clinical research that has led to treatment guidelines that consistently recommend trauma focused psychological therapies as the most effective first-line treatment. When pharmacotherapy is required SSRI should be used first.

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Update on the management of post-traumatic stress disorder

Introduction

Post-traumatic stress disorder (PTSD) is characterised by the development of psychological and behavioural symptoms. The trauma involves exposure to death, serious injury, natural calamities/disaster or sexual violence. PTSD can be associated with high rates of comorbid depression and substance abuse.[1]

Clinical presentations

The typical symptoms of PTSD include distressing memories of the trauma, disturbed dreams and flashbacks. The person tries to avoid things that are reminders of the trauma. They may present in a variety of ways. Some may present with the usual symptoms and have a willingness to engage in treatment. Others can present dramatically, with rapid decompensation that may include alcohol abuse, uncharacteristic anger, aggression or violence, and sometimes deliberate self-harm. More subtle and gradual presentations may include increasing work problems, impaired work performance, changes in personality, social isolation and presentation with non-specific somatic complaints, in particular, insomnia.[2] Anxiety symptoms may generalise to situations that are not directly connected to the traumatic memory and may lead to intolerance of all stress.

Assessment

The presence of PTSD is often missed. When patients present with repeated non-specific health problems the physician should consider asking about exposure to traumatic events. A screening tool can be helpful[3]. This brief screen can be supplemented by a more detailed symptom review such as the PTSD Checklist.[4]

Diagnostic criteria

As PTSD is being better understood, it has been classified under "trauma and stressor-related disorders" according to Diagnostic and Statistics Manual of Mental Disorders, Fifth Edition(DSM 5).

The following diagnostic criteria apply to adults, adolescents, and children older than six years:

- Exposure to actual or threatened death, serious injury, or sexual violence
- Presence of one (or more) intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred
- Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred
- Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred

- Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred
- duration of the disturbance is more than one month
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The disturbance is not attributable to the physiological effects of a substance (e.g. drug, alcohol) or another medical condition

With a more explicit definition of what comprises a traumatic event, the diagnostic criteria for PTSD has been revised as shown in the box.

Treatment

Drugs for PTSD should not be used as routine first-line treatment over trauma-focused psychotherapy.[6] The management of PTSD needs to consider any comorbidities. These can influence the approach to therapy.

• Psychological therapies

Trauma-focused psychological treatments which primarily includes trauma focused cognitive behaviour therapy are the most effective evidence-based interventions for PTSD.[6] Non trauma focused second-line psychological treatment includes stress inoculation training. Typically, 8–12 trauma-focused therapy sessions are required to produce the best therapeutic effects.

• Drug treatment

Drug therapy may be used when[6]:

- Patients are unwilling or not in a position to engage in psychotherapy
- Patients have a serious comorbid condition or associated symptoms, for example severe depression.
- Patients' circumstances are not sufficiently stable to commence trauma -focused psychotherapy, for example high risk of suicide or harm to others
- The severity of patient distress cannot be managed by psychological means alone
- There has been an insufficient response to psychotherapy alone
- There is a past history of a positive response to medication.

When drugs are used, the patient's mental state needs to be reviewed regularly with a view to starting psychotherapy when appropriate.

Antidepressants

Selective serotonin reuptake inhibitors (SSRIs) are the first choice of drug. As patients of PTSD may be very aware of their somatic reactions, such as nausea or headache, it is essential to 'start low, go slow, aim high' to minimise initial adverse effects and to achieve doses that are more likely to be effective.[7] The Australian guidelines recommend that patients with PTSD who have responded to drug treatment should continue on the dose that achieved remission for at least 12 months before gradual withdrawal is attempted.[6]

Patients who respond to antidepressant drugs usually show some improvement within the first two weeks of treatment with an adequate dose. If there is no response, then consultation with a psychiatrist is advised and consideration should be given to changing to another class of antidepressant. Specifically, if a patient has not responded to an adequate trial of a SSRI, then either another SSRI or a serotonin noradrenaline reuptake inhibitor (SNRI) should be tried, after a suitable withdrawal and washout period. If the patient still does not respond, then switching to a different class of antidepressant is advised. Further trials of either mirtazapine, moclobemide, a tricyclic antidepressant or an irreversible monoamine inhibitor could be considered, if required.[8]

Benzodiazepines

'Appropriate sleep medication' should only be used cautiously and then only in the short term (for less than one month continuously) in those patients who have not responded to non-drug interventions.[6]

Antipsychotics

The use of antipsychotic drugs for post-traumatic stress disorder is not well supported by research evidence. When there is an inadequate symptom response to other drugs, the Australian guidelines recommend a specialist opinion to determine the appropriateness of using olanzapine or risperidone as augmentation strategies.[9] Anecdotal experience suggests that this class of medication can, in individuals with more severe and complex PTSD, improve nightmares, insomnia, mood, anxiety, anger and dissociation. Despite the lack of evidence, many clinicians prefer quetiapine to olanzapine and risperidone as an augmentation strategy, as it is less likely to cause metabolic or extrapyramidal adverse effects.

If atypical antipsychotics are used, metabolic monitoring should be undertaken and documented. This should include regular monitoring of blood pressure, waist measurement, body weight, blood lipid profile and fasting blood glucose.

Prazosin

Prazosin, an alpha 1 adrenoreceptor antagonist, has yielded mixed results in the treatment for PTSD. However, it has shown consistent efficacy in improving sleep and reducing nightmares. As prazosin can cross the blood-brain barrier it may dampen the noradrenergic activity thought to contribute to nightmares. Both the US and the Australian guidelines[9] has recommended prazosin as an adjunctive treatment. A subsequent study confirmed its effectiveness with sleep symptoms and found prazosin was effective for overall PTSD symptoms in a study over 15 weeks.[10] Postural hypotension, headache, dry mouth and fatigue are among the reported adverse effects.

There are no evidence-based recommendations for how long prazosin should be used in the treatment of PTSD. It is recommend that when prazosin is used, its efficacy and tolerability be regularly reviewed, and when there is clear clinical evidence for ongoing benefit it should be continued.

Referral and patient support

Consultation with a psychiatrist is recommended when:

- diagnostic clarification is required
- comorbid conditions are present
- PTSD is severe or complex with concern about patient safety
- there is treatment resistance requiring consideration of augmentation strategies, polypharmacy or the use of irreversible monoamine inhibitors.

Conclusion

PTSD is a common mental health disorder that can cause severe distress and disability. It is frequently underdiagnosed so screening for it could improve detection. There is a growing body of