely to be secondary to trauma to also partially or completely resolve, i.e. the issues that became worse following the development of PTSD. These may include:
        - The severity of anxiety and agitation when awaking at 4.30am
        - The frequency of anxiety based nightmares
        - The increased negativity about himself and other people
        - The reduced joy he feels in life and the flatness of his mood
        - The increased difficulty getting into a positive loving mode and feeling love
        - Possibly his inability to get back to sleep after waking at 4.30am
        - The difficulty in reducing his level of alcohol consumption
    - However I would not necessarily expect the treatment of PTSD to affect certain other issues which are less likely to be related to PTSD and more likely to be related to other health issues such as alcohol use or long covid. It is for example **much less likely that PTSD treatment will result in:**
        - Improved appetite
        - Reduced nausea (related to swallowing tablets)
        - Improved mood
        - Improved energy or reduced fatigue
        - Reduced muscle aching
        - Reduced shame
        - Improved balance, reduced dizziness or reduced risk of vasovagal episodes
        - Improved blood pressure
        - Reduced nausea
        - Reduced sneezing, reduced rhinorrhoea (runny nose)
        - Reduced urinary issues.

**Treatment and support to reduce and stop alcohol:** In view of XXXXXXX's continued drinking, the strategy to reduce this should involve the following:

- *Psychological support and treatments:*
    - *Optimising treatment for any mental health condition:* See discussions above on PTSD (and complex PTSD), which are primarily psychological treatments.
    - *Counselling:* Where issues exist that are associated with but not directly due to PTSD, such as shame, then counselling can facilitate change to reduce the risk of drinking or relapse.
    - *Continuing to reduce consumption:* Putting effort into continuing to reduce consumption of alcohol. Where the alcohol is being used for 'self-medication' to treat anxiety, pain, insomnia, putting other strategies of self-medication in their place.
    - *Identifying cognitive and other strategies that help:* When stopping an addictive behaviour, it is important to substitute something else in its place, and this is particularly where the alcohol is being used for self-medication, but also in situations where it is not used for self-medication. XXXXXXX describes using:
        - Cognitive 'self-talk' (rationalising why not to drink),

        - Drinking cups of tea to relax
        - Using colouring to relax, which is often considered a mindful activity
        - Distracting his mind by reading or other activities
- *Use of support and mutual aid groups:*
    - *The importance of discretion in support groups:* XXXXXXX wishes to maintain discretion and confidentiality about his alcohol and health issues, while he continues to practice as an engineer. Support groups are commonly 'mutual aid' groups which research has shown are highly beneficial for people in supporting their recovery goals, and especially for those who have had the more severe forms of alcohol dependence. As such the online groups such as AA and Soberistas (where one can more easily conceal one's identity) are likely to be more discrete, whereas face-to-face AA and SMART recovery are less likely to provide a high level of discretion. These groups are described in more detail below.
    - *Soberistas:* Soberistas is a worldwide online support group which involves mainly women and which requires a subscription which was started by a woman who felt there was support needed for people with less severe degrees of alcohol dependence (https://soberistas.com/).
    - *12 step groups such as Alcoholics anonymous (AA):* Support groups such as AA can be highly beneficial in supporting people and helping them reduce or remain abstinent from alcohol, particularly because the groups are so numerous in number covering many localities in the UK. There are also online AA groups. These 12 step meetings can provide a 'wrap around' philosophy of life, continual encouragement to remain motivated for abstinence, and support 24 hours a day if one requests a 'sponsor' and gets on with them.
    - *SMART (Self-Management and Recovery Training):* SMART groups are based on CBT (cognitive behavioural therapy) principles that provides shorter term group treatment (https://smartrecovery.org.uk/), but is much less widely available than AA.
    - *Other Mutual Aid groups:* Other mutual aid groups apart from those mentioned above also exist, but are typically much fewer in number and confined to one or more localities.
- *Medication treatments to support alcohol reduction and health while drinking:*
    - *Thiamine (vitamin B1):* People who are drinking regularly are recommended to take high dose oral thiamine 100mg three times daily, and to continue this for the first three months when abstinent. This is because alcohol does not contain thiamine and drinkers absorb thiamine very poorly, and a deficiency can lead to a variety of neurological conditions including Wernicke's encephalopathy, which if untreated leads to Korsakov's disorder (brain damage with loss of short term memory). If people continue to drink, then indefinite treatment with high dose oral thiamine is recommended. Alcohol dependent people with a poor diet are recommended to have 3 to 5 doses of parenteral Pabrinex which contains both vitamin B and C (given IM or IV) to reduce the risk of developing Wernicke's encephalopathy, when doing an alcohol detox because an alcohol detox is a catabolic process with a high demand for thiamine, which exceeds the ability of the body to absorb oral thiamine.
    - *Other vitamins:* A daily multivitamin tablet is also recommended, such as Sanatogen complete A-Z. This particular multivitamin contains a higher dose of magnesium (100mg) compared to most multivitamins, which is important as magnesium aids the absorption of thiamine. Vitamin B compound strong (which contains only 5mg thiamine per tablet) two tablets daily has also traditionally been recommended along with the high dose oral thiamine for 'neural repair' in drinkers. However NICE does not recommend either multivitamins or vitamin B compound strong, because of the absence of studies showing benefit.

- *Nalmefene:* Nalmefene is an opioid antagonist which is licenced in the UK for the reduction of alcohol consumption in patients with alcohol dependence who have a high drinking risk level without physical withdrawal symptoms, and who do not require immediate detoxification. It is taken as one tablet when there is a risk of drinking alcohol on that day, preferably taken 1–2 hours before the anticipated time of drinking. If a dose has not been taken before drinking alcohol, 1 dose should be taken as soon as possible. The maximum dose is one tablet (18 mg) daily.
- *Acamprosate:* Acamprosate is sometimes used to help reduce alcohol consumption when used in combination with psychosocial support, based on NICE guidance. The dose is two capsules (each capsule being 333 mg) three times a day (6 capsules in total) where the body-weight is less than 60 kg, and four capsules in total a day where the body-weight is 60 kg or more. It's product licence relates to the maintenance of abstinence in alcohol-dependent patients for adults aged 18–65 years only.

- *Medication treatments to support abstinence:*
  - *Use of vitamins:* It is recommended to continue vitamins (especially the high dose oral thiamine) as described above for 3 months once abstinence from alcohol has been achieved, or indefinitely if there is a return to drinking.
  - *Using 'aftercare' medications:* Aftercare medications that double the abstinence rate following stopping alcohol include oral naltrexone, nalmefene, acamprosate or disulfiram. Naltrexone and nalmefene both reduce unwanted cravings by about 50%, increase the sense of control over drinking the first drink and also subsequent drinks and reduce the pleasure experienced from drinking. Disulfiram is however not usually recommended in impulsive people, who may drink on top of it, with potentially severe consequences. If regular drinking is returned to, then it is recommended to stop acamprosate as an aftercare medication if it continues for more than 6 weeks. Both naltrexone and nalmefene can also be continued for a period following a return to drinking, but disulfiram should be stopped completely. All such medication is used in conjunction with counselling, and is typically prescribed for 6-12 months once abstinence is achieved, but can be longer if it still appears to be helping after the 6-12 month period.
  - *Considering more 'experimental treatments':* These include among others the use of transcranial magnetic stimulation for addiction, psychedelic treatment for addiction, and if oral naltrexone is beneficial the use of longer acting naltrexone implants. There is some limited evidence for their benefit, but they are not available on the NHS for addiction treatment.

**Evidence of progress:**

XXXXXXX has made progress with reducing his alcohol consumption and by seeing a counsellor weekly for the last 2-3 months. My assessment is that he has made significant progress in becoming motivated to seek help for his alcohol dependence issues.

**Indicators of positivity for the future:**

- He returned to work after being off work for 9 months with medical issues, returning to an important job high up in an engineering company.

- He has faced his fears by going back to work at a site near where he experienced some of the traumas that led to the development of PTSD.
- Following having a flashbacks, the anxiety settles after about 30 minutes.
- When he has a reminder of the trauma that triggered the PTSD, although this brings back distressing memories he normally recovers within a few seconds.
- He is no longer in pain from any medical condition.
- He goes for a walk daily with his partner covering about one mile.
- He has shown a strong commitment to work on his psychological issues by seeing a counsellor weekly for the last 2-3 months.
- He is interested in feeling loving, and being loved by his partner and children.
- He plans to take up photography again.
- He has a plan to manage his retirement, with lots of hobbies that he could engage with. In addition to the above, he enjoys cooking and gardening, and used to paint water colours
- He has an attitude of gratitude, both towards his career and his recovery from multiple health problems.
- He comes across as a stoical individual who tends to get on with life, despite any hardships involved.
- He is using various strategies to manage anxiety when he is feeling anxious on awaking at 4.30am, including drinking a cup of tea, doing reading and colouring.
- He recognises that he is dependent on alcohol, and that his level of dependence has reduced over time as he has managed to reduce his level of alcohol consumption.
- He reports low levels of craving and withdrawal symptoms such as sweating and shaking on awaking, since he has cut down his drinking.
- He wishes to develop a plan to reduce and stop his dependency on alcohol, and to identify strategies as part of an evidence based care plan to support and encourage him to stop drinking.
- He recognises that he feels better in himself when he has not been drinking.
- When he thinks of drinking, he stops and thinks and is already using cognitive 'self-talk' to reason with himself as to why he should not drink.
- When he is feeling like drinking, he is considering drinking water when he is thirsty or a cup of tea to feel calmer.
- He expressed an interest in Soberistas and the online AA group to support his recovery.
- I was impressed by his degree of honesty and openness about his issues, and the impact that it is having on him

**RECOMMENDATIONS:**

- XXXXXXX to consider reading more about the nature of PTSD, trauma and its effects, for example by reading 'The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma', Bessel van der Kolk, 2015.
- XXXXXXX to focus on treatment for PTSD when he feels able to do so, such as EMDR, as once the PTSD has largely been dealt with, he will probably find it easier to reduce his level of drinking.
- XXXXXXX to continue his weekly counselling.
- XXXXXXX to consider engaging with Soberistas and/or the online AA group (described in more detail above).

- XXXXXXX to continue to use cognitive strategies to counteract his desires to drink, such as the use of rationalising self-talk, and the identification of alternatives to put in place when he is using alcohol for 'self-medication'.
- XXXXXXX to continue to use the management strategies that are working well for him, which involve occupying his mind (distraction) and relaxation such as reading, cups of tea, and colouring.
- Although XXXXXXX's current strategies for managing physiological hyperarousal appear to be working well, he could consider using other strategies such as relaxing breathing (breathing out for twice as long as he breathes in) as a way of managing the anxiety response.
- XXXXXXX to consider using self-help strategies for stress, sleep problems or other mental health tendencies. A wide range of self-help leaflets on mental health issues are available at https://web.ntw.nhs.uk/selfhelp/
- If the management of PTSD symptoms and anxiety get worse, and interfere significantly with his life, XXXXXXX to consider using medication strategies to help him manage this.
- XXXXXXX is advised that as he comes under the definition of persistent alcohol misuse or dependence, that he should inform the DVLA who will wish to revoke his licence, and that if he continues to drive and has an accident then his insurance will be invalidated and he may face prosecution.
- XXXXXXX to consider getting a 'fibroscan' ultrasound to measure the extent of any damage to his liver, as this is often not picked up by liver function tests (which typically only measure acute effects).
- XXXXXXX to consider starting high dose oral thiamine 100mg three daily as he has a poor appetite, to reduce the risk of developing Wernicke's encephalopathy and permanent brain damage.
- XXXXXXX to consider other medication to help him continue to cut down his alcohol consumption, and once abstinent to help him remain abstinent (as described in detail above).

**Kind Regards**

Dr Fergus Law MBChB, BSc, FRCPsych
GMC number: 3121317

Copy to:

XXXXXXX XXXXXXX
Michael Rawlinson, RHC CEO and treatment coordinator

PsychInsight

## APPENDIX 1: Criteria for Post Traumatic stress disorder, acute stress reaction, and adjustment disorders in the Major International Classification Systems (ICD-11 DCR and DSM-5)

## International Classification of Diseases, 10th Edition (ICD-10), Geneva: World Health Organization 1993

**Post Traumatic stress disorder, acute stress reaction, and adjustment disorders**

**F43.1 Post Traumatic stress disorder**

A. The patient must have been exposed to a stressful event or situation (either short- or long-lasting) of exceptionally threatening or catastrophic nature, which would be likely to cause pervasive distress in almost anyone.
B. There must be persistent remembering or "reliving" of the stressor in intrusive "flashbacks", vivid memories, or recurring dreams, or in experiencing distress when exposed to circumstances resembling or associated with the stressor.
C. The patient must exhibit an actual or preferred avoidance of circumstances resembling or associated with the stressor, which was not present before exposure to the stressor.
D. Either of the following must be present:
   (1) Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor;
   (2) Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor), shown by any two of the following:
      (a) Difficulty in falling or staying asleep;
      (b) Irritability or outbursts of anger;
      (c) Difficulty in concentrating;
      (d) Hypervigilance;
      (e) Exaggerated startle response.
E. Criteria B, C and D must all be met within 6 months of the stressful event or of the end of a period of stress. (For some purposes, onset delayed more than 6 months may be included, but this should be clearly specified).

**F43.0 Acute stress reaction**

A. The patient must have been exposed to an exceptional mental or physical stressor.
B. Exposure to the stressor is followed by an immediate onset of symptoms (within 1 hour).
C. Two groups of symptoms are given, the acute stress reaction is graded as:
   F43.00 Mild
   Only criterion (1) below is fulfilled.
   F43.01 Moderate

Criterion (1) is met and there are any two symptoms from criterion (2).

F43.02 Severe

*Either* criterion (1) is met and there are any four symptoms from criterion (2); *or* there is dissociative stupor (see F44.2),

(1) Criteria B, C and D for generalised anxiety disorder (F41.1) are met.

(2) (a) Withdrawal from expected social interaction.

(b) Narrowing of attention.

(c) Apparent disorientation.

(d) Anger or verbal aggression.

(e) Despair or hopelessness.

(f) Inappropriate or purposeless overactivity.

(g) Uncontrollable and excessive grief (judged by local cultural standards)

D. If the stressor is transient or can be relieved, the symptoms must begin to diminish after not more than 8 hours. If exposure to the stressor continues, the symptoms must begin to diminish after not more than 48 hours.
E. *Most commonly used exclusion clause.* The reaction must occur in the absence of any other concurrent mental or behavioural disorder in ICD-10 (except F41.1 (generalised anxiety disorder) and F60.- (personality disorders)), and not within 3 months of the end of an episode of any other mental or behavioural disorder.

**F43.2 Adjustment disorders**

A. Onset of symptoms must occur within 1 month of exposure to an identifiable psychosocial stressor, not of an unusual or catastrophic type.
B. The individual manifests symptoms or behaviour disturbance of the types found in any of the affective disorders (F30-F39) (except for delusions and hallucinations), any disorders in conduct disorders (F91.-), but the criteria for an individual disorder are not fulfilled. Symptoms may be variable in both form and severity.

The predominant feature of the symptoms may be further specified by the use of a fifth character:

F43.20 Brief depressive reaction

A transient mild depressive state of a duration not exceeding 1 month.

F43.21 Prolonged depressive reaction

A mild depressive state occurring in response to a prolonged exposure to a stressful situation but of a duration not exceeding 2 years.

F4322 Mixed anxiety and depressive reaction

Both anxiety and depressive symptoms are prominent, but at levels no greater than those specified for mixed anxiety and depressive disorder (F41.2) or other

mixed anxiety disorders (F41.3).

F43.23 With predominant disturbance of other emotions

The symptoms are usually of several types of emotion, such as anxiety, depression, worry, tensions, and anger. Symptoms of anxiety and depression may meet the criteria for mixed anxiety and depressive disorder (F41.2) or for other mixed anxiety disorders (F41.3), but they are not so predominant that other more specific depressive or anxiety disorders can be diagnosed. This category should also be used for reactions in children when regressive behaviour such as bed-wetting or thumb-sucking is also present.

F43.24 With predominant disturbance of conduct

The main disturbance is one involving conduct, e.g. an adolescent grief reaction resulting in aggressive or dissocial behaviour.

F43.25 With mixed disturbance of emotions and conduct

Both emotional symptoms and disturbances of conduct are prominent features.

F43.28 With other specified predominant symptoms

C. Except in prolonged depressive reaction (F43.21), the symptoms do not persist for more than 6 months after the cessation of the stress or its consequences. However, this should not prevent a provisional diagnosis being made if this criterion is not yet fulfilled.

F43.8 Other reactions to severe stress

F43.9 Reactions to severe stress, unspecified

**The 11th Edition (ICD-11) of the International Classification of Diseases, Geneva: World Health Organization 2019**, introduced the diagnosis of Complex post traumatic stress disorder (Complex PTSD).

**Complex post traumatic stress disorder (Complex PTSD)** ICD-11 code: 6B41

Complex post traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (e.g. torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). All diagnostic requirements for PTSD are met, and in addition there are severe and persistent issues In 3 other areas in complex PTSD:

1) Severe and pervasive problems in affect regulation, e.g. heightened emotional reactivity to minor stressors, violent outbursts, reckless or self-destructive behaviour, dissociative symptoms when under stress, and emotional numbing, particularly the inability to experience pleasure or positive emotions;
2) Persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event or stressor, e.g. the

individual may feel guilty about not having escaped from or succumbing to the adverse circumstance, or not having been able to prevent the suffering of others; and

3) Persistent difficulties in sustaining relationships and in feeling close to others. The person may consistently avoid, deride or have little interest in relationships and social engagement more generally, or alternatively, there may be occasional intense relationships, but the person has difficulty sustaining them.

These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

**The Diagnostic and Statistical Manual of Mental Disorders**, Fifth Edition (DSM-5), Washington, DC: American Psychiatric Association 2013

**Post-traumatic Stress Disorder 309.81 (F43.10)**

Diagnostic Criteria

**Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. 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.
   4. 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). **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   **2.** Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   **Note:** In children, there may be frightening dreams without recognizable content.
   **3.** Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
   **Note:** In children, trauma-specific reenactment may occur in play.
   **4.** Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. XXXXXXX ed physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
   1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
   2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or- closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Inability to remember an important aspect of the traumatic event(s) (typically due to dis sociative amnesia and not to other factors such as head injury, alcohol, or drugs).
   2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted", The world is completely dangerous," "My whole nervous system is permanently ruined'').
   3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
   4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
   5. XXXXXXX edly diminished interest or participation in significant activities.
   6. Feelings of detachment or estrangement from others.
   7. Persistent inability to experience. positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. XXXXXXX ed alterations in arousal and reactivity associated with the traumatic event(s), be ginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
   1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
   2. Reckless or self-destructive behavior.
   3. Hypervigilance.
   4. Exaggerated startle response.
   5. Problems with concentration.
   6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

*Specify* whether:

**With dissociative symptoms:** The individual's symptoms meet the criteria for post traumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

*Specify* if:

**With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

**Acute Stress Disorder 308.3 (F43.0)**

Diagnostic Criteria

**A.** Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
   **1.** Directly experiencing the traumatic event(s).
   **2.** Witnessing, in person, the event(s) as it occurred to others.
   **3.** Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   **4.** 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). **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

**B.** Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

**Intrusion Symptoms**

   **1.** Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
   **2.** Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
   **3.** Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
   **4.** Intense or prolonged psychological distress or XXXXXXX ed physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

**Negative Mood**

   **5.** Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

**Dissociative Symptoms**

   **6.** An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
   **7.** Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

**Avoidance Symptoms**

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

**Arousal Symptoms**

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically ex- pressed as verbal or physical aggression toward people or objects.
12. Hypervigilance.
13. Problems with concentration.
14. Exaggerated startle response.

**C.** Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.
**Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.

**D.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**E.** The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

**Adjustment Disorders**

Diagnostic Criteria

**A.** The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

**B.** These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
   1. XXXXXXX ed distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
   2. Significant impairment in social, occupational, or other important areas of functioning.

**C.** The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a pre-existing mental disorder.

**D.** The symptoms do not represent normal bereavement.

**E.** Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

*Specify* whether:

**309.0 (F43.21) With depressed mood:** Low mood, tearfulness, or feelings of hope lessness are predominant.

**309.24 (F43.22) With anxiety:** Nervousness, worry, jitteriness, or separation anxiety is predominant.

**309.28 (F43.23) With mixed anxiety and depressed mood: A** combination of de pression and anxiety is predominant.

**309.3 (F43.24) With disturbance of conduct:** Disturbance of conduct is predominant.

**309.4 (F43.25) With mixed disturbance of emotions and conduct:** Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.

**309.9 (F43.20) Unspecified:** For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

## APPENDIX 2: XXXXXXX's Questionnaire Results

XXXXXXX completed 8 questionnaires in April 2024 (ReQoL-10, Wellbeing - SWEMWBS, BAI-21, BDI-II, ISI, Audit, SADQ and APQ-R), the Long Covid Symptom Burden Questionnaire prior to the assessment, and 4 others following the assessment on 13/05/2024 (GADI, MMOCI, IES-R and ITQ). His results on each questionnaire are summarised below.

**Measure of Mental Well-Being:** XXXXXXX completed the 7 item Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS) which measures functioning rather than feeling. A lower score indicates a lower mental well-being, and higher scores indicate a higher mental well-being. The questionnaire asks the client to tick the box that best describes their experience relating to each statement over the last 2 weeks. XXXXXXX obtained a high total raw score of 32 (scale range 0-35). The raw score is transformed to make the intervals between scores more comparable, a total score of 32 becomes 29.3.Typical mean scores (and standard deviations) for 55+ year olds in the UK are 23.3 ± 3.7, so his score is within two standard deviations of the mean for the transformed score.

- *He scored "All of the time" on 4 items, namely:* I've been feeling useful, I've been dealing with problems well, I've been thinking clearly, and I've been able to make up my own mind about things.
- *He scored "Often" on the remaining 3 items, namely:* I've been feeling optimistic about the future, I've been feeling relaxed, and I've been feeling close to other people.
- *He did not score "Some of the time", "Rarely" or "None of the time" on any items.*

**Measure of Recovering Quality of Life (ReQoL-10):** XXXXXXX completed the 10 item Recovering Quality of Life Questionnaire and obtained a high total score of 39 (scale range 0-40). A lower score indicates a lower quality of life, and higher scores indicate a higher quality of life. The questionnaire asks the client to tick the box that best describes their thoughts, feelings and activities over the last week. A score of 24 or lower is within the clinical range for low quality of life and a score of 25 or higher is within the non-clinical range for quality of life, i.e. within the range of the general population. XXXXXXX's score is within the normal range.

- *He scored 'zero' (indicating "none of the time" or if the item is reverse scored as indicated by an asterisk "Most or all of the time") on 9 items, namely:* I found it difficult to get started with everyday tasks*, I felt able to trust others, I felt unable to cope*, I could do the things I wanted to do, I thought my life was not worth living*, I enjoyed what I did, I felt hopeful about my future, I felt lonely*, and I felt confident in myself.
- *He scored 'one' (indicating "Only occasionally" or if the item is reverse scored as indicated by an asterisk "Often") on the remaining 1 item, namely:* I felt happy.
- *He did not score 'three' or 'two' (indicating "Sometimes" or "Only occasionally") on any items.*

There is also a separate item on this questionnaire that asks the person to rate their physical health (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) over the last week. On this item he scored: "No problems".

**Measure of sleeping difficulty:** XXXXXXX completed the 7 item Insomnia Severity Index (ISI) which asks about the sleep pattern over the last two weeks, and obtained a total score of 7 (score range 0-28). Scores of 0-7 do not indicate clinically significant insomnia, 8-14 indicate mild to moderate insomnia (below the clinical threshold), 15-21 indicate clinical insomnia of moderate severity, and 22-28 indicate clinical insomnia of severe severity associated with significant impairments of daytime functioning. A man with an ISI score of 7 would rank at the 62nd percentile of the adult population, meaning that only 48 individuals out of 100 would be expected to score higher on the same measure. XXXXXXX scores in the range for not having clinically significant insomnia.

- In terms of severity of insomnia over the last two weeks, he rated that he had no "Difficulty falling asleep' or 'Difficulty staying asleep', but that he had moderate 'Problems waking up too early'.
- He described being 'Dissatisfied' with his current sleep pattern, and that his sleep problem was 'A Little Interfering' with his daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.).
- He described it would be "not at all noticeable" to others that his sleep problem was impairing the quality of his life, and that he was "A Little" worried/distressed by his current sleep problem.

**Measure of Post Traumatic Stress Disorder Symptoms:** XXXXXXX completed the 22 item Impact of Event Scale – Revised and obtained a moderate total score of 24 in relation to his assault XX years ago (average item score 1.1). Scores above 1.5 on any subscale are suggestive of the presence of post traumatic stress disorder (score range 0.0 to 4.0), and warrants further investigation. The scores and item responses on the subscales are described below:

- **Intrusion subscale:** He scored an average of 1.75 on the 8 item intrusion subscale.
    - *He did not score "Extremely" on any item.*
    - *He scored "Quite a bit" on 1 item, namely:* I had trouble staying asleep.
    - *He scored "Moderately" on 4 items, namely:* Any reminder brought back feelings about it, Other things kept making me think about it, I found myself acting or feeling like I was back at that time, and I had dreams about it.
    - *He scored "A little bit" on 3 items, namely:* I thought about it when I didn't mean to, Pictures about it popped into my mind, and I had waves of strong feelings about it.
    - *He did not score "Not at all" on any item.*

- **Avoidance subscale:** He scored an average of 0.75 on the 8 item avoidance subscale.
    - *He did not score "Extremely" or "Quite a bit" on any item.*
    - *He scored "Moderately" on 1 item, namely:* I tried to remove it from my memory.
    - *He scored "A little bit" on 4 items, namely:* I avoided letting myself get upset when I thought about it or was reminded of it, I felt as if it hadn't happened or wasn't real, I tried not to think about it, and I was aware that I still had a lot of feelings about it but I didn't deal with them.
    - *He scored "Not at all" on 3 items, namely:* I stayed away from reminders of it, My feelings about it were numb, and I tried not to talk about it.

- **Autonomic arousal subscale:** He scored an average of 0.67 on the 6 item autonomic arousal subscale.
    - *He did not score "Extremely" or "Quite a bit" on any item.*
    - *He scored "Moderately" on 1 item, namely:* Reminders of it caused me to have physical reactions such as sweating or trouble breathing or nausea or a pounding heart.
    - *He scored "A little bit" on 2 items, namely:* I had trouble falling asleep, and I had trouble concentrating.

- *He scored "Not at all" on 3 items, namely:* I felt irritable and angry, I was jumpy and easily startled, and I felt watchful and on guard.

**Measure of Complex Post-Traumatic Stress Disorder (CPTSD) Symptoms:** XXXXXXX completed the 18 item International Trauma Questionnaire (ITQ) and met the criteria on 1 of the 4 subscales for PTSD and on 0 of the 4 subscales for Complex PTSD. The ITQ briefly measures both PTSD and Complex PTSD (as indicated by Disturbances in Self-Organisation). PTSD is likely if the criteria of a score of 2 or more on at least one item are met on each of the 4 subscales in the first section of the questionnaire (items 1-9). Disturbances in Self-Organisation is likely if the criteria of a score of 2 or more on at least one item are met on each of the 4 subscales in the second section of the questionnaire (items 10-18). Complex PTSD is likely if the criteria are met for all 8 subscales (PTSD and complex PTSD). On the basis of this questionnaire, he did not met criteria for PTSD or complex PTSD. His scores on the subscales are as follows:

- **PTSD measure:** The first part of the ITQ asks the person to identify the experience that troubles them the most, which was the assault XX years ago. It then asks how much he has been bothered by the issues specified in the past month.
  - *Reexperiencing subscale:* He met the threshold of 2 or more on one of the 2 items of the reexperiencing subscale (and scored 3 out of a maximum of 8 on the sum of the item scores): He scored "A little bit" on "Having upsetting dreams that replay part of the experience or are clearly related to the experience"; and he scored "Moderately" on "Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now".
  - *Avoidance subscale:* He did not meet the threshold of 2 or more on one of the 2 items of the avoidance subscale (and scored 2 out of a maximum of 8 on the sum of the item scores): He scored "A little bit" on both "Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)"; and on "Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)".
  - *Sense of threat subscale:* He did not meet the threshold of 2 or more on one of the 2 items of the sense of threat subscale (and scored 0 out of a maximum of 8 on the sum of the item scores): He scored "Not at all" on both "Being "super-alert", watchful, or on guard"; and on "Feeling jumpy or easily startled".
  - *Functional impairment subscale:* He did not meet the threshold of 2 or more on one of the 3 items of the functional impairment subscale (and scored 0 out of a maximum of 12 on the sum of the item scores): He scored on "Affected your relationships or social life"; on "Affected your work or ability to work"; and on "Affected any other important part of your life such as parenting, or school or college work, or other important activities".

- **Disturbances in self-organisation measure:** The second part of the ITQ asks the person about ways he typically feels, ways he typically thinks about himself and ways he typically relates to others, and then asks how much he has been bothered by the issues specified in the past month.
  - *Affective dysregulation subscale:* He did not meet the threshold of 2 or more on one of the 2 items of the affective dysregulation subscale (and scored 0 out of a maximum of 8 on the sum of the item scores): He scored "Not at all" on "When I am upset, it takes me a long time to calm down"; and on "I feel numb or emotionally shut down".
  - *Negative self-concept subscale:* He did not meet the threshold of 2 or more on one of the 2 items of the Negative self-concept subscale (and scored 0 out of a maximum of 8 on the sum of the item scores): He scored "Not at all" on both "I feel like a failure"; and on "I feel worthless".

- *Disturbances in relationships subscale:* He did not meet the threshold of 2 or more on one of the 2 items of the disturbances in relationships subscale (and scored 0 out of a maximum of 8 on the sum of the item scores): He scored both "Not at all" on "I feel distant or cut off from people"; and on "I find it hard to stay emotionally close to people".
- *Functional impairment subscale:* He did not meet the threshold of 2 or more on one of the 3 items of the functional impairment subscale (and scored 0 out of a maximum of 12 on the sum of the item scores): He scored "Not at all" on "Created concern or distress about your relationships or social life"; on "Affected your work or ability to work"; and on "Affected any other important parts of your life such as parenting, or school or college work, or other important activities".

**Measure of physical symptoms of anxiety (BAI):** XXXXXXX completed the 21 item Beck Anxiety Inventory and obtained a low total score of 6 for how much he had been bothered by the symptoms during the past week (score range 0-63). Scores of 0-7 are associated with 'minimal anxiety', 8-15 with 'mild anxiety', 16-25 with 'moderate anxiety', and 26-63 with 'severe anxiety'. XXXXXXX scores in the 'minimal anxiety' range. The questionnaire is good at measuring physical symptoms of anxiety, and likely response to treatment, but is not appropriate for assessing Generalised Anxiety Disorder.

- He did not score "severely – I could barely stand it" on any items.
- *He also scored "moderately – it was very unpleasant but I could stand it" on a 1 item, namely:* heart pounding or racing.
- *He scored "mildly – it did not bother me much" on 4 items, namely:* unable to relax, indigestion or discomfort in abdomen, face flushed, and sweating (not due to heat).
- *He scored "not at all" on the remaining 16 items, namely:* numbness or tingling, feeling hot, wobbliness in legs, fear of the worst happening, dizzy or lightheaded, unsteady, terrified, nervous, feelings of choking, hands trembling, shaky, fear of losing control, difficulty breathing, fear of dying, scared, and faint.

**Measure of generalised symptoms of anxiety:** XXXXXXX completed the 18 item Generalised Anxiety Disorder Inventory and obtained a mild to moderate overall score of 16 (score range 0-72), with an average item score of 0.9. On the subscales, he scored an average of 0.9 on the 7 item Cognitive Subscale (C), 2.0 on the 2 item Sleep Subscale (Sl), and 0.7 on the 9 item Somatic Subscale (So):

- *He did not score "extremely" on any items.*
- *He scored "very much" on 1 item, namely:* I am wakeful at night (Sl).
- *He scored "somewhat" on a further 5 items, namely:* I am anxious on most days (C), I feel 'on edge' (C), I fear losing control or passing out or going crazy (So), I suffer from dizzy spells (So), and I have difficulty controlling my anxiety (C).
- *He scored "a little bit" on 3 items, namely:* I suffer from a dry mouth (So), I have difficulty getting off to sleep (Sl), I suffer with tense or aching muscles (So),
- *He scored "not at all" on the remaining 9 items:* I worry about everyday events (C), I find it difficult to relax (C), I experience hot flushes or cold chills (So), I am troubled by trembling and shaking (So), I am troubled by difficulty breathing (So), I am easily startled (So), I am troubled by tingling feelings or numbness (So), I worry excessively (C), and I am irritable (C).

**Measure of obsessional symptoms (MMOCI):** XXXXXXX completed a 20 item screening questionnaire of obsessive-compulsive symptoms (the Modified Maudsley Obsessional-Compulsive Inventory), and obtained a low score, scoring positively on only 1 of the 20 items with a total score of 2 (range 0-60). The questionnaire asks how much they were bothered by the symptoms this week.

- *He did not score "extremely" on any items.*
- *He scored "quite a bit" on 1 item, namely:* I hate to throw old used things away.

- *He did not score "a little" on any items.*
- *He scored "not at all" on the remaining 19 items, namely:* I avoid using public telephones because of possible contamination, I am more concerned than most about honesty, I am often late because I can't get through everything on time, I frequently have to check things such as gas or electricity or water taps or doors several times, daily I am upset by unpleasant thoughts that come to my mind against my will, I seem to worry more than others about their health and safety, my mind tells me to keep things such as cans of food or boxes of detergent even though they are empty, I worry if I accidentally bump into somebody, I tend to get behind in my work because I repeat things over and over again, I use more than the average amount of soap, it takes me longer than others to dress in the morning, I am excessively concerned about cleanliness, I find myself paying too much attention to detail, my house is cluttered by old things I hate to throw away, I am unduly concerned about germs and disease, my hands feel dirty after touching money, I usually have to count when doing a routine task, hanging and folding my clothes at night takes up a lot of my time, and even when I do something very carefully I often feel that it is not quite right.

**Measure of depression symptoms (BDI-II):** XXXXXXX completed the 21 item Beck Depression Inventory and obtained a low total score of 8 (scale range 0-63). With each item the questionnaire asks the client to pick out one of the four the statements (which reflect different severities) that best describes the way they have been feeling during the past two weeks. Scores of 0-13 are associated with 'minimal depression', 14-19 with 'mild depression', 20-28 with 'moderate depression', and 29-63 with 'severe depression'. XXXXXXX scores in the 'minimal depression' range. The questionnaire is good at measuring symptoms of depression, but is not so good for discriminating between depression and anxiety, i.e. people with symptoms of anxiety can also score highly on the Beck Depression Inventory.

- *He obtained the highest possible score on 1 item, namely:* I wake up 1 – 2 hours early and can't get back to sleep.
- *He did not obtain a moderate score on any items.*
- *He obtained a mild score on 5 items, namely:* I feel more restless or wound up than usual, I have less energy than I used to have, My appetite is somewhat less than usual, I get more tired or fatigued more easily than usual, and I am less interested in sex than I used to be.
- *He obtained the lowest possible score on the remaining 15 items, namely:* I do not feel sad, I am not discouraged about my future, I do not feel like a failure, I get as much pleasure as I ever did from the things I enjoy, I don't feel particularly guilty, I don't feel I am being punished, I feel the same about myself as ever, I don't criticize or blame myself more than usual, I don't have any thoughts of killing myself, I don't cry any more than I used to, I have not lost interest in other people or activities, I make decisions about as well as ever, I do not feel I am worthless, I am no more irritable than usual, and I can concentrate as well as ever.

**Alcohol Use Disorders Identification Test (AUDIT):** XXXXXXX completed the AUDIT which is a 10 item questionnaire, with each item having up to 5 response categories. He obtained a score of 14 on this questionnaire. Scores of 0–7 indicate lower risk drinking (non-problematic drinking), 8–15 increasing risk (hazardous) drinking, 16–19 Higher risk (harmful) drinking, and 20+ Possible alcohol dependence. XXXXXXX's score is in the increased risk (hazardous) drinking category.

- *Highest scoring item (scored 4 on 2 items):* How often do you have a drink containing alcohol? (Reported as 4+ times per week); and How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? (Reported as daily or almost daily).
- *High scoring item (scored 3 on 2 items):* How many units of alcohol do you drink on a typical day when you are drinking? (reported 7-9 units); and How often during the last year have you found that you were not able to stop drinking once you had started? (reported as weekly).

- *He did not score moderate or low on any items (scored 2 or 1).*
- *Lowest scoring items (scored 0 on the remaining 6 items):* How often during the last year have you failed to do what was normally expected from you because of your drinking?, How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?, How often during the last year have you had a feeling of guilt or remorse after drinking?, How often during the last year have you been unable to remember what happened the night before because you had been drinking?, Have you or somebody else been injured as a result of your drinking?, and Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

**Severity of Alcohol Dependency Questionnaire (SADQ):** XXXXXXX completed the 20 item SADQ which asks in part 1 about a period of heavy drinking in the last 6 months, and consists of 4 subscales (physical withdrawal, affective withdrawal, withdrawal relief drinking, level of alcohol consumption) and in part 2 a rapidity of reinstatement of withdrawal symptoms subscale asking about the morning after drinking very heavily for two days (after being completely off drink for a few weeks). XXXXXXX obtained a total score of 7 (range 0-60), indicating possible mild alcohol dependence. Scores of 0-15 indicate possible mild dependence; 16 -30 moderate dependence, and 31-44 severe alcohol dependence, 45-60 very severe alcohol dependence. His scores on the subscales are below:

On part 1 about a period of heavy drinking in 2023 prior to having any operation:

- **Physical withdrawal subscale** (4 items): He scored 1 out of a possible 12 on this subscale, which is a low score.
    - *He did not score 'Nearly Always' or 'Often' on any items.*
    - *He scored 'Sometimes' on 1 item, namely:* The day after drinking alcohol I woke up feeling sweaty.
    - *He scored 'Almost Never' on the remaining 3 items, namely:* The day after drinking alcohol my hands shook first thing in the morning, The day after drinking alcohol my whole body shook violently first thing in the morning if I didn't have a drink, and The day after drinking alcohol I woke up absolutely drenched in sweat.

- **Affective withdrawal subscale** (4 items): He scored 0 out of a possible 12 on this subscale, which is a low score.
    - *He did not score 'Nearly Always' or 'Often' or 'Sometimes' on any items.*
    - *He scored 'Almost Never' on all 4 items, namely:* The day after drinking alcohol I dread waking up in the morning, The day after drinking alcohol I was frightened of meeting people first thing in the morning, The day after drinking alcohol I felt at the edge of despair when I awoke, and The day after drinking alcohol I felt very frightened when I awoke.

- **Withdrawal relief drinking** (4 items): He scored 2 out of a possible 12 on this subscale, which is a low score.
    - *He did not score 'Nearly Always' or 'Often' on any items.*
    - *He scored 'Sometimes' on 2 items, namely:* The day after drinking alcohol I liked to have an alcoholic drink in the morning, and The day after drinking alcohol I drank more alcohol to get rid of the shakes.
    - *He scored 'Almost Never' on the remaining 2 items, namely:* The day after drinking alcohol I always gulped my first few alcoholic drinks down as quickly as possible, and The day after drinking alcohol I had a very strong craving for a drink when I awoke.

- **Level of alcohol consumption** (4 items): He scored 2 out of a possible 12 on this subscale, which is a low score.
    - *He did not score 'Nearly Always' or on any items.*
    - *He scored 'Often' on 1 item, namely:* I drank more than half a bottle of spirits per day (OR 1.5 bottles of wine OR 15 units of beer).
    - *He did not score 'Sometimes' or on any items.*
    - *He scored 'Almost Never' on the remaining 3 items, namely:* I drank more than a quarter of a bottle of spirits in a day (OR 1 bottle of wine OR 8 units of beers), I drank more than one bottle of spirits per day (OR 3 bottles of wine OR 30 units of beer), and I drank more than two bottles of spirits per day (OR 6 bottles of wine OR 60 units of beer).

- **Rapidity of reinstatement of withdrawal symptoms** (4 items): He scored 2 out of a possible 12 on this subscale, which is a low score.
    - *He did not score 'Quite A Lot' on any items.*
    - *He scored 'Moderately' on 1 item, namely:* I would be craving for a drink.
    - *He did not score 'Slightly' on any items.*
    - *He scored 'Not At All' on the remaining 3 items, namely:* I would start to sweat, My hands would shake, and My body would shake.

**Alcohol Problems Questionnaire - Revised (APQ-R):** XXXXXXX completed the APQ-R which is a 47 item questionnaire asking about issues related to alcohol in the last six month, with questions answered 'Yes' or 'No' in 9 different areas (not all of which would necessarily apply to every individual). He obtained a total score of 3, with a score of 1 on the 4 item Friendship subscale, 0 on the 4 item Money subscale, 0 on the 3 item Legal subscale, 0 on the 6 item Physical subscale, 0 on the 6 item Psychological subscale, 0 on the 3 item Spiritual subscale, 1 on the 9 item Partner/spouse subscale, 1 on the 4 item Children subscale, and 0 on the 8 item Work subscale.

- **Friendship subscale** (4 items):
    - *Responded 'Yes' to 1 item, namely:* Have you tended to drink on your own more than you used to?
    - *Responded 'No' to 3 items, namely:* Have you worried about meeting your friends again the day after a drinking session?, Have you spent more time with drinking friends than other kinds of friends?, and Have your friends criticised you for drinking too much?

- **Money subscale** (4 items):
    - *Responded 'Yes' to 0 items.*
    - *Responded 'No' to 4 items, namely*: Have you had any debts?, Have you pawned any of your belongings to buy alcohol?, Do you find yourself making excuses about money?, and Have you been caught out lying about money?

- **Legal subscale** (3 items):
    - *Responded 'Yes' to 0 items.*
    - *Responded 'No' to 4 items, namely:* Have you been in trouble with the police due to your drinking?, Have you lost your driving licence for drinking and driving?, and Have you been in prison?

- **Physical subscale** (6 items):

- *Responded 'Yes' to 0 items.*
- *Responded 'No' to 6 items, namely:* Have you been physically sick after drinking?, Have you had diarrhoea after a drinking session?, Have you had pains in your stomach after a drinking session?, Have you had pins and needles in your fingers or toes?, Have you had any accidents requiring hospital treatment after drinking?, and Have you lost any weight?

- **Psychological subscale** (6 items):
  - *Responded 'Yes' to 0 items.*
  - *Responded 'No' to 6 items, namely:* Have you been neglecting yourself physically?, Have you failed to wash for several days at a time?, Have you felt depressed for more than a week?, Have you felt so depressed that you have felt like doing away with yourself?, Have you given up any hobbies you previously enjoyed due to your drinking?, and Have you found it hard to get enjoyment from your usual interests?

- **Spiritual subscale** (3 items):
  - *Responded 'Yes' to 0 items.*
  - *Responded 'No' to 3 items, namely*: Have you felt in need of forgiveness because of the things that your drinking has led you to do?, Have you ever felt that only a great outside power such as a higher power or God could help you regain some of the things you have lost because of your drinking?, and Have you ever worried that your behaviour under the influence of alcohol might affect what happens to you after your death?

- **Partner/spouse subscale** (9 items):
  - *Responded 'Yes' to 1 item, namely:* Has your partner/spouse complained about your drinking?
  - *Responded 'No' to 8 items, namely:* Has your partner/spouse tried to stop you from having a drink?, Has he/she refused to talk to you because you have been drinking?, Has he/she threatened to leave you because of your drinking?, Has he/she had to put you to bed after you have been drinking?, Have you shouted at him/her when you have been drinking?, Have you injured him/her when you have been drinking?, Have you been legally separated from your partner/spouse?, and Has he/she refused to have sex with you because of your drinking?

- **Children subscale** (4 items):
  - *Responded 'Yes' to 1 item, namely:* Have your children criticised your drinking?
  - *Responded 'No' to 3 items, namely:* Have you had rows with your children about your drinking?, Do your children tend to avoid you when you have been drinking?, and Have your children tried to stop you from having a drink?

- **Work subscale** (8 items):
  - *Responded 'Yes' to 0 items.*
  - *Responded 'No' to 8 items, namely:* Have you found your work less interesting than you used to?, Have you been unable to arrive on time for work due to your drinking?, Have you missed a whole day at work after a drinking session?, Have you been less able to do your job because of your drinking?, Has anyone at work complained about you being late or absent?, Have you had any formal warnings from your employers?, Have you been suspended or dismissed from work?, and Have you had any accidents at work due to your drinking?

**The Symptom Burden Questionnaire for Long COVID (SBQ-LC):**
This questionnaire of 142 items asks about physical and mental health symptoms in 15 different areas over the last 7 days, with an additional subscale on the impact the symptoms have had on daily life. The scores on each subscale (the raw scores) are summed (with items 76 and 77 reverse scored) and then converted to a score in the 0-100 range to aid comparison between the different scales. XXXXXXX's overall score on the 15 symptom scales was 443 or an average of 29.5 on each subscale, and the score on the impact on daily life was zero. There are 6 subscales of the converted scores where XXXXXXX scores 40 on more which are highlighted in bold, related to circulation, fatigue, movement, sleep, muscles and joints, and mental health. XXXXXXX's scores are summarised in the table below:

| | **Scale** | **Number of Items in subscale** | **Maximum Raw Score** | **Raw Score** | **Converted Score 0-100** |
|---|---|---|---|---|---|
| **A.** | Breathing | 7 | 17 | 0 | 0 |
| **B.** | Pain | 4 | 12 | 2 | 20 |
| **C.** | Circulation | 5 | 11 | 5 | **44** |
| **D.** | Fatigue | 4 | 12 | 7 | **40** |
| **E.** | Memory, Thinking, and Communication | 10 | 30 | 5 | 29 |
| **F.** | Movement | 3 | 9 | 2 | **42** |
| **G.** | Sleep | 4 | 12 | 4 | **57** |
| **H.** | Ears, Nose, and Throat | 14 | 38 | 5 | 32 |
| **I.** | Stomach and Digestion | 8 | 20 | 5 | 32 |
| **J.** | Muscles and Joints | 9 | 27 | 9 | **40** |
| **K.** | Mental Health | 9 | 23 | 10 | **40** |
| **L.** | Skin and Hair | 8 | 18 | 1 | 14 |
| **M.** | Eyes | 10 | 20 | 0 | 0 |
| **N.** | Female Reproductive and Sexual Health | 7 | 13 | N/A | N/A |
| **O.** | Male Reproductive and Sexual Health | 3 | 5 | 1 | 35 |
| **P.** | Other Symptoms | 18 | 38 | 2 | 18 |
| **Q.** | Impact on Daily Life | 8 | 24 | 0 | 0 |
| | **TOTAL:** | 123 + 8 | 305 + 24 | 58+0 | 443+0 |

Among these items are 13 clinical alert items from a variety of scales that ask about issues or behaviours that could represent more severe physical issues or danger to themselves or others. If any of these items score above zero, then they should be thought about and potentially discussed further. XXXXXXX scored above zero on 3 of these items: being confused about what is happening around him, difficulty with movement and coordination, and difficulty swallowing food and drink.

Items on which he scored positively are summarised below:

- *Breathing subscale:*
    - None.
- *Pain subscale:*
    - He scored 'moderately' for one item about how severe was his aching or burning pain in any place on his body at its worst.
- *Circulation subscale:*

    - He scored ‘moderately’ for two items about how severe were his palpitations (feeling like his heart skipped a beat or a pounding heartbeat) at their worst, and how severe was his dizziness on standing at its worst.
    - He also confirmed that he had felt faint in the last 7 days.
- *Fatigue subscale:*
    - He scored ‘moderately’ for three items about how severe was his fatigue (feeling of physical or mental exhaustion that does not improve with rest) at its worst, how severe was his low energy (being interested and wanting to do things but not having the energy), and how severe was his tiredness (need for sleep) at its worst.
    - He scored ‘mildly’ for one item about how severe was the worsening of his symptoms following simple physical or mental activities at its worst.
- *Memory, Thinking, and Communication subscale:*
    - He scored ‘mildly’ for three items about how severe was his difficulty remembering things at its worst, how severe was his brain fog (feeling sluggish, jet-lagged, or blanking out) at its worst, and how severe was his difficulty planning at its worst.
    - He scored ‘rarely’ for two items about how often did he feel confused about what was happening around him, and how often did he have difficulty concentrating.
- *Movement subscale:*
    - He scored ‘mildly’ for two items about how severe was his balance difficulty at its worst, and how severe was his difficulty with movement and coordination at its worst.
- *Sleep subscale:*
    - He scored ‘sometimes for two items about how often was his sleep shorter than usual, and how often was his sleep interrupted.
- *Ears, Nose, and Throat subscale:*
    - He scored ‘moderately’ for two items about how severe was his sneezing at its worst, and how severe was his stuffy or runny nose at its worst.
    - He also confirmed that he had difficulty swallowing food or drink in the last 7 days.
- *Stomach and Digestion subscale:*
    - He scored ‘severe’ for one item about how severe was his nausea (urge to vomit) at its worst.
    - He scored ‘moderately’ for one item about how severe was his indigestion and/or heartburn at its worst.
- *Muscles and Joints subscale:*
    - He scored ‘moderately’ for two items about how severe was his muscle stiffness at its worst, and how severe was his joint pain at its worst.
    - He scored ‘mildly’ for five items about how severe was his muscle pain at its worst, how severe was his muscle weakness at its worst, how severe was his joint stiffness at its worst, how severe was his muscle twitching at its worst, and how severe was the tingling and numbness (pins and needles) in his arms and legs at its worst.
- *Mental Health subscale:*
    - He scored ‘severe’ for one item about how severe was his change in appetite at its worst.
    - He scored ‘moderately’ for two items about how severe was his anxiety at its worst, and how severe were his feelings of sadness and being miserable at their worst.
    - He scored ‘mildly’ for two items about how severe was his lack of interest in things around him at its worst, and how severe were his mood swings at their worst.
    - He scored ‘rarely for one item about how often did he feel lonely or unsupported.
    - He also reported that in the last 7 days he did feel like the person he was before having COVID-19.
- *Skin and Hair subscale:*

    - He scored ‘mildly’ for one item about how severe were the changes to his nails (ridging, pitting, discolouration, or brittle nails) at their worst.
- *Eyes subscale:*
    - None
- *Male Reproductive and Sexual Health subscale:*
    - He also confirmed that he had a decreased interest in sex in the last 7 days.
- *Other Symptoms subscale:*
    - He scored ‘moderately’ for one item about how severe was his aching all over the body at its worst.
    - He also confirmed that he had a loss of control of urine (leakage) in the last 7 days.
- *Impact on Daily Life subscale:*
    - None