Reprinted from the German Journal of Psychiatry · http://www.gjpsy.uni-goettingen.de · ISSN 1433-1055

CASE REPORT

Olanzapine as an Add-on Therapy in Post-Traumatic Stress Disorder (PTSD)

Dietrich Koelsch

Corresponding author: Dr. med. Dietrich Koelsch, Facharzt fuer Psychiatrie und Psychotherapie, Flachsbergstr. 2, D-89551 Koenigsbronn, Germany. E-mail: dietrich.koelsch@web.de

Abstract

A 48 year old woman was kidnapped, tortured and raped by her former boy-friend and consequently developed post-traumatic stress disorder. A combined SSRI and behaviour therapy showed only limited improvement of the relevant symptoms. On adding olanzapine to the drug regime there was complete remission of all symptoms of post-traumatic stress disorder (PTSD)(German J Psychiatry 2007;10:50-52).

Keywords: Olanzapine, SSRI, PTSD, anxiety disorder, combined therapy

Received: 29.9.2006
Revised version: 3.2.2007
Published: 1.4.2007

Introduction

A 48 year old woman was treated for depression in the psychiatric unit of the Heidenheim district hospital. During her stay she started a relationship with another inpatient treated for paranoid schizophrenia. After both patients had left hospital, the schizophrenic male patient kidnapped his girl-friend, mistreated, tortured and raped her for several days and threatened to kill her. Finally the woman managed to escape and call the police.

As a consequence of her mistreatment the woman developed posttraumatic stress disorder F43.1 according to ICD-10 (309.81 according to DSM-V). A subsequent inpatient treatment, consisting of psychotherapy based on depth psychology and mirtazapine medication at 45 mg per day for five weeks was not successful, possibly because her stay at the hospital was overshadowed by police interrogations that revived her traumatic experiences. In addition, there was an underlying conflict between the patient and her therapists. She felt betrayed because she had been given no warning that her partner would act out his paranoid thoughts aggressively, although his aggressive behaviour in the past was known to the hospital staff. On the other hand, hospital doctors and psychologists feared legal claims by their patient and seemed rather negatively prejudiced against her. So the therapeutic climate during her stay in hospital was rather poor.

When the patient first presented in my practice, she was very frightened, tense and insecure. She had great difficulties in talking about her martyrdom. She reported nightly panic attacks with flashbacks of the events and a nearly complete social retreat. Symptoms of a major depression occurred as well.

Diagnosis and Treatment

The patient presented with typical symptoms of posttraumatic stress disorder. She had a history of severe depression (ICD-10 F32.2), a short episode of alcohol abuse (F10.1) and a dependent personality disorder (F60.6). It was not totally clear if the low self-esteem of the patient was due to post-traumatic stress disorder or rather a part of her pre-existing personality disorder. Her social history showed a number of psychiatric risk factors, the patient being divorced, unem-

ployed and dependent on social welfare. There was no history of mental disease in the family.

Treatment was based on both, medication and behaviour psychotherapy. The aim of psychotherapy was to reduce the social fears and to encourage her to engage in normal social contact. Fears should be outspoken and a rational way of coping with past stressors was elaborated. Drug treatment consisted of citalopram, a highly selective serotonin reuptake inhibitor (SSRI), at a starting dosage of 20 mg a day. The dosage was increased to 60 mg/day for six weeks. Under this treatment, depressive symptoms were controlled effectively, but there was no sufficient effect on anxiety. In order to control the anxiety symptoms, olanzapine was added to the therapy. The patient received 5 mg of olanzapine per day in addition to 60 mg of citalopram. Within a week, anxiety symptoms disappeared almost completely, leaving the patient in a friendly, slightly extroverted and optimistic mood that has been persisting under continued medication for three months now.

Discussion

Posttraumatic stress disorder has a prevalence of 8 percent in the average population. Risk factors are female gender, low social status and psychiatric co-morbidity (Wenzel et al. 2000, Smith et al. 1990, Breslau et al. 1995, Breslau 2002, Keane and Kaloupek 1997, McFarlane 2000, Perkonigg et al. 2000, Smith et al. 1990, Wenzel et al. 2000). SSRI and behaviour psychotherapy are supposed to be first line treatment in PTSD. As above mentioned this treatment was not sufficient for symptom control in this female patient. Earlier successes in the treatment of patients suffering from anxiety disorder with a combined treatment of SSRI and olanzapine led to the idea of using this drug regime in the treatment of PTSD. A survey of the psychiatric publications regarding the use of olanzapine in anxiety disorders and PTSD shows controversial results. One study did not find a difference between the effect of placebo and olanzapine in PTSD (Butterfield et al. 2001), others showed a better outcome for the olanzapine group (Barnett 2002, Petty et al. 2001). However, these placebo-controlled studies compared the effect of olanzapine monotherapy to placebo only. There has been no placebo controlled or double blind study comparing the effect of a combined SSRI and olanzapine regime to placebo in PTSD. For anxiety disorders, there are three studies showing in improvement of the patients' outcome after a combined SSRI and olanzapine therapy in comparison to placebo (Chao 2004, Etxebeste et al. 2000, Pollack et al 2006). The successful treatment of this patient should therefore encourage further research on the efficacy of combined SSRI-olanzapine treatment in PTSD and anxiety disorders.

References

Barnett S, Kramer ML, Casat CD, Connor KM, Davidson JRT. Efficacy of olanzapine in social anxiety disorder: a pilot study. Journal of Psychopharmacology, 2002, 16, 365-368

Butterfield MI, Becker ME, Connor KM, Sutherland S, Churchill LE, Davidson JRT. Olanzapine in the treatment of posttraumatic stress disorder: a pilot study. International Clinical Psychopharmacology, 2001, 16 (4), 197-203

Breslau N. Epidemiologic Studies of Trauma, Posttraumatic Stress Disorder, and other Psychiatric Disorders. Canadian Journal of Psychiatry 2002, 47, 923-929

Breslau N, Davis GC, Andreski P. Risk factors for PTSD-related traumatic events, a prospective analysis. American Journal of Psychiatry, 1995, 152, 529-535

Chao IL. Olanzapine Augmentation in Panic Disorder: a Case Report. Pharmacopsychiatry 2004, 37, 239-240

Etxebeste M, Arags E, Malo P, Pacheco L. Olanzapine and Panic Attacks. American Journal of Psychiatry, 2000, 157, 659-660

Keane TM, Kaloupek DG. Comorbid psychiatric disorders in PTSD, implications for research. Annals of the New York Academy of Sciences, 1997, 821 (1), 24-34

McFarlane AC. Posttraumatic Stress Disorder: a model of the longitudinal course and the role of risk factors. Journal of Clinical Research, 2000, 61 (5), 15-20

McFarlane AC, Yehuda R. Clinical treatment of posttraumatic stress disorder: conceptual challenges raised by recent research. Australian and New Zealand Journal of Psychiatry, 2000, 34, 940

Meltzer-Brody S, Hidalgo R, Connor KM, Davidson JRT. Posttraumatic stress disorder: prevalence, health care use and costs, and pharmacologic considerations,.Psychiatric Annals, 2000, 30, 722

Perkonigg A, Kessler RC, Storz S, Wittchen HU. Traumatic events and posttraumatic stress disorder in the community: prevalence, risk factors, and comorbidity. Acta Psychiatrica Scandinavica, 2000, 101, 46

Petty F, Brannan S, Casada J, Davis LL, Gajewski V, Kramer GL, Stone RC, Teten AL, Worchel J, Young KA. Olanzapine treatment for post-traumatic stress disorder: an open-label study. International Clinical Psychopharmacology, 2001, 16 (6), 331-337

Pollack M, Simon N, Zalta A, Worthington J, Hoge E, Mick E, Kinrys G, Oppenheimer J. Olanzapine Augmentation of Fluoxetine for Refractory Generalized Anxiety Disorder: A Placebo Controlled Study. Biological Psychiatry 2006, 59, 211-215

Sepede G, De Berrardis D, Gambi F, Campanella D, La Rovere R, D'Amico M, Cicconetti A, Penna L, Peca S, Carano A, Mancini E, Salerno RM, Ferro FM. Olanzapine Augmentation in Treatment-Resistant Panic Disorder: A 12-Week, Fixed-Dose, Open-Label Trial. Journal of Clinical Psychopharmacology, 2006, 26, 45-49

Smith EM, North CS, McCool RE, Shea JM. Acute postdisaster psychiatric disorders: identification of persons at risk. American Journal of Psychiatry, 1990, 147, 202-206

Wenzel T, Griengl H, Stompe T, Mirzaei S, Kieffer W. Psychological disorders in the survivors of torture: exhaustion, impairment and depression. Psychopathology, 2000; 33, 292

The German Journal of Psychiatry · ISSN 1433-1055 · http:/www. gjpsy.uni-goettingen.de
Dept. of Psychiatry, The University of Göttingen, von-Siebold-Str. 5, D-37075 Germany; tel. ++49-551-396607; fax: ++49-551-392004; e-mail: gjpsy@gwdg.de