

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) - F43.1 (Clinical code: Post-traumatic stress disorder Eu43.1)

Presenting complaints

Physical symptoms (eg various pains, poor sleep or fatigue) and various anxiety and depressive symptoms linked to a particular trauma, of more than a month's duration.

Differential diagnosis and co-existing conditions

- Depression - F32# (if showing preoccupation with and rumination about a past traumatic event that emerged during a depressive episode).
- Phobic disorders - F40 (if patient avoids particular objects, situations or activities after a traumatic event, but has no non-phobic distress).
- Adjustment disorder - F43.2 (if the patient only partly fulfils criteria or the problem followed an event that was not especially traumatic).
- Generalized anxiety - F41.1 (if there are no intrusions and/or avoidance).

Essential information for patient and family

- Traumatic events often have psychological effects. For the majority, symptoms subside with no intervention. (see Psychological responses to traumatic stress: what to expect)
- Once symptoms have continued for over a month, treatment can be effective.
- The patient needs support and understanding, not to be told to 'snap out of it'.

General management and advice to patient and family

(ref 197)

- Educate the patient and family about PTSD to help them understand the patient's altered attitude and behaviour.
- Most people find it helpful to discuss the event unhurriedly with sympathetic friends and family. Explain that avoidance of cues associated with the trauma strengthens and maintains fears and distress. Encourage the patient to face avoided activities and situations gradually (see Phobic disorders - F40).
- Ask about suicide risk (see Self-harm).
- Avoid using alcohol, tobacco or street drugs to cope with anxiety.
- Single session intervention is not needed for everyone after a trauma (ref 198).
- Provide a few sessions of cognitive behaviour therapy from about a month after the trauma benefit patients (ref 199-201)
- The evidence for a benefit from eye movement desensitization and reprocessing remains controversial (ref 202).
- Other psychological therapies, including group and psychodynamic therapies, are of unknown effectiveness (ref 203).

References

197 NICE will publish a guideline on the management of Post-traumatic stress disorder in January 2005.

198 Rose S, Bisson J, Wessley S. Psychological debriefing for preventing post traumatic stress disorder (Cochrane Review). In: The Cochrane Library, Issue 1, 2003. Oxford: Update Software. (AI). The routine use of single-session debriefing given to non-selected trauma victims cannot be recommended at present.

199 Bisson JI. Early interventions following traumatic events. *Psychiatric Ann* 2003, 33: 37-44. (BI) The authors review randomized controlled trials and conclude that the evidence base does not support routine early intervention but that multiple session cognitive behavioural early interventions might help.

200a Foa EB, Keane TM, Friedman MJ (eds.) *Effective Treatments for PTSD*. New York: Guildford Press, 2000. This work summarizes evidence for a wide variety of treatment approaches for Post-traumatic stress disorder. Cognitive therapy and exposure therapy emerge as the psychological treatments with the best evidence for efficacy.

200b Bisson JI., Andrew M. Psychological treatment of Post-traumatic stress disorder (PTSD) (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

201 Marks I, Lovell K, Noshirvani H et al. Treatment of Post-traumatic stress disorder by exposure and/or cognitive restructuring: a controlled study. *Arch Gen Psychiatry* 1998, 55: 317-25. (BII) This randomized control trial shows that exposure, cognitive restructuring, or both combined, were equally effective in Post-traumatic stress disorder and better than relaxation without exposure.

202 Shepherd J, Stein K, Milne R. Eye movement desensitization and reprocessing in the treatment of Posttraumatic stress disorder: a review of an emerging therapy. *Psychol Med* 2000, 30(4): 863-871. (AI) This is a systematic review of 16 studies. Eye movement desensitization and reprocessing might be as effective as imaginal exposure therapy and more effective than relaxation techniques in Post-traumatic stress disorder but it is unclear if it is the technique or the imaginal exposure component that is effective.

203 Stein DJ, Zungu-Dirwayi N, Van der Linden GJ, Seedat S. Pharmacotherapy for post-traumatic stress disorder (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Fifteen studies were examined. The research base is limited but there is increasing evidence that drugs can help in Post-traumatic stress disorder. Sertraline and paroxetine have been the most researched and have been shown to be effective. There is good evidence for the efficacy of fluoxetine and some evidence for tricyclic antidepressants and monoamine oxidase inhibitors.

Medication

The long-term outcome appears better after psychosocial approaches than after drug treatment.

Antidepressants might help, especially if depression is prominent (ref 203). Drugs for PTSD are generally needed in higher doses and for longer than when used for depression. Improvement may take up to eight weeks to manifest.

References

203 Stein DJ, Zungu-Dirwayi N, Van der Linden GJ, Seedat S. Pharmacotherapy for post-traumatic stress disorder (Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software. (AI) Fifteen studies were examined. The research base is limited but there is increasing evidence that drugs can help in Post-traumatic stress disorder. Sertraline and paroxetine have been the most researched and have been shown to be effective. There is good evidence for the efficacy of fluoxetine and some evidence for tricyclic antidepressants and monoamine oxidase inhibitors.

Referral

See general referral criteria.

If available, consider behaviour therapy (exposure) or cognitive techniques (ref 199-201).

References

199 Bisson JI. Early interventions following traumatic events. Psychiatric Ann 2003, 33: 37-44. (BI) The authors review randomized controlled trials and conclude that the evidence base does not support routine early intervention but that multiple session cognitive behavioural early interventions might help.

200a Foa EB, Keane TM, Friedman MJ (eds.) Effective Treatments for PTSD. New York: Guildford Press, 2000. This work summarizes evidence for a wide variety of treatment approaches for Post-traumatic stress disorder. Cognitive therapy and exposure therapy emerge as the psychological treatments with the best evidence for efficacy.

200b Bisson JI., Andrew M. Psychological treatment of Post-traumatic stress disorder (PTSD) (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

201 Marks I, Lovell K, Noshirvani H et al. Treatment of Post-traumatic stress disorder by exposure and/or cognitive restructuring: a controlled study. Arch Gen Psychiatry 1998, 55: 317-25. (BII) This randomized control trial shows that exposure, cognitive restructuring, or both combined, were equally effective in Post-traumatic stress disorder and better than relaxation without exposure.

Resources for patients and families

Medical Foundation for the Care of Victims of Torture

Website: <http://www.torturecare.org.uk>

Provides survivors of torture with medical treatment, social assistance and psychotherapeutic support.

CombatStress 01372 841 600

Email: contactus@combatstress.org.uk; website: <http://www.combatstress.com>.

Supports men and women discharged from the armed services and merchant navy who suffer

from mental health problems, including post-traumatic stress disorder. Has a regional network of welfare officers who visit people at home or in hospital.

Refugee Support Centre 020 7820 3606

Counsels refugees, asylum seekers. Gives training and information to health and social care professionals on psychosocial needs of refugees.

Victim Support 0845 3030 900 (support line 9 am–9pm, Monday–Friday; 9am–7pm, Saturday and Sunday; 9am–5pm, bank holidays)

Email: contact@victimsupport.org.uk; website: <http://www.victimsupport.org.uk>

Provides emotional support and practical information for anyone who has suffered the effects of crime, regardless of whether the crime has been reported.

Rape Crisis Federation 0115 900 3560 (9am–5pm, Monday–Friday)

Email: info@rapecrisis.co.uk; website: <http://www.rapecrisis.co.uk>

Women against Rape 020 7482 2496

Email: war@womenagainstrape.net; website: <http://www.womenagainstrape.net>

Fear Fighter <http://www.fearfighter.com>

Self-help guidance plus the option of live helpline advice, if you get stuck.

Living With Fear by Isaac Marks, 2nd edition. McGraw Hill, 2001, tel: 01628 252 700; Email: orders@mcgraw-hill.co.uk.

Self-help manual. Includes help with fear and avoidance symptoms of PTSD.

Overcoming Traumatic Stress by Claudia Herbert and Ann Wetmore. London: Robinson Publishing, 1999.