



BRIDGES TO MENTAL HEALTH

PTSD

Case



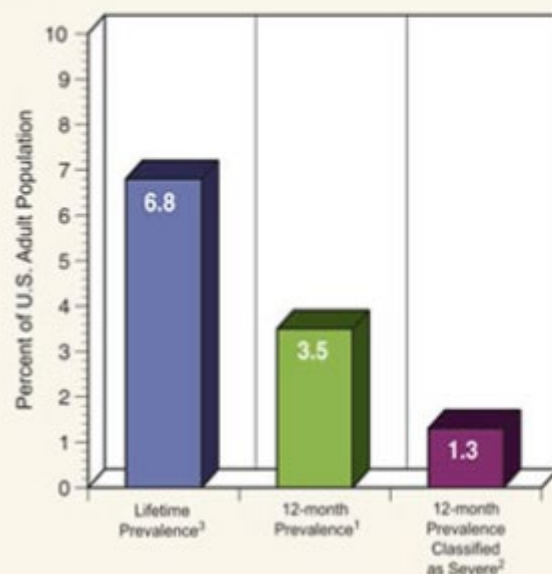
Tony, a 43-year-old entrepreneur experienced a serious trauma and presented 10 days post-trauma with intrusive memories, emotional numbness, sleep disturbance, exaggerated startle response, avoidance of driving, and prominent dissociative symptoms such as feeling detached and unreal, while remaining largely functional. When he returned three months later, his symptoms had persisted and worsened, including recurrent nightmares, ongoing avoidance, hypervigilance, irritability, negative beliefs about safety, and significant impairment in work and relationships.



Prevalence of Adult PTSD

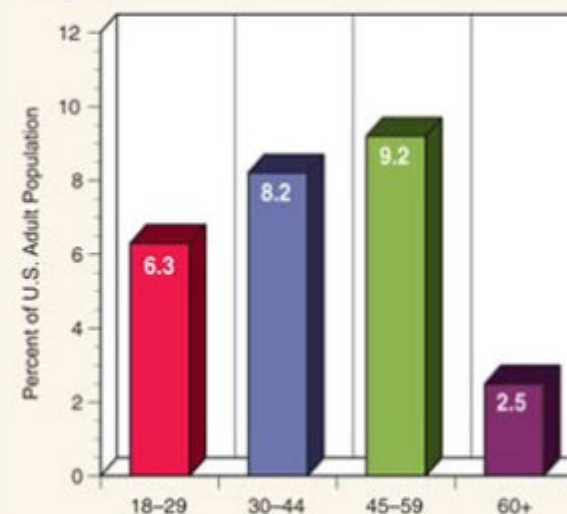
Prevalence

- **12-month Prevalence:** 3.5% of U.S. adult population¹
- **Severe:** 36.6% of these cases (e.g., 1.3% of U.S. adult population) are classified as "severe"²



Demographics (for lifetime prevalence)⁵

- **Sex:** Not Reported
- **Race:** Not Reported
- **Age:**



Average Age-of-Onset: 23 years old⁴

From Kessler et al., Arch Gen Psychiatry, 2005

Comorbidity



- Other Anxiety Disorders
- Depression
- Personality Disorders
- Sleep Disorders

What Symptoms Are Being Targeted?

- **Intrusion.** For example, nightmares, unwanted thoughts of the traumatic events, flashbacks, etc.,
- **Avoidance.** For examples, avoiding places, people, conversations that might be triggers.
- **Negative alterations in cognitions and mood.** For example, negative beliefs about self or the world, persistent fear, guilt, or shame, inability to experience positive emotions.
- **Alterations in arousal and reactivity.** For example, sleep problems, exaggerated startle, hypervigilance.

Feature	Acute Stress Disorder (ASD)	Post-Traumatic Stress Disorder (PTSD)
Onset	Begins 3 days to 1 month after trauma	Begins ≥1 month after trauma (may have delayed expression)
Duration	Symptoms last less than 1 month	Symptoms persist more than 1 month
Purpose of Diagnosis	Identifies early trauma response and risk for PTSD	Diagnoses chronic or persistent trauma response
Trauma Exposure	Direct, witnessed, or indirect exposure to actual or threatened death, serious injury, or sexual violence	Same trauma exposure criteria as ASD
Symptom Clusters	9+ symptoms from any category (intrusion, negative mood, dissociation, avoidance, arousal)	Symptoms required across 4 specific clusters (intrusion, avoidance, negative cognitions/mood, arousal)
Dissociation	Prominent and required symptom option (e.g., depersonalization, derealization, amnesia)	May occur but not required
Functional Impairment	Causes distress or impairment but often time-limited	Causes clinically significant distress or impairment
Course	May resolve spontaneously or transition to PTSD	Often chronic without treatment
Treatment Focus	Early intervention, psychoeducation, symptom stabilization	Trauma-focused psychotherapy (e.g., CPT, PE, EMDR)

What Classes of Agents?

- SSRIs
- SNRIs
- Other novel antidepressants
- TCAs/MAOis
- Antiepileptics
- Antipsychotics
- Other agents

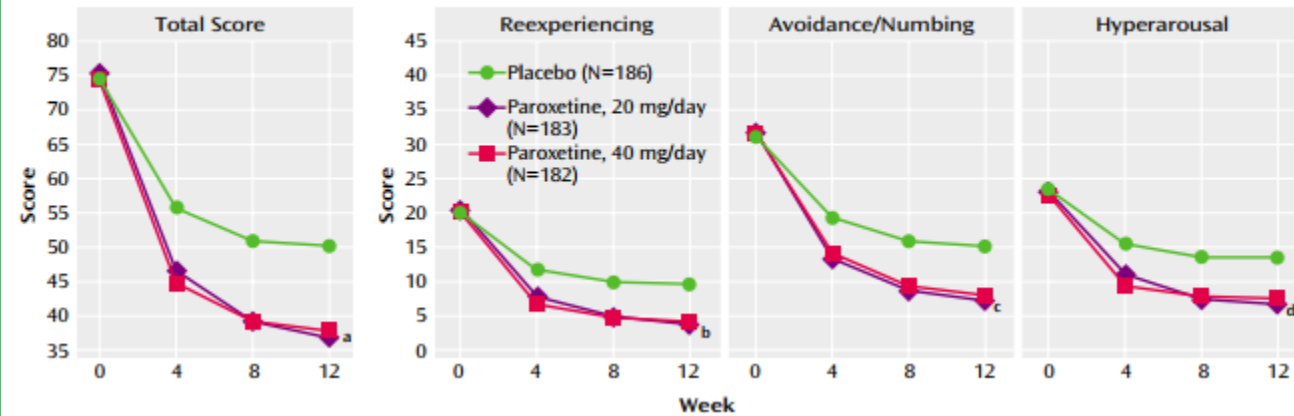
SSRIs



- Demonstrated to have the most impact on all aspects of PTSD symptoms
- Only two with FDA indications for PTSD (paroxetine and sertraline). Mostly chosen based on side effects
- Concerns are use in comorbid bipolar disorder, sleep impairments, sexual dysfunction, and other standard SSRI effects

SSRIs

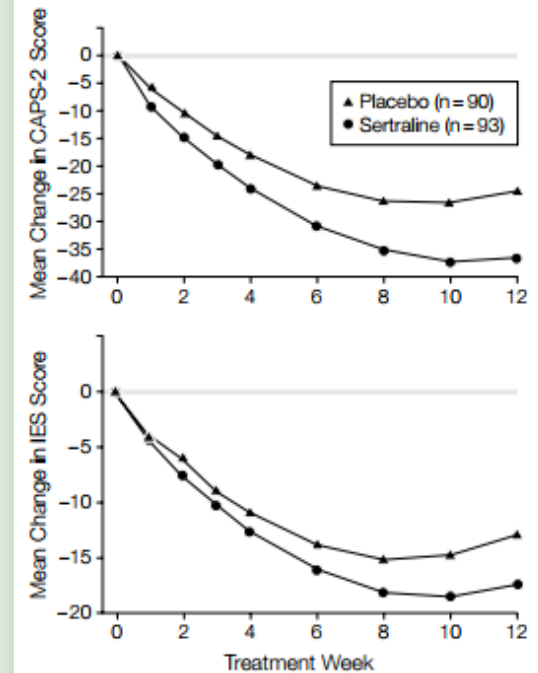
FIGURE 2. Change in Scores on the Clinician-Administered PTSD Scale, Part 2, for Patients With Chronic PTSD Who Were Given Placebo or Paroxetine



Paroxetine
Marshall et al. (2001)

Sertraline
Brady et al. (2000)

Figure 2. Results of Random Regression Analyses Comparing the Effects of Sertraline vs Placebo



Mean change in Clinician Administered PTSD Scale Part 2 (CAPS-2) scores from baseline (top) ($t_{893} = -3.68$; $P < .001$) and the Impact of Event Scale (IES) score from baseline (bottom) ($t_{1236} = -3.00$; $P = .003$), estimated from random regression analyses plotted over the 12-week course of study treatment. Gray line indicates baseline. Negative change in scores reflects clinical improvement.

SSRIs

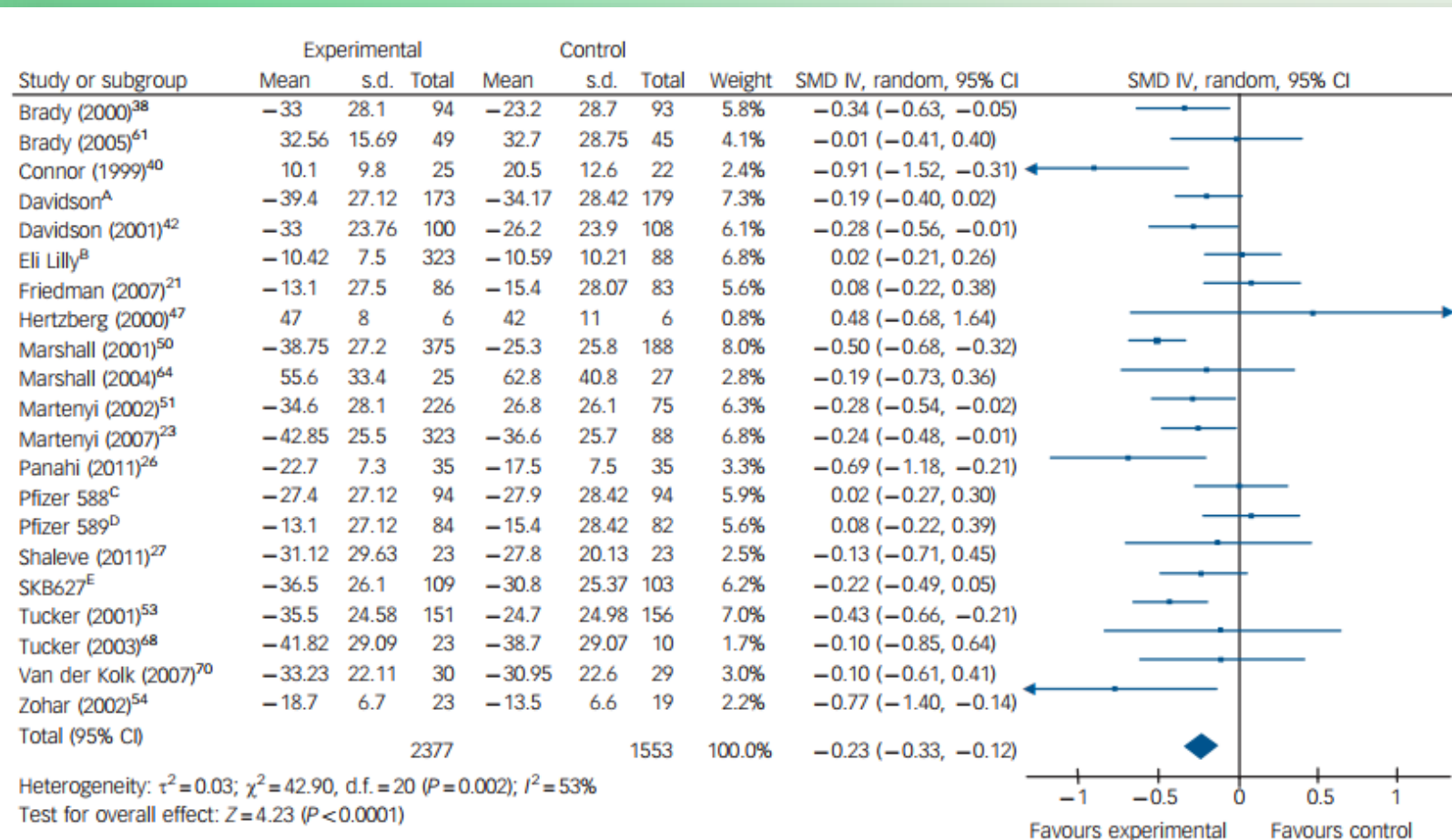


Fig. 2 Meta-analysis of selective serotonin reuptake inhibitors v. placebo (SMD, standardised mean difference).

SNRIs

- No FDA indication, but positive trials for venlafaxine

Davidson et al (2016)

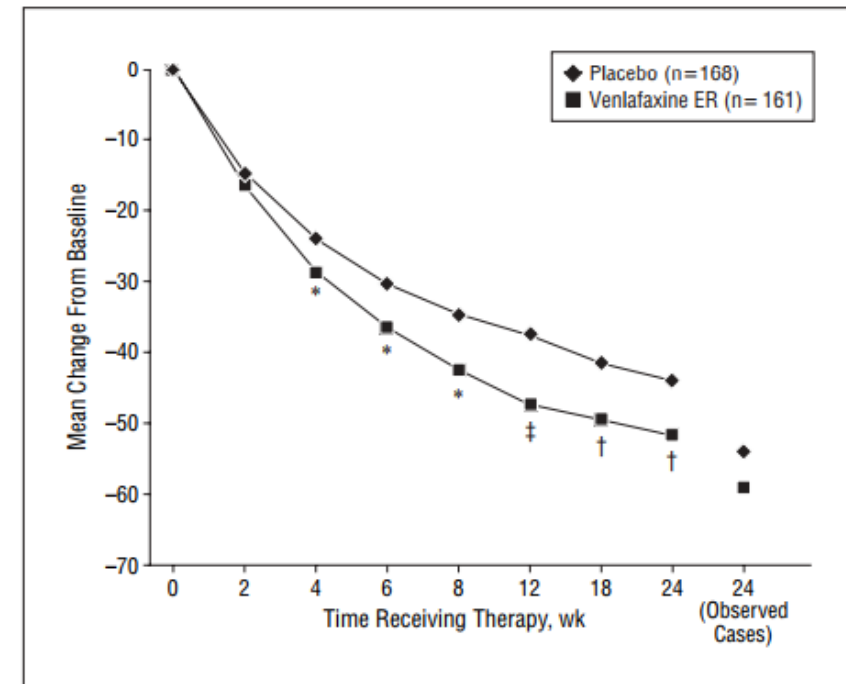


Figure 2. Change in score on the Clinician-Administered Posttraumatic Stress Disorder Scale, the abbreviated 1-Week Symptom Status Version, from the baseline score. All values represent last observation carried forward unless otherwise stated. ER indicates extended release. *P* values are based on pairwise comparisons from an analysis of covariance model with treatment as the main effect and baseline as the covariate. Asterisk indicates *P* < .05; dagger, *P* < .01; and double dagger, *P* < .001.

Other Antidepressants

- Mirtazapine – no FDA indication, but demonstrable effects and often used to promote sleep if that is an issue. Recent (Oct 2020) small controlled trial was negative. Other trials with demonstrable effects of adding mirtazapine
- Bupropion – no FDA indication, and no evidence for efficacy on core PTSD symptoms

TCAs

- TCAs were the “original” antidepressants used for combat-related PTSD and have the most evidence for use
- Often not used because of concerns about cardiac toxicity, especially in overdose. However, can be used – especially tertiary TCAs (imipramine*, amitriptyline*). Desipramine shown to be equivalent to paroxetine
- May have fewer sexual side effects than SSRIs and many improve sleep initiation

* No FDA indication for PTSD

MAOi



- Phenelzine* shown to be effective in the treatment of PTSD
- Dietary restrictions are not as stringent as one might think and can be managed
- Not to be used with (prescribed or illicit) stimulants, SSRIs

* No FDA indication for PTSD.

Antiepileptics

- Topirimate
 - Recent meta-analysis showed support for the use of topirimate* in PTSD (Jonah et al 2013)
 - Helpful in reducing alcohol consumption in those with an alcohol use disorder
- Two negative RCTs for divalproex* and one negative RCT for tiagabine*
- A small trial of lamotrigine* (n = 15) demonstrated possible benefit

* No FDA indication for PTSD.

Antipsychotics

- Risperidone*
 - Randomized controlled trial of >240 patients with RISP added to SSRI treatment for treatment refractory PTSD showed no effect of the addition (Krystal et al 2011)
- No clear benefit to the second generation antipsychotics as monotherapy in the absence of psychotic or cycling mood symptoms

* No FDA indication for PTSD.

Other Agents

- Prazosin*
 - Dosing during the day in addition to bedtime for nightmares shows a significant reduction in daytime intrusive PTSD symptoms and nightmares (Raskind et al. 2013)
 - Mean doses were:
 - Men: 4 mg midday and 17 mg at HS
 - Women: 2 mg midday and 7 mg at HS
- D-cycloserine*
 - Still in trials. Appears to reduce some of the startle reactivity and reduces cortisol reactivity in animal models

* No FDA indication for PTSD.

Other Agents

- Methylphenidate*
 - Appears to improve cognitive symptoms in small trials
- Ketamine* Psilocybin*
 - Some promise in early, small trials
- Cannabinoid agonists*
 - Negative effects thus far

* No FDA indication for PTSD.

Medication Options for PTSD in adults

- 1st Line
 - SSRIs (sertraline, paroxetine, fluoxetine*) – with psychotherapy
- 2nd Line
 - Other novel and traditional antidepressants*; anticonvulsant/mood stabilizers*; second generation AP medications* (if cycling mood or psychotic symptoms)
- Not recommended
 - Traditional APs*, benzodiazepines*

* = no FDA indication for PTSD

Trauma-focused CBT (TF-CBT) and Prolonged Exposure (PE)



TF-CBT and Prolonged Exposure PE are among the most strongly supported treatments for PTSD

Emphasize direct engagement with trauma memories and reminders to reduce fear and avoidance

- Core Components:
 - Psychoeducation about PTSD
 - Skills training (e.g., breathing, emotion regulation)
 - Imaginal exposure (recounting traumatic memories)
 - In-vivo exposure (gradual confrontation with avoided situations)
- Evidence Base:
 - Demonstrated large and sustained reductions in PTSD symptoms
 - Effective across military, civilian, and disaster-exposed populations
 - Recommended as first-line treatments in major clinical guidelines

Cognitive Processing Therapy

CPT is a structured, trauma-focused cognitive therapy targeting maladaptive trauma-related beliefs.

Typically delivered over 12 sessions, individually or in groups.

- Core Components:
 - Identification of “stuck points” related to trauma (e.g., safety, trust, blame)Cognitive restructuring through written and verbal exercises
 - Trauma narrative may be included but is not required
- Evidence Base:
 - Strong empirical support from randomized controlled trials
 - Comparable efficacy to PE
 - Effective for PTSD with comorbid depression and guilt/shame

Eye Movement Desensitization and Reprocessing (EMDR)



EMDR integrates elements of exposure and cognitive therapy with bilateral stimulation (e.g., eye movements).

Focuses on processing traumatic memories to reduce emotional distress.

- Core Components:
 - Identification of distressing memories
 - Concurrent bilateral stimulation while recalling trauma
 - Installation of adaptive beliefs
- Evidence Base:
 - Numerous RCTs show EMDR is effective and well-tolerated
 - Comparable outcomes to TF-CBT and PE
 - Recognized as a first-line PTSD treatment by international guidelines

Additional Evidence-Based Treatments



- Exposure Therapy (NET): Especially effective for survivors of multiple or complex traumas (e.g., refugees)
- Brief Eclectic Psychotherapy for PTSD (BEPP): Combines CBT, psychodynamic, and exposure techniques
- Clinical Considerations:
 - Trauma-focused therapies outperform non-trauma-focused approaches
 - Treatment choice should consider:
 - Patient preference
 - Comorbid conditions
 - Cultural context
 - Therapist training and availability

Bottom Line: Trauma-focused psychotherapies are the gold standard for PTSD treatment

Screening tools for PTSD

Tool	Setting	Time	Use
PC-PTSD-5	Primary care	<1 min	Initial screening
PCL-5	Primary/specialty care	5–10 min	Severity & monitoring
IES-R	Early trauma/research	~10 min	Trauma impact
CAPS-5	Mental health	45–60 min	Diagnosis

Clinical Responsibilities to Traumatized Patients



- Recognize trauma-related patterns
- Normalize reactions (“Many people experience this after trauma”)
- Reduce stigma
- Encourage follow-up and continuity of care
- Coordinate referrals and reinforce treatment plans