



John Cooper  
Olivia Metcalf  
Andrea Phelps

# PTSD – an update for general practitioners

## Background

Australians are commonly exposed to traumatic events, which can lead to the development of post-traumatic stress disorder (PTSD). Several recent developments in the trauma field have led to significant changes in how PTSD is diagnosed and treated.

## Objective

This article provides up-to-date guidance for general practitioners (GPs) in the recognition of PTSD and the current best practice recommendations for pharmacological and psychological treatment.

## Discussion

Often the first port-of-call, GPs are well placed to help patients who have recently experienced a potentially traumatic event and are at risk of developing PTSD. The role of the GP can include initial support, assessment, treatment and, where indicated, appropriate specialist referral. There are recent clinical practice guidelines that GPs can use to assess and determine appropriate treatment for their patients with PTSD.

## Keywords

stress disorders, post-traumatic; diagnosis; general practice



Post-traumatic stress disorder (PTSD) is one of the more common mental health problems that can arise following exposure to psychological trauma. Approximately two-thirds of the Australian population will experience events that are potentially traumatic,<sup>1</sup> so called to reflect the subjective element in what is perceived as traumatic. The Australian prevalence rates for PTSD are 4.4% (12 month) and 7.2% (lifetime).<sup>2</sup> Rates are higher after specific traumas; interpersonal trauma such as rape and torture leading to lifetime prevalence rates as high as 50%.<sup>3</sup> The impact of these traumatic experiences has been recently well publicised in the context of The Royal Commission into Institutional Responses to Child Sexual Abuse. There are also increasing numbers of contemporary veterans leaving the Australian Defence Force, including those who have been deployed to Afghanistan and Iraq, where high rates of traumatic exposure have occurred. These are examples of the backgrounds of many patients who will see general practitioners (GPs) and rely on them for timely and accurate diagnostic assessment and coordination of necessary treatment.

## Recent developments in PTSD diagnosis

In the past 18 months there have been two significant developments in the domain of post-traumatic mental health that have clinical relevance to GPs. The first is the release of the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association,<sup>4</sup> and the second is the update of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* (the Guidelines).<sup>5</sup> These developments will be outlined, and the role of the GP in the management of PTSD considered.

After 19 years of the fourth edition (DSM-IV), the fifth edition (DSM-5) was released in May 2013. Significant changes have been made to the way PTSD is classified and diagnosed (*Table 1*). First, DSM-5 has separated 'Trauma- and stressor-related disorders' from the chapter on 'Anxiety disorders'. The requirements for an event to be considered traumatic have been more explicitly defined and a subjective response of intense fear, helplessness or horror is no



longer required to make a diagnosis. Sexual violence has been added as a specific example. There are now four groups of symptoms as the previous grouping 'avoidance and numbing' has been separated into two distinct clusters. The avoidance cluster requires one of the two avoidance symptoms (avoidance of memories or thoughts or avoidance of external reminders), whereas the emotional numbing symptoms have been included in a new cluster of negative cognitions and mood, which also includes features typically associated with complex presentations of PTSD, such as persistent negative beliefs about self, others and the world. 'Recklessness or self-destructive behaviour' has been added to the arousal cluster of symptoms.

Despite the substantial changes from DSM-IV to DSM-5, early research suggests that DSM-5 PTSD will be diagnosed at similar or slightly lower prevalence rates than DSM-IV PTSD.<sup>6</sup> Although overall rates may not differ, exclusion of those without active avoidance while inclusion of those who did not experience the subjective trauma response at the time of the event may capture a slightly different group.

The revised version of the Guidelines<sup>5</sup> was released in 2013 and has been expanded to cover children and adolescents. The Guidelines have been approved by the National Health and Medical Research Council (NHMRC) and endorsed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP), Royal Australian College of General Practitioners (RACGP) and the Australian Psychological Society. The Australian Centre for Post-traumatic Mental Health (ACPMH) developed the Guidelines in collaboration with national experts. The Guidelines also investigate evidence for resilience training and consider the treatment of PTSD in older age groups.

## Evidence-based management

The best available research evidence continues to support the first-line use of trauma-focused psychological treatments for PTSD across all age groups. Other higher-level recommendations include that routine psychological debriefing for those exposed to potentially traumatic events should not be offered. There is no evidence that psychological

debriefing prevents PTSD and it may even be harmful for some.

The strongest recommendations around pharmacotherapy are that it should not be offered preferentially over trauma-focused psychological treatment and when pharmacotherapy is considered necessary, selective serotonin reuptake inhibitors (SSRIs) should be considered the first choice. Generally, the evidence base around pharmacotherapy for PTSD is not strong and has not progressed dramatically over the past 7 years, since the previous version of the Guidelines were published. The full Guideline recommendations are available at <http://guidelines.acpmh.unimelb.edu.au/>.

## The role of the GP

The role of GPs in managing PTSD is central and includes:

- provision of initial support and monitoring (eg psychological first aid, PFA)<sup>7</sup>
- early detection, initial assessment and supportive management
- use of initial pharmacotherapy
- appropriate and timely referral for specialist treatment
- support of family and carers
- crisis assistance
- management of comorbid medical conditions
- maintenance treatment for chronic conditions.

GPs with appropriate training and interest may also provide evidence-based psychological treatment.

## Recognising PTSD

The consequences of untreated PTSD include poor quality of life, chronicity and, at times, mortality.<sup>8</sup> GPs can have a substantial role in reducing delays in treatment by remaining vigilant. At-risk patients may not readily report PTSD symptoms, making it important for GPs to ask probing questions, use screening tools and raise the possibility of PTSD. GPs should be particularly vigilant with patients who work in occupations such as law enforcement, the military and emergency services, who are more likely to be exposed to multiple traumatic

**Table 1. Key differences between DSM-IV and DSM-5 PTSD criteria**

DSM-IV	DSM-5
Broader definition of what constitutes a traumatic event	More tightly defined, with the removal of some stressor events (eg unexpected deaths from natural causes) as well as the exclusion of learning about a traumatic event through electronic media such as television, video games, movies or pictures (unless exposure is work-related)
Stipulates the individual must have experienced an emotional response of intense fear, helplessness or horror during the traumatic event	Emotional response of intense fear, helplessness or horror during the traumatic event criterion has been removed
Three symptom clusters – re-experiencing; avoidance and numbing; increased arousal	Four symptom clusters distinguishing active avoidance from numbing (negative cognitions and emotions) symptoms
Minimum of six symptoms required for diagnosis	Minimum of six symptoms required for diagnosis
	Dysphoric mood symptoms added, including persistent distorted blame of self or others and persistent negative emotional state



events, communities that are subject to natural disasters such as bushfires and floods, and patients presenting with physical injuries, for example following motor vehicle accidents. Another group in primary care settings with higher rates of PTSD are patients presenting repeatedly with non-specific somatic complaints.<sup>9–11</sup>

## Initiating pharmacotherapy

GPs should consider the use of antidepressant medications such as SSRIs for people who:

- are unwilling to seek or do not have access to the preferred first-line psychological treatment
  - have a comorbid depression or other symptoms that require pharmacological treatment
  - are in situations that are not sufficiently stable (eg ongoing domestic violence)
  - have not benefited from trauma-focused psychological treatment.
- There is evidence that the required doses are higher when treating PTSD, compared with uncomplicated depression. When there is a good response to an antidepressant, a course of treatment lasting at least 12 months reduces rates of relapse. When second- and third-line pharmacotherapy options need to be considered because of non-response or side effects, other newer-generation antidepressants such as selective serotonin and noradrenaline reuptake inhibitors (SNRIs), mirtazepine or moclobemide are recommended.<sup>12</sup>

Poor response to initial treatments, complex comorbidities, safety concerns and patient request should lead to referral for psychiatric assessment. Additional treatments such as tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs), atypical antipsychotics (APs), mood stabilisers and benzodiazepines may need to be considered, but clinicians need to be aware of the limited evidence base supporting the efficacy of these treatments, inform patients accordingly and carefully manage associated risks (eg metabolic syndrome with APs, abuse and dependency with benzodiazepines, risk of overdose with TCAs).

Augmentation strategies used to treat more severe and complex PTSD come in and out of favour. The evidence base supporting the use of APs is weak and, if they are to be used, the well-established and significant side effect profile must be assessed for acceptability and be outweighed by the expected and actual benefits.<sup>13</sup> In comparison, prazosin, an alpha-1 adrenoceptor antagonist, has been proven to have a more favourable risk–benefit profile. While this profile has been established specifically in the treatment of PTSD insomnia and nightmares, a recent well-designed study also showed benefit for overall PTSD symptoms.<sup>14</sup>

## Psychological therapy

It is important for GPs to have a good working knowledge of what treatment entails when referring patients for evidence-based psychological treatment of PTSD. Often, patients appreciate general counselling, dealing with daily issues and stresses, and talking around,

but not about, the trauma, but these techniques do not improve core symptoms of PTSD. Efficacious trauma-focused interventions include therapies such as prolonged exposure, eye movement desensitisation and reprocessing (EMDR), and cognitive processing therapy (CPT). The common factors in these therapies that are considered to be the ‘potent’ elements are strategies that:

- enable the patient to confront the distressing traumatic memories
- manage the accompanying avoidance responses
- facilitate reduction and management of the associated arousal.

These evidence-based psychological treatments are time-limited and usually involve 8–12 sessions, although more sessions may be required for complex presentations or repeated traumatic experiences. Therapies such as prolonged exposure may also require longer sessions (ie 90 minutes) to ensure appropriate management of distress. In choosing a psychologist to refer patients to, we would recommend that the GP enquire about their experience in treating PTSD with trauma-focused cognitive behavioural therapy (TF-CBT) or EMDR.

## Conclusion

PTSD is a common mental health problem. GPs should be aware of recent important updates that have been made for the diagnosis and treatment of PTSD to assist in their critical role of ensuring evidence-based care for patients with PTSD.

## Authors

John Cooper MBBS, MPM, FRANZCP, Consultant Psychiatrist, Australian Centre for Posttraumatic Mental Health, Department of Psychiatry, The University of Melbourne, Parkville, VIC; Heidelberg Repatriation Hospital, Heidelberg, VIC. [jacooper@netspace.net.au](mailto:jacooper@netspace.net.au)

Olivia Metcalf BA, BSc-Psychology (Hons), PhD, Research Fellow, Department of Psychiatry, Australian Centre for Posttraumatic Mental Health, Carlton, VIC

Andrea Phelps BA (Hons) MPsych (Clin) PhD, Director Policy and Service Development, Australian Centre for Posttraumatic Mental Health, Carlton, VIC

Competing interests: None.

Provenance and peer review: Commissioned, externally peer reviewed.

## References

1. Creamer M, Burgess P, McFarlane AC. Posttraumatic stress disorder: findings from the Australian National Survey of Mental Health and Wellbeing. *Psychol Med* 2001;31:1237–47.
2. McEvoy PM, Grove R, Slade T. Epidemiology of anxiety disorders in the Australian general population: findings of the 2007 Australian National Survey of Mental Health and Wellbeing. *Aust N Z J Psychiatry* 2011;45:957–67.
3. Breslau N, Peterson E, Poisson L, Schultz L, Lucia V. Estimating posttraumatic stress disorder in the community: lifetime perspective and the impact of typical traumatic events. *Psychol Med* 2004;34:889–98.
4. American Psychiatric Association. *DSM 5*. Arlington VA: American Psychiatric Association, 2013.
5. Australian Centre for Posttraumatic Mental Health. *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder*. Melbourne: ACPMH, 2013. Available at <http://guidelines.acpmh.unimelb.edu.au/> [Accessed 15 September 2014].
6. O’Donnell ML, Alkemade N, Nickerson A, et al. Impact of the diagnostic changes to posttraumatic stress disorder for DSM-5 and the proposed changes to ICD-11. *Br J Psychiatry* 2014;205:230–35.



7. Wade D, Howard A, Fletcher S, Cooper J, Forbes D. Early response to psychological trauma: What GPs can do. *Aust Fam Physician* 2013;42:610.
8. Priebe S, Matanov A, Jankovi Gavrilovi J, et al. Consequences of untreated posttraumatic stress disorder following war in former Yugoslavia: morbidity, subjective quality of life, and care costs. *Croat Med J* 2009;50:465–75.
9. Hoge C, Terhakopian A, Castro C, Messer S, Engel C. Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans. *Am J Psychiatry* 2007;164:150–53.
10. Stein MB, McQuaid JR, Pedrelli P, Lenox R, McCahill ME. Posttraumatic stress disorder in the primary care medical setting. *Gen Hosp Psychiatry* 2000;22:261–69.
11. Gillock KL, Zayfert C, Hegel MT, Ferguson RJ. Posttraumatic stress disorder in primary care: prevalence and relationships with physical symptoms and medical utilization. *Gen Hosp Psychiatry* 2005;27:392–99.
12. Baldwin DS, Anderson IM, Nutt DJ, et al. Evidence-based guidelines for the pharmacological treatment of anxiety disorders: recommendations from the British Association for Psychopharmacology. *J Psychopharmacol* 2005;19:567–96.
13. Krystal JH, Rosenheck RA, Cramer JA, et al. Adjunctive risperidone treatment for antidepressant-resistant symptoms of chronic military service-related PTSD: A randomized trial. *JAMA* 2011;306:493–502.
14. Raskind MA, Peterson K, Williams T, et al. A trial of prazosin for combat trauma PTSD with nightmares in active-duty soldiers returned from Iraq and Afghanistan. *Am J Psychiatry* 2013;170:1003–10.