# Psychopharmacology and PTSD 6
## Written Video Transcript

So, does anyone here have any questions? Sure.

I've seen patients being prescribed (haldol) or other typical antipsychotics. What would you suggest?

Well, this comes up as far as the question being whether or not when patients are being [00:00.20.00] given any typical agent, you know, should you continue with them on it? That part of it depends on having a conversation with the patient. Some patients are totally convinced that this has been the, you know, one drug that's worked and its really helped their anger. And so, you know, you have to proceed with caution when you talk about switching a patient over to an [00:00.40.00] atypical agent. I've known of a few, you know, cases where that transfer process, that switching, did not go very well. So, one needs to have a lot of discussion, frequent visits when one switches over and, you know, proceed carefully. [00:01.00.00]

What's known about the compliance with the major medications that we use to treat PTSD in our veterans? Do they discontinue the medications without supervision, doctor's orders or are they good compliers?

Well, yeah that actually [00:01.20.00] hasn't been to my knowledge been looked at in a systematic way. Clinically we always see—we see the treatment failures. We see people who just stopped it. They were doing better, they felt they were doing better and then they just either forgot or they got tired of taking it or they couldn't remember so they stopped taking it. And then they have a relapse, you know. And from this data that we just saw [00:01.40.00] with the (Certraline) in this continuation study, you know, I think it's important to present that to patients and say, "Hey, just because you got better you have to stay on this medication if you have chronic PTSD," you know. Unless, again, you're making a plan that you're going to try to [00:02.00.00] discontinue them. I believe we have a caller. Is there a caller out there? Hello?

Hello?

Yes, you're on. What's your question?

I'm wondering if you could give us any information about the use of EMDR in combination with [00:02.20.00] meds and by itself.

Okay. The question being about EMDR or the therapy. And as I just referred to as far as psychotherapy in general we really don't have much in the way of information about

combination treatment. I just I was reviewing the area of EMDR research [00:02.40.00] and I did not see any study that had looked at, you know, the combination of the two. And I don't even remember whether the patients were on medications who were in these trials with the EMDR, so I can't really say too much about that. Other questions? [00:03.00.00]

What about adding Lithium [3:02].

Okay. So, the question being?

Adding Lithium to an antidepressant for PTSD.

Okay. Yeah, the area—I guess I think there's like a case report out there [00:03.20.00] or two saying that that may be effective. Lithium has been shown to be effective in depression. If you're on an antidepressant and not responding or partially responding that the addition of low doses of Lithium can be effective in boosting effect of the antidepressant. There's no reason that, you know, [00:03.40.00] to believe that this probably would not also work in PTSD. And we often don't think of that, I mean, as an option. But, you know, I think it's worth a try. Lithium, again, at higher doses can be very dangerous in overdose. So, one has to proceed with caution but [00:04.00.00] I think it's a good option. Okay.

I have two questions. One is, how long after the trauma do you think treatment should start? And second question is, is there any role of (antistaminic) like (Periactin) or [4:17] in the treatment of PTSD?

Okay. [00:04.20.00] Well, taking the first question first about how long after a trauma the symptoms should start. It's an open question really. We don't really know. [00:04.40.00] I mean what we do likewise with depression is normally wait, you know, some vague period of time, three months, six months, depends on the severity of the patient's symptoms. But that being said if someone is having severe symptoms that seem to be out of, you know, [00:05.00.00] just certainly either very disabling or greater than one would expect, earlier on, you know, may be worth trying to intervene with an antidepressant at that time as well. That's probably—that's one of the preventive strategies that is being looked at [00:05.20.00] at this point, is whether or not, you know, using an SSRI during early on after a trauma whether or not that could prevent the progression of PTSD symptoms. So, hopefully we'll be able to answer that shortly. And then the second question was about (siperheptadene)? [00:05.40.00] Yes, which has been—there's a report out there, open labeled report that I believe it said nightmares that (siperheptadene) has been reported to be effective. Another report, I think it's from 1994, mid-'90s anyway. I haven't seen any follow up, any future, you know, [00:06.00.00] double blind data. Certainly there isn't on (siperheptadene). So that, you know, it's kind of unknown. It has been reported in open labeled trials. Now, I should report—kind of going back, I've been making this emphasis about double blind data [00:06.20.00] because I think it's what we should use to guide our clinical practice if we can. That

being said, open label trials have their purpose, have their use and their use is to screen out drugs that don't work at all. I mean if it doesn't work in open label trial then forget it, there was no sense in proceeding. So, the fact that it worked in an open label trial, there's a reason to try it. [00:06.40.00] I believe we have somebody on the telephone. Caller? Is?

[6:46] my call was [6:50]

Uh, (with) [6:55]?

Yes.

Okay. Yes, that's kind of interesting. I presented [00:07.00.00] all of this stuff about the (antiadrenergic) effect but (mertazopine) as you know can to potentiate noreprinephrine transmission. It works through, working under—the adrenergic receptors actually. Instead of being an alpha 2 agonist it's an alpha 2 antagonist, can increase noreprinephrine concentrations as well as [00:07.20.00] having an effect on serotonin. And as most people know there's antihistamine effects. It's fairly sedating. It can be very sedating with patients particularly at lower doses. That in my experience has sometimes been useful when patients have had severe insomnia, [00:07.40.00] other things have (not) worked, low doses of (mertazipene) [7:46] have been useful in—use that term again killing two clinical birds with one stone—so both being able to treat the sedation, I mean the insomnia with the sedating effect and [00:08.00.00] having an antidepressant effect as well. So, it's often a good option. But again no—there's open label reports but no double blind information. Okay. We have another question back there?

Yes, Steve. In the field after an acute trauma, like after 9/11, [00:08.20.00] if you have patients coming in with hyperarousal type of symptoms, insomnia, that kind of stuff and you're of the philosophy that you shouldn't begin antidepressants for that period of time you were talking about, three to six months, what are you using immediately with these patients [00:08.40.00] that need relief?

I think that the best option, particularly depending on the patient's history, if they don't have a history of substance abuse or dependence or at least significantly, (benzodiazepenes) are going to be the most—it's a humane treatment. Treating the acute anxiety, letting them get some sleep. [00:09.00.00] And again the jury's still out as to whether or not that may end up being, you know, prevent the progression of symptoms. And hopefully we'll have that. And because that's one of the agents I believe they're looking at after—in New York at this point is a lot of people were on (benzodiazipene). I don't know if you saw the report about the, [00:09.20.00] you know, increase in prescriptions that were in the general New York area really skyrocketed. So but that I think is the best, you know, most appropriate treatment.

Would you suggest any limits on use of those considering the potential for problems?

Well, I mean most people would say like 30 days, [00:09.40.00] you know, a month, two months. You get beyond that you have to reconsider what you're doing. Because then you've moved beyond acute treatment, if the anxiety is still continuing. Certainly, I mean, what you would want to do is start an antidepressant at that point. If they haven't responded, they're still having significant anxiety after a month then, you know, [00:10.00.00] at least pharmacologically, you know, antidepressant would be warranted. Other questions? There's a couple back there.

Steve, you mentioned that small study where [10:18] seemed like it was helping nightmares. And you mentioned a couple of other drugs that maybe are [00:10.20.00] helping nightmares. I gather you don't have really good evidence, but what if you had a client and that was his worse symptom, that was his main complaint, would you consider trying one of these drugs?

No, I would. I would. Actually I have kind of changed [00:10.40.00] recently. As I said we're doing this (clonanine) trial ourselves and we're double blinded. So, I probably shouldn't even comment because I don't know what the patients have been on. But that's come up spontaneously. I haven't looked for it but people have said, "I'm not quite sure if I'm better on anything else but my nightmares seem to be better." So, yeah I think they—you know it's possible that there's [00:11.00.00] something to it. And again, so like a lot of things if we're not—you know, we don't have any other information, this is the primary symptom, that's probably the way we should go. Nightmares are interesting, though, in the fact that in my experience they seem to be—it is a very idiosyncratic response to medications that lots of different—I mean like (trazidone), [00:11.20.00] some people their nightmares go away. Some people they get worse. And some people start having them, they didn't have them before. I mean it's all over the place. So, it's often hard to predict how patients are going to respond. Okay, we have a caller online. Caller?

[11:38] your [00:11.40.00] question about (trazidone), wondering dose range to go up to, whether [11:44] is really a problem and whether there's a role for [11:48]?

Okay, taking those in order, often with most patients—I mean with (Trazidone) I try to stick [00:12.00.00] in the maximum dose is between 100 and 200 milligrams at one time. Above that you get in the—it's kind of it's a different realm that you're in which it's getting very just overly kind of knocking them over the head with sedation often. And yes, (pripizm) can [00:12.20.00] certainly in our population be a problem. It can be a problem if you're not doing an appropriate or an informed consent. If you have patients who have problems with erectile dysfunction and you don't tell them about this they may, you know, not react to it right away. They may think this is a good thing and not seek medical help. So, I always [00:12.40.00] emphasize, you know, that this could be a potentially very serious problem. And then (zopidem), which is a benzodiazepine variant that supposedly has a—it works on one of the subtypes of benzodiazepine receptors that overall is probably less addicting. [00:13.00.00] But I mean overall it's still kind of in

that same class. So, I would still want to restrict it to a short term use if I can. [13:14] addictive properties of benzos but the other problem that I've referred to is the short term memory [00:13.20.00] deficits that can occur. And those are ones that patients often don't know about. No one's really explained to them that, you know, the (adivan) that they're taking or—(had a patient recently, it was) like six milligrams of (clonodine) that—(clodapine)—[00:13.40.00] that he—that short term memory can be a problem. And so patients don't really think that they're having early dementia, they don't realize it's the benzodiazepine that they're on that is causing it. We have the luxury within our residential program in order to take—we have a restriction on benzodiazepine, so we can take people [00:14.00.00] off and, you know, treat them with other agents. We've had, except for that one dose, the one patient I just referred to with the high doses of benzo, we've had a very good success rate in converting people from a benzo to things like (gabapentin) or various other combinations. [00:14.20.00] So, that's not to say again that when they leave the program they no longer have the social support that they're getting and they're back to every three months, you know, follow-up visits that they may not go back on the benzo. But I think [14:33] should always be considered. Which is always easier to do in a residential or inpatient program than it is out there [00:14.40.00] in the trenches in the outpatient clinics. Other questions? There's a question back there?

What are your thoughts about prescribing (adivan) to a patient with chronic PTSD and a history of substance abuse?

Okay. [00:15.00.00] Yeah, that's a good question in that I just kind of referred to that. You know, generally people would think you would have a total prohibition to doing that because of the potential of two thing—both abusing the [15:17] the (adivan) and [00:15.20.00] some evidence that being on a benzodiazepine could actually trigger addictive impulses. I mean that seeing it can work similarly to alcohol, it can have a alcohol like effect, may be more likely to go into relapse. That being said, I certainly have seen patients who have been, you know very large, long [00:15.40.00] substance abuse histories, a lot of it (driven) by anxiety and they've been able to maintain low doses, you know, in a non—with no signs of addiction being on a drug like (lorazapan). So, I think you always have to take patients, [00:16.00.00] patient by patient, case by case when we're making that decision. Mm-hmm. Other questions?

Thank you. What are the options if a patient you're treating for sleep problems [00:16.20.00] fails to respond to (trazidone)? What options does a clinician have then?

Okay. Well, I mean at that point you really—part of it you have to look at—first of all we always talk to about sleep hygiene to start with and work on that Again, within our residential program it's a little bit easier to do that, seeing they're going to bed at a certain time [00:16.40.00] and you know, the staff is working them—with them on sleep hygiene issues. Other non-sedating like antihistaminic agents, Benadryl being one that's often the next best choice to see whether or not that can induce sleep. [00:17.00.00] From there you kind of move into more, you know, unknown territory. We talked about (mortazipene) as being an agent that's an antidepressant that's both, you know,

sedating—sedating antidepressant that can often be a good choice. These, the more sedating are the atypical antipsychotics. Particularly when they're involved, it's not just [00:17.20.00] insomnia but, you know, physical agitation and affective instability can be a good option, a way to go as well. Sometimes (gabapentin) at higher doses at bedtime, again, is sedating and can work in some patients and not others. [00:17.40.00] And again, in my experience it's always it's very idiosyncratic. It's very much, you know, every patient is very different of how they respond. And so one should never give up. I've definitely had patients that have failed (trazidone) and Benadryl and have even seen people that say they didn't respond to a benzone and they say that [00:18.00.00] (gabapentin) is the best thing that's ever happened to them, that they're now getting sleep. So, one can never tell of how a patient is going to respond. But we emphasize sleep as being, you know, a very serious and troubling problem. It is very common. [00:18.20.00] Very distressing to our patients and of having chronic insomnia, you know, can lead to relapses, lead to suicidal thinking. I mean anxiety being one of the bigger driving forces behind [00:18.40.00] suicide attempts. So, it should always be taken very seriously. Okay. Any other questions? Okay.

I'm wondering if you could comment [00:19.00.00] on a couple of things related to the way prescribing is done in the VA. What is your impression about the match up between what you're advocating toady and what would be common prescription practices in the VA? What changes would you advocate, if any? And also a secondary issue, a lot of patients with PTSD [00:19.20.00] show up in primary care, not in specialized mental health. Are primary care physicians trained in ways that will enable them to use these same medications and manage patients themselves or would there need to be more support training, other resources [00:19.40.00] placed around them if they wanted to manage PTSD themselves?

Okay. Well, taking that last question first, and it has to do with, you know, primary care physicians treating patients with PTSD. I think, again I don't know that there's a lot of information on this but my experience it's been a more of a rare [00:20.00.00] event that patients—that primary care physicians are much less likely to appreciate PTSD when it exists and are less likely to intervene. Now, they may label it something else such as depression and treat like that. And from that standpoint, you know, for the first line [00:20.20.00] treatment that we're talking about, which is the SSRIs, primary care physicians are very—you know, they're very used to doing that these days. The one problem being that—and this is of course becomes more of a—I guess more of a philosophical debate than a clinical debate is when psychotherapy should intervene [00:20.40.00] and whether or not it's different for depression than it would be for PTSD. In depression you could probably make more of an argument that you could try a medication trial first. See if it works, the patient gets better, you know, particularly if they're resistance to getting into therapy. And with PTSD where you have an obvious [00:21.00.00] psychological event that has taken place as driving their symptoms that, in my opinion, one should intervene with psychotherapy quicker. And that's not—in most primary care offices that's not [00:21.20.00] likely to occur, at least in a, you know, in a systematic manner or they often don't have the time to refer people out very easily either.

As far as a treatment, the prescribing practices in the VA, I mean I've spent some time nosing around [00:21.40.00] our pharmacy database here so I have a little idea as to what people are being prescribed and how they're being prescribed. I think its very variable. I mean it depends on the type of clinic, how things are set up. And, you know, from everything with very good follow up, monthly visits with [00:22.00.00] a psychiatrist working with a case manager very closely, both, you know, monitoring treatment response overall, monitoring the psychotherapy along with the pharmacotherapy to patients—by patient's report anyway, somebody being seen every three months being given a prescription and say, you know, "Come back sometime [00:22.20.00] in May." And that of course in addition to being often lost in follow up is that noncompliance becomes an issue. I mean, you get patients, I hear this all the time, where patients are just irate that, you know, "They just sent me out, they didn't tell me anything that was going on and I, you know, had a follow up in three months down the road. So, [00:22.40.00] and they don't want to try it again. So, I, you know, I think it in particularly in the initial stages of treatment that a very close follow up, working as a team with the case manager, psychotherapist and the psychiatrist [00:23.00.00] together would be the best, you know, standard of practice at this point that we should be try to obtain in all areas. So, I guess with that we just have a few minutes left. So, I'd like to [00:23.20.00] thank everybody for coming here and I'm going to turn it over to Pamela to make some closing remarks.

Thank you, Steve. And on behalf of everyone here today, the National Center and EES we'd really like to thank you [00:23.40.00] for your time, effort, insights and expertise that you shared with us today. We're really quite grateful and appreciate your support of this program. And to all of you here in the audience, again, thank you for your support of our program and we hope that you'll join us for future courses. The next one [00:24.00.00] will be coming up shortly. So, thank you for joining us.

[end of audio]