Introduction

New Strategies for the Treatment of Posttraumatic Stress Disorder

Jonathan R. T. Davidson, M.D.

A roundtable conference was held June 29–30, 1999, at which 5 participants discussed areas of major importance with respect to posttraumatic stress disorder (PTSD). In recent years, it has become evident that PTSD is a major health concern both in the United States and worldwide. Unfortunately, it continues to be poorly recognized and not well treated, though long-lasting morbidity results from the disorder. In this report of the roundtable, we have included all presentations, which will be summarized below.

Drs. Hidalgo and Davidson present a review on the prevalence of trauma and of PTSD, finding both to be common. More recent surveys have found increasingly higher rates of both, in part a function of the methodology used by the investigator. Risk factors for trauma and PTSD are not identical, and these are discussed in detail. The second part of their article reviews the all-too-heavy cost of PTSD, which, by any standards, must be viewed as among the most serious of all psychiatric disorders.

In a review of the biology of PTSD, Dr. Yehuda provides a lucid exposition of the changes which take place in both the hypothalamic-pituitary-adrenal (HPA) axis and sympathetic nervous system (SNS). She explains how PTSD in a biological sense represents a failure to resolve or "turn off" the fear response, and how the distinctive HPA and SNS changes may underlie the failure to fully incorporate and process traumatic memory. She describes how biological changes in PTSD can be an evolving process, and how it is distinguishable from both normal stress and the related condition of depression.

It is unusual for PTSD to exist in isolation: most commonly one or more Axis I disorders will be found to coexist. Dr. Brady and colleagues cover in comprehensive fashion the associations between PTSD and common disorders such as depression, anxiety, and alcohol and substance abuse. The authors also raise our awareness of important but less widely studied associations between PTSD, eating disorders, and somatoform states. The implications of these findings for treatment of PTSD and its comorbidities are discussed.

Drs. Hembree and Foa describe how traumatic experiences can be processed and how cognitive-behavioral treatment may be effective in this regard. They provide detailed descriptions of the many well-conducted studies examining the efficacy of psychosocial treatments and offer a balanced interpretation of each treatment. Quite clearly, psychosocial treatments of PTSD are effective and provide a robust and enduring impact. However, some limitations are also acknowledged by the authors, who remind of the importance of a strong therapeutic alliance.

The Expert Consensus Treatment Guidelines for PTSD[1] have indicated that nearly all of the surveyed practitioners and researchers recommended pharmacotherapy, in particular antidepressants, as an important treatment for PTSD. Published literature on pharmacotherapy of PTSD is still quite limited, considering that the diagnosis was formally introduced 20 years ago. Dr. Pearlstein reviews what is known about antidepressants in the disorder and concludes that evidence definitely supports fluoxetine and sertraline in PTSD with

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suggestive, but not conclusive, findings in favor of other antidepressants, e.g., paroxetine, fluvoxamine, nefazodone. For mood stabilizers, evidence is only suggestive. Dr. Pearlstein's presentation, as well as Dr. Friedman's, has taken on greater relevance now that the first treatment for PTSD has been formally approved, toward the end of 1999, by the Food and Drug Administration.

Dr. Friedman addresses further biological aspects of PTSD, including the opioid, glutamatergic, serotonergic, and corticotropin-releasing factor (CRF) antagonists, neuropeptide agonists, and substance P antagonists. He raises some intriguing possibilities that one day we will reach a point where drugs selective to one or other of these systems will be demonstrated to have efficacy in PTSD, but with fewer side effects. This possibility remains an intriguing idea, and one that ushers in an era of effective drugs with normal side effects.

REFERENCE

1. Foa EB, Davidson JRT, Frances A. The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. J Clin Psychiatry 1999;60(suppl 16):1–76