TRAUMA- AND STRESSOR-RELATED DISORDERS

Posttraumatic Stress Disorder

PTSD

DSM-5-TR 309.81 | ICD-10-CM F43.10

Persistent intrusion, avoidance, negative alterations in cognition and mood, and hyperarousal lasting beyond one month after trauma.

LIFETIME PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~6.8% (US adults)	Within 3 months of trauma	~2:1 female:male	~50% remit within 1 year

CLINICAL PICTURE

- Intrusions are involuntary and sensory rather than deliberate recall: flashbacks, nightmares, and cue-triggered distress with autonomic surge.
- Avoidance of reminders progressively narrows life domains, and patients present for insomnia, pain, or substance use rather than for trauma.
- Negative cognitions center on self-blame, permanent damage, and a foreshortened future, accompanied by persistent shame, guilt, and anger.
- Hyperarousal includes hypervigilance, exaggerated startle, irritability or aggression, reckless behavior, and fragmented sleep.
- Depersonalization or derealization mark a dissociative subtype associated with early, repeated interpersonal trauma and worse function.
- Children may show trauma reenactment in play, frightening dreams without recognizable content, and developmental regression rather than verbal report.

DIAGNOSTIC CRITERIA AT A GLANCE

- Requires exposure to actual or threatened death, serious injury, or sexual violence, directly, as a witness, by learning of it, or through repeated occupational exposure.
- Symptoms span four clusters: at least one intrusion, one avoidance, two negative alterations in cognition and mood, and two arousal or reactivity symptoms.
- Duration must exceed one month with clinically significant distress or impairment, and symptoms cannot be attributable to substances or medical illness.
- Specify with dissociative symptoms, or with delayed expression when full criteria are not met until at least six months after the event.
- A separate developmental criteria set applies to children age six and younger, requiring fewer symptoms and using behavioral anchors.

NEUROBIOLOGY & PHYSIOLOGY

- Amygdala hyperreactivity with reduced ventromedial prefrontal inhibition impairs fear extinction learning and, critically, extinction recall.
- Hippocampal volume reduction correlates with symptom severity and degrades contextual discrimination between genuinely safe and dangerous cues.
- The HPA axis shows low cortisol with enhanced glucocorticoid receptor sensitivity and exaggerated negative feedback, opposite the pattern in depression.
- Noradrenergic hyperactivity originating in the locus coeruleus underlies startle and nightmares and provides the rationale for **prazosin**.
- Twin heritability is roughly 30-40%, and FKBP5 variants interact with childhood adversity to raise risk after adult trauma exposure.
- Chronic PTSD carries elevated rates of cardiovascular disease, metabolic syndrome, autoimmune illness, and later dementia.

PSYCHOLOGICAL MECHANISMS

- Two-factor learning theory: fear is classically conditioned to trauma cues, then avoidance is negatively reinforced and blocks natural extinction.
- Emotional processing theory holds that a fragmented fear structure must be activated and then met with corrective information to change.
- The cognitive model emphasizes stuck points, distorted appraisals of ongoing danger, self-blame, and beliefs assimilated to preserve prior worldview.
- Peritraumatic dissociation, prior trauma, low social support, and poor post-trauma support predict chronicity more strongly than event severity.
- Moral injury, institutional or caregiver betrayal, and guilt often respond better to cognitive approaches than to exposure-only protocols.

DIFFERENTIAL & COMORBIDITY

- Acute stress disorder covers 3 days to 1 month; adjustment disorder covers non-Criterion A stressors or subthreshold responses to trauma.
- Differentiate from panic disorder, OCD intrusions, traumatic brain injury sequelae, and psychotic disorders with true hallucinations.
- Comorbidity is the rule: major depression in about half of patients, alcohol or substance use disorders in 30-50%, and frequent chronic pain.
- Suicide risk is elevated roughly two- to threefold, so assess ideation, means access, and reckless behavior at every clinical contact.
- Screen veterans for TBI, obstructive sleep apnea, and hearing loss, since untreated sleep pathology blunts response to trauma therapy.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- **Sertraline 50-200 mg/day** and **paroxetine 20-60 mg/day** are FDA-approved, and venlafaxine XR 75-225 mg/day has comparable evidence.
- Allow 8-12 weeks at an adequate dose; effect sizes are modest and VA/DoD guidance prefers trauma-focused psychotherapy first-line.
- **Prazosin 1-15 mg at bedtime** reduces trauma-related nightmares in many patients; titrate slowly and monitor orthostatic hypotension.
- Avoid **benzodiazepines**, which impair extinction learning, worsen long-term outcomes, and carry high dependence risk in this population.
- Do not use antipsychotics routinely; adjunctive **risperidone** showed no benefit over placebo in the large VA cooperative study.

PSYCHOTHERAPY

- Trauma-focused therapies are first-line: **prolonged exposure**, **cognitive processing therapy**, and **EMDR**, each across 8-16 sessions.
- **Cognitive processing therapy** addresses stuck points over 12 sessions and can be delivered with or without a written trauma account.
- **Prolonged exposure** combines in vivo and imaginal exposure with post-exposure processing across 8-15 sessions of 60-90 minutes.
- **Written exposure therapy** achieves noninferior outcomes in only five sessions and produces markedly lower dropout rates.
- Trauma-focused **CBT** is the standard for children and adolescents, running 12-16 sessions with structured caregiver participation.

ADJUNCT & SUPPORTIVE

- Administer the **PCL-5** at baseline and every 2-4 weeks; a 10-20 point decrease indicates clinically meaningful improvement.
- Treat sleep directly with **CBT-I** and imagery rehearsal therapy, since residual insomnia and nightmares predict relapse.
- Concurrent treatment of substance use disorder alongside trauma-focused therapy outperforms requiring abstinence before starting.
- Aerobic exercise, trauma-sensitive yoga, and mindfulness lower hyperarousal but do not substitute for trauma-focused psychotherapy.
- **MDMA-assisted therapy** is not FDA-approved; the 2024 application drew a complete response letter and further trials are ongoing.

CLINICAL PEARLS

- Benzodiazepines block extinction learning; they make PTSD worse, not better.
- Prazosin at bedtime for nightmares; titrate slowly and check orthostatic vitals.
- Trauma-focused psychotherapy beats medication; lead with PE, CPT, or EMDR.

References

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NOTE

References are formatted in APA 7th edition style with hanging indents. Diagnostic terminology, criteria structure, and coding follow the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; APA, 2022); criteria are paraphrased for instructional use and are not reproduced verbatim. Verify all citations against the original sources before use in academic work, and confirm medication dosing against current prescribing information.