Psychopharmacology and PTSD 1
Written Video Transcript

Hello, everyone on behalf [00:02.20.00] of The National Center for Post-Traumatic Stress Disorder here in Menlo Park, California and EES, I'd like to welcome you all to our fifth continuing education course on PTSD. Today's speaker is Dr. (Steven Linley), who's currently the associate director for research here at The National Center [00:02.40.00] in Menlo Park. I'd like to share with you just a bit about his background. In addition to his medical degree, Steve has a PHD in pharmacology and performed much of his basic background research on stress and neurobiology at Stanford University where he was a psychiatry fellow. [00:03.00.00] For the last three years Steve's been with us here at The National Center and has continued his basic research. In addition to that he's in the process of conducting clinical pharmacological research trials on patients suffering with PTSD. Also, [00:03.20.00] in addition to this heavy work load he's one of our staff psychiatrists serving both our men's and women's residential PTSD treatment programs. Today, he'll be talking to us regarding the latest information on the pharmacological treatment of PTSD. So, it's my sincere pleasure [00:03.40.00] to welcome Dr. (Linley) and I'd like to do so now. Steve?

Thanks, Pamela, for that lovely introduction. And thank all of you for coming here today. As Pamela said and most of you probably should know since you signed up to be here today, [00:04.00.00] this section on the series on PTSD is on the treatment—specifically the medical treatment—of post traumatic stress disorder. A few years ago it would have been difficult to present much—been difficult to present this talk because there wasn't a lot of [00:04.20.00] objective data on whether medications worked in PTSD. And this may have been due to a variety of reasons, primarily because PTSD being started from a psychological trauma, you know, medications aren't the first thing one would think of I guess. But I hope you'll [00:04.40.00] appreciate by the end of today's lecture that we now particularly in the last couple of years have accumulated a body of evidence—particularly with the antidepressants—that medications do work for treating chronic PTSD. I've tried to structure this lecture to be open for the general mental health practitioner [00:05.00.00] with no particular background in psychopharmacology. But before all of our psychiatrists run to the door I've also included the latest information even from the last few months. So, there should be a little bit of something for everybody. I'm going to be stopping at a couple of points [00:05.20.00] along the way to open it up for questions. And in fact I'll be asking you some questions too, so there will be a quiz. So, but if we could open—during the lecture if you could keep the questions to the audience here rather than out in TV land it would probably let me stay on time [00:05.40.00] because I've been warned if I go over time here I'll end up being shot by out TV producers. So, in which case you'll all be traumatized so we wouldn't want that to happen. Okay, so, what are we going to be talking about today? First, [00:06.00.00] I'm going to start by just briefly reviewing the

symptoms of post-traumatic stress disorder. And I realize that this is a series on PTSD but I think it's still important for us to all start at the same baseline. As part of that I'm going to briefly mention an assessment tool called the clinician [00:06.20.00] administered PTSD scale or CAPS which measures the severity of PTSD symptoms and has been used in most of the trials that I'm going to be talking about today. And then I'm going to briefly review some of the co-morbid conditions and symptoms associated with PTSD most of which can also—[00:06.40.00] can actually be the target of pharmacological treatment. And then I'm going to move on to briefly review neurochemical communication. Now I'm not doing this to put anybody to sleep in the audience here but that I think it's important that we all start from the basic [00:07.00.00] background in which to understand this process will help us understand how these medications work. And then the bulk of the lecture is going to be discussing the efficacy of the different classes of medications that are used in PTSD. And the data [00:07.20.00] that I'm going to present will be from double blind randomized trials. What I mean by that are double blind trials are trials in which the research subjects either take the medication or they take an inactive placebo. The patient doesn't know, the researcher doesn't know, the treatment is randomized. And then we see, [00:07.40.00] you know, who gets better and who does not. So, that's definitely the strongest objective data that one can get today on whether a treatment works for a psychiatric disorder. And recently we've had there's been a number of studies that have met this criteria so I'm going to focus on those. And then finally [00:08.00.00] I'm going to at the end of the talk make some recommendations for approaches to pharmacological treatment. And then we'll open it up to questioning. I don't need to tell this audience that PTSD is a problem with veterans as indicated by these prevalence rates for various types of trauma exposure. For instance, [00:08.20.00] Vietnam veterans both male and female having a possibly 30% prevalence of lifetime PTSD. So, it's a common and serious problem with a lot of social impact. [00:08.40.00] Now, the current DSM-IV definition of post-traumatic stress disorder begins, as you would expect, with a trauma and defining a trauma. Which in DSM-IV it is currently defined as exposure to an event that involves actual or threatened death or serious injury [00:09.00.00] or threat to physical integrity and that the reaction to that event involves intense fear, helplessness or horror. This is subject to debate as whether or not this is too high of a bar to define a trauma but this is what our current standard is. Symptoms that have been described in PTSD [00:09.20.00] fall into three different clusters. The first cluster is what are known as the criterion B symptoms which are the re-experiencing symptoms. And what are meant by those are intrusive thoughts, images or perceptions of the event, the trauma, [00:09.40.00] dreams of the trauma, a sense of re-experiencing. And this can be something fairly subtle. Actually, normally that's kind of what it is, it's kind of a general perception that you kind of feel like you're back at the time of the trauma. You know, maybe overcome with both physical and psychological symptoms or this could be more dramatic [00:10.00.00] in more rare cases and kind of meet the criteria for what are called flashbacks. And then both psychological and physical distress upon exposure to cues are listed under the re-experiencing symptoms. Second cluster of symptoms are the numbing and avoidance [00:10.20.00] symptoms and these include efforts to avoid thoughts or feelings of the event, efforts to avoid activities, people and places often associated with the trauma, inability to recall

details. Some patients have a very vivid memory of what happened, some of them [00:10.40.00] have some amnesia. And some of this may be due from an active process of trying not to think about what happened. Diminished interests, a sense of detachment from others, a restricted range of affect and a sense of a foreshortened future. And as you see [00:11.00.00] a lot of these symptoms overlap with those of depression. Okay, the third cluster of symptoms include the arousal symptoms. And they include difficulty falling asleep or staying asleep, insomnia, irritability or anger outbursts, difficulty in concentrating, [00:11.20.00] hypervigilance, exaggerated startle response. Now, I have mentioned this assessment tool that's been developed for trying to measure the severity of these symptoms and that's called the CAPS. And what that does, it goes through each one of those symptoms in those three different clusters and measures both the frequency of the event [00:11.40.00] and severity. Now, like all measures this is somewhat subjective in how you're defining this. But it is our best attempt to, you know, come up with the severity score for PTSD symptoms. And I'll be referring to those in these medication trials. Now, [00:12.00.00] PTSD is somewhat unique among psychiatric disorders in having a lot of co-morbidity, a lot of co-morbid symptoms that can occur along with PTSD. And the ones that are shown here are ones that can often be the target of pharmacological treatment. And that includes both, you know, alcohol [00:12.20.00] and other substance abuse and use disorders being very prevalent, particularly within our male veteran population. Disorders of depression or anxiety including panic. I mention impulsive anger being one of the core symptoms, this can be associated [00:12.40.00] with problems with interpersonal conflict. That anger can also be self-directed particularly in female victims and result in extreme with self-mutilation behaviors. Rapid mood swings, affective instability, social withdrawal. I mentioned with one of the symptoms this can actually look [00:13.00.00] a lot like social phobia in some patients. The distress of others can reach a severe intensity, so both the paranoia and guilt can actually be delusional. With some patients I think this is very similar to what you see in depression, that you sometimes have mood congruent [00:13.20.00] psychotic symptoms, when it's called psychotic depression. Likewise you can get that within PTSD as well. And that can be—those need to be taken in account and be treated with pharmacological interventions as well. And finally both somatic complaints [00:13.40.00] and the associated medical problems which are sometimes hard to disentangle of how much of it's (metazation) versus a lot of the stress related physical disorders that go along with PTSD. And that was covered in the first talk of this series by Matt Friedman on the idea that under chronic stress the body can develop certain disorders, you know being [00:14.00.00] diabetes, hypertension, for example. Then and some of these disorders can, as you'll see, be in overlap with the pharmacological treatment can address both the semantic or the medical problems and the psychiatric distress as well.

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